STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145453	A. Building B. Wing	03/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace of McHenry Rehab	803 Royal Drive McHenry, IL 60050

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. 47552 Based on observation, interview, and record review the facility failed to provide residents with coffee between meals per resident preferences. This applies to 4 of 4 residents (R31, R5, R110, R111) reviewed for choices in the sample of 50. The findings include: On 3/24/25 at 10:40 AM, R110 said a group of residents on the 500/600 units have had concerns about receiving coffee between meals per their preference. R110 said himself, R31, R5, R111, and a few others would get to the dining room early before meals, sit around tables together and converse or play games while drinking coffee. R110 said for a few months, the kitchen stopped bringing coffee up until just before meal time, resulting in these residents no longer getting together before meals. On 3/24/25 at 1:58 PM, R111 corroborated the concerns brought up by R110 that coffee is not served between meals when requested. On 3/25/25 at 9:15 AM, R31 said when the facility stopped serving coffee between meals, R31's family bought and provided R31 with a single serving coffee maker for in R31's room. R31 said the facility notified R31 and R31's family that the single serving coffee maker was not allowed in resident rooms due to safety concerns and R31's coffee maker was returned to R31's family. R31 said having coffee in the dining rooms early before meals was how R31 would socialize with other residents and since removing it, R31 believes R31's social care has diminished. On 3/26/25 at 12:08 PM, R5 also expressed having concerns with not getting coffee between meals per preference. During the course of this survey, activities staff were seen in the dining room on the 600 unit between breakfast and lunch and after lunch on 3/24/25, 3/25/25, and 3/26/25. Coffee was not available in the dining room during those times. On 3/26/25 at 11:41 AM, V24 (Activities Director) said he takes the resident council meeting minutes for the residents during the monthly meetings. V24 said starting approximately three months ago, about five residents have brought up concerns about not receiving coffee between meals. V24 relayed these concerns to V1 (Administrator) but V24 said V24 is not aware of the status of these concerns. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/25/25 at 12:58 PM, V1 said in order to provide coffee between meals, V1 would need to have staff available to monitor residents with hot liquids in order to prevent burns. V1 said there are scheduled activities available between meals (breakfast and lunch as well as lunch and dinner) on the 600 unit where activities staff are present. V1 also said V1 is working with the activity department in providing and making a coffee social activity that other units already have available. February 2025 resident council minutes states, . Dining Services (including snacks): Residents expressed that they would like to have coffee available all day in the dining room. February 2025 and March 2025 activities staff schedules were reviewed showing activities staff were/are scheduled to be on the 600 unit for activities every day. On 3/26/25 at 11:41 AM, V24 said a U denotes an employee is scheduled to be on the 600 unit. On 3/26/25 at 11:41 AM, V24 said there is always an activity assistant upstairs in the 600 dining room for activities which usually includes a morning and evening activity aide. V24 said V1 and V24 have not discussed having a coffee hour activity added to the activities schedule, but V24 believes that the residents could benefit from one being added.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to provide privacy during personal care for two of two residents (R60, R85) reviewed for privacy in the sample of 50. The findings include: 1. R60's Admission Record dated March 24, 2025 shows she was admitted to the facility on [DATE] with diagnoses including heart failure, vascular dementia, and history of falling. On March 24, 2025 at 10:17 AM, V9 CNA (Certified Nursing Assistant) provided personal care for R60. R60 was laying on her back in her bed. R60 had two roommates. One of R60's roommates was sitting in her wheelchair facing R60's bed. The privacy curtain was half pulled. V9 performed incontinence care to R60 exposing R60's front peri area. R60's private areas were visible to R60's roommate and R60's roommate glanced over at V9 and R60 multiple times. On March 25, 2025 at 9:28 AM, V13 (R60's daughter/power of attorney) said, I would hope that they are keeping it private when they are changing [R60's] incontinence brief or cleaning her up. 2. R85's Admission Record dated March 25, 2025 shows she was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, acute and chronic respiratory failure, dysphagia, neuromuscular dysfunction of bladder, bipolar disorder, depression, anxiety, and history of falling. On March 24, 2025 at 10:38 AM, V9 and V10 CNA (Certified Nursing Assistant) were in R85's room emptying her urinary drainage bag. V9 wiped R85's front peri area and R85's buttocks. There was a small open area on R85's buttocks so V10 went into the hall to get R85's nurse. R85's bedroom door was left open while R85 was laying on her right side facing the door while it was open. V3 ADON (Assistant Director of Nursing) entered R85's room to assess R85's buttocks. R85's door was still open and the hallway was visible from R85's bed. V10 walked into R85's room and left R85's door open while he retrieved gloves from R85's bathroom. V3 cleaned R85's buttocks wound and placed a dressing on it while the door was open. On March 25, 2025 at 2:31 PM, V2 DON (Director of Nursing) said staff should shut residents' doors and pull the curtains to provide privacy for residents during cares. The facility's Resident Rights Policy for People in Long-term Care Facilities dated October 2014 shows, Your medical and personal care are private.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. 34314 Based on observation, interview and record review the facility failed to keep a resident free from physical abuse. This applies to 4 of 31 residents (R32, R92, R105, R80) reviewed for abuse in the sample of 50. The findings include: R32, R92, R105 & R80 all reside in a locked memory care unit. 1. R32's face sheet lists her diagnoses to include: dementia, delirium, mood disorder & unspecified psychosis not due to a substance or known physiological condition. On March 24, 2025 at 11:05 AM, R32 was upset and yelling. I had a slice of cabbage for supper, it's bullsh*t, call the police! I want a walker and a decent meal! On March 25, 2025 at 10:04 AM, R32 was upset and yelling in the dining room. I want a cup of coffee and want the hell out of here now! I want these people out, this is my house! R32's progress notes dated January 19, 2025 shows, Overheard another resident telling R32 That isn't your coffee and this RN (Registered Nurse) observed her trying to take someone else's coffee and then hit his arm while I was on the way to intervene . The facility did not provide an abuse investigation, incident report or any other documentation about R32's incident of January 19, 2025. On March 26, 2025 at 12:44 PM, V4 RN stated, she was the nurse that documented R32's progress note on January 19, 2025. She believes the other resident was R92. I think the other resident was (R92). They were in the TV room. I saw (R32) swat (R92) (moved her hand in a swat motion) to get out of here. She did hit his arm, like a little swat. R32's care plan (no date) shows, Focus: (R32) is receiving antidepressant psychotropic medication sertraline for a diagnosis for dx of dementia with agitation. Resident as a hx (history) of displaying aggressive behaviors and crying. Resident is receiving antianxiety psychotropic medication busiprone with dx of dementia with agitation and alprazolam with dx of anxiety disorder with observed behaviors of screaming out and displaying aggressive behaviors. In addition, resident has a hx of sitting near the entrance screaming to call for a taxi wanting to go to (Shop Name) shop, the bank, go to town, and call her (Insurance Agency) agent. (R32) prefers to have her wallet on her at all times or she will start to scream asking for 'help'. (R32) will started to scream and scream 'help' when she does not have her shoes that she likes on. (R32) gets upset when she wants 'to go home and these people are in her house'. R92's face sheet lists his diagnoses to include: Alzheimer's disease, dementia, anxiety disorder, schizoaffective disorder & unspecified psychosis not due to a substance or known physiological condition. