STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145563	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Saint Anne Place	4405 Highcrest Road Rockford, IL 61107

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure residents dependant on staff for cares was treated in a dignified manner, and failed to care for a female resident with facial hair for 3 of 3 residents (R232, R332, R54) reviewed for dignity in sample of 59. The findings include: 1. R232's face sheet documents she was admitted to the facility on [DATE] with multiple diagnoses including a chronic non-pressure wound to her right lower leg. The treatment record shows a skin tear to the right hand with a dressing change three times a week, and a surgical incision to the left upper arm with a daily dressing change. All treatments are scheduled for the night shift. R232's admission assessment and care screening of 5/28/25 shows her to be cognitively intact. The same assessment shows she requires supervision or touch assistance with transfers to the toilet and sit to stand movements. On 6/05/25 at 11:48 AM, R232 said he biggest concerns was the nurses doing dressing changes in the middle of the night. She said her pain medication was scheduled every 8 hours around her therapy and it was given at 2-2:30 AM. But they do not just bring in the pain medication, they turn on the lights and do the bandage changes too. She said all she needs is the pain medication. The bandages should be changed at 9:30 - 10:00 PM, before going to sleep. She said it takes about 20 minutes to get the whole procedure done, then have to try and get back to sleep. R232 also said the waiting time for the call lights seems to be at least 30 minutes. They seem to be short staffed, but she needed help to get up to the bathroom. On 6/5/25 at 9:25 AM, V10 Registered Nurse (RN) said all of the dressing changes are scheduled on the night shift. But the staff should not be just going in to wake up residents just for a dressing change. She said it should be done closer to early morning. She said she tries not to wake anyone up for anything except a scheduled medication. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/05/25 at 9:05 AM, R232 said the call light times were not any better. She put on her call light at 5:00 AM today, and someone finally came in at 5:50 AM. When the aide came in, she stated she had 22 other rooms to try and cover. R232 said she had to use the bathroom so bad she started dribbling, and needed to get cleaned up. She reported having a care conference on 6/4/25 and she voiced her complaints with the call lights not being answered and the dressing changes getting done in the middle of the night. She said the issue was to be resolved, then at midnight last night the nurse came in and turned the lights on and changed the bandages. R232 was sitting up in her wheelchair visibly upset with her situation. On 6/5/25 at 10:53 AM, V8 Social Service Assistant said she attended R232's care plan meeting on 6/4/25, and recalls the concens with call lights and the timing of her dressing changes. She said those issues should have been addressed. The 11/2024 facility policy for resident rights documents 2. Residents are entitled to exercise their personal and legal rights and privileges to the fullest extent possible. 3. Our ministry will make every effort to assist the resident in exercising his/her rights and to assure that the resident is always treated with respect, kindness and dignity. 2. R332's face sheet showed she was admitted to the facility 5/29/25 with diagnoses to hyperkalemia, hyperlipidemia, sleep apnea, essential hypertension, and muscle weakness. R332's care plan initiated 5/29/25 showed, [R332] needs assistance with ADL (activities of daily living) care . [R332] will have daily care needs met . On 6/03/25 at 11:09 AM, R332 said she had made a complaint to a staff member. R332 said her main problem is that her call light is not answered timely and often takes an hour or more. R332 said one day she was in her room and had her call light for a long time. R332 said two aides walked past her room pushing someone in a wheelchair. R332 said she called out to the hall and told the aides my call light is on. R332 said the aides responded to her by saying Yeah, we can't help you and they walked away. R332 said she felt like a non-person because she depends on the aides. R332 said no one was checking on her. On 6/05/25 at 2:18 PM, V2 DON (Director of Nursing) said it is not appropriate to tell residents they can not help them. V2 said she would have at least expected the staff to see what she needed and communicate with her regarding when they will be back to assist her. The facility's policy and procedure with last approval date of 01/2024 showed, Quality of Life - Dignity . Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Policy Interpretation and Implementation Residents shall be treated with dignity and respect at all times . Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self worth . 3. R54's electronic face sheet printed on 6/5/25 showed R54 has diagnoses including but not limited to generalized anxiety disorder, depression, hypertensive chronic kidney disease, and urinary tract infection. R54's facility assessment showed R54 is dependent on staff for personal hygiene. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/3/25, R54 had 2 dime-sized patches of facial hair on her chin. The hair was dark and curling under her chin. R54 was unable to keep on task with questions regarding her facial hair during interview. On 6/4/25 at 11:28AM, V26 (R54's daughter) stated, My Mom would be mortified if she had all that chin hair. She always kept it shaved and definitely wouldn't want anyone seeing her with patches of chin hair. I don't know why she would even have that because she has an electric razor in her room that I bought her so all they have to do is give it to her and have her do it by herself. On 6/5/25 at 2:25PM, V2 (Director of Nursing) stated, No female resident should have long patches of chin hair on their face unless that is their preference. (R54) may not have had hers shaved because she refuses showers and that would be the time when staff deal with facial hair. They could do it in between the shower days though if they see that it needs to be addressed. I agree this is a dignity issue because if her daughter says she wouldn't like it then we need to be sure we are addressing it. The facility's policy titled, Quality of Life-Dignity dated 12/2021 showed, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. A. Residents shall be treated with dignity and respect at all times. B. Treated with Dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth .

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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** The facility failed to assess and obtain treatment orders for a resident (R86) with two skin tears. This applies to 1 of 2 residents reviewed for non-pressure skin conditions in the sample of 59. The findings include: R86's electronic face sheet printed on 6/5/25 showed R86 has diagnoses including but not limited to congestive heart failure, severe protein-calorie malnutrition, pressure ulcer of sacral region, stage 4, and pressure ulcer of left lower back, stage 2. R86's facility assessment dated [DATE] showed R86 has no cognitive impairment. R86's May 2025 and June 2025 physician's orders showed no orders for R86's skin tears to his left arm. On 6/4/25 at 8:39AM, R86 had 2 patches on his left arm, one on his lower arm and one on his upper arm. R86 stated, I have been waiting for them to change my dressings. I think it happened about a week ago when they were in here taking care of me. I don't really remember the exact scenario but there are 2 skin tears on my arm. On 6/5/25 at 1:17PM V3 (Registered Nurse) stated When a resident obtains a skin tear, we immediately clean the area, assess it, and typically we will put steri-strips on it and then notify the physician and obtain treatment orders. Once the orders are received, we enter them into the resident's orders, and it would go on their treatment record so we can be sure we treat the area until it is healed. (R86) has 2 dressings on his left arm where he has skin tears. I have no idea what's under those dressings or how they even look because he hasn't let us take them off. There are no orders in his chart for any treatment and there is no assessment that I can see so I'm not sure how big they are. On 6/5/25 at 1:22PM, V2 (Director of Nursing) stated, When a resident obtains a skin tear the nurse will clean and dress the wound, perform an assessment, and enter it into the computer system. Once that is completed, they will notify the resident's physician for treatment orders and enter it into the orders so that the nurses can continue treatment. There would be no reason not to do any of this because it is a skin alteration which is something we track until it is resolved. If (R86's) wounds are not treated, they could worsen or become infected. The facility's policy titled, Procedure: Skin Tears-Abrasions and Minor Breaks, Care of dated 01/2024 showed The purpose of this procedure is to guide the prevention and treatment of abrasions, skin tears, and minor breaks in the skin .A. Obtain a physician's order as needed. Document physician notification in medical record .D. Generate Non-Pressure form and complete .A .A skin tear is the disruption of epidermis resulting in lifting or friction of the skin .O. Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress, and wound stage .

