STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145581	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Meadows of Cahokia	2 Annable Court Cahokia, IL 62206

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 respect a residents privacy and dignity during a social media post for 1 (R46) of 3 residents reviewed for dignity in a sample of 67. Findings Include: R46's Undated Face Sheet, documents R46 was initially admitted to the facility on [DATE] with diagnoses including Parkinson's Disease with Dyskinesia, History of Falling, Hypertension, and Aphasia. R46's Minimum Data Set (MDS) dated [DATE] documents R46 is severely cognitively impaired. R46's Resident Consent to Photograph and Authorization for Use or Disclosure of Protected Health Information dated 4/7/2025 documents an illegible signature for consent. Unknown dated Social Media Post documents, a photo of R46 with V48, Restorative Nurse/QA. The photo documents R46 in his wheelchair with V48, Restorative Nurse/Quality Assurance, posing next to R46 with a sign taped her V48, Restorative Nurse/QA's buttock stating, R46's First Initial and Last Name, Fall Risk. On 5/13/2025 at 10:09 AM R46 denied knowing if the facility had him sign a consent allowing the facility to take his photo and post the photo on social media. On 5/13/2025 at 2:11 PM V73, R46's POA stated she was unaware that a picture of R46 had been taken and posted on social media. V73 stated R46 does not know much about social media, and she is sure R46 would not want his pictures posted on it. V73 stated the facility has never reached out to her to consent for R46's picture to be taken and posted on social media. V73 stated it is hard to say if R46 could write his name to consent to have his photo taken and posted on social media due to his Parkinson's. V73 stated R46 does not care for his picture to be taken and she knows he would not want his picture to be posted on social media. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/13/2025 at 2:22 PM R46 stated he just found out about a photo being taken of him and posted social media from a friend. R46 was shown the photos there were posted and confirmed that it is him in the photograph and R46 could not say who the employee was in the photo with him. R46 stated he cannot say what the context of the photo was. R46 stated he does not recall giving consent for his photo to be taken. R46 stated he feels fair about his picture being taken and does not like the photo. R46 stated he would like the picture to be taken down from social media and for the facility to not post his picture. R46 could tell this surveyor his name but is unable to recall what year it is currently, stating the year is 2022. On 5/13/2025 at 2:35 PM V1, Administrator, stated regarding the photo of R46, it was Twin/ Day at the facility and staff were to pick a resident to dress alike and coordinate with. On 5/13/2025 at 2:39 PM V48, Restorative Nurse/ QA, stated she did not write the sign that is in the picture, that another co-worker wrote the sign and posted it on social media. V48 stated she dressed like R46 for Twin Day and was bringing awareness because R46 falls all the time. V48 stated it was just a joke between herself and R46. V48 stated R46 was okay with the picture, and he was able to give consent and R46 is not confused at all. On 5/20/2025 at 11:00 AM, V1, Administrator, stated the facility does not have an actual social media policy and every resident signs a consent for their picture to be taken and used on any social media when they sign their admission paperwork. V1, Administrator, stated a consent to photograph is included in the facility's admission paperwork. V1, Administrator, stated the facility follows the Illinois Long Term Care Ombudsman Program Resident Rights document for their resident rights policy. On 5/27/2025 at 1:25 PM, V2, DON, stated the facility's admission Contract does include a consent to photograph each resident and photos can be used for advertising their services and on social media. V2, DON, stated R46 is fully aware of what is happening and is alert and oriented x 3. V2, DON, stated R46 could give verbal consent for his photograph to be taken and thinks R46 could sign his name on a consent form. V2, DON, stated he is unsure who took the picture of R46 and the staff member in the photo, who took the picture with R46 in it, or who took the photo down from social media. V2, DON, stated R46 and the staff member present in the picture both gave verbal consent for their picture to be taken. V2, DON, stated regarding the content of the photograph, R46 was asked if R46 was okay with it and R46 said it was okay for the photograph to be taken. The Illinois Long Term Care Ombudsman Program Resident Rights pamphlet last revised 11/18 documents Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review the facility failed to ensure availability and working order of a personal wheelchair for 1 of 3 (R6) residents reviewed for accommodation of needs in the sample of 67. Findings Include: R6's Occupational therapy Progress Report, dated 2/13/2023 to 2/23/2023 documents patient currently unable to utilize personal tilt and space wheelchair with ROHO due to missing cushion and chair in disrepair. R6's Occupational Therapy Progress Note, dated during certification period of 3/14/2023 through 4/12/2023, documents patient tilt and space chair still in disrepair. Patient has assessment for new chair 3/23/2023. R6's Occupational Therapy Treatment Encounter Note, dated 2/28/2024, documents skilled occupational therapist assessment indicates need for a tilt and space wheelchair with a hybrid ROHO cushion, adjustable headrest, pommel and fix leg rest. R6's Wound Nurse Practitioner Progress Note, dated 4/23/2025 V13 documented visit specific information: patients broda chair was found and I do recommend that he gets up for short periods of time. Recommend discussing with therapy for best option of offloading cushion for chair. A Typed Statement, dated 4/24/2025 signed by V18, documents (R6) was seen by skilled OT (Occupational Therapy) at this facility from 3/28/2025 to 4/22/2025 during that POC (plan of care) this therapist recommended patient utilize a tilt and space wheelchair with adjustable leg rest and a ROHO cushion (hybrid select or enhancer) when out of bed to maximize offloading and pressure relief. As of 4/24/2025 there had been no documented change in function or medical status that would change this recommendation. From a therapy perspective, when properly inflated a ROHO remains the gold standard for pressure relief and the aforementioned cushions provide the versatility to customize weight distribution to the patient's needs. Unless, due to the severity of the wounds, a wound care specialist has an alternative cushion recommendation that would provide comparable or superior pressure relief this would be the best option for patient's comfort and wound healing. Periodic observation of R6 throughout the annual survey, dated 4/22/2025 through 5/20/2025 noted him sitting in a high back wheelchair. His personal tilt and space wheelchair was in a storage room at the facility. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/24/2025 at 8:23 AM V18, OT stated (R6) had a specialty tilt and space wheelchair order years ago he got the wheelchair then he was admitted to hospice, he was discharged from hospice on 1/30/2023 and he never got his specialty wheelchair back. V18 recently assessed (R6) in OT from 3/28/2025 through 4/22/205 and it was her professional recommendation that he have his specialty tilt and space wheelchair with specialty wheelchair cushion with leg rests. The cushion she recommended was a special cushion for him because she could air up and deflate different cells of the cushion to assist with offloading his coccyx pressure ulcer and to ensure he had proper pressure relief. V18 stated she asked the former therapy manager many times about (R6's) wheelchair but it fell on deaf ears, she didn't know where (R6's) wheelchair or cushion was and she stated the facility never planned on replacing or even tried to locate R6's wheelchair. On 5/1/2025 at 2:15 PM V13, Wound Nurse Practitioner stated she would follow therapy's recommendations for what wheelchair (R6) should be using and whatever chair he is up in should have a pressure relieving cushion to offload pressure on his coccyx pressure ulcer, if the pressure ulcer isn't offloaded properly is could potentially lead to the worsening of the pressure ulcer. A facility policy regarding accomodation of needs was requested multiple times throughout the survey to V1 (administrator), but never provided.