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R92's care plan (no date) shows, Focus: (R92) is at risk for abuse related to :has a dx of severe mental illness and/or dementia. R92's electronic medical record (EMR) did not show anything about this incident with R32. 2. R32's progress notes dated December 22, 2024 shows, Resident seen hitting another resident's arm and calling her names. The facility did not provide an abuse investigation, incident report or any other documentation about R32's incident of December 22, 2024. On March 26, 2025 at 12:44 PM, V4 RN stated, she was the nurse that documented R32's incident on December 22, 2024. The incident was a long time ago and she couldn't remember 100% who the resident was but thought it was R105. R32 likes to swat people if they get to close to her and will tell them to get out of here. She thinks it was an activity aide that reported it to her but she couldn't remember. She just documented what was reported to her. R105's EMR or care plan didn't show any documentation regarding this incident. 3. R105's face sheet lists her diagnoses to include: Alzheimer's disease, dementia, mood disorder, & anxiety disorder. R105's progress notes dated January 16, 2025 shows, Resident seen in a physical altercation with another resident. R80's progress notes dated January 19, 2025 shows, Resident seen in a physical altercation with another resident . On March 26, 2025 at 1:12 PM, V18 Licensed Practical Nurse (LPN) stated, she was the nurse who documented R105's progress note on January 19, 2025. She remembered R105 was in the TV room after dinner waiting to go to bed. She heard a commotion in there. R105 grabbed onto R80. R105 is a grabber. R80's face sheet lists her diagnoses to include: bipolar disorder, major depressive disorder, dementia, alcohol dependence & unspecified psychosis not due to a substance or known physiological condition. R105's care plan does not show any aggressive behaviors, grabbing or risk for abuse. R80's care plan (no date) shows, Focus: (R80) is at risk for abuse related to: diagnosis of dementia.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 34314 Based on interview and record review the facility failed to follow it's own abuse policy. This applies to 4 of 31 residents (R32, R92, R105, R80) reviewed for abuse in the sample of 50. The findings include: On December 22, 2025, R32's progress notes show R32 hit R105. On January 16, 2025, R105's progress notes show R105 had a physical altercation with R80. On January 19, 2025, R32's progress notes show R32 hit R92. The facility did not provide an abuse investigation, incident report or any other documentation regarding any of the incidents. On March 26, 2025 at 1:38 PM, V1 (Administrator) stated, he didn't have any abuse investigations for the past four months. The facility's abuse policy dated September 2020 shows, Policy: This facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. The facility will report reasonable suspicion of crime. This facility therefore prohibits mistreatment, neglect or abuse of its residents and has attempted to establish a resident sensitive and resident secure environment. The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents Definitions: The following definitions are based on federal and state laws, regulations and interpretive guidelines. Abuse means any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means in a facility. Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Willful means the individual acted deliberately, not that the individual must have intended the injury or harm Physical Abuse: includes hitting, slapping, pinching, kicking and controlling behavior through corporal punishment 4. Identification: Employees are required to immediately report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator 6. Investigation: a. Appoint an investigator. Once an allegation has been made, the administrator or designee will investigate the allegation and obtain a copy of any documentation related to the incident

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 34314 Based on interview and record review the facility failed to ensure staff identified and reported allegations of physical abuse to the administrator. This applies to 4 of 31 residents (R32, R92, R105 R80) reviewed for abuse reporting in the sample of 50. The findings include: On December 22, 2025, R32's progress notes show R32 hit R105. On January 16, 2025, R105's progress notes show R105 had a physical altercation with R80. On January 19, 2025, R32's progress notes show R32 hit R92. The facility did not provide an abuse investigation, incident report or any other documentation regarding any of the incidents. On March 26, 2025 at 12:44 PM, V4 Registered Nurse (RN) stated, she wasn't sure if she reported the incidents or not (December 22, 2024 and January 19, 2025). On March 26, 2025 at 1:18 PM, V18 Licensed Practical Nurse (LPN) stated, she did report the incident to both V1 (Administrator) and V2 (Director of Nursing). On March 26, 2025 at 1:38 PM, V1 (Administrator) stated, he did not have any abuse investigations for the past four months. Sometimes what they see and what they document isn't always the same. On March 27, 2025 at 10:22 AM, V1 (Administrator) clarified, the incidents were reported to him as behaviors and not as a physical exchange therefore he did not take them as abuse allegations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. 34314 Based on interview and record review the facility failed to investigate allegations of physical abuse. This applies to 4 of 31 residents (R32, R92, R105, R80) reviewed for abuse investgations in the sample of 50. The findings include: On December 22, 2025, R32's progress notes show R32 hit R105. On January 16, 2025, R105's progress notes show R105 had a physical altercation with R80. On January 19, 2025, R32's progress notes show R32 hit R92. The facility did not provide an abuse investigation, incident report or any other documentation regarding any of the incidents. On March 26, 2025 at 1:38 PM, V1 (Administrator) stated, he did not have any abuse investigations for the past four months. Sometimes what they see and what they document isn't always the same. On March 27, 2025 at 10:22 AM, V1 (Administrator) clarified, the incidents were reported to him as behaviors and not as a physical exchange therefore he did not take them as abuse allegations.