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. R117's face sheet documents she was admitted to the facility on [DATE] with multiple diagnoses including the presence of a stage 3 pressure ulcer to the left buttock, a stage 4 pressure ulcer to the left lower back, stage 3 pressure ulcer to the sacral region, and stage 3 pressure ulcers to the right upper back and left lower back. On 6/4/25 at 10:25 AM, R117 was lying in her bed with an air mattress, and she was positioned onto her right side with pillows. The skin evaluation forms were requested and reviewed and show the first pressure ulcer assessments were completed on 5/8/25. On 6/5/25 at 9:24 AM, V10 RN, said when a resident is admitted with pressure injuries it is the responsibility of the admitting nurse to perform wound assessments and document them in the wound sheets. She said this should be done on the day of admission. After the initial assessment the resident is placed on wound rounds and will be seen by the wound physician and V6. She said the initial assessment should include the measurements of each wound, and the wound bed description. Based on observation, interview, and record review the facility failed to identify pressure injuries for a resident at risk for pressure ulcers, failed to identify pressure wounds prior to becoming advanced stages, failed to perform an initial wound assessment for a resident with a new pressure ulcer, failed to perform weekly assessments on pressure wounds, and failed to implement treatments upon identification of pressure wounds for 4 of 11 residents (R28, R3, R86, and R117) reviewed for pressure ulcers in the sample of 59. This failure resulted in R28's pressure wound not being treated for 26 days after it was identified and deteriorated to a stage 4 and resulted in R3's pressure wounds not being identified until they progressed to stage 3 and stage 4, and this failure also resulted in R86's sacral pressure wound not being assessed between December 2024 and March 2025 at which time it had progressed to a stage 4. The findings include: 1. R28's face sheet showed he was admitted to the facility 9/21/22 with diagnoses to include anemia, hypertension, atrial fibrillation, primary osteoarthritis of left knee, primary osteoarthritis of left hip, and pressure ulcer of right ankle. R28's care plan initiated 10/3/22 showed, Risk for impaired skin integrity due to incontinence and decreased functional mobility . Approaches: . Daily skin inspection; report any changes in skin or signs of possible skin breakdown or redness . Nutritional support based on assessment and MD (physician) orders . R28's care plan initiated 5/21/25 showed, Pressure Ulcers/Skin Prevention . [R28] has a stage 4 pressure wound to sacrum. Factor complicating wound healing include impaired mobility and occasional incontinence . R28's Dietary Note entered 3/27/25 by V4 (Registered Dietitian) showed, Patient with pressure wound to coccyx . To promote skin health, additionally this writer recommends Active Liquid Protein 60ml/daily. This will provide 200 calories and 30 grams of protein . R28's medical record showed no evidence of R28 receiving the Active Liquid Protein supplement. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R28's Wound Assessment Report dated 2/15/25 showed, Date wound identified: 2/15/25 . Wound Location: sacrum; tunneling wound . Present Upon admission: No . Measurements: Length 0.5 cm, Width 0.6 cm, Depth 1.0 cm . Physician Notified: Yes Treatments: Pending treatment orders . This assessment showed no classification of R28's sacral wound. R28's medical record showed no evidence of wound assessments completed for his sacral wound between 2/15/25 and 3/13/25. R28's February 2025 eTAR (electronic Treatment Administration Record) showed no treatments for R28's wound. R28's March eTAR showed an order initiated on 3/13/25 for Hydrocolloid Dressing to Coccyx . for Open wound . (26 days after the wound was identified). R28's Skin Evaluation Form for his coccyx wound dated 3/13/25 showed, . Origin Date: 3/13/25 . Treatment: Hydrocolloid patch to coccyx . Tunneling wound to coccyx . Length 2.0 cm, Width 0.1 cm Depth 1.0 cm . Smooth undermining Sinus Tract: 1 cm . Resident noted to have reopened wound to his coccyx Area cleaned and covered with a hydrocolloid dressing until wound physician can assess. R28's Wound Physician Initial Wound Evaluation dated 3/25/25 showed, . Stage 4 Pressure Wound, Sacrum, Full Thickness . Duration: greater than 60 days . Wound size 2.0 x 0.4 x 0.9 . On 6/05/25 at 12:13 PM, V6 (Wound Care Nurse) said R28's coccyx wound was changed to a sacral wound after it was reassessed. V6 said the floor nurses do the initial wound assessments when the wound is identified on a skin evaluation form. V6 said the wound started out as MASD (moisture associated skin damage) and was real wet and nasty. V6 said the wound opened up then into pressure. V6 said she has a skin assessment for R28 dated 2/26/25 showing no existing skin issues. V6 then said she found a wound evaluation in the electronic record showing a wound assessment from 2/15/25 confirming the wound was present. V6 confirmed the assessment dated [DATE] was a wound assessment. V6 said no further assessments were documented until 3/13/25. V6 said she follows pressure wounds, vascular wounds, diabetic wounds, and arterial wounds but anything surgical, skin tears, MASD the floor nurses follow weekly. On 6/05/25 at 2:31 PM, V2 DON (Director of Nursing) said when the nurses think they see a pressure injury they are supposed to let the Wound Champion (V6) know. V6 would then go evaluate, put treatment orders in place and put him on the list to see V7. V2 said treatments should be initiated as soon as possible for the quickest possible healing for the resident. V2 said assessment of wounds is important to see if the wound has made progress, if the treatment is working, or if something needs to be changed. The nurses are supposed to be doing a skin assessment weekly and documenting the changes. On 6/05/25 at 8:50 AM, V7 (Wound Physician) said he has been seeing R28 for about a month now. V7 said he believes R28's wound was a stage 4 when he started following him. V7 said they should be discovering wounds when they are a stage 1 or 2.V7 said high protein supplements for wound healing and offloading are the two most important measures for pressure ulcer prevention and healing. 2. R3's face sheet showed she was admitted to the facility 10/10/24 with diagnoses to include muscle weakness, moderate protein calorie malnutrition, anemia, hypothyroidism, major depressive disorder, delusional disorder, anxiety disorder, and rheumatoid arthritis. R3's facility assessment dated [DATE] showed she has severe cognitive deficit and is dependent upon staff for all cares. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R3's care plan initiated 5/23/25 showed, Pressure Ulcers/Skin Prevention . [R3] will maintain skin integrity without new skin related injuries over the next review period . Observe skin for redness and breakdown during routine care . Follow community skin care protocol . [R3] has impaired skin integrity, has a stage 4 pressure ulcer on sacrum, stage 3 pressure ulcer on left heel, stage 4 pressure ulcer on right heel, stage 4 pressure ulcer to right, upper, lateral shin .provide supplements to promote healing as ordered by physician . R3's medical record showed she was present in the facility from 10/10/24 through 2/23/25. R3's Wound Assessment Report dated 12/19/24 showed, . Date wound identified 12/19/24 . Wound Location: Right Heel; Left outer heel . Assessment Occasion: New Wound . Stage: Unstageable due to slough/eschar . Measurements Length 2.4 cm x Width 3.0 cm . Pain with wound/treatment: Yes . Pain Intensity: Moaning, grimacing . Wound Bed: Eschar 100%. R3's medical record showed she was present in the facility from 4/2/25 through 4/19/25. R3's Skin Evaluation Form dated 4/17/25 showed, . Origin Date: 4/17/25 . Category: Full Thickness Wound . Type: Pressure Injury . Description: Stage 3 Pressure Injury of Right Upper Lateral Shin . Cause: Pressure . Size: Length 1.5 cm x Width 0.3 cm x Depth 0.3 cm . R3's Wound Physician Evaluation dated 4/17/25 showed, . Stage 3 Pressure Wound of the Right, Upper, Lateral Shin, Full Thickness . 1.5 cm x 0.3 cm x 0.3 cm . Duration: greater than 2 days . On 6/05/25 at 12:26 PM, V6 (Wound Care Nurse) said a skin check is done on admission and they put all the same wounds in all over again. V6 said R3 had an immobilizer in place at one time to her right leg from some fractures. V6 said she is not sure where the pressure wound came from to R3's shin. V6 said it could have been the immobilizer but she couldn't say for sure. V6 said the wound was facility acquired on 4/17/25. V6 said she expects new areas to be brought to her through the wound module in addition to notification to the unit manager or herself. On 6/5/25 at 8:50 AM, V7 (Wound Physician) said R3's wound on her right shin was caused by her being in a cast or immobilizer after a fracture. V7 said when they took the immobilizer off there was that wound. V7 said if there was an immobilizer in place covering the leg he would not be looking under that during his rounds. The facility's policy and procedure with revision date of 07/2024 showed, Pressure Injury Assessment/Treatment . Purpose: The purpose of this procedure is to provide guidelines for a consistent method of identification of and for the initial care of identified pressure injuries, alterations in skin integrity, and the prevention of acquiring additional pressure injuries . General Guidelines . Skin risk and general skin assessment is to be completed upon admission and then weekly times 4 weeks. Basic skin assessment is to be completed on residents weekly and as needed . 3. R86's electronic face sheet printed on 6/5/25 showed R86 has diagnoses including but not limited to congestive heart failure, severe protein-calorie malnutrition, pressure ulcer of sacral region, stage 4, and pressure ulcer of left lower back, stage 2. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R86's facility assessment dated [DATE] showed R86 has no cognitive impairment and has a stage 2 and stage 3 wound and is at risk for pressure ulcers. R86's wound assessment dated [DATE] showed, Coccyx: irritation/excoriation 1x1x0.5cm(centimeters). Area assessed and is getting better . R86's wound physician assessment dated [DATE] showed, Stage 4 pressure wound of the sacrum, full thickness. Present greater than 30 days, 2.9x1.1x0.7cm, 2.9cm undermining, light serous exudate, 10% slough 70% granulation. Surgical excisional debridement procedure performed during this visit to remove necrotic tissue and establish margins of viable tissue . No wound assessments were present from 12/27/24-3/18/25 for R86's sacral wound. R86's care plan dated 3/19/25 (after initial wound physician visit) showed, (R86) has a stage 4 pressure injury to his sacrum related to noncompliance with repositioning in bed and refusing care. He is also incontinent of bowel. Due to his pressure injury, he is at risk for further deterioration, infection, fluid loss, and pain .float heels in bed, reposition side to side every 1-2 hours . (No pressure ulcer care plan was present for R86 prior to this date) A review of R86's treatment records dated January 2025-February 2025 showed R86's sacral wound treatment was not performed 8 days during the month of January and 4 days during the month of February. R86's skin assessment dated [DATE] showed no new areas of skin concern besides his sacral wound. On 6/4/25 at 8:39AM, R86 stated, I've been sitting like this since 4:30AM and my feet and butt are killing me. (foot of bed elevated and feet turned outward with ankles lying flat and rubbing on bed). I have sores on my butt, I came with one of them, one I think I got here; I'm waiting for them to change my dressings. (R86's right ankle was red and appeared to have a sore on it) They give me a bed bath every few days and wash my whole body because I don't to take a shower. I supposed if there were any sores on my ankles they would have seen them. I can't have my feet elevated because it hurts too much, I've tried everything, and I can't stand it. I wish I had some foam or something on my ankles. the nurse was supposed to put my dressings on my ankle at 4am and she brought the dressings and then left and hasn't been back. On 6/4/25 at 9:24AM, V3 (Registered Nurse) stated, (R86) doesn't have any orders for bandages to his ankles, he has nothing on them so there isn't a reason for a bandage. At 1:10PM (V3) stated, I did look at his ankles and he does have an open area on his right ankle now. That should have been noted during his bed bath or skin checks, but it wasn't. I put some padded dressings on to keep them covered until the wound nurse & doctor see him tomorrow. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 6/5/25 at 8:49AM, V7 (wound physician) stated, Facility acquired wounds should not be identified as stage 3 or 4, they should be identified at stage 1 or 2. (R86) has a new wound to his right ankle that is a stage 2. This should have been identified by staff during cares and his heels should have been elevated. It was resolved for a few weeks and now it is back. I am assuming because his heels are not being elevated. There are different strategies the facility could be using for pressure reduction. Some patients don't like the boots, so you need to be mindful of that, just using a heel protector is not enough, he has a special pillow, and I don't know why they aren't using it, the heels up device is the best for him but he is noncompliant with certain things. He must have something instead of the feet resting on the mattress, plain and simple. I didn't know he was refusing the heels up device otherwise I would have tried something different for him. He is a high risk for skin breakdown due to his noncompliance and lower weight because he doesn't have a lot of fat on him. They should be keeping a very close eye on him. You should not have identified his new wound, that should have been identified by the staff. On 6/5/25 at 2:47PM, V6 (wound champion) stated, I checked in our old charting system and there are not any assessments for (R86's) wound from 12/27/24-3/18/25. It is the responsibility of the floor nurse's to ensure these wound assessments and treatments are being done.