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow advanced directives for 1 of 4 (R89) residents reviewed for advanced directives in the sample of 67. This failure resulted in an Immediate Jeopardy on [DATE] when R89 was transferred to the hospital with lifesaving measures, against the documented DNR (do not resuscitate) advanced directive status. R89 ultimately expired at the hospital after being subjected to CPR, Mechanical Ventilation and the use of an AED (automated external defibrillator) which subsequently re-started his heart for a period of time. On [DATE] at 2:28 PM V1, Administrator, V2 DON and V3 ADON were notified of the Immediate Jeopardy. The surveyor confirmed by interview and record review, the Immediate Jeopardy was removed on [DATE], after abatement reviews dated [DATE] at 3:05 PM and 3:17 PM, [DATE] at 12:11 PM and [DATE] at 10:57 AM but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-servicing training. Findings include: R89's Undated Face Sheet, documents R89 was initially admitted to the facility on [DATE]. R89's admission Minimum Data Set (MDS) dated [DATE] documents he was cognitively intact. R89's Social Services Note, dated [DATE] at 4:18 PM documents R89 was admitted from a local hospital on [DATE]. He signed the POLST to be DNR. POLST will need to be signed by NP or Doctor. Order needs to be entered in PCC (Point Click Care). On [DATE] at 11:53 AM V7, Director of Social Services stated she documented the wrong year on the social service note dated [DATE] should be documented [DATE]. V7 confirmed (R89's) code status was DNR because she spoke to him herself about it and he definitely didn't want anyone pounding on his chest or being electrically shocked to restart his heart, he'd rather die peacefully. R89's POLST Form, dated [DATE] documents do not resuscitate, comfort-focused treatment. Primary goal is maximizing comfort through symptom management. Allow natural death. Do not use treatments listed in full and selective treatment. Full treatment: mechanical ventilation and cardioversion (use of an AED shocking the heart.) Selective treatment: do not use invasive mechanical ventilation. R89's Care Plan dated [DATE], documents resident chose to be a DNR per POLST. No CPR in the event that patient has no pulse, do not attempt resuscitation/DNR. Comfort focused treatment if patient is not in cardiac arrest. Follow if patient has a pulse. On [DATE] at 2:59 PM, V27, Medical Records stated she uploaded (R89's) POLST form on [DATE] and although she stated it wasn't a good and clear copy to scan into the resident's medical record, she could still read the form after it was uploaded to (R89's) medical record. R89's Nursing Note, dated [DATE] at 8:00 AM documents nurse alerted by staff that resident showing a change in condition. Resident observed with a thready, faint pulse. Patient assessed and treated until EMS arrived. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R89's Nursing Note, dated [DATE] at 8:50 AM documents hospital notified facility patient expired at 8:48 AM. Arrangements made from hospital to be transported to funeral home. R89's Health Status Note, dated [DATE] at 10:37 AM documents EMS arrived at 8:09 AM and departed at 8:21 AM. On [DATE] at 2:00 PM V11, CNA stated she recalled (R89) he was alert and oriented and was able to make his needs know. On [DATE] V14, CNA was assigned to (R89) and she recalled they both reported to V15, RN that (R89) was out of it that morning and the resident was really spacy. A while later she entered (R89's) room and observed V14 transferring (R89) with a gait belt from his bed to wheelchair and (R89) stated, I can't stand, I'm dizzy! and V14 lowered (R89) to the floor. V11 stated she ran down the hall and yelled for a nurse and grabbed the crash cart. V11 stated staff (names unknown) laid (R89) on the floor and started CPR and continued CPR until EMS arrived to the facility. V11 stated she was really concerned for (R89) because he was slow to respond earlier that morning but when she reported it to V15 she was receiving nurse report from the night shift nurse and she waived her away. On [DATE] at 2:15 PM V12, LPN stated she recalled (R89) and the day he was transferred to the hospital on [DATE]. V12 stated she wasn't assigned to the resident that day but at around 6:30 AM, at the beginning of the shift she overheard V11, CNA report to V15 that (R89) wasn't acting himself, she didn't know if V15 assessed (R89) or not because she was assigned to another hall. A while later, V12 heard staff yelling down the hall they need a nurse. She entered (R89's) room and observed V17, LPN and V16, LPN was on the floor administering CPR compressions to (R89) she relieved V16 from doing CPR compressions and checked (R89's) pulse and she didn't feel a pulse at that time. She didn't know (R89's) code status was but she did CPR because the other nurses were doing it. V12 stated after the code was over and (R89) was transferred to the hospital V15 told her that she was very upset because (R89) was a DNR and they did CPR on him and shouldn't have. She was concerned for her nursing license at that time and V12 didn't know what V15 documented as to what occurred when (R89) coded. V12 stated she didn't see V15 in the room during this time, V15 may have been outside at that time. R89's Medical Record dated [DATE] documents no vital signs documented. On [DATE] at 3:45 PM V17, LPN stated on [DATE] she was assigned to the 500 hall and during nurse report she overheard V11, CNA and V14, CNA report to V15, RN that (R89) was not himself and something was wrong with him. V17 didn't know if V15 went to assess (R89) or anything because she was assigned to the 500 hall and (R89) resided on 300 hall. Sometime in the morning (time unknown) V15 asked her, We don't do CPR on a resident that's still breathing, right? V17 responded, No, we only do CPR if the resident's not breathing. V17 didn't know what was going on or if V15 assessed (R89) at that time. A while later (time unknown) V17 heard staff yelling, CODE and she ran to (R89's) room and noted (R89) was sitting on the edge of the bed as V14 was holding him up and she assisted V14 to placed (R89) on the floor. V16, LPN arrived to (R89's) room and they started doing CPR at that time. V17 stated she didn't know (R89's) code status if he was a DNR or a full code but she went with performing CPR because that was her nurse intuition. After the EMS left the facility V17 stated V15 looked at (R89's) medical record she told her (R89) was supposed to be a DNR not a full code so staff shouldn't have done CPR on (R89) and they were nervous about it and didn't want to get in trouble. V17 stated she doesn't know what V15 documented in (R89's) medical record but she told her she wasn't going to document that staff did CPR because she didn't want to get in trouble or lose her nursing license. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 10:45 AM V14, CNA was assigned to (R89) on [DATE] and he recalled what occurred. V14 stated this was the first day he was assigned to (R89) and didn't know him at all. V14 stated he asked V11 if she could help him and she went into (R89's) and told V14 that (R89) wasn't acting himself and she left the room and reported to a nurse (name unknown) that (R89) wasn't right and V11 came back to (R89's) room and said she told the nurse about it. Over an hour later V14 stated (R89) was laying in bed and was yelling, Get me up! I want to get up! No nurse came to (R89's) room V14 and V11 transferred (R89) to his wheelchair and as they did (R89) fainted/passed out and wasn't responsive. V14 and V11 got (R89) back to bed and he wasn't talking and his eyes were closed. V11 left (R89's) room and yelled down the hall that they need a nurse and V12, V16, V17 responded to (R89's) room immediately. They told them to put (R89) on the floor and the nurses started CPR. V14 stated he's a CNA and didn't know (R89's) code status. V14 recalled when EMS arrived to the facility he saw they used a mechanical ventilator to pump (R89's) chest and used an AED to shock (R89's) heart. EMS stated they got a heartbeat back on (R89) and he was transported to the hospital. V15 entered (R89's) and finally assessed him, 911 was called and he was transported to the hospital. On [DATE] at 11:14 AM V15, RN stated she was assigned to (R89) on [DATE] and she was familiar with him and was assigned to him often. V15 stated (R89's) baseline was he was alert and able to make his needs known and was a 1-2 person transfer. On [DATE] she recalled she got to work around 6:30 AM and got report from the night shift nurses (names unknown) and no issues or concerns was expressed for (R89.) No staff reported that he wasn't acting right during nurse report. It wasn't until around 8:00 AM that V11 reported that (R89) was not acting himself and she immediately went to his room and laid eyes on him. At that time (R89) was in bed and he stated he didn't want to get up out of bed. V15 stated (R89) was lethargic at that time and was very slow to respond to her and while she was assessing his vital signs including blood pressure, heart rate, pulse oxygenation and respirations and he was rapidly declining right in front of her. V15 recalled (R89's) pulse was faint and the oxygen saturation machine didn't register on his finger and she tried different fingers but it still would register a reading. She instructed V11 and V14 to put (R89) on the floor and she ran and got the crash cart and yelled, Code blue! She looked up (R89's) code status in the computer but she stated it was grayed out and she couldn't read it so she errored on the side of caution and instructed staff to start CPR. V12, V16 and V17 helped with CPR compressions and bagged (R89) until EMS arrived to the facility. V15 reported to EMS that (R89) was a full code and they continued CPR using a mechanical ventilator and also shocked (R89's) heart with an AED. (R89) heartbeat came back and EMS transferred him to the hospital. Hospital staff called back a few minutes later and stated (R89) was deceased . V15 stated she didn't ask other staff if a resident was breathing if you should start CPR because she is an RN and knows if the resident is breathing you don't start CPR. V15 stated she documented the entire change in condition regarding (R89) in the nurse progress notes in the computer including his vital signs and how staff provided CPR that day, she didn't know why the assessment wasn't documented in (R89's) medical record because she knows if you don't document it it wasn't done and she definitely wanted to protect her nursing license. After (R89) was transferred to the hospital the medical records staff showed her a code status book at the nurse's station and she read (R89's) code status and it showed he was a DNR. She was really upset because of everything staff did to save his life including mechanical ventilation and using the AED to shock his heart when they weren't supposed to do any of that. On [DATE] at 12:25 PM V15 called back and stated she recalled when she got the crash cart to (R89's) room staff (name unknown) was on the phone with V2 and he told staff to start CPR on (R89) immediately and that's why staff did CPR. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:45 AM V34, Former Therapy Program Manger stated she worked with (R89) and provided occupational therapy, she noted (R89) was alert and able to make his needs known. V34 stated she got to the facility at 5:00 AM on [DATE] and noted (R89) was in bed around 6:30 AM and observed V11 and V14 were transferring (R89) from his bed to wheelchair and he was yelling out that he didn't want to get up. V34 entered (R89's) room and told the CNAs to sit him back on the bed and they did. V15, RN entered (R89's) room and asked what he's yelling about and at that time V34 noted (R89) took a gasp for breath which she thought was odd. V15 instructed the CNAs to lay him in bed and raise the head of the bed and that he'd be fine V15 then left (R89's) room. V34 stated she was gravely concerned about (R89) but that V15 was an RN and she trusted her nurse judgement. Around 8:00 AM she went to (R89's) room to check on him and V11, CNA was in his room and told V34 that she reported to V15, RN that (R89) was not responsive but that no one was doing anything about it. V34 stated she went to get a blood pressure cuff and a pulse ox and put it on (R89), neither the blood pressure or pulse ox would register a reading at that time and from what she could tell (R89) wasn't breathing. V34 stated she called V2, DON at that time on her cell phone and V2 stated he wasn't at the facility but if (R89) wasn't breathing that she needed to call a code blue and start doing CPR. V11, CNA yelled code blue down the hall and V12, LPN and V17, LPN entered (R89's) room and started doing CPR on him. V34 stated (R89) was transferred to the hospital after EMS got a heartbeat and she was informed he passed away shortly after arriving to the emergency room. V34 stated she found out from staff on [DATE] that (R89) was supposed to be a DNR, not a full code. On [DATE] at 3:00 PM V16, LPN stated she worked night shift and arrived to the facility at 10:30 on [DATE] and also worked day shift on [DATE] as well. V16 stated she was assigned to (R89) night shift and administered a medication, (medication name and dose unknown) to him at 6:00 AM on [DATE], V16 stated he was sleeping and she woke him up and he was at baseline at that time he took the medication and went back to sleep. He didn't complain of shortness of breath or pain at that time. V16 gave nurse report to the day shift nurses V12, V15 and V17 and V15 was (R89's) day shift assigned nurse. V16 didn't recall any staff reporting (R89) was having any changes during nurse report. A while later she was at the nurse's station and V11 came to the nurse's station and reported to V15 several times that (R89) wasn't acting right and was slow to respond to them. V16 stated V11 is assigned to (R89's) hall and knows him well so she knew something must be wrong if she kept saying something was wrong with (R89.) A few minutes went by and V15 was still on the computer at the nurse's station at that time and wasn't going to assess (R89) so her and V12 went to assess (R89.) V16 stated she was halfway down the hall when a therapy employee (name unknown) came out of (R89's) and stated he's no longer responsive. V16 stated when she entered (R89's) he was in bed and eyes were closed. Her and V12 assessed (R89) by doing a sternal rub which he had no response to and the pulse oximetry machine wasn't displaying a reading at that time. We called for a crash cart at that time and an unknown staff told them he is a full code. She instructed staff to put (R89) on the floor and she, R12 and V17 started CPR. When EMS arrived they used a mechanical ventilator and an AED to shock his heart a few times. After (R89) was transferred to the hospital she recalled a staff said (R89) was supposed to be a DNR and she didn't know that and she knew if a resident is a DNR they aren't supposed to do CPR on them. On [DATE] at 2:20 PM V27, Medical Records stated she recalled on [DATE] when (R89) was transferred to the hospital. V27 stated she told the nurse (name unknown) that was on the phone with EMS that she has a binder with resident information in it and that they could use the binder information if needed and she would replace whatever documents they use from the binder after (R89) was transferred to the hospital. V27 stated she didn't recall telling a nurse that the resident's code status was in the binder. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R89's Hospital Medical Record, dated [DATE] documents History of Present Illness patient presents to the ER by EMS in cardiac arrest. Per EMS 10 minutes of downtime with bystander CPR. When EMS arrived 3 shocks were advised. EMS was a BLS crew, no medications give. No other history obtained. ACLS was continued on arrival to the ER. Pt airway was intubated on arrival, ACLS was continued. On arrival was initially given epinephrine, calcium bicarb. On pulse check, was in V Fib was shocked and provided with 300 mg of amiodarone. On next pulse, was V-Tach was provided with 150 of amiodarone and shock. Next pulse check was also V-Tach was provided with 100 of lidocaine and shock. At next pulse check, PE, AA was given epinephrine next couple pulse checks 2, still PE with cardiac standstill. Eventually time of death was called at 8:48 AM. On [DATE] at 12:45 PM V2, DON stated when a resident has a change in condition he expects staff to obtain vital signs including blood pressure, heart rate, oxygen saturation and respirations. He also expects the nurse to assess the resident from head to toe noting any abnormalities. The nurse should talk to the resident and see what their orientation status is to see if there is a change in baseline. The nurse should also assess the resident for pain and dizziness. and to notify the physician of what the assessment was and to obtain orders from the physician. V2 stated the full change in medical condition assessment including vital signs is expected to be documented in the resident's nurse progress notes. V2 recalled R89 and stated he was sent to the emergency room for his catheter at one point but he was readmitted to the facility the same day and he didn't recall any specifics of what occurred on [DATE]. On [DATE] on 12:12 PM V2, DON stated if staff call him and notify him of a resident having a change in condition he would tell staff to get the resident's vital signs and have a nurse assess the resident and to notify the resident's physician of the change in condition to get physician's orders but he would never tell staff to initiate or start CPR because he doesn't know residents' code status and denied telling staff to initiate or start CPR on (R89) when he coded on [DATE]. He doesn't know why staff would say that he said that. On [DATE] at 11:25 AM V2, DON stated when a resident is initially admitted to the facility he expects staff to assess the resident's code status and document it on the POLST form. He expects the POLST form to be scanned into the computer in the resident's medical record and expects staff to upload a readable POLST form so staff can view it in an emergency situation. V2 stated he noted (R89's) POLST appeared [NAME] and it was poor quality and he couldn't read what (R89's) code preference was on the form. V2 stated (R89) was a DNR and staff should have provided comfort measures only and shouldn't have done CPR or had an AED used on him to restart his heart. A DNR comfort measures only means staff should still assess the resident, obtain vital signs, apply oxygen to the resident and ensure the resident is pain free and stabilize the resident to the best of the nurse's ability. V2 expected staff to honor the resident's POLST form wishes. On [DATE] at 11:40 AM V1, Administrator stated the facility doesn't have an advanced directive policy and they probably should so staff would know what it is and to follow it. V1 expects the POLST form in resident's medical records to be readable to ensure in an emergency the licensed nurse can read the POLST form and abide by the resident's documented POLST form code decision. (continued on next page)

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	145581	A. Building B. Wing	06/10/2025

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On [DATE] at 9:50 AM, V21 Nurse Practitioner stated staff including the assigned nurse should know the resident's code status and should most definitely follow it because that is the resident's wishes which are usually documented upon admission to the facility. V21 stated if (R89's) comfort measures only then staff shouldn't have done CPR including mechanical ventilation or using an AED to shock his heart. The only thing staff should have offered (R89) should be oxygen if his signed POLST form documents comfort measures only. Identified opportunity for improvement/deficient practice: Improving nursing skill sets for conducting a code blue status and executing physician orders timely and efficiently. Immediate Corrective Action for those affected by the deficient practice: -V22, Wound Nurse from hospital held a CPR class that was completed for nurses on [DATE]. -Code Blue status in-service completed on [DATE]. The in-service outlines reviewing the POLST before performing CPR or when a Code Blue is active. Completed by DON and ADON. -Physician Orders for Life sustaining treatments inservice and Change in Medical Condition policy inservice completed on [DATE]. Completed by DON and ADON. -Medical order that outlines patients specifics wishes for end of life-sustaining procedures in-service completed on 4/25. Completed by DON and ADON and LNHA. -Night shift charge nurse currently audits Crash Carts daily. Inservice completed by DON and ADON on [DATE]. -Performing CPR on a resident with no pulse return demonstration, initiated [DATE] and will be ongoing. Completed on [DATE] by DON and ADON. -Immediate DNR and Full Code Status Audit completed on [DATE]. Completed by SSD. -Ordered AED Machine, pending delivery Date, Order placed on [DATE] by Medical Records on [DATE]. Pending tracking number. -Inserviced Medical Record [NAME] and [NAME] SSD to ensure all POLST forms are readable. Completed by LNHA on [DATE]. 2. Process/Steps to identify others having the potential to be impacted by the same deficient practice: -All residents have the potential to be affected. R89 expired on [DATE]. 3. Measures put into place/systematic changes to ensure the deficient practice does not reoccur. -DON/ADON or designee will review physician's orders (e.g., code status) daily for the next 4 weeks. (continued on next page)