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to provide ADL (Activities of Daily Living) assistance for one of three residents (R60) that are dependent on staff for ADL care in the sample of 50. The findings include: R60's Admission Record dated March 24, 2025 shows she was admitted to the facility on [DATE] with diagnoses including heart failure, vascular dementia, and history of falling. R60's Care Plan initiated June 8, 2019 shows she has an ADL self care performance deficit due to diagnoses of dementia. Interventions include assist with ADL care tasks as needed, assist with toileting needs as necessary. R60's Care Plan initiated August 23, 2019 shows R60 experiences frequent bladder incontinence due to diagnosis of dementia, Check residents for incontinence. On March 24, 2025 at 10:17 AM, V9 CNA (Certified Nursing Assistant) provided incontinence care to R60. V9 removed R60's incontinence brief. R60's incontinence brief was saturated with dark urine and had some stool in it. The incontinence pad that R60 was laying on was also wet. V9 said R60's incontinence brief was last changed at about 6:30 AM. On March 25, 2025 at 2:31 PM, V2 DON (Director of Nursing) said incontinence care should be done every two hours and as needed. The facility Morning Care policy dated September 2020 shows, Morning care is provided to the residents to refresh, provide cleanliness, comfort and neatness, to prepare resident for the day and for meal, to assess her/his condition and needs, to promote psychosocial well-being, and to maintain and improve quality of life.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47552 Based on observation, interview, and record review the facility failed to ensure residents received treatments, care, and services in accordance with professional standards for 3 of 31 residents (R91, R88, R62) reviewed for quality of care in the sample of 50. The findings include: 1. On 3/25/25 at 8:57 AM, R91 said he had been having loose stools for approximately 9 days. On 3/26/25 at 11:02 AM, V2 (Director of Nursing) said R91 had been seen by the physician the week prior and again on 3/26/25. On 3/26/25 at 10:52 AM, V22 (Registered Nurse/RN) said R91 has been having some loose stools and R91 received an order for loperamide (a medication to help with loose stools). R91's physician progress note dated 3/18/25 performed by V27 (Nurse Practitioner) states resident had complaints of diarrhea for a few days. V27 recommended to give R91 loperamide as needed for relief and to also hold R91's stool softener. R91's Order Summary Report dated 3/25/25 shows an order for Loperamide HCl (Hydrochloride) with a start date of 3/24/25. R91's Order Summary Report also shows R91 receives docusate sodium (stool softener) for bowel management and polyethylene glycol (laxative) for constipation. R91's March 2025 Medication Administration Record (MAR) shows R91's first received dose of loperamide HCl was on 3/25/25. R91's March MAR also shows R91 continued to receive doses of polyethylene glycol until the morning of 3/26/25 when it was put on hold. R91 also continued to receive docusate sodium, which was never put on hold per R91's March MAR. On 3/26/25 at 12:56 PM, V2 said when a provider makes recommendations, the provider will usually put the order into the system and the the nursing staff will just confirm it in the system for the order to go into effect. 34314 2. On March 24, 2025 at 11:00 AM, R88 was sitting in the dining room. Her right arm is in a sling. Her right thumb nail was extremely long (about an inch, inch an half long past the fingertip). It appeared to be popping off and black and hard underneath. The nail was only connected to the nail bed by a little bit. On March 25, 2025 at 12:08 PM, R88 was sitting up in the dining room. Her right arm was in a sling. Her right thumb nail was still long and appeared the same as the day before. On March 25, 2025 at 1:34 PM, V21 Registered Nurse (RN) stated, wound care was following R88 for her right thumb nail. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R88's skin/wound progress notes dated February 2, 2025 shows, right nail avulsion, healed. R88's electronic medical records (EMR) did not show anything else about R88's right thumb nail. On March 26, 2025 at 10:47 AM, V6 Wound Care Nurse stated, he has never seen R88's nail since he has been the wound care nurse. He just found out about it yesterday (March 25, 2025). He confirmed the nail was really long and hanging part way off. It's going to snag on something, just needs to come off. No one reported anything to me about it. R88's skin/wound progress notes dated March 25, 2025 shows, Right thumb nail: R thumb nail noted to be pulling loose from the nail bed. Cleansed with NSS (normal saline solution) and bandaid applied to prevent nail from pulling off further R88's care plan (no date) shows, Focus: R88 has potential for alteration in skin integrity related to: Impaired cognition, decreased mobility, urine, and bowel incontinence. Interventions: Inspect skin daily with care, trim nails frequently to prevent any further skin tears The facility's prevention and treatment of pressure injury and other skin alterations dated March 2, 2021 shows, Policy: 2. Identify the presence of pressure injuries and/or other skin alterations. 3. Implement preventative measure and appropriate treatment modalities for pressure injuries and/or skin alterations thorough individualized resident care plan. Procedure: .8. At least daily, staff should remain alert for potential changes in the skin condition during resident care 34506 3. R62's Admission Record dated March 24, 2025 shows she was admitted to the facility on [DATE] with diagnoses including sepsis, chronic systolic congestive heart failure, anemia, severe protein-calorie malnutrition, heart disease, cardiomyopathy, and hypertensive heart and chronic kidney disease with heart failure. R62's Order Summary Report dated March 24, 2025 shows an order to obtain weekly weights. Inform cardio (cardiology) nurse practitioner of weight gain of five pounds or more in one week every Wednesday ordered on March 2, 2025. R62's Weights and Vitals Summary dated January 1, 2025-March 31, 2025 shows R62 was weighed on January 2, 2025, January 28, 2025, February 13, 2025, February 23, 2025, and March 3, 2025. R62 should have been weighed on March 5, 2025, March 12, 2025, March 19, 2025, and March 26, 2025. R62's MDS (Minimum Data Set) dated February 2, 2025 shows R62 does not have a history of refusing cares. The facility's Weights Policy dated September 2020 shows, Residents will be weighted to establish baseline weights and identify trends of weight loss or weight gain.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 35119 Based on observation, interview, and record review the facility failed to ensure pressure reducing interventions were in place for a resident at risk for pressure for 1 of 3 residents (R108) reviewed for pressure in the sample of 50. The findings include: On 3/24/25 at 9:48 AM, R108 was in bed with a pillow under her right side. R108's heels were flat on the bed. On 3/25/25 at 10:14 AM, V6 (Wound Nurse) said R108 has a stage 4 pressure injury to her sacrum that was first found on 1/10/24. V6 said R108 has pressure reducing interventions in place such as a low air loss mattress, dietary supplements, and frequent turning and repositioning. V6 said R108 does not have an order for padded heel boots. V6 said the facility follows orders for treatment and interventions from the Wound Doctor. On 3/25/25 at 12:30 PM, R108 was flat on her back in bed sleeping. R108's heels were flat on the mattress, not offloaded with pillows or heel boots. R108's Wound Doctor Progress Noted dated 3/18/25 shows R108 has a stage 4 pressure injury to her sacrum and shows Plan of Care- Avoid bony prominences under direct pressure, Heels offloaded with heel protectors or pillow. R108's Care Plan shows R108 has actual alteration in skin integrity and is at risk for further skin breakdown related to impaired cognition, decreased mobility, and urine and bowel incontinence. Off load boney prominences throughout every shift.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace of McHenry Rehab	803 Royal Drive McHenry, IL 60050