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F 0689 Level of Harm - 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** Based on observation, interview and record review the facility failed to assist a resident at risk for falls with reaching his urinal (R58), and safely transferring a resident with a mechanical lift (R23 and R2). This failure resulted in R58 falling and obtaining a fractured hip and wrist requiring surgery and hospital stay. The applies to three of eleven residents reviewed for safety in the sample of 59. The findings include: 1. The facility face sheet shows R58 was admitted to the facility with diagnoses to include adult failure to thrive, Type 2 Diabetes Mellitus, chronic kidney disease and low back pain. R58's facility assessment dated [DATE] shows he has no cognitive impairment and required maximum assist from staff for standing and toileting. On 6/04/25 at 2:18 PM, R58 said he was standing up at the foot of his bed reaching for his urinal. R58 said his legs gave out and he fell. R58 said he had his call light on because he could not reach his urinal. R58 said after half an hour he tried to do it himself and fell. R58 said he felt his hip break when he fell. R58 said he had to yell for help from the staff. R58 said because he is younger and has his wits about him the staff thinks he is independent. On 6/05/25 at 8:44 AM, V10 Registered Nurse (RN) said she was in the hall passing medications, when she heard someone yelling help me. V10 said she walked up and down the hall trying to find the source of the yelling and heard R58 yell out his room number. V10 said she found R58 on the floor at the foot of his bed near the bathroom door. V10 said she performed an assessment and felt due to the pain level, he probably had a fracture to his hip. V10 said R58's urinal was on the other side of the bed from where R58 had been sitting. V10 said she phoned 911 and R58 was sent to the hospital. On 6/5/25 at 11:22 AM, V9 Unit Manager said she investigates the falls for the facility, but if there is an injury, the Director of Nursing (DON) takes over the investigation. V9 said she did not talk to R58 about his fall, she just copied some papers for the DON. On 6/5/25 at 11:22 AM, V2 DON said during the facility investigation into the fall they determined R58 did not have his call light on. V2 said she believed R58 was in his wheelchair when the fall happened but wasn't sure. V2 said all falls are investigated to find the root cause of the fall so interventions can be put in place. The new interventions for R58 were to keep his personal items within his reach and provide R58 with a reacher/grabber tool. The facility investigation showed R58 was trying to grab something, stood up and fell. A reacher/grabber was to be given to R58 and all personal items needed to be within his reach. The nursing progress note dated 4/21/25 for R58 showed the nurse could hear someone yelling for help and she found R58 on the floor lying on his right side. The nurse (V10) wrote that R58 said he was moving around in his chair and slid out of the wheelchair. R58 said after the fall he rolled onto his other side. R58 said he broke his fall by putting down his left hand so he wouldn't hit his head. The note shows R58 was complaining of pain to his left hip. (continued on next page)

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	145563	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Saint Anne Place	4405 Highcrest Road Rockford, IL 61107

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The fall risk assessment completed on admission dated 3/14/25 shows R58 was a moderate risk for falls. The hospital records dated 4/29/25 shows R58 arrived at the hospital on 4/21/25 with complaints of left hip pain after a fall at the facility. Diagnosis after x-rays showed an acute mildly displaced left hip fracture. Surgery to repair the hip was completed on 4/22/25. An x-ray of R58's left wrist was completed on 4/21/25 and a fracture to his left wrist was also found. The care plan for R58 dated 4/29/25 for falls shows the interventions to have personal items within his reach due to his risk for falls, repeated falls, weakness and malnutrition. The same care plan shows R58 required one staff assistance for toileting. 2. The facility face sheet for R2 shows she was admitted to the facility for diagnoses to include Type 2 Diabetes Mellitus, peripheral vascular disease, muscle weakness and stress incontinence. The facility assessment for R2 dated 5/24/25 shows R2 to be cognitively intact, requires a wheelchair for mobility. The same assessment shows R2 is dependent on staff for toileting. R2's care plan dated 2/25/25 shows a sit to stand mechanical lift is used for transfers. On 6/4/25 at 10:0 AM, R2 said she was being moved in the sit to stand lift from her bed to the bathroom one morning and she slipped out of the lift and fell on the floor. R2 said there were two staff in the room with her and she did not get hurt. R2 said her feet slid and now she is supposed to wear her tennis shoes when she gets up in the lift. R2 said she was wearing her house shoes when the fall happened. On 6/05/25 at 10:16 AM, V19 Certified Nursing Assistant (CNA) said she was pushing R2 in the sit to stand lift to the bathroom from her bed and R2 just slipped out. V19 said R2 was wearing house shoes and R2 never said anything to her before she fell, or after she fell. The written statement given by V19 after the fall shows R2 was strapped onto the lift and was being pushed into the bathroom, when R2 began telling the staff to bring the lift up higher. Then V19 wrote she began to see R2's weight begin to go to one side and R2 kept saying to raise the lift, but the lift was as high as it goes. (V19 denied this conversation with R2 when I spoke with her on the phone.) On 6/05/25 at 11:05 AM, V20 Licensed Practical Nurse (LPN) said she was called to R2's room after her fall. V20 saw R2 on the floor with her arms out of the stand slings and her feet over the leg of the lift. V20 said R2 told her she felt herself slipping and told the staff to raise her up. On 6/5/25 at 11:16 AM, V9 Unit Manager said R2 told her feet just slipped while she was being transported to the bathroom. V9 said R2 was wearing her house shoes. The nursing progress note dated 5/17/25 shows the CNA informed the nurse that R2 had fallen out of the sit to stand lift and was on the floor. The nurse (V20) wrote R2 was found on the floor with both legs in front of her body and on top the legs of the machine. R2 told the nurse she felt herself slipping. (continued on next page)

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	145563	A. Building B. Wing	06/05/2025