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F 0578 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-DON/ADON or designee will review Review laboratory or radiology results pertinent to the resident's death when a death occurs for the next 4 weeks. DON/ADON will pull three random charts twice a week for the next 4 weeks and do the following:Review progress notes to determine what interventions were put into place to address the change or decline in condition (e.g., first aid measures, glucose monitoring, cardiopulmonary resuscitation [CPR], and immediate transfer)? 4. Plan to monitor performance to ensure solutions are sustained. Beginning [DATE] and continuing until further addressed in the plan of correction, the DON or Designee will conduct a chart review, 3 random charts twice a week for 4 weeks to ensure chart is the following: -Evaluate interventions to determine was intervention appropriate, monitored and modified as needed -Was pain assessed and treatment measures documented. -Ensure care was consistent with the resident advance directive or goals for care -If concerns are identified, review facility policies and procedures with regard to factors that led to the resident's death. -Review resident sig change and compare it to their baseline. -Ensure resident decisions were honored and executed. -Communicate changes with family/POA. -Do a complete audit on chart, after death. -Medical Records or SSD is responsible for auditing the POLST form in PCC, Emergency Response book on Wednesday weekly for the next 4 weeks. Surveyors validated the removal of abatement by reviewing medical records for change in medical condition. R89 was deceased and therefor his medical record was not further reviewed. Surveyors reviewed additional sampled residents medical records to ensure the facility's following notification changes in condition policy. The facility documented inservices of staff which the surveyors reviewed. Employees including (V1, V2, V3, V19, V29 and V29) were interviewed regarding the inservices. R48's does not have a POLST but does have a state guardianship paperwork that documents he is a DNR. V1 stated all staff have been inserviced on the facility's advanced directive policy and if they haven't been they will be inserviced on the policy prior to working on the floor with residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to completely investigate an allegation of sexual abuse for 1 of 3 residents (R40), reviewed for abuse in the sample of 67. Findings Include: On 5/29/25 at 2:10 PM, R40 was observed in room in wheelchair, with a calm, flat affect, and is alert and oriented to person, place, and time. R40 stated R8 is a friendly guy, and he touched her. When asked where, she pointed to her breasts and abdomen. R40 stated she doesn't recall where it happened or if anyone saw it, but it happened a few weeks ago and she reported it to her nurse, unsure of name. R40 stated she doesn't remember if anything like this has happened before, but it hasn't happened since. R40 stated she isn't afraid of R8. R40 stated she feels safe in the facility. R40's Face Sheet, undated, documents she has the following diagnoses, in part: Mild Cognitive Impairment, Unspecified Mood Disorder, and Cerebral Infarction. R40's MDS (Minimum Data Set), dated 5/14/25, documents R40 has a BIMS (Brief Interview of Mental Status) score of 15, indicating R40 is cognitively intact and doesn't have any indicators of Psychosis or Delirium. R40's Care Plan, dated 5/7/25 and 5/13/25, that she has a behavior problem of making false accusations of staff and other residents. On 5/11/25, R40 accused another resident of groping her in the dining room. R40's Progress Note, dated 5/11/25 at 12:25 PM, documents the following: Reported per staff that a male resident was in mdr (main dining room) attempting to touch this resident in private areas. Staff did intervene immediately, and male resident was removed from area. This resident said that male did not touch her. She did not have any s/s (signs or symptoms) fear/fright. Resident was assessed and had no redness or bruising noted. ED (Emergency Department), NP (Nurse Practitioner), PD (Local Police Department) made aware, and report filed. Resident to be referred to psych as well upon next visit. On 5/29/25 at 2:30 PM, R8 was observed in room in bed, calm, cooperative, alert to self and place only. R8 had no recollection of the alleged abuse involving R40 and denied any inappropriate touching of the female residents or staff. R8's Face Sheet, undated, documents R8 has the following diagnoses, in part: Diffuse Traumatic Brain Injury, Altered Mental Status, Bipolar Disorder, Anxiety, and Post-Traumatic Stress Disorder. R8's MDS, dated [DATE], documents R8 has a BIMS score of 12, indicating R8 has moderate cognitive impairment, has disorganized thinking, has physical, verbal, and other behavioral symptoms that put him at risk for significant risk of physical illness or injury. R8's Care Plan, dated 4/7/25 and 5/6/25, documents R8 is at risk of being physically aggressive towards others related to impaired cognition, poor impulse control, and anger. R8 has a behavior problem of making sexual inappropriate comments and groping staff. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R8's Progress Note, dated 3/8/25 at 6:35 PM, documents the following: Resident continues to be sexually hyperactive, approaching women, he also needs constant redirection. He will be sent to hospital for psych evaluation. R8's Progress Note, dated 3/9/25 at 3:30 AM, documents the following: Received call regarding increased behaviors, nurse attempt to send to ER (Emergency Room) for eval (evaluation), once EMT (Emergency Medical Technician) arrived resident refused. R8's Progress Note, dated 3/30/25 at 5:01PM, documents the following: Grabbing at staff, touching buttocks and attempting to touch breasts. Trying to get in RNs (Registered Nurse) med (Medication) cart. Explaining to him he can't touch med cart. Slapped RN across face. Administrator called, to send out for Psych eval. R8's Progress Note, dated 5/6/25 at 11:27 AM, documents the following: Resident conts. (continues) to displays inappropriate sexual behavior towards female staff. Resident attempted to grab writer's vagina during morning med pass. Writer informed resident that what he was doing was inappropriate. Resident told writer to shut up and give him some p****. Writer tried to administer morning meds resident refused. Writer reached out to Dr (Doctor), NP and left voicemail to call facility. R8's Progress Note, dated 5/8/25 at 9:53 AM, documents the following: It has been reported from several employees about (R8's) inappropriate behaviors. Staff reported that he makes inappropriate comments to them. The latest comment that he made to a staff member was Come here so I can grab your fat p****. Within minutes of being spoken to about his behavior he reached over and rub another employee down her leg. The nurse on 500 hall reported that (R8) touched her between the legs. SSD (Social Service Director) spoke with him and, called his POA (Power of Attorney) to see if she can speak to him about his behavior. Nurse notified. R8's Progress Note, dated 5/11/25 at 1:27 PM, documents the following: Resident up per w/c (wheelchair) propelling self around facility. Was observed in common areas attempting to touch female counterparts and staff inappropriately. Did not witness resident making contact and no female resident voiced concern. No resident displayed s/s fear or fright. Was redirected and taken to low stimulus environment for calming. Did notify NP and resident to be seen by psych upon next visit for consult r/t (related to) sexual aggression. POA made aware of behaviors. Behavior tracking initiated. (Local) police phoned, and report made. R8's Progress Note, dated 5/12/25 at 3:03 PM, documents the following: On May 8, 2025, at 9:53am SSD sent a message to RN Clinical Director for Long Term Psychiatric and Medical Management requesting that (R8) be seen by Psych on next visit. She asked what type of behaviors that he is displaying. SSD told her about several of the things that (R8) has done that was sexual inappropriate towards the staff. R8's Progress Noted, dated 5/20/25 at 6:22 PM, documents the following: Resident sexually inappropriate with nurse verbally and attempted to grab at private areas. Multiple attempts at redirection. R8's Progress Note, dated 5/25/25 at 6:55 PM, documents the following: Resident attempting to reach for staff members butts and private areas. Multiple staff members attempting to redirect him and tell him this is inappropriate behavior. Resident ignores staff and continues trying to grab us inappropriately. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse Investigation Final Report, dated, 5/14/25, documents there is insufficient evidence to declare there was intentional abuse. There was no interview with R8 in the investigation. In the final report there is mention that staff and residents interviewed, however there were no notes in the investigation file of who, when and by whom these interviews were conducted, other than V28, RN, V75, CNA (Certified Nursing Assistant), R40, and R71, to reach the conclusion. There is insufficient evidence in the investigation file provided by V1, Administrator, on 5/29/25 at 1:20PM, to validate that a complete and thorough investigation was completed due to a lack of interviews with other staff and residents. The Local Police Department Incident Report, dated 5/11/25 by V83, Local Police Officer, documents R8 was interviewed and R8 denied putting his hands on R40 and stated he did not know what the officer was talking about. R40 was interviewed and stated she was in the dining room with other people and R8 grabbed her by her breast and vagina. On 5/29/25 at 2:20 PM, V28, RN, stated she did not witness the alleged abuse involving R8 and R40. V28 stated she was the nurse for both residents and (V75) reported stopped her in the hallway and told her that R8 touched or attempted to touch R40. V28 stated when she initially talked to R40, she said nothing happened but then she told the police that R8 touched her inappropriately. V28 stated she notified V1, Administrator, the local police department, R8's family and the MD. V28 stated R40 had no s/s of fear or fright, so they monitored her for 3 days. V28 stated it has been reported that R8 will try to touch female staff or make inappropriate comments to them, but not the female residents. On 5/30/25 at 8:29 AM, V1, Administrator, stated she only talked to the witnesses of the alleged incident between R8 and R40. V1 stated since there were no other witnesses, she didn't interview other staff or residents, she only interviewed V28, V75, R40, and R71. On 5/30/25 at 10:57 AM, V75, CNA, stated he did not witness R8 touch R40. R40 had reported it to him and there were no other staff or residents around when it was reported to him. V75 stated he reported it to the nurse, V28, and she took it from there.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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** 3. R240's Electronic Medical Record (EMR) Medical Diagnoses Sheet, documented his code status was Do Not Resuscitate (DNR) with comfort focused measures. The Sheet documented R240 had the following diagnoses: Acute Kidney Failure, Type 2 Diabetes Mellitus, Essential Hypertension, Chronic Kidney Disease stage 2, Congestive Heart Failure, muscle weakness, sepsis, severe sepsis with septic shock, vascular dementia. R240's Physician's Orders (PO), dated 5/13/25, documented R240 was receiving Bactrim DS Oral, tablet 800-160 mg (milligram), Give 1 tablet by mouth two times a day for UTI (urinary tract infection) for 7 days. R240's Progress Note, dated 5/13/25, at 17:17 PM, documented Resident on antibiotic therapy due to UTI. Resident remains afebrile, vital signs WNL (within normal limits), no adverse reactions noted. Will continue to monitor. R240's Vital Summary, dated 5/15/25, at 9:38 PM, documented his blood pressure was 114/70 mmHg (millimeters of mercury); oxygen (O2) saturation level (sats) was at 98% at room air; temperature was 97.8 degrees Fahrenheit (F), and respirations 18 breaths/minute. There were no vital signs documented on 5/16/25 in R240's medical record. R240's Vital Summary, dated 5/17/25, at 12:24 PM, documented R240's temperature was 97.2 degrees F; at 12:26 PM respirations of 18 breaths/minute; and blood pressure of 135/72 mmHg ; and no O2 sats documented. No further vital signs were documented in R240's medical record. R240's Nursing Note, dated 5/18/25, at 1:37 PM, documented Resident has had a change in condition. Resident is refusing to eat, drink, or take noon meds. Resident is non-compliant with care. Writer reached out to resident POA (Power of Attorney), (V81) to make aware of changes and was sent to voicemail. There is no documentation R240's medical practitioner, V50 (Nurse Practitioner) was notified. R240's Nursing Note, dated 5/18/25, at 9:28 PM, documented Residents POA (V81) came up to facility to see resident. Writer informed POA of residents decrease in appetite and fluid intake. Writer also made POA aware of resident's resistance when it came to allowing staff to provide peri care, showers, and assistance with feeding. POA stated she noticed a change in resident as well. Writer suggested hospice POA stated she would talk with residents' sons, and will the facility know when they make their decision. There was no documentation R240's medical provider, including V50, Nurse Practitioner, was notified. R240's Nursing Note, dated 5/19/25, at 6:46 AM, documented Resident observed to be declining. No food or drinks consumed during a 24-hour period due to resident consistent refusal. Resident appears to be less responsive than baseline. Appropriate staff have been notified. There was no documentation R240's medical provider, including V50 was notified. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/27/25 2:44 PM V80, LPN stated she was the night shift nurse that had come in on 5/18/25. Stated that she recalls being notified by the off going nurse that day that R240 hadn't been himself that day and wasn't wanting to eat/drink/take meds. Stated they told her to keep an eye on him and they had talked to his family about initiating hospice. Stated that night she can't recall if she took any vital signs, stated the electronic medical record system prompts the nurses if vital signs are needed are needed per a schedule or with meds. V80 stated that night he slept well and displayed no emergent needs. Stated she had given report to the oncoming shift of the previous day expressed concerns and that he had no occurrences over the night. R240's Nursing Note, dated 5/19/25, at 7:25 AM, documented Residents conts (continues)to decline in condition. Resident is having shallow breathing, only responds to physical stimuli. Writer notified residents POA (V81) and stated she would be up today to visit resident. There was no documentation R240's medical provider, including V50, was notified. R240's Nursing Note, dated 5/19/25, at 9:00 AM, documented Writer got report resident health is declining. Writer got vitals, O2 (oxygen) was low, O2 was administered at 2L (Liters). Resident son is present, POA notified of changes in condition. POA and son requested resident be sent out to (out of state hospital) per POA. (Ambulance Service) EMS (Emergency Medical Service) called, ambulance arrived resident transported to (out of state hospital). R240s's Nursing Note, dated 5/19/25, at 2:07 PM, documented Writer called (out of state) ED (Emergency Department) to get report on resident, nurse stated resident was changed to full code and was intubated and sent to ICU (Intensive Care Unit). R240's Nursing Note, dated 5/19/25, at 5:23 PM, documented This nurse called (out of state hospital) ED for report on (R24). I spoke with charge nurse (name of charge nurse) who states that resident expired at 3:35 PM this afternoon. R240's Hospital Emergency Department (ED) Records, dated 5/19/25, documented R240 arrived at the hospital at 9:54 AM. The Hospital Records documented EMS (Emergency Medical Service) states that when they arrived pt (patient) was very lethargic and cool to touch, blood sugar read low. EMS gave Glucagon. Upon arrival pt still only responsive to pain and blood sugar read low. R240's Emergency Medicine Resident Note, in the hospital record dated 5/19/25, documented Patient was brought in by EMS from nursing home after he was found to be unresponsive. Patient had low blood sugars to below 40s per EMS. EMS was unable to establish any venous access, patient was given glucagon instead. Per EMS, patient has not been eating for the past several days, and patient was recently hospitalized (at out of state hospital) for an unknown sickness. Initial vital signs for normal on presentation aside from hypothermia to 88.9 Degree F. Patient was responsive to pain but was not alert to self or place. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R240's Attending Physician Supervisory Note, dated, 5/19/25, documented The patient is a [AGE] year-old male that comes from a nursing home initially for hypoglycemia. The patient is paperwork demonstrated that is patient status was DNR DNI with more so an emphasis on comfort measures. An ultrasound IV was placed by myself and during this time the patient continued to decline. We started the patient on pressors since the patient did not have any paperwork stating that he would not want this. Also, during this time, we attempted to contact the family after several attempts we finally were able to get a hold of the patient's son. At this point they completely changed the patient 's code status and made him a full code. The note continued We had multiple discussions with the family. Therefore, at this point the patient was CPR. The patient subsequently declared dead at 1525 by myself. On 5/23/25, at 11:36 AM, V24, LPN stated she took care of R240 on Monday, 5/19/25. She stated she was given report that he had a change of condition. V24 stated R240 had stopped eating and was being non-compliant with care. V24 stated R240's breathing was shallow, and his O2 sats were low. V24 stated she put oxygen on R240 for comfort. V24 stated R240's son, V82, was at the bedside while she took R240's vitals and was asking if there was something they could do. V24 stated that there was a conversation between V82 and V81 on the phone. V24 stated V81 and V82 decided to send him out. V24 stated V83 was R240's physician but the facility was notifying V50, as she was in the facility Monday through Friday. When questioned where this notification would be documented, V24 responded it would be documented the Progress Notes. V24 stated that on the weekend, the facility did have an on-call doctor that they could notify, but they were calling V50, as they had her direct number and could call her. V24 stated that the on-call service would be notified from 1:00 PM on Friday until 7:00 AM the following Monday. When asked what V50 directed them to do regarding R240, she stated nothing. V24 stated she notified V50 when the family requested R240 be sent to hospital as she needed V50's permission to send R240 out. On 5/23/25, at 11:50 PM, V10, LPN, stated that V50 was in the facility routinely and followed R240's care. V10 stated R240 wasn't eating or drinking. She said it all started on Tuesday of the previous week. V10 stated V50 was at the facility on Tuesday, and she notified V50 at that time. V10 stated it wasn't like R240 to not eat or drink. V10 said that he was not letting them care for him. She said that she came in on Saturday or Sunday and it was the same thing, he was not eating or drinking. She said that she called V81 and discussed possible Hospice. She said that was the family's choice. She encouraged V81 and the family come in as she thought they may be able to help or get him to eat. V10 stated said they notified V81 that needed to get in and see him. She said the son, V82, came in and was at the bedside. V10 stated she attempted to R240's blood pressure using the wrist cuff, and it was reading low, she thought 96/52. V10 stated it was up to the family as to what they wanted to. V24 stated V82 was at the bedside and V81 was talking to him, and they decided to send him out to the hospital. When asked if V50 was notified of his blood pressure and changes of condition, she said that she initially told V50 of the change but after that, he didn't have a big change it just continued. V10 stated she did not notify V50 because she was already aware of R240's change. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 5/23/25, at 10:28 AM, V50 stated that she was R240's medical practitioner and she was the one who saw him in the facility. V50 stated that she had not been notified on 5/18/25 of R240's change of condition as she does not take weekend call. She stated that the on-call service takes over at 1:00 PM on Friday and extends until 7:00 AM on Monday. V50 stated that she was not aware R240 had been sent to the hospital until Tuesday (5/20/25), at which time she was told he expired. She stated that notification of medical practitioner would have been documented in the Progress Notes. V50 stated that per standards of practice, vital signs would be taken if the initial vitals were abnormal. V50 stated that for example if a O2 sat was below 90%, the nurses should contact the medical practitioner and the medical practitioner would make the decision as if they wanted to send the resident to the hospital, continue to monitor vitals or get laboratory work. On 5/23/25, at 12:00 PM, during a follow-up call with V50, she stated that V10 did notify her of R240's change of condition on Tuesday, 5/13/25. She stated she was not notified on 5/18/25, that there was a change in R240's baseline. V50 stated she was not called regarding R240 being sent to the hospital, and she did not give that order. V50 stated she did not become aware of R240's change of condition until after he passed away. She stated that she was not sure if the outcome would have changed if she had been notified, but she said it would have allowed her to have a conversation with the family regarding how they wanted to proceed. She said they would have discussed possible medications to stimulate appetite, tube feeding and possible Hospice. She again stated that R240 had chosen Do Not Resuscitate with Comfort Measures. The facility took the following actions to remove the Immediacy: Identification of Residents Affected or Likely to be Affected: Improving nursing skill sets for conducting a complete assessment on residents who has acute change in condition and non-urgent change in condition. 1.Immediate Corrective Action for those affected by the deficient practice: DON, V2 and V3, ADON completed an in-service on 4/29/2025 on our Notification Changes in Condition policy. The policy includes the following: Upon identification of any change in condition licensed nursing personnel will contact the resident's attending physician/on-call physician/practitioner to notify him/her of the change. Acute changes in condition should occur immediately upon recognition while non-urgent changes should occur no later than 72 hours from the noted change. All notifications should be documented and should include; The date and time of the notification; a) The name of the individual contacted; b) (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The specific reason for the notification; c) And any specific responses that were given by the person contacted. All changes of condition require an immediate assessment and documentation of resident condition which should include, at a minimum: a) Pain b) Orientation c) Any change from baseline status d) Status of any pending labs/diagnostics e) Vital signs All changes of condition require a follow up assessment with proper documentation that will include the following: pain, orientation, baseline status and current status, updates on results from labs/diagnostics and vital signs. Nursing will continue to update MD/NP on the status of the resident. 2. Process/Steps to identity others having the potential to be impacted by the same deficient practice: -All resident have the potential to be affected. R89 expired on 2/25/2025. 3. Beginning April 29, 2025, measures were put into place/systematic changes to ensure the deficient practice does not recur. -DON/ADON or designee will review physician's orders (e.g., code status) daily for the next 4 weeks. -DON/ADON or designee will review laboratory or radiology results pertinent to the resident's change in condition for the next 4 weeks. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	-DON/ADON will pull three random charts twice a week for the next 4 weeks and do the following: Review progress notes to determine what interventions were put into place to address the change or decline in condition (e.g., first aid measures, glucose monitoring, cardiopulmonary resuscitation [CPR], and immediate transfer)? 4. Plan to monitor performance to ensure solutions are sustained. -Beginning April 29, 2025 and continuing until further addressed in the plan of correction, the DON or Designee will conduct a chart review, 3 random charts twice a week for 4 weeks to ensure chart is the following: -Evaluate interventions to determine was intervention appropriate, monitored and modified as needed -Was pain assessed and treatment measures documented. -Ensure care was consistent with the resident advance directive or goals for care -If concerns are identified, review facility policies and procedures with regard to factors that led to the resident's change in condition. -Review resident significant change and compare it to their baseline. -Communicate changes with family/POA. Surveyors validated the removal of abatement by reviewing medical records to ensure residents had readable POLST forms uploaded and a physician's order for code status, verification of code status documented in medical. R89 was deceased and therefor his medical record was not further reviewed. Surveyors reviewed POLST forms and physician's orders for code status. R48 didn't have an updated POLST form and this was brought to the attention of V7, Social Services Director. The facility submitted an advanced directive policy dated 4/30/2025 and they inserviced staff that day on the policy. V1, Administrator stated all staff will be inserviced before they start working, including agency staff. Employees including (V1, V2, V3, V7, V19, V27, V29 and V49.) Surveyors conducted a review of all facility inservices. Were interviewed to ensure they were aware of current policies and procedures and had been inserviced. The completion date was changed from 4/29/2025 to 4/30/2025 due to V1, DON and V2 ADON inservicing staff on the new advanced directive policy. V1 stated all staff have been inserviced on the facility's notification changes in condition policy and if they haven't been they will be inserviced on the policy prior to working on the floor with residents. Based on interview and record review, the facility failed to properly assess, monitor residents experiencing a change in condition for 3 of 5 residents (R89, R193, R240) reviewed for change in medical condition in the sample of 67. This failure resulted in R89's delay in medical treatment for a change in condition and R89 was pronounced deceased at the hospital on 2/25/2025. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This failure resulted in Immediate Jeopardy on 2/25/202 when R89, he had a change in condition and the facility failed to timely assess R89 which resulted in R89 being transferred to the hospital with lifesaving measures. R89 ultimately expired at the hospital. On 4/29/2025 at 9:15 AM V1, Administrator, V2 DON and V3 ADON were notified of the Immediate Jeopardy. The surveyor confirmed by interview and record review, the Immediate Jeopardy was removed on 4/30/2025, after abatement reviews dated 4/29/2025 at 1:18 PM, 2:00 PM and 2:29 PM but remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-servicing training. Findings include: 1.R89's Undated Face Sheet, documents R89 was initially admitted to the facility on [DATE]. R89's admission Minimum Data Set (MDS) dated [DATE] documents he was cognitively intact. R89's Nursing Note, dated 2/25/2025 at 8:00 AM documents nurse alerted by staff that resident showing a change in condition. Resident observed with a thready faint pulse. Patient assessed and treated until EMS arrived. R89's Nursing Note, dated 2/25/2025 at 8:50 documents hospital notified facility patient expired @ 8:48 AM. Arrangements made from hospital to be transported to funeral home. R89's Health Status Note, dated 2/25/2025 at 10:37 AM documents EMS arrived at 8:09 AM and departed at 8:21 AM. On 4/23/2025 at 2:00 PM V11, CNA stated she recalled (R89) he was alert and oriented and was able to make his needs know. On 2/25/2025 V14, CNA was assigned to (R89) and she recalled they both reported to V15, RN that (R89) was out of it that morning and the resident was really spacy. A while later she entered (R89's) room and observed V14 transferring (R89) with a gait belt from his bed to wheelchair and (R89) stated, I can't stand, I'm dizzy! V14 lowered (R89) to the floor. V11 stated she ran down the hall and yelled for a nurse. V11 stated she was really concerned for (R89) because he was slow to respond earlier that morning but when she reported it to V15 she was receiving nurse report from the night shift nurse, and she waived her away. On 4/23/2025 at 2:15 PM V12, LPN stated she recalled (R89) the day he had a change in medical condition and was transferred to the hospital on 2/25/2025. V12 stated she wasn't assigned to (R89) that day but at around 6:30 AM, at the beginning of the shift she overheard V11, CNA report to V15 that (R89) wasn't acting himself, she didn't know if V15 assessed (R89) or not because she was assigned to another hall. A while later V12 heard staff yelling down the hall they need a nurse that (R89) had a change in medical condition. R89's Medical Record dated 2/25/2025 documents no vital signs documented. On 4/23/2025 at 3:45 PM V17, LPN stated on 2/25/2025 she was assigned to the 500 hall and during nurse report she overheard V11, CNA and V14, CNA report to V15, RN that (R89) was not himself and something was wrong with him. V17 didn't know if V15 went to assess (R89) or anything because she was assigned to the 500 hall and (R89) resided on 300 hall. Sometime later that morning (time unknown) staff announced (R89) wasn't responsive and 911 was called and he was transferred to the hospital. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/24/2025 at 10:45 AM V14, CNA was assigned to (R89) on 2/25/2025 and he recalled what occurred. V14 stated this was the first day he was assigned to (R89) and didn't know him at all. V14 stated he asked V11 if she could help him and she went into (R89's) and told V14 that (R89) wasn't acting himself and she left the room and reported to a nurse (name unknown) that (R89) wasn't right and V11 came back to (R89's) room and said she told the nurse about it. Over an hour later, V14 stated (R89) was laying in bed and was yelling, Get me up! I want to get up! No nurse came to (R89's) room V14 and V11 transferred (R89) to his wheelchair and as they did (R89) fainted/passed out and wasn't responsive. V14 and V11 got (R89) back to bed and he wasn't talking and his eyes were closed. V11 left (R89's) room and yelled down the hall that they need a nurse and V12, V16, V17 responded to (R89's) room immediately. V15 entered (R89's) and finally assessed him, 911 was called and he was transported to the hospital. On 4/23/2025 at 11:14 AM V15, RN stated she was assigned to (R89) on 2/25/2025 and she was familiar with him and was assigned to him often. V15 stated (R89's) baseline was he was alert and able to make his needs known. On 2/25/2025 she recalled she got to work around 6:30 AM and got report from the night shift nurses (names unknown) and no issues or concerns was expressed for (R89.) No staff reported that (R89) wasn't acting right during nurse report. It wasn't until around 8:00 AM that V11 reported that (R89) was not acting himself and she immediately went to his room and laid eyes on him. At that time (R89) was in bed and he stated he didn't want to get up out of bed. V15 stated (R89) was lethargic at that time and was very slow to respond to her and while she was assessing his vital signs including blood pressure, heart rate, pulse oxygenation and respirations and he was rapidly declining right in front of her. V15 recalled (R89's) pulse was faint and the oxygen saturation machine didn't register on his finger and she tried different fingers but it still wouldn't register a reading. V15 also reiterated that no staff reported to her that (R89) was having an issues or any concerns prior to after nurse report and she started administering medications to residents. V15 stated she documented the entire change in condition regarding (R89) in the nurse progress notes in the computer including his vital signs, she didn't know why the assessment wasn't documented in (R89's) medical record because she knows if you don't document it it wasn't done and she definitely wanted to protect her nursing license. V15 stated (R89) was transferred to the hospital via EMS and he died shortly after arriving to the hospital. On 4/25/2025 at 9:45 AM V34, Former Therapy Program Manger stated she worked with (R89) and provided occupational therapy, she noted (R89) was alert and able to make his needs known. V34 stated she got to the facility at 5:00 AM on 2/25/2025 and noted (R89) was in bed around 6:30 AM and observed V11 and V14 were transferring (R89) from his bed to wheel chair and he was yelling out that he didn't want to get up. V34 entered (R89's) room and told the CNAs to sit him back on the bed and they did. V15, RN entered (R89's) room and asked what he's yelling about and at that time V34 noted (R89) took a gasp for breath which she thought was odd. V15 instructed the CNAs to lay him in bed and raise the head of the bed and that he'd be fine V15 then left (R89's) room. V34 stated she was gravely concerned about (R89) but that V15 was an RN and she trusted her nurse judgement. Around 8:00 AM she went to (R89's) room to check on him and V11, CNA was in his room and told V34 that she reported to V15, RN that (R89) was not responsive but that no one was doing anything about it. V34 stated she went to get a blood pressure cuff and a pulse ox and put it on (R89), neither the blood pressure or pulse ox would register a reading at that time and from she could tell (R89) wasn't breathing. V34 stated (R89) was transferred to the hospital and she was informed he passed away shortly after arriving to the emergency room. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/23/2025 at 3:00 PM V16, LPN stated she worked night shift and arrived to the facility at 10:30 PM on 2/24/2025 and also worked day shift on 2/25/2025 as well. V16 stated she was assigned to (R89) night shift and administered a medication, (medication name and dose unknown) to him at 6:00 AM on 2/25/2025, V16 stated he was sleeping and she woke him up and he was at baseline at that time he took the medication and went back to sleep. He didn't complain of shortness of breath or pain at that time. V16 gave nurse report to the day shift nurse V15 was (R89's) day shift assigned nurse. V16 didn't recall any staff reporting (R89) was having any changes during nurse report. A while later she was at the nurse's station and V11 came to the nurse's station and reported to V15 several times that (R89) wasn't acting right and was slow to respond to them. V16 stated V11 is assigned to (R89's) hall and knows him well so she knew something must be wrong if she kept saying something was wrong with (R89.) A few minutes went by and V15 was still on the computer at the nurse's station at that time and wasn't going to assess (R89) so her and V12 went to assess (R89.) V16 stated she was halfway down the hall when a therapy employee (name unknown) came out of (R89's) and stated he's no longer responsive. V16 stated when she entered (R89's) he was in bed and eyes were closed. Her and V12 assessed (R89) by doing a sternal rub which he had no response to and the pulse oximetry machine wasn't displaying a reading at that time. R89's POS and MAR dated 2/2025, documents no 6:00 AM medication was ordered for that time. No medications were signed out by staffing including V16. On 4/25/2025 at 8:35 AM V2 stated he looked into (R89's) POS and MAR dated 2/2025 he didn't see any physician ordered medications due at 6:00 AM and wasn't sure what medication V16 would have administered to (R89.) On 4/23/2025 at 12:45 PM V2, DON stated when a resident has a change in condition he expects staff to obtain vital signs including blood pressure, heart rate, oxygen saturation and respirations. He also expects the nurse to assess the resident from head to toe noting any abnormalities. The nurse should talk to the resident and see what their orientation status is to see if there is a change in baseline. The nurse should also assess the resident for pain and dizziness and to notify the physician of what the assessment was and to obtain orders from the physician. V2 stated the full change in medical condition assessment including vital signs is expected to be documented in the resident's nurse progress notes. V2 recalled (R89) and stated he was sent to the emergency room for his catheter at one point but he was readmitted to the facility the same day and he didn't recall any specifics of what occurred on 2/25/2025. On 4/23/2025 on 12:12 PM V2, DON stated if staff call him and notify him of a resident having a change in condition he would tell staff to get the resident's vital signs and have a nurse assess the resident and to notify the resident's physician of the change in condition to get physician's orders. On 4/25/2025 at 11:40 AM V1, Administrator stated she expects staff to follow facility policies and procedures for when a resident experiences a change in medical condition. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 4/23/2025 at 9:50 AM, V21 Nurse Practitioner stated she assessed (R89) on 2/21/2025 at the facility and he was sitting up in bed and was alert and oriented to person, time, place and situation and he told her he was struggling to walk but should be getting therapy soon so he hoped he gets better so he can go home. V21 assessed (R89's) and noted his lower extremities and left arm were swollen at that time. She ordered the following labs: CBC, CMP, BMP and a doppler to his left arm at that time and doesn't know if the facility got the order completed or not, she hasn't seen the blood work or the doppler results in (R89's) medical record. V21 stated although she didn't order the labs and doppler STAT (immediately) she expected staff to order the blood work and doppler the same day and to get the results as soon as possible. When staff report to a nurse that a resident isn't acting himself or is out of it she expects the assigned nurse to assess the resident immediately and to obtain vital signs including blood pressure, heart rate, respirations and pulse oxygenation and to check on the orientation of the resident at that time to see if he's had a change in medical condition. After the nurse assesses the resident they should call the physician and report the findings to see what if any interventions or new physician's orders are applicable. After the nurse completes the assessment on the resident if she thinks the resident should be 911 be transported to the emergency room then she can do that without a physician's order but after the resident is transferred to the hospital the nurse should call the physician's office and give them an update on the resident's medical status. V21 stated there is no documentation in the physician's medical record that (R89's) nurse notified the physician's office of the resident's change in medical condition. 2. R193's Undated Face Sheet, documents he was initially admitted to the facility on [DATE] with diagnoses included Stage 3 pressure ulcer of left hip. R193's POLST form, signed 2/16/2024 documents R193 was a full code. R193's Significant Change MDS, dated [DATE] documents R193 was severely cognitively impaired. R193'2 Nursing Note, dated 6/15/2025 at 11:20 AM, documents writer went into resident's room to perform wound care and found resident unresponsive. Writer called for assistance from staff. CPR administered 911 called CPR performed until ambulance arrived. Paramedics arrived and took over CPR. Writer notified Hospice along with POA and physician and DON. Paramedics continued to work on patient while they escorted him out the building to local hospital. No vitals signs or thorough assessment documented. The Facility's Notification Changes in Condition Policy, revised 2/20/2023 documents it is the responsibility of licensed staff to contact the physician and the resident's responsible party whenever there is a change in the resident's physical, mental or psychosocial status. Upon identification of any changes in condition licensed nursing personnel will contact the resident's physician/on call-physician/practitioner to notify him/her of the change. Acute changes in condition should occur immediately upon recognition. All notifications should be preceded by an appropriate physical assessment to enable the physician to make adequate and appropriate treatment and/or transfer decisions. For acute changes in condition this should occur immediately when practicable and after addressing the resident's immediate needs. All notifications should be documented and should include the date and time of the notification, the name of the individual contacted, the specific reason for the notification and any specific responses that were given by the person contacted. All changes of condition require follow-up assessment and documentation of resident condition which include at a minimum, vital signs, pain, orientation any change from baseline status.