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35119 Based on observation ,interview and record review the facility failed to monitor and implement interventions for a resident with a contracture for 1 of 1 residents (R42) reviewed for contractures in the sample of 50. The findings include: On 3/24/25 at 10:01 AM, R42 was in bed waiting for breakfast. R42's left hand was contracted with her fingers flat on the palm of her hand. R42 said her hand is contracted from a stroke. R42 used her right hand and was able to straiten her fingers out some (formed a C with her hand). R42 said they sometimes put a washcloth in her palm but only when she asks. V17 (Certified Nursing Assistant) came in to answer R42's call light and said she was not aware of any splint or brace for R42's hand. On 3/25/25 at 12:30 PM, R42 was up in her wheelchair at the bedside waiting for lunch. R42's fingers on her left hand were contracted and flat on the palm of her hand. On 3/25/25 at 2:11 PM, V15 (Restorative Licensed Practical Nurse) said R42 was seen by therapy some time ago with no recommendations that she was aware of. R42 said the Nurse Practitioner would monitor R42 for decline of her contracture. V15 said the restorative quarterly assess only charts if there is a splint or not, there is not an assessment of the contracture. V15 said if there was an order for a splint, she would assess it. On 3/26/25 at 10:48 AM, V15 said R42 has never had a splint and there is no doctor's order for a splint. V15 said there is no documentation regarding R42's contracture and it is not Care Planned. R42's Occupational Therapy Discharge Summary dated 6/27/23 shows Recommendation given to restorative nurse to order a splint for left hand. Discharge Recommendations: Functional Maintenance Program/ Restorative Nursing Program (RNP)- To facilitate patient maintaining current level of performance and in order to prevent decline, development of and instruction in the following RNPs had been completed with the Interdisciplinary Team: Active Range of Motion and splint or brace care. R42's most recent quarterly Restorative Nursing assessment dated [DATE] shows under adaptive activities of daily living equipment used, splint or brace is not marked. R42's Care Plan shows a diagnosis of hemiplegia and hemiparesis following a cerebral infarction affecting left non-dominant side and shows R42 has an activity of daily living self care performance deficit related to past medical history of cerebral vascular accident, left hip pain related to fall, left hand contracture. There is no other documentation of R42's left hand contracture and there are no interventions listed.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview and record review the facility failed to implement fall interventions for residents who are at risk for falling for 3 of 4 residents (R27, R105 and R403) reviewed for safety in the sample of 50. The findings include: 1. R403's Face Sheet shows that he admitted to the facility on [DATE] with diagnoses of: nondisplaced intertrochanteric fracture of right femur and history of falling. R403's current Care Plan shows that R403 is at risk for falls due to diagnosis of history of falling with interventions to include: assure resident is wearing eyeglasses, encourage appropriate use of wheelchair, promote placement of call light with in reach, provide an environment clear of clutter and provide proper, well maintained footwear. On 3/24/25 at 1:10 PM, R403 was self propelling down the hallway in his wheel chair. R403 had regular socks on. R403 propelled himself into his room. R403 was observed pushing up from his wheelchair trying to stand on his own. At 1:17 PM, V28 and V29, Certified Nursing Assistants (CNAs) transferred R403 to bed. R403 had a fall mat under his bed. V28 and V29 exited the room and did not move the fall mat to the side of R403's bed. At 2:11 PM, R403 was still laying in bed with the fall mat under his bed. R403's legs were hanging off of the side of the bed. R403 said that he was trying to get up to use the restroom. On 3/25/25 at 1:10 PM, V29 said that R403 has a fall mat because he is at really high risk for falling and the mat should be placed next to his bed if he is in bed. V29 said that R403 frequently tries to get out of bed on his own to get into his chair but R403 is unable to transfer himself. On 3/25/25 at 10:26 AM, V15 (Restorative Nurse) said that R403 is at risk for falls. V15 said that R403 had a fall at home that resulted in a fracture before coming to the facility. V15 said fall interventions that are currently in place for R403 to prevent future falls include: call light within reach, room free of clutter, eye glasses on and appropriate footwear. V15 said that appropriate footwear would include non-skid socks or shoes. V15 said that regular socks would not be appropriate foot wear because they do not provide grip and could contribute to falls. On 3/26/25 at 10:46 AM, V15 said that fall mats are used to help prevent injuries if a resident falls out of bed. V15 said that she was not aware that R403 frequently tries to get out of bed on his own but is she did, she most likely would have implemented fall mats on the side of his bed to try and prevent injuries. R403's Nursing Notes dated 3/18/25 shows, Patient is alert and oriented to self able to make needs known. Noted to be forgetful .He requires substantial/maximal with ADLs (Activities of Daily Living) . R403's Nursing Notes dated 3/21/25 at 3:21 AM shows, Resident in bed awake alert and very confused with occasional yelling trying to get out of bed. Hard to redirect at this time. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R403's Nursing Notes dated 3/24/25 at 10:11 AM shows, [R403] is A/O (alert and oriented) x 1 forgetful, resident is very high risk for fall, he attempting to get up from the bed often without assist. The facility's Fall Management Program dated 8/2020 shows, The facility is committed to minimizing resident falls and/or injury .it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventive strategies and facilitate a safe environment Plan of care reviewed and updated at time of occurrence, quarterly and as needed in order to minimize risk for fall incidents. 34314 2. On March 24, 2025 at the noon meal, R105 was sitting up in her wheelchair in the dining room eating lunch. Her wheelchair did not have anti-tippers on it. On March 25, 2025 at 10:04 AM, R105 was sitting up in her wheelchair in the dining room doing activities. Her wheelchair did not have anti-tippers on it. R105's incident report dated January 22, 2025 shows, Resident was in the dining room. This writer and the other NOD (nurse on duty) suddenly heard a loud sound then found the resident on the floor holding the back of her head On March 25, 2025 at 1:34 PM, V21 (Registered Nurse) stated, she was the nurse working when R105 fell on [DATE]. R105 tipped her wheelchair backwards and hit her head on the floor. She is supposed to have anti-tippers on her wheelchair. She confirmed that R105's wheelchair did not have anti-tippers on it and should. R105's care plan (no date) shows, Focus: R105 is at risk for falls due to dx (diagnosis) of history of falls. Interventions: anti-tip to wheelchair . 