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The care plan for R2 dated 5/14/25 for falls shows an intervention to ensure R2 has non-slip footwear at all times. A new intervention was added after the fall on 5/17/25 to ensure R2 has tennis shoes on before using the sit to stand lift. The fall risk assessment for R2 dated 2/16/25 shows a significant risk for falls. The facility fall investigation showed R2 felt herself slipping from the lift because her shoes did not have a good grip. The new intervention put in place was for R2 to wear tennis shoes when using the lift. 3. The facility face sheet shows R23 was admitted to the facility with diagnoses to include congestive heart failure, chronic obstructive pulmonary disease and cerebral infarction. The facility assessment dated [DATE] shows R23 to be cognitively intact and requires substantial assistance from staff for dressing and transfers. The care plan for R23 dated 5/15/25 shows he needs two assist with a gait belt for transfers. On 6/03/25 1:04 PM, R23 was observed with a black left eye. R23 said he hit by the lift when transferring out of bed. At 2:01 PM that same day, R23 said he was connected to the sit to stand lift and as he was being lifted up, he reached for a shirt that was hanging on the lift and as he was falling forward, he hit his head on the bar of the lift. On 6/5/25 at 11:08 AM, V20 LPN, said she was called to the room after being told R23 fell. V20 said she found R23 on his back with his legs crossed. V20 said the CNA told her he was not in the lift yet, but he fell when he reached forward to grab his shirt off the lift. V20 said the CNA said she left R23 sitting on the edge of the bed while she went to his closet to get him some clothes and she saw him lean forward and fall. V20 said R23 had a cut to his left eyebrow area that was beginning to swell, a scrape to his left knee and left ankle. On 6/5/25 at 11:19 AM, V2 DON said she had not interviewed R23 about his fall and was not aware R23 was saying he was already in the lift when he fell. V2 said she was told R23 was reaching for clothes while sitting on the edge of the bed and he fell forward off the bed. The facility investigation shows R23 was being assisted by staff with his morning routine, he reached for his shirt and fell to the floor. A written statement written by the CNA involved from the initial facility investigation shows R23 was sitting on the edge of the bed and the CNA V21 was at the closet getting clothes out, and the resident leaned forward and fell hitting his eye on the lift. The intervention added was to ensure the residents clothes are within his reach when sitting him up for AM care. The facility policy for fall prevention with a revision date of 7/2023 shows to provide an environment that is free from accident hazards, over which there is control, and provide supervision and intervention to residents to prevent avoidable accidents.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure accurate weights were obtained, failed to ensure significant weight loss was identified and reported to the dietitian, and failed to implement dietitian recommendations for 4 of 6 residents (R28, R3, R55, R41) reviewed for nutrition in the sample of 59. This failure resulted in R28 experiencing significant weight loss without the Registered Dietitian being notified. The findings include: 1. R28's face sheet showed he was admitted to the facility 9/21/22 with diagnoses to include anemia, hypertension, atrial fibrillation, primary osteoarthritis of left knee, primary osteoarthritis of left hip, and pressure ulcer of right ankle. R28's care plan initiated 10/3/22 showed, Risk for impaired skin integrity due to incontinence and decreased functional mobility . Approaches: . Nutritional support based on assessment and MD (physician) orders . R28's care plan initiated 9/28/22 showed, [R28] has increased potential for weight changes related to diuretic use . Goal and Target . Intakes to meet needs, Weight remain without significant changes . Medications per MD order . weigh resident per facility protocol. Record results and report any significant change to physician and dietitian . R28's weights were documented as follows: 5/22/25 - 226.4 lbs; 5/23/25 - 227.6 lbs; 5/24/25 - 226.7 lbs; 5/28/25 - 214.0 lbs; 5/29/25 - 214.0. These weight changes represented a significant 5.6 % weight loss from 5/22/25 through 5/28/25. R28's Nutrition Note entered 3/27/25 by V4 showed, Patient with pressure wound to coccyx . additionally, this writer recommends Active Liquid Protein 60 ml/daily. This will provide 200 kcal and 30 grams protein. On 6/05/25 at 9:56 AM, V4 RD (Registered Dietitian) said, They didn't notify me of that change, he is a monthly weight, so we obtain his weight the first shower of the month. I question the weights. It was as of yesterday that I was notified of his weight being 216. When I visibly look at him his chest and abdomen area does seem smaller. I think the readmission weight may have been incorrect because he was in the hospital . He comes out to the dining room to eat and when he first came back he wasn't wanting to eat. He used to eat 100% of his meals and he is telling me he isn't wanting to eat as much now. When they enter a weight, if it is significantly off I think it sends them a notification but I think there may be an issue with how it calculates the changes as 30 day, 60 day, 90 day changes. The nurses monitor the weights and let me know if there are changes. My hope would be after they enter the weight, it would be good practice to then look at their weight history to see if they have had a significant weight change . On 6/05/25 02:29 PM V2 DON (Director of Nursing) said the RD's dietary recommendations would be handed off to the unit manager or the nurse on the floor. The recommendations would be communicated to the Nurse Practitioner and they would give it as order. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	2. R3's facesheet showed she was admitted to the facility 10/10/24 with diagnoses to include muscle weakness, moderate protein calorie malnutrition, anemia, hypothyroidism, major depressive disorder, delusional disorder, anxiety disorder, and rheumatoid arthritis. R3's facility assessment dated [DATE] showed she has severe cognitive deficit and is dependent upon staff for all cares. R3's care plan initiated 5/23/25 showed, Nutritional Status; [R3] has increased nutrient needs related to need for healing as evidenced by history of stage 4 pressure wound to sacrum. Also as increased potential for pressure wounds related to limited mobility. [R3] will have nutritional needs met and will not have an unplanned significant weight change over the next review period . R3's Nutrition Risk assessment dated [DATE] showed, . Current weight: 120 pounds . Nutrition: Increased nutrient needs related to need for healing as evidenced by presence of multiple pressure wounds . Interventions: Diet as ordered . Continued 1:1 assistance at meals. Goals: . weight remain stable. R3's medical record shows the last weight obtained for R3 was 120 pounds on 5/10/25. R3's