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. R66's Face Sheet, print date of 5/21/25, documented diagnoses of Alzheimer's Disease with late onset, muscle weakness, difficulty walking, R66's Care Plan, revision dated of 3/6/25, documented left heel 'mushy'. R66's Care Plan intervention, initiated on 3/7/25, documented Left multipodus boot to be worn at all times. R66's MDS, dated [DATE], documented she was not at risk for pressure ulcer and did not have any pressure ulcers at that time. On 5/21/25, at 10:06 AM, R66 was seated in a wheelchair (w/c) at the nurse's station near the bird cage. R66 was wearing blue colored crocs with fur-type lining and pink socks. She was not wearing a pressure relieving boot on her left foot. On 5/21/25, from 10:07 AM until 12:06 PM, R66 remained in the small dining room for activities and then for lunch. She continued to wear crocs on both feet and was not wearing a pressure relieving boot on her left foot. At 1:05 PM, V41, CNA, was coming out of R66's room. R66 was sitting in her room in her w/c wearing crocs and socks. After asking R66 if I could see her heels, and she agreed, V41 assisted by removing R66's shoes off the left and right feet and removed R66's socks. R66's left heel was darkened, and she said it was sore. V41 placed R66's socks on both her feet and then placed a blue pressure relieving boot onto R66's left foot. V41 stated to R66, That will make it feel better. On 5/27/25, V22, Wound Nurse, stated that R66 should have skin prep to her left heel and the use of the boot for pressure relieving measure. V22 stated that the goal of the interventions is to prevent breakdown. V22 stated that R66's boot should be worn while out of bed and while also in bed if the heels are not being floated. Based on observation, interview, and record review, the facility failed to assess, timely treat pressure ulcer infection, and provide pressure relief, to prevent pressure ulcer development and worsening of pressure ulcers for 3 of 6 residents (R6, R29, R66) reviewed for pressure ulcers in the sample of 67. On 12/27/2024, R6 acquired a deep tissue injury from pressure to his left shoulder which opened to a Stage IV, exposing tendon. On 1/10/2025, (R6) acquired another deep tissue injury, unstageable, from pressure to right hip which opened to Stage IV pressure ulcer exposing hardware on his right hip. Subsequently, (R6's) pressure ulcers worsened and (R6) was admitted to the hospital with pressure ulcer infection from 2/28/2025 - 3/14/2025 with osteomyelitis. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	This failure resulted in Immediate Jeopardy on 12/13/2024 when R6, who is severely contracted and in fetal position, has a history of pressure ulcers and is at high risk for pressure injuries. (R6's) low air loss mattress malfunctioned on 12/13/2024, which caused him to lay on the metal frame with no pressure reducing device for the prevention of bedsore. On 12/27/2024, (R6) acquired a deep tissue injury which Wound Nurse Practitioner, V13, stated was from the facility not providing adequate pressure relief and from the low air loss mattress malfunctioning. From 12/27/2025 until 1/17/25, the facility did not follow the order from wound consultant for the left shoulder pressure ulcer. On 1/10/2025, (R6's) acquired an additional deep tissue injury, unstageable, to his right hip from pressure. (R6) was seen by Wound Nurse with pressure ulcers worsening and opening to Stage IV pressure ulcers, exposing tendon on his left shoulder and hip hardware on his right hip. On 2/28/2025, due to the decline in (R6's) pressure ulcer and possible infection in (R6's) left shoulder, V13 ordered (R6) be sent to hospital. (R6) remained in the hospital from [DATE] through 3/14/2025 and diagnosed with osteomyelitis. (R6) returned to the facility on 3/14/25 and had an order for IV antibiotic to be administered for 7 days. The MAR documented R6 did not receive the antibiotic for 3 of the 7 days prescribed. On 4/9/25, V50, Nurse Practitioner, concerned with possible infection in (R6's) pressure ulcer, ordered a culture. This culture was not obtained until 4/17 and not reported to V50 until 4/24/25 at which time, the lab indicated infection. V50 ordered PICC line placement for (R6) to administer antibiotics. The facility failed to gain venous access until 4/29/25, at which time antibiotic was started. V50, NP, stated the delay in treatment of the wound infection could cause R6 sepsis which could result in organ shutdown resulting in death. On 5/9/2025 at 10:44 AM V1, Administrator, V2 Director of Nursing DON and V3 Assistant Director of Nursing ADON were notified of the Immediate Jeopardy. The surveyors confirmed by observation, interview and record review, the Immediate Jeopardy was removed on 5/20/25, after the team attempted to validate abatement on 5/13 and 5/14/25, and 5/20/25, and observed that residents (R6, R51, and R59) at high risk for skin breakdown were lying on low air loss mattresses that were not set to the appropriate weight setting of each resident. On 5/20/25, at 12:10 PM, the survey team validated the facility's abatement but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the facility's in-service training, ongoing assessment, monitoring of pressure relieving equipment and pressure ulcer monitoring. Findings include: 1. R6's Undated Face Sheet, documents he was initially admitted to the facility on [DATE] with diagnoses including osteomyelitis, stage IV pressure ulcer to sacrum, stage IV left upper back pressure ulcer, stage IV right hip pressure ulcer, pressure induced deep tissue damage, paraplegia, hyperglycemia and contractures of both knees. R6's Physician's Order Sheet (POS) dated 10/10/2024 documents pressure relieving low air loss mattress to bed and pressure relieving cushion to wheelchair every shift for pressure relieving devices to protect skin. R6's Annual MDS, dated [DATE], documents severely cognitively impaired, dependent with toileting hygiene, shower/bathe self, personal hygiene, dependent with rolling left and right and chair/bed-to-chair transfers, incontinent of bowel and bladder, at risk for developing pressure ulcers, one stage III pressure ulcers, pressure reducing device for chair and bed, pressure ulcer/injury care treatment, application of nonsurgical dressings, applications of ointments/medications other than to feet. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145581	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Meadows of Cahokia	2 Annable Court Cahokia, IL 62206