34506 3. R27's Admission Record dated March 24, 2025 shows she was admitted to the facility on [DATE] with diagnoses including vascular dementia, protein calorie malnutrition, major depressive disorder, anorexia, and depression. R27's Fall Risk assessment dated [DATE] shows she is at risk for falls. R27's Care Plan initiated December 29, 2021 shows R27 is at risk for falls related to dementia, low back pain, lack of coordination, depressive disorders, weakness, altered mental status, and cognitive communication deficit. Encourage resident to call, don't fall and promote placement of call light with in reach. On March 25, 2025 at 2:31 PM, V2 DON (Director of Nursing) said fall prevention interventions are patient centered. Interventions include call don't fall, education for the residents on calling for help by using the call light. V2 said call lights should be positioned where residents can reach them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 24, 2025 at 10:03 AM, R27 was laying in her bed. There was a dry erase board that was above R27's head of the bed. Make sure call light is in reach. R27's call light string was attached to a small teddy bear. The teddy bear was on the floor behind R27's head of bed. R27's call light was not within R27's reach. The facility's Fall Management Program policy dated August 2020 shows, The facility is committed to minimizing resident falls and/or injury so as to maximize each resident's physical, mental and psychosocial well-being. While preventing all resident falls is not possible, it is the facility's policy to act in a proactive manner to identify and assess those residents at risk for falls, plan for preventative strategies and facilitate a safe environment.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to maintain an urinary drainage bag below the level of a resident's bladder for one of one resident (R85) reviewed for catheters in the sample of 50. The findings include: R85's Admission Records dated March 25, 2025 shows she was admitted to the facility on [DATE] with diagnoses including Parkinson's Disease, neuromuscular dysfunction of bladder, bipolar disorder, anxiety disorder, urinary retention, and history of falling. R85's Care Plan intitiated on December 6, 2023 shows, [R85] requires the use of an indwelling catheter. Catheter care per orders and position the collection bag below the level of the bladder. On March 24, 2025 at 10:38 AM, R85 was in bed laying on her back. R85 had a urinary drainage device. There was amber colored urine in the tubing of R85's urinary drainage device. V9 CNA and V10 CNA (Certified Nursing Assistants) prepared R85 to get out of bed via mechanical lift. V9 lifted R85's urinary drainage bag above the level of her bladder to place the bag in between R85's legs as R85 was still laying in bed. V9 then lifted the urinary drainage bag above the level of R85's bladder again to put the bag into R85's pants. On March 25, 2025 at 2:31 PM, V2 DON (Director of Nursing) said urinary drainage bags should be kept below the level of the resident's bladder.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview and record review the facility failed to ensure nutrional supplements were provided as ordered for residents with a history of a significant weight loss and failed to ensure weekly weights were obtained on a newly admitted resident. This applies to 4 of 4 residents (R18, R73, R140 and R148) reiviewed for nutrition in the sample of 50. The findings include: 1. R140's Face Sheet shows that she admitted to the facility on [DATE]. R140's Weights and Vitals Summary printed on 3/25/25 shows that R140 weighed 100 pounds (lbs) on 2/10/25. The summary shows that R140's weights as follows: 2/11-100 lbs, 2/12-100 lbs, 2/18-100 lbs, 3/5-95 lbs and 3/12-95.5 lbs. No additional weight were recorded. No weights were recorded for the week of 2/24/25. R140's Registered Dietitian Note dated 3/11/25 shows, Weight is 95 lb (5% loss x 1 mo (month), undesired, . below weight for age po (oral) intake variable aware of her weight, weight loss, agreeable to fortified pudding bid (twice a day) .discussed in IDT (Interdisciplinary Team Meeting) meeting, adding fortified pudding bid to aid weight regain; weekly wts (weights) in progress. REC-fortified pudding bid . R140's Physician's Order Sheet shows an order dated 3/18/25 for, Fortified pudding two times a day for nutritional supplement. Give with lunch and dinner. On 3/24/25 at 12:56 PM, R140 was eating the noon meal in her room. R140 did not have any pudding on her tray. On 3/25/25 at 1:00 PM, R140 was eating the noon meal in her room. R140 did not have any pudding on her tray. On 3/26/25 at 11:40 AM, V14 (Dietitian) said that she evaluates residents if they have had a significant weight change. V14 said that when she recommends a nutritional supplement, she places the order into the computer system. V14 said that the recommendation is discussed with nursing and nursing will get the recommendation approved by the physician. V14 said that once the order is approvied by the physician, nursing fills out a blue diet change form and sends it to the dietary department. V14 said that the dietary department then adds the order to the resident's meal ticket. V14 said that the dietary department should follow the nutritional orders on the meal ticket and would expect resident's to receive their nutritional supplements as ordered. V14 said that newly admitted residents should get their weights done once a week for four weeks to identify any trends of weight gain or loss. V14 said that she spoke with R140 on 3/11/25 regarding her weight loss and discussed interventions with her that could be added to mitigate her weight loss and gain back the weight that she had lost. V14 said that R140 was agreeable to fortified pudding twice a day with lunch and dinner. R140's Meal Ticket was printed on 3/25/25. The meal ticket does not show that R140 is supposed to get fortified pudding with lunch and dinner. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Weights Policy dated 9/2020 shows, A baseline weight will be established upon admission. The resident will be weighed weekly for 4 weeks after admission and monthly thereafter .Dietary supplements may be required to enhance the resident's nutritional status. The licensed nursing staff will advise the Food and Nutrition Services Department, through a Diet Order Form, physician order for a Dietary Supplement . Food based Dietary Supplements are delivered to the nursing station at the appropriate times by dietary personnel. 35119 2. On 3/24/25 at 11:05 AM, R73 was propelling his wheelchair in the hall. R73's left and right leg were amputated below the knee. R73 said he just got back from his doctor appointment about his right leg amputation. R73 stated I don't want to lose any more weight. I had to get new clothes, none of mine fit me. I was 149 pounds and now I'm down to 128. I eat, I don't want to lose any more weight. I talked to nurse and she is going to talk to the doctor and get me a shake, but I'm not sure if they did that yet. I'm not sure if I talked to dietitian or not. On 3/25/25 at 12:15 PM, R73 was sitting at the dining room eating lunch. R73 was served the noon meal of chicken, potato wedges and peas and milk. R73 asked for soup and was given the potato soup. There was no mighty shake provided on R73's tray or during the course of the meal. R73's diet card on his tray showed, 4 fluid ounce carton mighty shake no sugar added, any flavor at lunch. R73's admission weight on 3/1/25 shows 134 pounds. R73's weight on 3/11/25 shows 125.6 pounds, and the most recent weight on 3/22/25 was 127.5 pounds. R73's Nutrition Progress noted dated 3/11/2025 shows: no concentrated sweet/regular texture, mighty shake no sugar added at lunch, pro T gold (protein supplement) 30ml/day oral intakes 51-100% weight at 125.6 lb (6.3% loss x 1 week) weight loss may be related to increased nutrient needs for healing continue to monitor. On 3/26/25 at 11:47 AM, V14 (Dietitian) said it is the expectation that the dietary recommendations/orders should be followed for weight loss interventions. V14 said it is important, nutritionally speaking, to get the supplements every day as ordered. V14 said she was seeing R73 for significant weight loss and had added supplements due to his increased calorie need for wound healing. V14 said she added the a mighty shake at lunch for R73 on 3/1/25 for added nutrition. R73's Physician Orders shows and order dated 2/28/25 Mighty shake no sugar added in the afternoon for nutritional supplement GIVE WITH LUNCH. R73's Care Plan dated 3/3/25 shows R73 is noted with a weight loss and to provide supplements per order. The facility's Dietary Supplement Policy dated 1/18 shows Dietary supplements may be required to enhance the resident's nutritional status. 