medical record showed she was discharged to the acute care hospital 5/20/25 and returned as a readmission to the facility 5/23/25. R3's record contained no weights between her return to the facility 5/23/25 and 6/5/25. On 6/05/25 at 10:32 AM, V4 RD (Registered Dietitian) said R3 came back from the hospital 5/23/25 and no weights have been done since her readmission. V4 said R3's record showed a significant weight loss prior to her hospitalization but she feels that the weight that had been entered on 4/2/25 was not accurate. V4 said if a reweigh was done and a weight confirmed her record would show confirmed next to it. V4 said R3's 127 lb weight was not confirmed but R3 usually stays around 120 lbs. V4 said upon admission or readmission the facility policy is to get a weight every day for 3 days, then once weekly for 4 weeks, and if stable they would start doing monthly weights to monitor. V4 said she would have expected them to get readmission weights. V4 reviewed R3's record and said weekly weights were scheduled on the eMAR (electronic Medication Administration Record) but none of them were signed off. V4 said it is important to get readmission weights so she can assess R3 for significant loss. V4 said if she doesn't have those weights she has nothing to compare them to. On 6/05/25 at 2:21 PM, V2 DON (Director of Nursing) said weights are done with the first shower of the month, so they are all in the system by the 7th. V2 said the CNAs are getting the weights and entering them in the system and if they don't enter them sometimes the nurses do. V2 said if there was a significant change the system should flag it and it asks them if they really want to enter it. V2 said she does not know how the Registered Dietitian gets notified of significant weight changes. V2 said V4 (Registered Dietitian) should be looking at the weights at least every month. V2 said if there is anyone that has significant weight loss V4 would be documenting it and talking about it in their meetings. V2 said V4 should be able to print out all the residents weights every month. If there is a reweigh needed V4 will ask us for that. V2 said V4 is the expert with weight loss, she is the one who can give us the input on recommendations. V2 said it is V4's expertise the facility relies on for recommendations for getting supplements in place if needed. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	The facility's policy and procedure with approval date 06/2025 showed, Weight Monitoring . It is the policy of [the facility] that appropriate nutritional care shall be provided to residents who have a significant weight change. A significant weight change is identified as a weight loss or gain of 5.5% in 30 days, 7.5% in 60 days, or 10% in 180 days. Each resident should be weighed daily for the first three days of admission, weekly for the first four weeks, and monthly thereafter . Residents with a weight change of 5 lbs or greater should be reweighed to determine an accurate weight. The accurate weight should be entered in the resident's medical record . The RD should make recommendations for nutritional interventions based on the information obtained from the weekly Resident At Risk Review huddle meetings. RD recommendations should be reviewed and initiated by nursing associates . A nursing or nutrition associate should notify the health care provider of any significant weight change that is unexplainable or in which the RD has requested a nutritional intervention . 4. R55's Face Sheet showed she was admitted to the facility on [DATE] with diagnoses to include Alzheimer's (dementia), a Stage 4 pressure ulcer, and a hip fracture. R55's active order set showed an order for monthly weights, which was ordered on admission. R55's electronic health record (EHR) showed she weighed 154.6 pounds on 2/11/25; 142.8 pounds on 3/23/25; and 132.4 pounds on 4/4/25. R55's EHR showed this was a weight loss of 14.3 percent. R55's electronic health record showed no weight documented following the 4/4/25 weight as of 6/3/25 at 4:00 PM. R55's 5/21/25 progress note from 12:58 PM (Authored by V4, Registered Dietitian) showed: Late Entry for month of May. Resident weight for month of May not documented [in] EMR (electronic medical record). Will assess weight trend when June weight measurement received . On 6/04/25 at 1:44 PM, V15, Registered Nurse, stated monthly weights are done for all residents with the first shower of the month. V15 stated the CNAs (Certified Nursing Assistants) will notify her of the resident's weight, and she will enter the weight in the electronic health record. V15 stated the facility does not document weights in any other location other than the electronic health record. V15 stated R55 does not refuse care. On 6/04/25 at 1:59 PM, V16, Certified Nursing Assistant (CNA), stated CNAs measure residents' weights on their first shower of the month. V16 said the CNA will notify the nurse of the weight. V16 said CNAs can also enter weights into the EHR. V16 said she is R55's CNA, and R55 does not refuse care. On 6/04/25 at 2:21 PM, V4 stated R55 should have been weighed in May 2025 when she had her first shower of the month. V18 said she had noticed the missing weight in May, and per her normal practice, she would have sent a list of residents with either missing weights or weights that needed to be redone. V18 said monthly weights are important so she knows if her interventions are working and if they need to be adjusted to the unit manager. (The facility was requested to weigh R55.) On 6/04/25 at 03:42 PM, V2, Director of Nursing, stated R55's weight was 150 pounds. The facility's Weight Monitoring policy (last approved 6/2025) showed: Each resident should be weighed daily for the first three days of admission, weekly for the first four weeks, and monthly thereafter . (continued on next page)

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Ascension Saint Anne Place	4405 Highcrest Road Rockford, IL 61107