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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 - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's POS, dated 12/1/2024 documents the following active physician's orders: 10/12/2023 document weekly skin assessment every Monday day shift and 7/9/2024 waffle boots on when in bed every shift pressure release. 6/11/2024 apply pillows between left and right legs and thighs every shift for positioning. 10/10/2024 pressure relieving low air loss mattress to bed and pressure relieving cushion to wheelchair every shift for pressure relieving devices to protect skin. Notify MD/DON/Wound Nurse if he has or c/o (complaint of) any excoriated and/or open areas. R6's Undated Care Plan, documents resident is at risk for decline in wound impairment to skin integrity r/t (related to) poor PO (by mouth) intake, incontinence and decreased mobility. 12/31/2023 left shoulder stage IV pressure ulcer -nosocomial (acquired in house) and right hip pressure ulcer stage IV pressure ulcer. Goal: resident will have a decline in wound status through next review date. Interventions: pressure relief techniques, left to right side to side t/p (turn and reposition) every hour and PRN (when needed), use positioning devices as indicated. Multipodus boots on when in bed. Use positioning devices when in bed to maintain positioning when in bed. Use pillows between legs when in bed. Educate staff on the importance of maintaining left to right t/p schedule to promote healing and reduce the risk for skin breakdown. Apply padding to bony areas (such as pillows, boots, heel protectors etc.) as indicated. Low air loss, pressure relieving mattress to bed. He uses a pressure relieving cushion to protect the skin while up in chair. Notify nurse of any redness areas, s/s (signs or symptoms) of infection, excoriation or skin breakdown immediately, treatments as ordered (see physician's order sheet/TAR), notify PCP (primary care provider) DON (Director of Nursing) if decline noticed in wound status, monitor/document location, size, and treatment of skin injury. Report abnormalities, failure to heal. s/s of infection, maceration etc. to MD (physician.) R6's POS dated 12/13/2024, documents late entry: d/c (discontinue) low air loss mattress until replaced, due to it not functioning properly, per wound consultation company CNAs moved resident from broken low air loss mattress today and put on regular mattress until replacement mattress is available. R6's Wound Nurse Practitioner Progress Note, dated 12/13/2025 stage 3 coccyx pressure ulcer measured 2. 3 cm x 2.3 cm x 0.6 cm, 50% slough, granulation tissue 30%, skin intact 20%, exposed structure: blank. Pressure ulcer length, width, depth and tissue status deteriorated as compared to previous visits conclusion. Visit specific information: patient now has a regular mattress and appears to be able to turn and reposition much better. This was the only pressure ulcer R6 had as of 12/13/2024. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's Nursing Progress Note, dated 12/18/2024 at 3:14 PM documents, Upon doing daily treatment to coccyx, this nurse noticed an area to the right hip which appears to be consistent with an abrasion. Area measures 5.5 x 4.5 x 0.1 cm. (whole reddened area.) with a small open area to the middle measuring 2 x 2 x 0.1 cm. Area bright red in color, small amount of clear yellowish drainage noted. No odor, not warm to touch. Area surrounding open area intact, yet bright (whole reddened area.) with a small open area to the middle measuring 2 x 2 x 0.1 cm. Area bright red in color, small amount of clear yellowish drainage noted. No odor, not warm to touch. Area surrounding open area intact, yet bright red. Facial grimacing noted when area cleansed. This nurse also noted an area to the Right shoulder/deltoid measures; 8 x 3.5 x 0.1 cm (whole reddened area) with a small open area to the middle measuring; 2 x 0.5 x0.1 cm small amount of clear yellowish drainage noted. No odor, not warm to touch. Area surrounding open area intact, yet, bright red in color. Facial grimacing noted when area cleansed. Area consistent with an abrasion as well. This nurse reported findings to the Administrator as well as DON and ADON. Message left with POA to return call. MD made aware as well as well as V13- new orders redc'd to Cleanse areas with soap and water, pat dry. Apply skin prep to periwound apply TAO and cover with dry protective dressing daily and PRN. Education provided to staff regarding turning and repositions q2. Resident also provided with more offloading devices such as pillows and wedges. Spoke with maintenance regarding status of the replacement low air loss mattress, maintenance states that one came in today he was going to check and see if it belonged to him or not. On 5/2/2025 at 2:55 PM, V63, LPN stated she was assigned to R6 on 12/18/2025 and stated she observed (R6) laying on the air loss mattress but all the air was in the foot of the mattress, no air was at the head of the bed and the (R6) lay directly on the bedframe. V63 stated she spoke to the maintenance man regarding (R6's) air loss mattress malfunctioning but he said it was working just fine and he wouldn't switch the bed out or change (R6's) bed. V63 stated there were numerous times that she observed (R6) laying on the air loss mattress with no air in the head of the bed and she spoke to V13, Wound Consultant about her concerns but (R6) continue to lay in the broken air mattress bed. R6's Wound Nurse Practitioner Progress Note, dated 12/19/2024, documents (R6) was removed off the low air loss mattress last week due to his wound continuing to decline. Patient is contracted and lies on fetal position and on the low air loss mattress this potentially place him on the frame depending on the level of inflation that the bed is set to. We placed them on a regular mattress so he would stop sinking into the bed however this week he now has two new wounds. I did discuss with V2, DON that maybe we could place a thinner foam on the bed frame and then a low air loss mattress which would help reduce pressure to the area if the mattress deflated enough to where he's putting pressure on the frame. Also discuss with V2 the need for frequent turning and repositioning. Stage 3 pressure ulcer to right trochanter wound 3 initial assessment measured 3.5 cm x 2.1 cm x 0.2 cm wound bed 60% granulation and 40% slough. Stage 3 pressure ulcer to right shoulder wound 4 initial assessment measured 1.5 cm x 5.5 cm x 0.2 cm wound bed 30% granulation and 70% skin intact. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	5/1/2025 at 3:25 PM V32, Maintenance Director stated there was a situation with R6's low air loss mattress and he wasn't here at that time but he recalled it was in December 2024 that maintenance staff reported to him that the resident's air loss mattress was found to be faulty, all the air was out of the mattress and the resident lay in a concave hole in the middle of the bed and the resident was laying on bedframe. Staff told him the mattress needs to be replaced and it was replaced the same day. He replaced several low air loss mattresses for the resident due to staff not pushing the static mode button to the off position when the resident is in the prone position. Observation showed at that time that the static mode button was in the on position, and it should have been off, V32 turned it to the off position. V32 stated when the resident's head of bed is elevated the static mode should be in the ON position because if not it doesn't distribute the air in the air loss mattress properly. V32 stated he has replaced R6's low air loss mattress at least 4 times in the last 2 years because it just wears out after time. On 5/8/2025 at 9:30 AM V32, Maintenance Director stated they don't document work orders when they change out resident's bed even if they are faulty. V32 didn't know what dates (R6's) air loss mattress was malfunctioning or when (R6) had a regular pressure relieving mattress. On 5/8/2025 at 9:45 AM V22, Wound Nurse stated she doesn't know what dates (R6's) air loss mattress wasn't working properly or when he lay on a regular mattress. R6's Wound Nurse Practitioner Progress Note, dated 12/27/2024 documents a new Unstageable pressure ulcer on left shoulder measured 0.9 cm x 1.5 cm x 0.1 cm. Treatment: skin prep, paint wound edges and surrounding skin. Visit specific information: Patient is still on a regular mattress and his wounds are improving this week. This was the suspicion that patient just needed better off flowing and not necessarily the low air loss mattress which was sinking him into the frame of the bed. Due to patient's falling (means balling) up in the fetal position it is highly likely that he needs offloading more frequently. R6's POS dated 12/27/24 through 12/31/20242024 documents no physician's order for skin prep. R6's TAR, dated 12/27/2025 through 12/31/2025 no documentation staff administered skin prep to (R6's) unstageable left shoulder pressure ulcer. R6's Wound Nurse Practitioner Progress Note, dated 1/3/2025 documents a initial/new assessment an unstageable pressure ulcer on left shoulder/wound 5 measured 3.0 cm x 2.5 cm x 0.1 cm. Wound assessment documents the pressure ulcer was facility acquired. Treatment: skin prep, paint wound edges and surrounding skin. Right trochanter wound 3 and right shoulder wound 4 documented healed. R6's POS, dated 1/1/2025 through 1/9/2025 physician's order for skin prep to (R6's) unstageable left shoulder pressure ulcer. R6's TAR, dated 1/3/2025 through 1/9/2025 no documentation staff administered skin prep to (R6's) unstageable left shoulder pressure ulcer. R6's Wound Nurse Practitioner Progress Note, dated 1/10/2025 documents left shoulder unstageable pressure ulcer/wound 5 treatment: cleanse with soap and water, skin prep to periwound, apply calcium alginate to wound base and cover with bordered gauze. New pressure ulcer assessed unstageable right trochanter wound 6 measured 2.0 cm x 2.5 cm x 0.1 cm, 100% skin intact treatment: skin prep. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's Wound Nurse Practitioner Progress Note, dated 1/10/2025 documents wound 5 unstageable left shoulder pressure ulcer/wound 5 measured 3.1 cm x 3.8 cm x 0.2 with 30% slough and documents pressure ulcer deteriorated compared to previous visit. New unstageable pressure ulcer right trochanter (hip) wound 6 measured 2.0 cm x 2.5 cm x 0.1 cm wound bed 100% intact. Treatment: paint surround skin with skin prep. R6's POS dated 1/10/2025 no physician's order for (R6's) unstageable left shoulder pressure ulcer/wound 5 treatment of calcium alginate to wound base and cover with bordered gauze per wound nurse practitioner documentation dated 1/10/2025 and no physician's order for skin prep to right trochanter wound 6 unstageable pressure ulcer per the wound nurse practitioner's documentation dated 1/10/2025. R6's Braden, dated 1/16/2025 at 1:08 PM documents moderate risk for skin breakdown. R6's Annual MDS, dated [DATE], documents severely cognitively impaired, dependent with toileting hygiene, shower/bathe self, personal hygiene, dependent with rolling left and right and chair/bed-to-chair transfers, incontinent of bowel and bladder, at risk for developing pressure ulcers, two stage III pressure ulcers, pressure reducing device for chair and bed, pressure ulcer/injury care treatment, application of nonsurgical dressings, applications of ointments/medications other than to feet. R6's Wound Nurse Practitioner Progress Note, dated 1/17/2025 documents left shoulder unstageable pressure ulcer/wound 5 and unstageable right trochanter pressure ulcer/wound 6 treatment changed to cleanse with soap and water, skin prep to periwound, calcium alginate to wound bed and cover with bordered gauze. It was documented both pressure ulcers had deteriorated compared to the conclusion of the previous visit. R6's TAR dated 1/1/2025 through 1/16/2025 no documentation staff administered skin prep to (R6's) left shoulder of right trochanter. R6's POS dated 1/17/2025 and discontinued on 1/21/2025 documents a new physician's order for skin prep to both shoulders and right hip daily. (The wound nurse practitioner initially ordered skin prep to left shoulder daily on 12/27/2024 and right hip on 1/10/2025 this is the first physician's order for skin prep.) No new physician's order from the wound nurse practitioner progress note, dated 1/17/2025 documented both left shoulder and right trochanter pressure ulcer treatments to soap and water, skin prep to periwound, calcium alginate to wound bed and cover with bordered gauze. R6's POS dated 1/21/2025, documents a new physician's order left shoulder and right trochanter pressure ulcer cleanse with soap and water, pat dry, apply skin prep periwound, apply Santyl to wound bed, calcium alginate to wound bed and cover with bordered gauze. R6's POS dated 1/17/2025 documents pressure relieving mattress to bed and a pressure relieving cushion to wheelchair every shift for pressure relieving devices to protect skin. R6's TAR dated 1/2025 documents blank boxes dated 1/22/2025, 1/29/2025 and 1/30/2025 for the left shoulder and right trochanter pressure ulcer treatment. R6's Braden, dated 2/10/2025 at 4:18 PM documents high risk for skin breakdown. (continued on next page)