34314 (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R148's face sheet lists his diagnoses to include: Alzheimer's disease, dementia, diabetes mellitus type 2, benign prostatic hyperplasia and hypertension. He was admitted to the facility on [DATE]. R148's weight on February 22, 2025 (on admission) was 178.4 lbs (pounds). On March 14, 2025 he weighed 166.0 lbs (down 12.4 lbs in 27 days). R148's comprehensive nutritional assessment/reassessment dated [DATE] shows, R148 is 77 yo (year old) M (male) admitted to facility from hospitalization dx (diagnosis)- gross hematuria (blood in urine) weakness generalized weakness, Alzheimer's disease, acute cystitis (bladder infection) with hematuria recent COVID per hospital RD (registered dietitian) nutrition documentation. 2/19/25 poor po (poor by mouth), undesired 9% wt loss x 1 mo (month), 9.5% wt loss x 3 mo, 11.8% loss x 6 mo <75% energy consumption >D hx wt loss meds reviewed altered skin integrity upon admission MNA screen complete-met criteria/indicators for malnutrition-wt loss, <75% est energy requirement relayed to IDT (interdisplinary team) with adding ORA (oral) nutrition supplement, add mighty shake BID (twice per day) R148's order summary report printed on March 25, 2025 shows, mighty shake no sugar added two times a day for nutritional supplement, give with lunch and dinner. On March 24, 2025 at the noon meal, R148 was sitting up in the dining room eating lunch. His meal tray had the noon meal and nothing else on his tray. He did not have a mighty shake. On March 26, 2025 V14 Dietitian stated, R148 had a potential risk for weight loss so she recommended the health shake (mighty shake). It is important that residents get their recommendations everyday like she recommends. R148's care plan initiated on March 6, 2025 shows, Focus: R148 requires nutritional support. R148 is on the following diet: No concentrated sweets (NCS), No added salt (NAS) diet regular texture, thin liquids consistency. Interventions: Mighty shake no sugar added two times a day for nutritional supplement give with lunch and dinner. Provide supplements as ordered. 4. R18's face sheet list his diagnoses to include: Alzheimer's disease, emphysema, dementia, chronic obstructive pulmonary disease, alcohol induced pancreatitis, chronic atrial fibrillation, duodenal ulcer, major depressive disorder, gastro-esophageal reflux disease and benign prostatic hyperplasia. R18's weight on January 6, 2025 was 137.9 lbs. His weight on March 3, 2025 was 129.2 lbs (down 8.7 lbs in approximately two months). R18's nutrition progress note dated March 13, 2025 shows, RD note. mechanical soft thin liquids (upgraded on 3/4/25) double portions at breakfast, fortified pudding BID, fortified potatoes BID, fortified cereal (double portions) at B (breakfast), magic cup BID po intakes improving per staff endorsed ~51-100% po intakes. weight at 129.2 lb (10.6 % loss x 6 mo), bmi (body mass index) 22.2 wnl (within normal limits) wt for ht, weight stable x past month- nutrition supplements increased last month, po intakes improving On March 25, 2025 at the noon meal, R18 did not have fortified pudding. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R18's order summary report printed out on March 25, 2025 shows, fortified pudding two times a day for nutritional supplement give with lunch and dinner. On March 26, 2025 at 11:40 AM, V14 (Dietitian) stated, he should be getting all of his supplements with every meal as ordered. R18's care plan (no date) shows, Focus: R18 is noted with weight loss. 3/3/25- 10.0% change (comparison weight 9/9/24, 144.5 lbs, -10.6%, -15.3 lbs). Interventions: Provide supplements per order.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 35119 Based on observation, interview, and records review the facility failed to implement interventions to an excoriated gastrostomy tube (G-tube) for 1 of 2 residents (R2) reviewed for G-tubes in the sample of 50. The findings include: On 3/24/25 at 10:39 AM, R2 was in bed with a tube feeding pump connected to her G-tube. V17 (Certified Nursing Assistant) lifted R2's gown to show this surveyor R2's G-tube site on her abdomen. R2 did not have a dressing around the entrance of the G-tube. There was noticeable red excoriation on R2's skin around the bottom of the G-tube extending out approximately 1.5 inches in width and 2.5 inches in length. V17 said she would let the nurse know about the redness. On 3/25/25 at 10:17 AM, V6 (Wound Nurse) said the nurse had him look at R2's G-tube site yesterday. V6 said R2 had some red excoriation around the site and he got an order for zinc oxide and a drain sponge dressing. V6 said he was not aware of any skin issues to R2's site prior to yesterday. On 3/25/25 at 1:54 PM, V16 Registered Nurse (RN) said is a skin issue is found the nurse makes a skin progress note and lets the doctor and wound nurse know and get orders for treatment. R2's Treatment Administration Record shows enteral feeding order every night shift cleanse feeding tube insertion site daily and as needed with normal saline leave open to air. This orders shows signed off as completed on night shift of 3/23/25 (the previous night shift) with no documentation of skin breakdown. R2's Care Plan shows monitor stoma site. Record the size, color, presence/absence of skin breakdown, presence/absence of infection. R2's Progress Note dated 2/7/25 shows G-tube site- surrounding tissue is pinkish. No drainage noted. There is no documentation that the doctor or wound nurse was notified and no treatment orders shown implemented. The facility's Enteral Feeding Tube (site care) Policy dated 9/2020 shows Purpose: to decrease potential for irritation, excoriation, infection or discomfort at the tube insertion site.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47552 Based on interview and record review the facility failed to ensure medications were ordered before running out resulting in a missed medication administration. This applies to 1 of 31 residents (R5) reviewed for medications in the sample of 50. The findings include: R5's Facesheet dated 3/26/25 shows R5 has diagnoses that include, but are not limited to, diabetes mellitus type two, systolic (congestive) heart failure, hypertensive heart disease with heart failure, and cardiomyopathy. On 3/26/25 at 12:08 PM, R5 said R5 receives an expensive heart medication for R5's diagnoses of heart failure and heart disease. R5 said there were a few occasions that the facility did not have the medication on hand and R5 missed doses of the heart medication. R5's Order Summary Report dated 3/26/25 shows R5 receives Sacubitril-Valsartan for hypertensive heart disease with heart failure with a start date of 9/9/24. R5's December 2024 Medication Administration Record (MAR) shows R5 did not receive the 9:00 PM dose for Sacubitril-Valsartan on 12/8/24. R5's Orders Note for eMAR (electronic MAR) dated 12/8/24 states the medication was not available. R5's January 2025 Medication Administration Record (MAR) shows R5 did not receive the 9:00 PM dose for Sacubitril-Valsartan on 1/19/25. R5's Orders Note for eMAR (electronic MAR) dated 1/19/25 states the medication was not available. On 3/26/25 at 12:48 PM, V2 (Director of Nursing) said V2 was not aware that R5 had missed doses of R5's heart medication. The process for ordering more medications is through the electronic medical records system and more medications should be ordered before they run out. V2 said medications usually can be received the same day or the next day. On 3/26/25 at 1:36 PM, V23 (Physician) said the facility notified V23 of the missed medications at the time they occurred. V23 also said R5 should not have missed the dosage, but missing a single dosage would cause no harm to R5.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Terrace of McHenry Rehab	803 Royal Drive McHenry, IL 60050