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F 0692 Level of Harm - Actual harm Residents Affected - Few	3. R41's electronic face sheet printed on 6/5/25 showed R41 has diagnoses including but not limited to epilepsy, acute kidney failure, Bipolar Disorder, Alzheimer's Disease, and type 2 diabetes. R41's facility assessment dated [DATE] showed R41 has experienced a weight loss and is not on a physician-prescribed weight-loss regimen. R41's care plan dated 2/25/25 showed, (R41) has increased potential for weight changes related to fluctuating intakes. Has a history of both significant weight gains and losses .(R41) is offered diet and oral nutritional supplement as prescribed, see physician order sheet. R41's Nutrition Risk assessment dated [DATE] showed, Comments/Recommendations: Interventions: Diet as ordered. Recommend Ensure 240ml once daily. This will provide 350kcal and 20g protein . R41's physician's orders for May 2025 and June 2025 showed no orders for R41 to receive a nutritional supplement. On 6/5/25 at 9:40AM, V4 (Registered Dietician) stated, The last time I reviewed (R41's) nutritional status was on May 12th and her weight had stabilized at that point since her previous significant weight loss. She is a picky eater, and I didn't want her weight to go down at all if possible, so I recommended a daily nutritional supplement for her. My recommendations go to the physician or nurse practitioner for each resident to approve. I put the recommendations in their box so they can sign off on it and then nursing enters the orders. I don't see the order for her supplement in her record though so I'm not sure what happened. If there isn't an order, then she won't receive it. The facility's policy titled, Weight Monitoring dated 01/2023 showed, It is the policy of (facility) that appropriate nutritional care shall be provided to residents who have a significant weight change .E. The RD (Registered Dietician) should make recommendations for nutritional interventions based on the information obtained from the weekly Resident at Risk Review huddle meetings. RD recommendations should be reviewed and initiated by nursing associates .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to ensure orders were in place for a resident with a CPAP (Continuous Positive Airway Pressure) and failed to properly clean and store CPAP equipment for 1 of residents (R108) reviewed for respiratory services in the sample of 59. The findings include: R108's face sheet showed he was admitted to the facility 5/15/25 with diagnoses to include pulmonary embolism, cough, obstructive sleep apnea, and muscle weakness. R108's Physician Order sheet for June 2025 which was printed 6/5/25 showed no orders for R108's CPAP machine. R108's June 2025 eTAR (electronic Treatment Administration Record) showed new treatments added 6/4/25 for CPAP - Place CPAP on at HS (hour of sleep) and remove in the AM (morning) for sleep apnea; Cleanse CPAP - Every day clean CPAP mask and tubing with soap and water and dry mask and tubing every morning. There was no evidence of R108's CPAP being cared for from 5/15/25 through 6/4/25. R108's care plan initiated 5/23/25 showed, Pulmonary . [R108] has potential for SOB (shortness of breath) and/or respiratory complications related to diagnosis of pulmonary embolism and obstructive sleep apnea . Oxygen/CPAP . Currently uses as need supplemental oxygen related to diagnosis of obstructive sleep apnea. Oxygen therapy puts him at risk for dry mouth, skin pressure points, poor stamina, lethargy, insufficient fluids, and anxiety . R108's complete care plan was reviewed and showed no CPAP settings or CPAP care. On 6/3/25 at 10:53 AM, R108's CPAP was on the bedside table. A sign was placed nearby that showed to put water in the CPAP machine. The CPAP mask was lying on the bedside table and was not bagged. On 6/04/25 at 1:39 PM, R108 said the staff help him with his putting his CPAP on at night. R108 said, They usually just leave it there on the table but I noticed yesterday, they put it in a bag and today too. On 6/05/25 at 2:16 PM, V2 DON (Director of Nursing) said if a resident has a CPAP machine, the orders should be entered upon admission. V2 said she would need to check their policy for her expectation for cleaning and storage of CPAP equipment but that she would expect the staff to follow the facility's policy and procedures. The facility's policy and procedure with last approved date of 09/2023 showed, . Procedure: CPAP/BiPAP Support . Purpose: A. To provide the spontaneously breathing resident with continuous positive airway pressure with or without supplemental oxygen . Preparation: . C. Review the physician's order to determine the oxygen concentration and flow, and the PEEP pressure (CPAP) for the machine . General Guidelines for Cleaning . D. Machine cleaning: Wipe machine with disinfecting wipes or wipe with warm, soapy water, and then rinse at least once a week and as needed F. Filter cleaning; 1. Rinse washable filter under running water once a week to remove dust and debris .G. Masks, nasal pillows and tubing: Clean daily by placing warm, soapy water and soaking/agitating for 5 minutes. Rinse with warm water and allow it to air dry between uses .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to answer the residents call light in a timely manner. This applies to three of three residents (R58, R99, R332) in the sample of 59 reviewed for call lights. The findings include: 1. The facility face sheet shows R58 was admitted to the facility with diagnoses to include adult failure to thrive, Type 2 Diabetes Mellitus, chronic kidney disease and low back pain. R58's facility assessment dated [DATE] shows he has no cognitive impairment and required maximum assist from staff for standing and toileting. On 6/04/25 at 2:18 PM, R58 said he was standing up at the foot of his bed reaching for his urinal. R58 said his legs gave out and he fell. R58 said he had his call light on because he could not reach his urinal. R58 said after half an hour he tried to do it himself and fell. R58 said he felt his hip break when he fell. R58 said he had to yell for help from the staff. R58 said because he is younger and has his wits about him the staff thinks he is independent. 2. The facility face sheet for R99 shows she was admitted to the facility with diagnoses to include Bell's Palsy, Atrial fibrillation and paralysis to her left side. The facility Brief Interview for Mental Status (BIMS) shows her to cognitively intact. On 6/04/25 at 1:44 PM, R99 said the call lights take a long time to be answered. R99 said it was an hour before she got changed this morning, and it takes a long time, almost all the time for the staff to answer her call light. 3. The facility face sheet for R332 shows she was admitted to the facility with diagnoses to include muscle weakness, chronic obstructive pulmonary disease and type 2 Diabetes Mellitus. The BIMS assessment dated [DATE] shows her to cognitively intact. On 6/03/25 at 11:09 AM, R332 said, getting the staff to answer her call light has been a big problem for her. R332 said, I can turn this on and wait for an hour. I generally walk myself to the bathroom but when I get in there, get the pull ups off and then I can't get a new one back on. One time 2 aides walked past pushing someone while I had my call light on, it had been on a long time, and they said oh yeah we can't help you. That made me feel like a nonperson, no one was checking on me, a lot of times its something simple I needed. On 6/05/25 at 2:18 PM, V2 DON (Director of Nursing) said, the facility has an old call light system and we don't have a way to monitor. I would have at least expected the staff to see what a resident needed, and communicate with them regarding when they will be back. No facility policy was provided by the facility regarding call lights.