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	145581	A. Building B. Wing	06/10/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's Quarterly MDS, dated [DATE], documents R6 was severely cognitively impaired, dependent with toileting hygiene, shower/bathe self, personal hygiene, dependent with rolling left and right and chair/bed-to-chair transfers, incontinent of bowel and bladder, two stage III pressure ulcers, two unstageable pressure ulcers, pressure reducing device for chair and bed, pressure ulcer/injury care treatment, application of nonsurgical dressings, applications of ointments/medications other than to feet. R6's Wound Nurse Practitioner Progress Note, dated 2/12/2025 documents visit specific information: patient now has a low air loss mattress. R6's Wound Nurse Practitioner Progress Note, dated 2/21/2025 documents wound 5 left shoulder pressure ulcer is now documented as a Stage IV measured 10.0 cm x 6.0 cm x 0.8 cm with tunneling and wound bed was covered with 80% slough, with exposed tendon, serosanguineous drainage. Wound 6 right trochanter pressure ulcer is now documented a stage IV measured 5.8 cm x 6.3 cm x 0.6 cm with tunneling no exposed structure documented. Both pressure ulcers per wound nurse practitioner documentation had deteriorated compared to the conclusion of the previous visit. R6's TAR dated 2/2025 blank boxes for left shoulder and right trochanter pressure ulcer treatments on 2/3/2025, 2/4/2025, 2/10/2025, 2/12/2025, 2/18/2025, 2/20/2025 and 2/26/2025. R6's Wound Nurse Practitioner Progress Note, dated 2/28/2025 documents wound 5 left shoulder pressure ulcer stage IV measured 8.5 cm x 6.2 cm x 0.8 cm, wound bed 80% slough, 10% granulation and 10% exposed structures, exposed structure: tendon and serosanguineious exudate. Wound 6 right trochanter pressure ulcer stage IV measured 6.5 cm x 6.5 cm x 0.7 cm with tunneling tissue type: 10% granulation and 10% exposed structures (no specific exposed structures documented) with purulent exudate. Both pressure ulcers per wound nurse practitioner documentation had deteriorated compared to the conclusion of the previous visit. Visit specific information: recommend culture to left shoulder and right trochanter today and if it is not completed today patient needs to go to the hospital. R6's POS, dated 3/2/2025 discontinue pillows between left and right legs and thighs every shift for positioning. Physician's order discontinued: pressure relieving mattress to bed and a pressure relieving cushion to wheelchair every shift for pressure relieving devices to protect skin. R6's Nursing Note, date 3/3/2025 at 9:27 AM documents R6 was admitted to the hospital for osteomyelitis. R6's POS dated 3/12/2025 a new physician's order pillows between left and right legs and thighs every shift for positioning related to contracture, left and right knee. A new physician's order pressure relieving low air loss mattress to bed and wheelchair every shift for pressure relieving devices to protect skin. A new physician's order weekly skin assessment on day shift every Monday and pressure relieving mattress to bed and chair. R6's Braden, dated 3/14/2025 at 7:11 PM documents moderate risk for skin breakdown. R6's Hospital After Summary dated 3/14/2025, documents Ertapenem 1 gram into a venous catheter daily last given on 3/14/2025 at 10:14 AM. Pressure ulcer treatment documented Santyl apply topically daily to left shoulder and right trochanter. (continued on next page)

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	145581	A. Building B. Wing	06/10/2025

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's readmission assessment dated [DATE] at 6:54 PM no documentation of a readmission skin assessment. R6's Nurse Progress Note, dated 3/14/2025 no documentation of skin upon readmission to the facility. R6's Weekly Observation Note, dated 3/17/2025 at 12:44 PM documents (R6) was admitted on [DATE]. Skin color is pale. Skin temperature is warm. Skin turgor shows tenting due to a delay in return of skin. Skin issues present. Refer to assessment for more information. Recent readmit with wound vac in place. Refer to full assessment for more information. R6's Medical Record, dated 3/17/2025 no documentation of (R6's) skin or wounds. R6's POS dated 3/14/2025 documents Ertapenem 1 gram IV every 24 hours for infection for 7 days until finished. End date 3/19/2025. On 3/19/2025 new physician's order Ertapenem 1 gram IV every 24 hours for infection until 3/21/2025. No pressure ulcer treatment to coccyx on POS. R6's MAR dated 3/2025 documents new physician's order on 3/14/2025 documents Ertapenem 1 gram IV every 24 hours for 7 days for infection. No documentation Ertapenem was administered on the following days: 3/15/205, 3/17/2025, 3/19/2025 was blank on the MAR and 3/21/2025 had an X on the MAR. R6's Medical Record no documentation of reason why staff didn't administer Ertapenem IV antibiotic medication per physician's orders. R6's Weekly Skin Observation Note, dated 3/17/2025 at 12:44 PM documents (R6) was admitted on [DATE], skin color is pale, skin temperature is warm, skin turgor shows tenting due to delay in return of skin, skin issues present refer to assessment for more information. No additional skin/wound assessment was documented in (R6's) medical record. R6's Significant change MDS, dated [DATE], documents severely cognitively impaired, dependent with toileting hygiene, shower/bathe self, personal hygiene, dependent with rolling left and right and chair/bed-to-chair transfers, incontinent of bowel, indwelling urinary catheter, at risk for developing pressure ulcers, three stage IV pressure ulcers, 2 unstageable pressure ulcers, pressure reducing device for chair and bed, pressure ulcer/injury care treatment, application of nonsurgical dressings, applications of ointments/medications other than to feet. R6's Wound Nurse Practitioner Progress Note, dated 3/19/2025 documents wound 5 left shoulder stage IV pressure ulcer measured 7.6 cm x 6.5 cm x 0.9 cm with tunneling, wound bed 70% covered with slough with tendon exposed. Right trochanter wound 6 stage IV pressure ulcer measured 8.5 cm x 6.5 cm x 0.7 cm with tunneling. Wound bed was covered with 50% slough, with exposed hardware, purulent drainage. Both pressure ulcers documented to have deteriorated compared to the conclusion of the previous visit. R6's Braden, dated 3/21/2025 at 8:36 AM documents moderate risk for skin breakdown. R6's Weekly Skin Observation Note, dated 3/21/2025 at 9:05 AM documents skin color is normal, skin temperature is dry, skin turgor is normal as skin returns promptly, skin issues present refer to assessment for more information. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's POS, dated 3/25/2025 a new physician's order prevalon boots on at all times every shift for pressure relieving device. R6's Wound Nurse Practitioner Progress Note, dated 3/26/2025 documents a new treatment order for (R6's) stage IV right trochanter pressure ulcer was cleanse with soap and water, skin prep to periwound, calcium alginate to wound base, santyl to wound bed and cover with bordered gauze daily. R6's Braden, dated 3/28/2025 at 8:38 AM documents moderate risk for skin breakdown. R6's Skin/Wound Note dated 4/4/2025 at 11:23 AM documents wound care provided. Treatment applied per treatment orders. Resident's wound is red a bright red beefy color with white slough present on wound bed. Resident tolerated wound care well with no s/s (signs or symptoms) of pain or discomfort noted during treatment. R6's Medical Record no documentation of wound nurse practitioner weekly wound assessment dated [DATE] through 4/8/2025. R6's Wound Nurse Practitioner Progress Note, dated 4/9/2025 documents stage IV left shoulder pressure ulcer wound 5 treatment: wash with soap and water, skin prep, calcium alginate, Bactroban and bordered gauze dressing change twice a day (BID.) Wound nurse practitioner documented pressure ulcer deteriorated compared to the conclusion of the previous visit. R6's POS dated 4/15/2025 documents Bactroban apply to left shoulder topically everyday shift for wound healing, cleanse wound with w/s apply Bactroban and calcium alginate and dry dressing every day and PRN. There was no physician's order to change the dressing BID per the wound nurse consultant's recommendation, dated 4/9/2025. R6's TAR, dated 4/2025 Bactroban apply to left shoulder topically everyday shift for wound healing, cleanse with w/s apply Bactroban and calcium alginate and dry dressing every day and PRN. Blank boxes on the TAR for the following dates that R6 did not recieve treatments: 4/15/2025, 4/16/2025, 4/25/2025, 4/28/2025 and 4/29/2025. R6's POS, dated 4/9/2025 documents a new physician's order obtain wound culture from (R6's) left shoulder related to possible infection. R6's Wound/Skin Note, dated 4/9/2025 at 2:39 PM, documents NP stated to obtain cultures form area due to discoloration of wound related to possible infection. R6's Lab Result, documents specimen collected 4/22/2025 documents organisms present. Moderate growth organism growth for two and rare growth for one organism. (No documentation of which pressure ulcer/wound was cultured.) On 5/6/2025 at 3:07 PM V64, Lab Client Solutions Representative stated a specimen was collected from the facility on 4/14/2025 but it was tossed out by the lab due to missing resident identification information. A second specimen was collected from the facility on 4/22/2025 and arrived to the out of state lab on 4/23/2025. (continued on next page)

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F 0686 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R6's POS, dated 4/24/2025 documents a new physician's order for Meropenem 1 gram IV every 12 hours for 7 days for wound infection, wound location not documented. R6's MAR, dated 4/2025 documents evening dose on 4/24/2025, both morning and evening doses on 4/25/2025 and 4/26/2025, morning dose on 4/27/2025, evening dose on 4/27/2025 staff documented administered, morning dose on 4/28/2025 staff documented 9/other, then physician's order was discontinued. On 5/1/2025 at 3:34 PM V58, LPN stated he did not give (R6) the IV dose of Meropenem 1 GM on the morning of 4/28/2025. V58, LPN, stated if his initials are on (R6's) MAR it is by accident and he is not allowed to give IV medication because he is an LPN. R6's POS dated 4/28/2025 documents a new physician to discontinue the IV antibiotic Meropenem 1 gram and reordered it on 4/29/2025. On 5/7/2025 at 11:40 AM V3, ADON stated she was aware the V50, NP ordered a wound culture (wound location unknown) at the beginning of 4/2025 and the first wound culture was sent to the lab (date unknown) and it was thrown out from the lab due to not have appropriate resident labeling/identification on it. The second wound culture was obtained at the facility a few days later and sent to the lab. V22, Wound Nurse reported the wound culture results to V50, NP on 4/24/2025 and she spoke to V50 on 4/25/2025 regarding (R6's) wound culture report results showing there was an infection. V50 ordered 7 days of IV antibiotics at that time and ordered (R6) to have a PICC line placed or to have a mobile PICC line company come to the facility and insert a PICC line. V3 stated she discussed PICC line placement with V22, wound nurse and she was told (R6) needed an appointment to have the PICC line placed and the facility doesn't have a mobile PICC line company service. V3 stated on 4/28/2025 she attempt multiple times to insert an IV peripherally and (R6's) veins were not cooperating so she was not able to get IV access. She notified V50 of no IV access and V50 put the IV antibiotics on hold and (R6) got an appointment and had the PICC line placed on 4/30/2025 and since then the IV antibiotics were reordered and (R6) has received the IV antibiotics were administered per physician's orders. When staff administer medications, including IV antibiotics they are expected to sign off the medication was administered as soon as they administer it. On 5/7/2025 at 3:22 PM V22, Wound Nurse stated she looked up the wound culture results from the lab in the computer on 4/24/2025 and notified (V50), NP of the lab results. (V50) called her back on 4/25/2025 and gave a physician's order for (R6) to get a PICC line inserted and to have IV antibiotics for 7 days for a wound infection. V22 stated she couldn't just send (R6) to the hospital for PICC line placement and the facility didn't have a mobile company to come place the PICC line in the facility. V22 stated V3, ADON attempted multiple times to place a peripheral IV in (R6) but it was unsuccessful. An appointment was made for (R6) on 4/29/2025 and the PICC was placed at an outside office on 4/30/2025. V22 stated (R6) has received the IV antibiotics since they had PICC line access on 4/30/2025. V22 stated IV antibiotics were put on hold by (V50) because (R6) didn't have [TRUNCATED]