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 35178 Based on observation, interview, and record review the facility failed to ensure R30 and R97 received their medication on time for 2 of 4 residents reviewed for medication errors in the sample of 50. The findings include: The facility CMS-671 exit date 3/26/25 shows, a Medication Error Rate of 6.67 percent. On 03/24/25 at 10:01AM, V5 (Registered Nurse) was at the 400 Hall medication cart. Five residents were displayed on the EMAR-Electronic Medication Administration Record including R97 and R30 with a red background. V5 RN closed the computer and locked the medication cart. On 03/24/25 at 10:01 AM, V5 RN said, the medications are late. I will call the residents' doctors to let them know. On 03/24/25 at 10:07AM, V5 RN returned to the medication cart and said, the doctors gave me permission to pass the medications late. 1. R97's EMAR dated March 2025 shows, multiple diagnoses including psychosis, psychotic disturbances. On 03/24/25 at 10:07AM, V5 RN provided R97 with her 9:00AM, Physician Ordered medications: quetiapine 50mg (milligrams) by mouth, sertraline 50mg by mouth, and a multivitamin by mouth. The pills were crushed and placed in apple sauce. R97's EMAR dated March 2025 shows, administer Quetiapine fumarate 50mg give one tablet by mouth two times a day for psychosis at 9:00AM, and 5:00PM. 2. R30's Medication Administration Record dated March 2025 shows, multiple diagnoses including Chronic Respiratory Failure with Hypercapnia, Malignant Neoplasm of Unspecified part of Unspecified Bronchus or lung. Cough Variant Asthma, Chronic Obstructive Pulmonary disease, Acute and Chronic Respiratory Failure with Hypoxia. On 03/24/25 at 10:15AM, V5 RN provided R30 with 9:00AM, physician ordered medications that included, aspirin 81mg, cranberry 500mg, Digoxin 125micrograms, escitalopram 10mg, iron 325mg, losartan 25mg, metoprolol 100mg, guaifenesin, multi-vitamin, vitamin D3, omeprazole, oxybutynin, calcium, risaquad, fluticasone-umeclidinium-vilanterol inhaler. R30's Medication Administration Record dated March 2025 shows, administer guaifenesin extended release give one tablet by mouth every 12 hours for congestion at 9:00AM, and 9:00PM. 3. On 03/24/25 at 10:15AM, R30 was lying in bed waiting for her medications. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/25 at 9:50AM, R30 ambulated independently with a rolling walker and a portable oxygen concentrator from the smoking area on the far southeast side of the facility, 40 feet through the dining area, 100 feet through the tunnel, 150 feet down the hall, 200 feet around the nurses station to the elevator, and an additional 70 feet from the elevator to the second floor dining table to attend the resident counsel surveyor meeting. R30 had labored rapid breathing with use of accessory muscles, breathing improved with rest. On 03/25/25 at 10:30AM, R30 said, I would like to keep my fluticasone-umeclidinium-vilanterol inhailer at bedside. I really need that one to get my lungs working in the morning. I am not concerned about the other medications. If I had it at bedside, I could take it before I got up and got dressed. I know my medications and need them to ensure I can breathe well enough to get up and get moving. On 03/25/25 at 10:33AM, R126 said, medication pass has improved. At one time our medications were always late. R30 interjected, Yes, we were getting our 9:00AM medications at 2:00PM. That is a long time to wait. On 03/26/25 at 12:15PM, R30 said, the guaifenesin keeps mucus from forming in the base of my throat. If I do not take it the mucus builds up and I have difficulty breathing. The facility's Medication Administration policy dated 09/2020 shows, drugs must be administered in accordance with the written orders of the attending physician.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on interview and record review the facility failed to ensure a discrepancy with a resident's psychotropic medication was reconciled with a physician upon re-admission after a hospitalization for hypertension for 1 of 31 residents (R137) reviewed for significant medication errors in the sample of 50. This failure resulted in R137 not receiving depakote, which was previously prescribed for aggressive behaviors, to display aggressive behaviors towards another resident and subsequently be sent out to the hospital for an evaluation. The findings include: R137's Face Sheet shows that he admitted to the facility on [DATE] with diagnoses of: depression, anxiety, history of traumatic brain injury and history of suicidal behavior. R137's Psychiatric Nurse Practitioner Note dated 10/9/24 shows, Nursing and staff report moods labile with sarcastic passive aggressive comments at times .He endorses a history of becoming angry and threatening people, states you don't want to piss me off; admits to recent feelings of anger with moods up and down at times .I recommend to continue his current medication regimen and start depakote 125 mg (milligrams) bid (twice a day). R137's Psychiatric Nurse Practitioner Note dated 12/11/24 shows, He feels that his moods are generally stable, but he still gets angry more frequently than he believes he should, especially regarding his roommate when they turn on the lights during the night or early morning. An increased dose of depakote to 250 mg p.o (by mouth) twice daily was discussed and patient is agreeable to this change. R137's Psychiatric Nurse Practitioner Note dated 2/19/25 shows, Mood and behaviors at baseline. Currently on depakote 250 mg twice daily, which was increased 12/11/24 due to anger management issues, and patient tolerating the dose well. Continue current psychiatric medication regimen including depakote. R137's Hospital After Visit Summary shows that he was admitted to the hospital from 3/17/25-3/19/25 for hypertension. R137's After Visit Summary does not show that R137 should stop taking depakote nor does it say to start taking depakote. R137's March Medication Administration Record (MAR) shows that he received depakote 125 mg - two tablets twice a day until 3/17/25. R137 March MAR does not document that he received depakote upon re-admission on 3/19/25 to 3/26/25. R137's Administration Note dated 3/25/25 shows, On 3/24/25 at approximately 9:30 AM [R137] stated to this writer that he was very unhappy with his roommate. During the conversation [R137] verbalized signs of aggression involving his roommate. He stated, If my roommate is still here tonight I'm going to kill him.he was sent to the hospital for a psych evaluation. On 3/26/25 at 1:25 PM, R137 said that he does not recall the hospital changing or discontinuing his depakote when he was admitted to the hospital for his high blood pressure. (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	On 3/26/25 at 1:30 PM, V23 (Physician) said that once a resident re-admits from the hospital, the nurse from the hospital and the nurse from the facility should go over all ordered medications and compare them to their previous medications and if there is a discrepancy, they should discuss the reason for the discrepancy and if they can not figure out why a certain medication is not re-ordered, they should contact the physician or nurse practitioner to get the discrepancy clarified. V23 said, Especially if it is an important medication like this one.