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	145563	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ascension Saint Anne Place	4405 Highcrest Road Rockford, IL 61107

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to correctly transcribe a physician's order for 2 residents (R60, R129), failed to ensure the correct dose of a medication was given for 1 resident (R90), failed to ensure the correct medications were given for 1 resident (R25). These failures apply to 4 of 4 residents outside of the sample reviewed for medication errors. The findings include: 1) R25's electronic face sheet printed on 6/5/25 showed R25 has diagnoses including but not limited to cerebral infarction, insomnia, dementia with behaviors, anxiety disorder, and major depressive disorder. The facility's document titled, Safety Event Entry dated 4/9/25 showed, (R25) given incorrect medications including cetirizine 10mg, gabapentin 100mg, quetiapine 50mg, and memantine 5mg. Error noted by another RN (Registered Nurse) as I was exiting the room. Nurse Practitioner notified and advised to monitor resident . resident has no change from baseline . 2) R60's electronic face sheet printed on 6/5/25 showed R60 has diagnoses including but not limited to liver cell carcinoma, multiple sclerosis, chronic kidney disease, chronic viral hepatitis C, and hypertension. The facility's document titled, Safety Event Entry dated 5/21/25 showed, Resident was admitted to the facility with antibiotic order for a total of 5 days and antibiotic continued to be administered for 7 more days . medication stop date was never entered by the nurse . 3) R90's electronic face sheet printed on 6/5/25 showed R90 has diagnoses including but not limited to weakness and repeated fall. R90's physician's orders from her original admission on [DATE] showed, Budesonide DR (Delayed Release)-ER (Extended Release) take 9mg by mouth every day. The facility's document titled, Safety Event Entry dated 5/14/25 showed, Resident has had diarrhea since admission. She has a history of chronic bowel disease and has been on Budesonide ER tab 9mg daily at home and also was ordered upon admission to (facility) .Gastroenterologist confirmed via fax that she should be on 9mg Budesonide daily. After further investigation, it was noted that the table dose from pharmacy was 3mg not 9mg . 4) R129's electronic face sheet printed on 6/5/25 showed R129 has diagnoses including but not limited to urinary tract infection, hypertension, carotid arterial disease, and chronic obstructive pulmonary disease. The facility's document titled, Safety Event Entry dated 4/9/25 showed, (R129) was given orders for a prednisone taper and the orders were not entered correctly with stop dates and the nurse continued to give the medication. It should have been stopped on 3/25/25 and was given until today when I discontinued the order on 4/9/25. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/5/25 at 2:20PM, V2 (Director of Nursing) stated, We have had several medication errors over the past 3 months. I think it has to do with agency staff not knowing the residents and not knowing our admission process. We now have our admission nurse's double checking the orders to ensure they are transcribed and entered correctly so hopefully that will help cut down on the errors. These errors never should have happened but thankfully there were no significant outcomes to these residents.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review, the facility failed to puree peas to a smooth consistency. This applies to 6 of 6 residents (R7, R12, R35, R48, R103, R330) reviewed for altered diets in the sample of 59. The findings include: The 6/3/25 facility-provided list of residents receiving pureed diets showed that R7, R12, R35, R48, R103, and R330 were receiving pureed foods. On 6/3/25 at 11:05 AM, V14, Cook, began the puree process for the residents' peas. On 6/3/25 at 11:13 AM, V14 completed the puree process and placed the pureed peas into a metal steam table pan. There were visible chunks in the pureed peas. The peas were tested by this surveyor; the pureed peas had chunks, and it required chewing to comfortably swallow them. V14 stated the puree process was complete. V14 then covered the peas with plastic wrap and placed them in the steam oven. On 6/3/25 at 11:34 AM, V13, Dietary Supervisor, tested the pureed peas and stated, They have chunks. V13 stated there were also pieces of skin. V13 said the peas should be smooth, and she stated peas are difficult to puree. On 6/3/25 at 11:39 AM, V13 placed the pureed peas back into the food processor and blended them until they were smooth. On 6/4/25 at 12:53 PM, V13 stated the pureed peas were not a smooth consistency, and they should have been blended until they were smooth. On 6/4/25 at 1:08 PM, V4, Registered Dietitian, stated residents are generally placed on puree diets due to a diagnosis of difficulty swallowing. V4 said strokes can cause difficulty swallowing. V4 stated a resident ordered a puree diet could experience a choking episode if served food that is not smooth. V4 stated pureed foods should be smooth and not have chunks. R12's Face Sheet showed a diagnosis of difficulty swallowing. R7's Face Sheet showed a diagnosis of stroke. R48's Face Sheet showed a diagnosis of difficulty swallowing. R35's Face Sheet showed a diagnosis of difficulty swallowing. R103's Face Sheet showed a diagnosis of difficulty swallowing. R330's Face Sheet showed a diagnosis of difficulty swallowing. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Dysphagia (Difficulty Swallowing) - Clinical Protocol policy (last approved 1/2024) showed: Treatment/Management .The physician will order an altered consistency diet when it is clinically relevant to manage significant risks of aspiration (choking) in individuals for whom other alternatives are unavailable .

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to handle food in a manner to prevent cross-contamination and failed to maintain food preparation equipment in a manner to prevent cross-contamination. This failure has the potential to affect all 131 residents residing in the facility. The findings include: On 6/3/25 at 11:46 AM, V14, Cook, began the lunch service from the steam table in the kitchen. All residents in the facility were served from this steam table. The lunch menu was battered fish with a lemon wedge, french fries, and peas. The lemon wedges did not have any utensils for handling. V14 placed a lemon wedge on each plate with her gloved hand. V14 also used her gloved hand to move the peas into a pile on the plate and organize the french fries on the plate. V14 also used her gloved hand to steady the fish as she moved the fish from the steam table to the residents' plates. On occasion, V14 also picked up the fish with her gloved hand and placed it on the plate. During the lunch service, V14 pulled down her shirt with her gloved hands, touched door handles, and she touched food carts; V14 did not change her gloves during the lunch service. On 6/3/25 at 9:22 AM, the facility's can opener showed caked-on debris. The debris was well-adhered, and it was on the sharp cutting tip. On 6/4/25 at 12:53 PM, the can opener tip was the same as observed on 6/3/25. On 6/4/25 at 12:53 PM, V13, Dietary Supervisor, stated the can opener had been used that day. V13 stated it had been cleaned. V13 said a new can opener had been ordered. V13 said the tip was dirty and there was a risk of cross-contamination using the dirty can opener. V13 also said food should not be touched with a potentially contaminated gloved hand. V13 said there was a risk of cross-contamination if staff handled food with a potentially contaminated hand. V13 said V14 should have used a utensil to handle the lemons and she should not have touched the residents' food on the plate unless she had clean gloves. The facility's Preventing Foodborne Illness-Food Handling policy (last approved 1/2023) showed, .All associates who handle, prepare or serve food shall be trained in the practices of safe food handling and preventing foodborne illness .All food service equipment and utensils shall be sanitized according to current guidelines and manufacturers' recommendations .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to wear the appropriate personal protective equipment (PPE) while providing wound care. This applies to 1 of 8 residents (R34) reviewed for infection control in the sample of 59. The findings include: R34's Face Sheet showed an original admission date of 11/8/23 with a diagnosis of a Stage 4 pressure ulcer. On 6/04/25 at 9:11 AM, R34's door had signage stating she was on Enhanced Barrier Precautions, and a gown and gloves were required for wound care. V17 provided R34's daily wound care for her Stage 4 pressure wound above her buttocks. V17 only wore gloves for the entirety of the wound care; he did not wear a gown. On 6/04/25 at 3:29 PM, V18, the Infection Preventionist, stated residents with chronic wounds, which have a dressing, are required to be on enhanced barrier precautions. V18 stated staff should wear gowns and gloves when providing wound care to prevent wound infections. V18 stated V17 should have worn a gown while providing R34's wound care. The facility's Enhanced Barrier Precautions policy (Last approved 5/2024) showed, Enhance Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of resistant organisms that employs targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply. EBP are indication for residents with any of the following: Wounds or indwelling medical devices .