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F 0689 Level of Harm - Actual harm Residents Affected - Some	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** 6. R31's Diagnoses Report, print date of 5/27/25, documents he has diagnoses of need for assistance with personal care, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, and cerebral infarction. R31's Care Plan, with revisions dated 12/21/21, documented (R31) has an ADL (Activities of Daily Living) self-care deficiency r/t (related to) CVA (stroke with left sided weakness, activity intolerance, confusion and fatigue. The Care Plan, interventions with revision on 8/16/23 documented Toilet Use: x2 extensive assist with toileting. Assist with dressing change and peri care after all toileting and incontinent episodes. The interventions documented Transfer x2 extensive assist with transfers. R31's MDS, dated [DATE], documented he has impairment on one side of lower extremities (hip, knee, ankle, foot). The MDS documents that R31 is dependent for toilet transfer as helper does ALL of the effort, Resident does none of the effort to complete the activity. On 5/14/25, at 12:50 PM, V6, CNA, stated that she was going to assist R31 to the toilet. V6 entered R31's room. R31 was seated in his wheelchair. V6 pushed R31 into the bathroom. She placed a gait belt around R31's waist. V6 directed R31 to stand up and he did so independently without assistance. She told him to grab both handicap rails on the wall to each side of the toilet. He did this. At this time, his right leg began to shake, as he faced the toilet. She cued him to grab the handicap bar to the right of the toilet, which he did. R31 was having difficulty moving his right and left legs to pivot to the right to sit on the toilet. V6 verbally cued him multiple times. He finally pivoted enough and then he fell heavy onto the toilet seat and sighed. On 5/27/25, at 12:57 PM, V2, DON, stated that he was unsure of R31's transfer status. Based on interview and record review the facility failed to properly supervise, develop and implement progressive intervention to prevent falls and provide safe transfers for 6 of 6 residents (R22, R31, R43, R46, R69, R72) reviewed for accidents in a sample of 67. This failure led to R69 having multiple visits to the emergency room and receiving a closed non-displaced fracture of right ilium, 0.5 cm laceration to right eyebrow, a laceration to the forehead, and bruising to face on 3 separate occasions. Findings include: 1. R69's EMR (Electronic Medical Records) undated documents that resident was admitted to the facility on [DATE]. R69's EMR dated 11/22/23 documents a diagnosis of epilepsy, history of falling, and unspecified convulsions. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	R69's MDS (Minimum Data Set) dated 1/30/25 documents a BIMS score of 11 out of 15. The MDS documents that the resident is independent with roll left and right. The MDS documents that the resident requires supervision or touching assistance for sit to lying, lying to sitting on side of bed, sit to stand, chair/bed to chair transfer, and toilet transfer. R69's Care Plan dated 11/23/23 documents (R69) is at risk for falls and/or injury r/t weakness, impaired gait, unsteadiness on feet and poor safety awareness. He will get self-up off the floor without notifying staff. The resident had 8 interventions for 24 falls from 4/19/24 until 4/19/25. R69's Nursing Note dated 4/19/24 at 8:07 PM documents This nurse was notified by staff members that resident fell out of his wc (wheelchair) while smoking and then started to have a seizure. This nurse and second nurse went to patio area. Resident noted to be on the ground on his back having tonic clonic seizure. This nurse came back into building called 911 and began printing paperwork for resident to be sent to (local hospital). Second nurse stayed outside with resident for assistance. Resident noted to be combative when staff tried to assist resident to his chair. Resident finally let staff assist him into wc. This nurse informed resident once inside building that he would be taking to the hospital for eval. Resident stated I don't agree with that. I don't take medicine. Resident then wheeled himself to his room. No intervention documented on the care plan for this fall. R69's Health Status Note dated 5/25/24 at 5:40 PM documents Summoned to room. Resident lying on floor, face down next to bed. Resident non-verbal. Blowing respiration noted. Eyes open and fixed. Upper and lower extremities jerking. Head moving in an up and down motion Resident not responding to verbal stimuli. Staff at side to prevent injury. V/S (vital signs) 97.8 108 22 O2 sat (oxygen saturation) 96. No intervention documented on the care plan for this fall. R69's Nursing Note dated 6/26/24 at 7:18 AM documents CNA (Certified Nursing Assistant) notified writer that resident was in his room on the floor. Writer went into residents' room and found resident lying on his rt side on the floor. ROM (Range of Motion) performed resident is able to move all limbs without any pain or discomfort. Limbs are equal in length no injuries or bruising present at this time Neuro Check performed. Staff assisted resident up into his wheelchair. MD (Medical Director) notified of fall along with POA (Power of Attorney). No intervention documented on the care plan for this fall. R69's Nursing Note dated 7/19/24 at 9:28 AM documents the aid answered the resident call light and noticed he was on the floor asked was he ok and after he stated yes the aid alerted the nurse. this nurse went into the resident ' s room to assess the resident while on the floor. he is alert and oriented x4. the resident stated he was on the floor because he tried to get in his wheelchair and did not make it so he got on the floor to keep from falling. the resident stated he did not hit his head nor hurt himself he just needed help getting back up into his wheelchair. no new s/s no c/o pain or discomfort. this nurse and the aid assisted him back into his wheelchair and will check on him throughout the day and f/u. No intervention documented on the care plan for this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	R69's Nursing Note dated 7/26/24 at 8:21 PM documents Resident noted on the floor in his room. Resident stated he wants to go to the hospital so he can get out of here. But needs help getting up. Resident states he is cold. Resident is spitting on the floor. Resident VS WNL (within normal limits). (Local Ambulance Service) called to transport Res to hospital. Psych MD Notified and a message was left. R69's Nursing Note dated 8/2/24 at 4:14 PM documents res was transported back to facility after x-rays r/t (related to) to large abd (abdomen) bruise on R side patients was diagnosed at ED (Emergency Department) w/ a closed nondisplaced fracture of R ilium resident has no recollection of fall or incident that would have caused fracture will cont to f/u (follow up) res is in bed resting quietly no outward c/o pain or discomfort at this time. No intervention documented on the care plan for this fall. R69's Nursing Note dated 8/11/24 at 9:15 AM documents Resident noted on the floor in his room next to AC (air conditioning) unit. Resident states he does not know what he was doing before or during time he was noted on floor. Resident is conscious and breathing. Resident's wheelchair was Parallel to his body and clothes were Neatley folded on the seat of the wheelchair. Resident refused to let staff check vital signs, Resident offered pain medication and declined it. Resident asked staff if he could smoke a cigarette. No apparent injuries noted, (local ambulance service) called to transport Resident to ER (Emergency Room) for further assessment. MD Notified and Aware. Resident's Guardian (V36) Notified via phone call he did not answer, A voicemail message was left with call back number. No intervention documented on the care plan for this fall. R69's Health Status Note dated 10/6/24 at 8:49 AM documents Resident was found on the floor this morning covered in wet having a hard time breathing lying on his left side. Resident asked what happened and how did he get on the floor? he stated he didn't know. he was assisted into chair and immediately started leaning to the left unable to stay conscious, when asked if he was in pain, he stated he was having pain to back. He was very lethargic, hard to keep eyes open. sent to (metro hospital) for evaluation via ems (Emergency Medical System). vitals 147/70 72 95 98.0 18. pupils slow to react. No intervention documented on the care plan for this fall. R69's Nursing Note dated 10/10/24 at 1:30 PM documents Resident had a fall in the dining room he was found bottom down, and wheelchair flipped over on the left side of him. Resident had no injuries, and he could not explain what he was doing. He refused vitals to be taken. No neuro initiated. Left voicemail for (V36). Md was notified. No intervention documented on the care plan for this fall. R69's Nursing Note dated 11/21/24 at 4:19 PM documents (R69) had possible seizure, unwitnessed fall with AMS (Altered Mental Status) and difficulty breathing. He is lying on the floor, wheelchair alongside him, tipped onto its side. (R69) is struggling to inhale through his trach stoma. He is refusing supplemental O2/Nursing care and being combative with care. Guardian notified that he will most likely be sent to the closest ER, (local hospital) and that bed hold policy is being sent with him. MD notified he is being sent out to the ER via *911. Face sheet, POS (Physician Orders), Code Status, Guardianship papers and Bed hold policy in folder to be sent with him. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	No intervention documented on the care plan for this fall. R69's Nursing Note dated 11/26/24 at 8:04 AM documents Resident had a seizure in the dining room. Resident was sitting up in his chair in dining room when he fell to the floor and began seizing. Seizure began at 753am and ended at 758am resident is alert per his usual baseline. Staff assisted resident up off floor and back into chair after seizing end no injuries noted at this time. MD notified. No intervention documented on the care plan for this fall. R69's Nursing Note dated 12/11/24 at 7:46 AM documents the halls CNA alerted the writer that the resident was on the floor so the writer went into the residents room and the resident was also covered in blood across his face, as the writer assessed the resident she noticed a gash across the residents right eye and scratches on his right leg that had an open wound where the blood was flowing from but was dried up. there is blood on the resident ' s pillow on his bed and blood on numerous items and the floor of the resident ' s room. the writer asked the resident was he experiencing any pain and the resident stated he was not in any pain, and he could not pull his WC close enough or push his self-back on the bed, so he eased his self to the floor. the resident was assisted back into his WC by two CNAS the writer attempted to wash his face, but he refused and stated he would do it his self the writer alerted the administrator and called the ambulance, and the writer will f/u. R69's Nursing Note dated 12/12/24 at 8:13 AM documents Per ER notes: (R69) has 0.5 cm (centimeter) laceration to right eyebrow, with bruising. (x2) absorbable sutures to right eyebrow. He received his Tdap (BOOSTRIX) while in ER. Intervention: 12/11/24 - educate on importance of medication compliance and possible consequences of not taking. Encourage him to taking medication to prevent consequences more frequent checks throughout the night. R69's Nursing Note dated 12/25/24 at 10:40 PM documents Resident had a seizure in the dining room and had an unwitnessed fall. Ambulance was called and resident refused to be transported. His vital were 98.1, 76, 18 149/88 patient is back at his current baseline. He refused all vital thereafter stating that he didn't fall. Intervention: 12/25/24 - fall due to seizure activity. Educate on need for and importance of taking all medications as prescribed. Notify MD of continued refusal of medications and seizure activity with fall. R69's Nursing Note dated 1/14/25 at 9:43 AM documents Writer observed a laceration to residents' forehead he also had a bruise on his nose that was reddish in color, he was also noted to have a discoloration on his right inner eye. Resident stated that he fell and didn't notify anyone. Resident will be sent out to (local hospital) for an evaluation. Md, DON (Director of Nursing) and there was a message left for (V36) to contact the facility at their earliest convenient. No intervention documented on the care plan for this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	R69's Nursing Note dated 1/20/25 at 9:55 PM documents Writer was notified by staff that resident was on the floor in his room. Upon evaluation of resident, he was lying on the floor on side trying to get to the door. His isn't complaining of any pain or discomfort. He couldn't stat what happened. His vitals are 98.1,76,18, 163/94, 96 % room air. Neuro checks where initiated, but the resident denied any further vitals. Md, (V36) where notified. No intervention noted on the care plan for this fall. R69's Nursing Note dated 1/29/25 at 4:45 AM documents 4:30am (R69) was found sitting on the floor. He says he rolled out of bed face first, no pain, redness in his face, ROM wnl, no other bumps or bruises, he says he feels fine, vitals wnl. Physician and DON notified. Will notify POA and continue to monitor. R69's Nursing Note dated 1/30/25 at 2:27 PM documents Resident noted to have an area protruding from right above the right eye. It is black and purple. Resident stated he has no pain. There is an open tiger text awaiting an answer from the MD. Intervention: 1/29/25 - increase nighttime checks, assist with getting out of bed as indicated. R69's Nursing Note dated 2/17/25 at 12:34 PM documents Writer was alerted to the dining room where patient had fallen out of the chair during a seizure. He denied falling or having a seizure and denied vitals. He agreed to go to the hospital and when the ambulance arrived, he declined to go. His family member was notified, and she knows he denied being assessed at the hospital. Resident is back at his current baseline. Intervention: 2/17/25 - Notify MD of continued refusal of medications and seizure activity with fall. educate on importance of medication compliance and possible consequences of not taking. Encourage him in taking medication to prevent consequences. more frequent checks throughout the night. R69's Health Status Note dated 2/27/25 at 5:05 AM documents Alerted to the resident's room, (R69) noted on floor near bedside laying on his left side in fetal position. Upon assessment for pain resident complaint of lower back and buttock pain. No c/o hitting head, resident noted with redness to left hip. Will transport to E.R. for exam related to lower back and buttock pain. Intervention: 2/27/25 - ask if he has to toilet of if he wants to get out of bed if noted to be awake. R69's Nursing Note dated 3/7/25 at 8:54 PM documents Resident found lying on ground in smoking area actively seizing and vomiting. Placed on left side, head protection provided by staff hand. 02 85% on room air. Seizure activity continued x5 minutes. Resident sat upright in wheelchair. Alert and oriented x2able to make needs known. Refusing vital signs and care at this time. CNA unable to clean vomit from resident. Remains non-compliant with all medication. On call Np contacted and notified of condition. Skin intact, no injuries noted related to fall. No intervention documented on the care plan for this fall. R69's Health Status Note dated 3/27/25 at 5:01 AM documents call placed to this pt's (V36) his p.o.a. to notify him of this pt having fallen, no answer, brief message left. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Intervention: 3/27/25 - Educate (R69) to ask for assistance prior to attempting to stand up. staff to increase rounding on (R69). R69's Nursing Note dated 4/01/25 at 3:05 AM documents Resident noted to be on the floor during rounds. resident noted to have seizure like activities. pupils fixed. extremities rigid. Resident legs lowered to the floor. resident not responding to verbal or painful stimuli. loss of bodily fluid. blue tinged lips. 911 initiated approx 0150. Resident monitored until ems arrival. resident began to respond back to stimuli approx 0212. EMS arrival 0220. Attempted to change resident clothing and assist to stretcher. resident required 3x assist. No intervention documented on the care plan for this fall. R69's Nursing Note dated 4/09/25 at 11:51 AM documents Resident was found in his room on the floor between the doorway and hallway. When asked if resident fell, he stated no and then when asked if he placed himself on the door he stated, he didn't know. Resident was placed on neuro checks as protocol. Resident A&Ox2, VS: 134/82, 98.0, 91, 18 with pupils equal and reactive to light. Will cont. to monitor. Intervention: 4/09/25 - Psych to eval. R69's Nursing Note dated 4/19/25 at 2:01 PM document Writer was notified by several staff members that resident was on the floor in the dining room having a seizure. Seizure lasted about 3 mins while resident was lying on his left side with head elevated by writer. When asked any of the witnesses if he hit his head, other alert and oriented residents gave full account of resident falling and hitting his head om another resident's chair. Neuro checks have been implemented. Assessment at baseline. Intervention: 4/19/25 - staff to assist (R69) to the floor if seizure activity is present. 2. R43's EMR undated documents that the resident was admitted to the facility on [DATE]. R43's EMR dated 5/6/22 documents a diagnosis of Dementia. R43's EMR dated 10/14/24 documents a diagnosis of history of Falling. R43's EMR dated 1/1/25 documents a diagnosis of muscle weakness (generalized) and difficulty in walking. R43's MDS dated [DATE] documents a BIMS score of 11 out of 15. The MDS documents that the resident is independent with roll left and right. The MDS documents that the resident requires supervision or touching assistance for sit to lying and lying to sitting on side of bed. The MDS documents that the resident requires partial/moderate assistance for sit to stand, chair/bed to chair transfer, and toilet transfer. R43's Care Plan dated 10/15/24 documents (R43) is at risk for falls r/t impaired Gait/balance, Psychoactive drug use, weakness, Poor safety awareness. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	R43's Nursing Note dated 10/15/24 at 5:43 PM documents Resident had a fall at 5:05pm. I was a couple doors down at my cart when I heard him fall. I walked into the room to find him laying on his right side. Resident was assesed and neuro vitals started. Resident denied any pain or discomfort. Resident did receive a skin tear to the back of his left arm. He stated that he was trying to get to the bathroom. Resident teaching provided on call light use. No intervention noted on the care plan for this fall. The intervention was noted in the nursing note that the resident was educated on call light use. R43's Nursing Note dated 10/19/24 at 8:46 AM documents CNA notified writer that resident was in his room on the floor. Writer went into residents' room and found resident was in his room on floor on fall mat on his hands and knees. Staff assisted resident up off floor and onto bed range of motion performed. Resident has no c/o of pain limbs equal in length. Writer asked resident what caused him to fall resident stated he was attempting to get into wheelchair unassisted. Writer educated resident on the importance of using call light to ask for assistance when attempting to get into wheelchair. Resident sister notified along with MD. No intervention documented on the care plan for this fall. Intervention noted in the nursing note that the resident was educated on call light to ask for assistance when attempting to get into wheelchair. R43's Nursing Note dated 11/14/24 at 1:34 PM documents Resident was found in room on his knees in staff assisted resident up off his knees and into his wheelchair. Rom (Range of Motion) performed no c/o pain or discomfort noted. MD notified along with family. No intervention documented on the care plan for this fall. R43's Nursing Note dated 11/25/24 at 9:36 AM documents Staff notified writer that resident was on the floor in the bathroom. Writer went into bathroom saw resident lying face first on floor. Staff assisted resident up off floor into wheelchair resident denied pain during transfer. Rom performed resident denied pain limbs are equal in length. Writer asked resident how fall occurred. Resident stated he was attempting to transfer himself on to toilet and lost his balance. Writer educated resident on the importance of using call light when needing to use restroom to get assistance from staff. No intervention documented on the care plan for this fall. Intervention noted in the nursing note that resident was again educated on call light use. This intervention was previously used twice and not progressive. R43's Nursing Note dated 11/30/24 at 6:45 PM documents Staff notified writer that resident was in dining area lying on floor. Writer went into dining room and found resident lying face first on floor. Staff assisted resident up off floor and into chair. Rom performed no c/o of pain noted all limbs equal in length. No injuries or bruising noted at this time. MD notified along with sister. No intervention documented on the care plan for this fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	R43's Nursing Note dated 12/05/24 at 11:49 AM documents Resident was attempting to get out of his wheelchair and into a regular chair at nurses station. Resident lost his footing and fell on to the floor. Resident denies hitting his head. Writer and another nurse assisted resident up off floor. No injuries noted no c/o of pain Rom performed all limbs equal in length no c/o pain. Residents' sister (V40) notified along with MD. Resident was educated to ask for assistance when attempting to ambulate. No intervention documented on the care plan for this fall. Intervention noted in the nursing note that resident was educated to ask for assistance when attempting to ambulate. R43's Nursing Note dated 12/07/24 at 11:36 AM documents CNA alerted this nurse that resident was on the ground this nurse upon assessment noted resident lying on floor in room, face up with head sticking out of doorway with legs towards bed. VS immediately taken, noted WNL limits. Resident is noted to be pleasantly confused and alert. ROM WNL. [NAME] without difficulty. Noted floor is dry, lighting is adequate and resident had on regular socks with shoes noted to be on floor at end of bed. Resident states that he was in his bed and wanted to get up so he got up and tried to get in my wheelchair but doesn't remember falling. No injury noted. Denies pain or discomfort. Noted call light on bedding. Resident assisted to wheelchair from floor with 2 staff assist and gait belt without difficulty or incident. Resident educated, reminded and encouraged to utilize call light for assistance. Resident voiced understanding. Up in wheelchair at this time, propelled by staff to dining room for lunch. MD/POA updated to fall. No intervention documented on the care plan for this fall. Intervention noted in the nursing note that the resident was educated, reminded, and encourage to use call light. R43 ' s Health Status Note dated 12/19/24 at 2:25 PM documents nurse alerted to resident on the floor in room, resident was lying on floor besides bed on his chest with legs lying on the side. resident stated he was trying to get into bed or into chair he couldn't specify which one he was attempting to do prior to fall. resident was assessed for pain and injury. He has a laceration to top of head, it was cleaned and tao (triple antibiotic ointment) applied. resident perrla (Pupils equal, round, reactive to light and accommodation) prom performed resident assisted off of floor into bed, vital taken b/p (Blood Pressure) 120/79 97.6 84 18 90. md and poa adon, notified. No intervention documented on the care plan for this fall. R43's Nursing Note dated 12/24/24 at 7:13 AM documents Observed laying on floor near bed, laying on face down with head propped up on folded arms, pt stated he tried to get out of bed without assistance, pt stated he did not hit his head, floor dry and free of clutter, bed in low position improper footwear on, pt alert and orientated x1, able to answer simple question and follow simple commands, some bouts of confusion observed, skin assessed, no apparent injuries, some redness to bilateral knees, ROM WNL, denies pain and discomfort, VS 97.8, 20,113/73,76, 97% RA, MD and POA notified, 72hr monitoring, neuro checks in place, encouraged pt to use call light for assistance. understanding verbalized, resting in bed eating candy, HOB elevated, call light in reach and grip socks on feet. No intervention documented on the care plan for this fall. Intervention noted in the nursing note was educated resident on using the call light assistance. (continued on next page)