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 35119 Based on observation, interview, and record review the facility failed to ensure dietary preferences were served for 2 of 3 residents (R142, R91) reviewed for preferences in the sample of 50. The findings include: 1. On 03/24/25 at 10:54 AM, R142 was in his room sitting at the bedside. R142 said he has a tube feeding and he can eat, but they serve him puree and he doesn't want it. R142 said there are a few things that he likes to eat and he had told them but they rarely bring them. R142 said he likes soup and apple juice. On 03/24/25 at 12:20 PM in the 400 hall dining room dietary staff was filling resident meal trays. R142's dietary ticket showed puree, general, thin liquid. SEND EVERY MEAL PER PREFERENCE soup broth or creamy soup (such as tomato soup), apple juice, ice cream, pudding and oatmeal. Standing orders: 4 fluid ounce Apple Juice 3.25 fluid ounce Assorted Pudding- Any flavor 6 fluid ounce Chicken Broth 1/2 cup Ice Cream-any flavor. On 03/24/25 at 12:35 PM, R142's tray was delivered to his room. There was no soup, ice cream, pudding, or apple juice observed. R142 was served pureed vegetables, meat, mashed potatoes, and pureed fruit. R142 stated I have to ask for apple juice. They are supposed to get me 2, but always short me. Everyday this happens. Now if I get oatmeal there is no brown sugar. Once in awhile I will get broth. I would eat soup, I like creamy soup. I give up asking, it never happens. On 03/24/25 at 12:47 PM, V25 (Dietary Manager) said that the soup for the lunch meal was pureed for the residents on a pureed diet. On 03/25/25 at 10:52 AM, V25 said when a new resident comes he does a food preference interview and gives it to the dietitian who puts it on the dietary cared. V25 said residents should receive their preferences with what the card says. R142's Physician Orders dated 2/24/25 shows General diet pureed texture, thin liquids consistency, GIVE APPLE JUICE AND CHICKEN BROTH WITH ALL MEALS SEND STANDARD PUDDING AND ICE CREAM LUNCH AND DINNER. R142's Care Plan shows R142 requires nutritional support. GIVE APPLE JUICE AND CHICKEN BROTH WITH ALL MEALS SEND STANDARD PUDDING AND ICE CREAM LUNCH AND DINNER. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	47552 2. On 3/25/25 at 8:27 AM, R91 was heard from the hallway yelling at nursing staff that the kitchen forgot R91's double portion of scrambled eggs for breakfast. R91 then told this surveyor that he is supposed to receive double portion scrambled eggs every morning and the kitchen staff frequently get this and other meal requests wrong on a daily basis. R91 said he does not like pancakes, French toast, or waffles. R91's breakfast that was received on 3/25/25 included one slice of French toast, one sausage patty, one carton of milk, and a bowl of cold cereal. R91 received the double portion of scrambled eggs at 8:32 AM after complaining to nursing staff about the error. On 3/26/25 at 8:39 AM, R91 said he only received a single portion of scrambled eggs this morning for breakfast, but R91 did not receive milk with the breakfast tray. R91 had already eaten the scrambled eggs before this surveyor entered the room. R91's breakfast meal ticket dated 3/25/25 shows R91 is supposed to receive a double portion of scrambled eggs every breakfast and 8 fl oz (fluid ounces) of milk. On 3/26/25 at 12:05 PM, V14 (Registered Dietitian) said R91 has been on a weight loss plan and has successfully lost a large amount of weight. V14 said due to the weight loss, the purpose of the double portion of eggs and milk are to help maintain R91's current muscle mass. V14 said the eggs and milk were R91's preferred dietary interventions to incorporate more protein into R91's diet.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to change gloves and perform hand hygiene in a manner to prevent cross contamination for four of six residents (R60, R85, R27, R62) reviewed for infection control in the sample of 50. The findings include: 1. R60's Admission Record dated March 24, 2025 shows she was admitted to the facility on [DATE] with diagnoses including heart failure, vascular dementia, and history of falling. R60's Care Plan initiated June 8, 2019 shows she has an ADL self care performance deficit due to diagnoses of dementia. Interventions include assist with ADL care tasks as needed, assist with toileting needs as necessary. R60's Care Plan initiated August 23, 2019 shows R60 experiences frequent bladder incontinence due to diagnosis of dementia, check residents for incontinence. On March 24, 2025 at 10:17 AM, V9 CNA (Certified Nursing Assistant) went into R60's room to perform incontinence care to R60. R60 was laying in her bed. V9 folded R60 incontinence brief from the front in between R60's legs while R60 was laying on her back. R60's incontinence brief was saturated with dark yellow urine. V9 wiped R60's front peri area then touched R60's body to help her to turn onto her right side. There was stool noted in R60's incontinence brief and R60's buttocks. V9 wiped the stool from R60's buttocks. There was visible stool to V9's gloves. V9 took a wet wipe and wiped the stool from her soiled glove, then place a new brief under R60, a new incontinence pad, and assisted R60 to lay back onto her back. V9 then touched R60's sheets, pillow, and bed controls. V9 did not change her gloves or perform hand hygiene while she provided incontinence care to R60. 2. R85's Admission Record dated March 25, 2025 shows she was admitted to the facility on [DATE] with diagnoses including Parkinson's disease, acute and chronic respiratory failure, dysphagia, neuromuscular dysfunction of bladder, bipolar disorder, depression, anxiety, and history of falling. On March 24, 2025 at 10:38 AM, V9 and V10 CNAs provided peri care to R85 while she was laying in bed. V9 wiped R85's front peri area, helped R85 to turn onto her right side, then wiped the stool smear from R85's buttocks. V9 then took R85 urinary drainage bag and placed it into R85's pants. V9 did not change her gloves or perform hand hygiene. 3. R27's Admission Record dated March 24, 2025 shows she was admitted to the facility on [DATE] with diagnoses including vascular dementia, protein calorie malnutrition, major depressive disorder, anorexia, and depression. On March 24, 2025 at 10:03 AM, V8 CNA (Certified Nursing Assistant) provided incontinence care for R27. V8 folded R27 incontinence brief down in between her legs while she was laying on her back. V8 wiped R27's front peri area, then grabbed a clean brief, helped R27 turn onto her side, wiped her buttocks, placed the clean brief and flayed R27 back onto her back. V8 did not change her gloves or perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R62's Admission Record dated March 24, 2025 shows she was admitted to the facility on [DATE] with diagnoses including sepsis, chronic systolic congestive heart failure, anemia, severe protein-calorie malnutrition, heart disease, cardiomyopathy, and hypertensive heart and chronic kidney disease with heart failure. On March 24, 2025 at 9:47 AM, V8 CNA performed incontinence care to R62. R62 was laying on her back. V8 folded R62's soiled incontinence in between her legs while she was laying on her back. V8 wiped R62's front peri area, then touched R62's body to help her turn onto her right side, wiped R62's buttocks. There was a stool smear in R62's buttocks. V8 then got a clean incontinence brief and helped R62 to turn back onto her back. V8 then touched R62's drawers. V8 did not change her gloves or perform hand hygiene. On March 25, 2025 at 2:31 PM, V2 DON (Director of Nursing) said gloves should be changed and hand hygiene should be performed when staff switch from dirty to clean items. The facility's Infection Prevention and Control Manual dated 2023 shows, [NAME] clean gloves between tasks and procedures on the same resident after contact with blood, body fluids, secretions, excretions. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. Perform hand hygiene after the removal gloves.