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	145581	A. Building B. Wing	06/10/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Autumn Meadows of Cahokia	2 Annable Court Cahokia, IL 62206

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F 0689 Level of Harm - Actual harm Residents Affected - Some	R43's Health Status Note dated 12/30/24 at 3:45 AM documents Alerted to the resident's room by staff. Resident noted on floor, sitting on buttocks near the bathroom. Resident denies pain and denies hitting head. Head-to-toe assessment performed. Resident's vital signs WNL. Transferred from floor to bed with 2 assists and gait belt. No intervention documented on the care plan for this fall. R43's Nursing Note dated 1/5/25 at 3:21 AM documents 3:15am resident called out for help. CNA went to see what resident needed, he was on the floor. When asked what happened resident stated that he was trying to get to the bathroom and fell. Resident was assessed by this nurse. The only thing found on him was a red spot to the right hip where he fell. Resident denies pain or discomfort. ROM WNL. Vital signs taken and stable T 97.3 BP 124/69 P 85 R 18. Resident was assisted by two CNAs back into the bed and reminded to use his call light when assistance is needed. He agreed. He is currently resting in bed with call light in reach. Will continue to monitor. No intervention documented on the care plan for this fall. Intervention noted in the nursing note to remind resident to use call light. R43's Nursing Note dated 1/22/25 at 6:50 PM documents Noting the resident was observed lying on left side on the floor in dining room area. There were no liquids or obstacles in the area of the fall. The resident stated, he was trying to get up out of the w/c and suddenly went forward to the floor landing on left side and bi-lateral arm. A head-to-toe assessment was completed with no c/o pain or discomfort voiced or observed at this time. When questioned on rather he hit his head, the resident stated, I didn't hit my head.1mm brisk, PERRLA, A & O x2, Vitals: 145/60 B/P ,90P, 97.9T, 20R with glucose 277, ROM in bi-lateral arm area observed equal with raise, and grip. A 72-neurological observation has been started. (V30) and POA will be notified of the above note. No intervention documented on the care plan for this fall. R43's Health Status Note dated 2/16/25 at 11:09 AM documents resident found on the floor in the hallway of 500 hall outside of resident's room. Resident was lying on his right side with head on the floor his legs and feet under his wheelchair. with a small skin tear to his r elbow. resident states he did hit the front of his head. resident states he just fell forward. Resident was assessed for injury and pain, prom performed, perrla, assisted off of floor and into wheelchair. md and poa (V40) notified. Intervention: 02/16/2024 When assisting him to his wheelchair, staff to ensure it is HIS wheelchair, NOT anyone else's. Treatment to right elbow skin tear as ordered. R43's Nursing Note dated 3/15/25 at 1:56 PM documents CNA alerted this nurse that resident had fallen. Upon visualizing resident, noted wheelchair to be in resident doorway, resident is lying face down on floor with head turned to the right and legs straight out. Resident states I peed this nurse and CNA noted that resident was not incontinent of urine but of bowel. Noted small BM, brown and soft in adult brief. Peri care provided. VS 97.1 76 120/80 18 97%RA 118bs. Resident pleasant and cooperative with care and staff. Resident assisted via 2 assist and gait belt from floor to bed. ROM WNL. [NAME] without difficulty or complaint. MD aware, no new orders. POA made aware. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Some	Intervention: 03/17/2025 When noted to be going to his room, staff to cue him through mobility task while going through his doorway. Practitioner Note dated 4/4/25 at 8:38 AM documents Patient was found sitting on the floor in the restroom around 8:40. Notified staff who then got him up. Also discussed with nurse. Upon examination patient appears alert. No bruises noted. Good ROM to both upper and lower extremities. Denies hitting his head also does not appear to have hit his head. No erythema noted to head arms or legs at this time. Patient denies dizziness, shortness of breath, or any pain. Reports that he thinks therapy is going well he just can't get to the bathroom . Continues to work in therapy on strength for independence with ADLs. Intervention: 4/4/25: Staff to increase rounding on (R43). Take (R43) out of room when he is up. 3. On 4/22/2025 at 8:58 AM a Call don't fall sign was observed on R22's wall by R22's television, along with a sign stating Do not get out of bed by yourself sign on R22's side wall by bed. R22 observed sitting in wheelchair in the middle of the room and call light pinned to R22's bedsheets. 04/25/25 9:38 AM, R22 observed standing up in the room by self in front of the sink. R22's wheelchair noted in the middle of the room and call light on R22's bedsheets. 04/25/25 10:32 AM R22 observed sitting in chair watching television, call light observed noted on R22's bed. 4/25/25 at 11:08 AM, V35, Certified Nursing Assistant (CNA), stated See he is trying to get up now on his own. R22 observed trying to get out of chair by himself, call light was observed to be on R22's bedsheets. V35, CNA, helped R22 get up and get into his wheelchair. R22's Care Plan reviewed/revised on 12/5/2024 documents R22 has an Activities of Daily Living (ADL) self-care performance deficit related to activity intolerance, weakness, hypotension, anemia, polyneuropathy, and shortness of breath (SOB) with exertion. Interventions include mobility/ambulation x1 supervision to limited assist with mobility. R22 uses a wheelchair without bilateral leg rests. Partial/Moderate to Substantial/Maximum assist with ambulation utilizing a wheeled walker. Partial/Moderate to Substantial/Maximum assist with transfers. Ensure he has on non-skid footwear (non-skid socks or shoes) when out of bed. Notify nurse if he complains of weakness, pain and/or shortness of breath. R22's Care Plan revised on 10/9/2022, documents R22 is at risk for falls related to syncope, hypotension, weakness, poor safety awareness. Care Plan documents intervention on 12/27/2024, ensure that he has on proper footwear, encouraged him to use call light for assistance with transfers and ADL's. If noted to be awake with rounds, ask if he needs to toilet. Intervention added on 03/12/2025, documents encourage him to request assist with weight bearing tasks/ADL's due to weakness and SOB with exertion/sitting/lying flat. Refer to therapy. Intervention a[TRUNCATED]

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the Facility failed to provide adequate heating and ensure roof and utility hoppers were leak-free. This has the potential to affect all 90 residents living in the Facility. Findings include: On 4/24/25 at 10:38 AM, R22 stated the activity dining area has been cool in the mornings. On 4/24/25 at 10:45 AM, R15 stated the activity dining area has been cool in the mornings. On 4/24/2025 at 10:58 AM, V25, Licensed Practical Nurse (LPN), stated the activity dining area is a little chilly some days. On 4/24/25 at 2:30 PM, V32, Maintenance Supervisor, stated the heat does not work in the activity dining room and has not worked at all during the two years he has worked here. He stated the surrounding heaters help warm the room, so it might get up to 60 degrees (Fahrenheit) in there even when it is 0 degrees (F) outside. He stated, You can try to turn the heat on, but it just won't work. On 4/24/2025 at 11:05 AM, V26, Certified Nursing Assistant (CNA) Coordinator, went to the soiled utility room between the 200 and 300 halls and tried to flush the hopper multiple times. The water in the basin would flush partially, but did not fully empty. V26 stated the hopper must be clogged, and she will make sure maintenance is aware. V26 then went to the soiled utility room between the 500 and 600 halls where water was dripping from the faucet into the hopper. V26 stated V32 was aware of the leak. On 4/24/25 at 2:30 PM, V32 entered the soiled utility room between the 200 and 300 halls. V32 flushed the hopper, and most of the water in the basin went down the drain, but not all of it. He stated all of the liquid should go down the drain because it is basically a toilet. He flushed several more times for a total of five flushes. There was a drip of water coming out of the faucet. V32 stated he needed to work on it, and the other hopper usually works better. V32 then walked to the soiled utility room between the 500 and 600 halls. V32 flushed the hopper, and there was a drip of water coming from the faucet. He stated he needed to put a seal on the cold water faucet handle. On 4/24/25 at 2:30 PM, V32 stated there are leaks in the roof and they probably need a new roof, but they are out of warranty and it probably comes down to money. He pointed to the ceiling outside room [ROOM NUMBER]. The ceiling was peeling off in places with brown water stains measuring approximately two square feet. V32 stated the roof leaks with heavy rain which is about five times per year. V32 then went to the mechanical room where there was peeling tape across the ceiling above the hot water heater which he said is due to the roof leaking. On 4/29/2025 at 10:34 AM, the shower in R45's room did not have a shower head. The faucet was turned on, but no water came out. On 4/29/2025 at 12:45 PM, V45, R45's Family, stated the shower in R45's room does not work and have never worked since R45 was been admitted to the facility. (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 4/29/25 at 9:26 AM, V32 stated nothing has been done with the hoppers, the roof or the activity dining room heat since we toured the Facility last week. He stated there are a lot of bigger issues that he has to take care first. On 4/30/25 at 9:26 AM, V1, Administrator, stated she was aware the heat in the activity room was not working, but just did not know how long it had been a problem. She was notified of the leaking roof by V32 on 4/29/25. On 4/29/25 at 2:58 PM, V1 stated the Facility does not have a policy regarding functionality of equipment. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 4/22/25 documents there are 90 residents living in the Facility.