STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145657	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downers Grove Rehab & Nursing	3450 Saratoga Avenue Downers Grove, IL 60515

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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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303 Based on interview and record review, the facility failed to refer a resident with a new mental health diagnosis for a level II PASRR (Preadmission Screening and Resident Review). This applies to 1 of 2 residents (R19) reviewed for PASRR in the sample of 18. The findings include: The EMR (Electronic Medical Record) showed R19 was admitted to the facility on [DATE], with admitting diagnoses including major depressive disorder, anxiety disorder, and seizures. The EMR continued to show R19 was diagnosed with unspecified psychosis not due to substance or known physiological condition on October 5, 2024. R19's Active Order Summary Report dated April 9, 2025, showed R19 had the following active medication orders: olanzapine (antipsychotic) oral tablet 10 mg (milligrams), give one tablet by mouth at bedtime related to major depressive disorder; and venlafaxine extended-release oral capsule 150 mg, give one capsule by mouth one time a day related to major depressive disorder. On April 9, 2025, at 8:50 AM, V26 (Admissions Coordinator) said she is responsible for submitting the level I PASRR for residents if it was not completed prior to admission to the facility. V26 said she has never submitted a re-screening for a resident's level I PASRR if the resident received a new mental health diagnosis. On April 9, 2025, at 9:42 AM, V24 (Social Services Director) said he has nothing to do with PASRRs for residents. V24 continued to say he is not able to log into the website to conduct PASRRs. V24 said the admissions department is responsible for PASRRs. On April 9, 2025, at 12:19 PM, V2 (DON/Director of Nursing) said R19 must have been diagnosed with psychosis because she had new behaviors at that time. V2 said V2 does not have anything to do with PASRRs. (continued on next page)

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

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R19's Notice of PASRR Level I Screen Outcome dated October 23, 2023, completed by V26 (Admissions Coordinator) showed . Ascend Outcome: Level I Outcome: No Level II Required- No Serious Mental Illness/Intellectual Disabilities/Related Conditions. Rationale: The Level I screen indicates that a PASSR disability is not present because of the following reason: There is no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. The facility does not have documentation to show R19 had a rescreening completed when R19 was diagnosed with psychosis. The facility's undated policy titled Long-term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy, showed .Policy: The organization observes preadmission screening requirements to ensure that: Medicaid-eligible individuals meet required level of care criteria for Long-term Services and Supports; People with known or suspected mental illness, intellectual disabilities, and/pr related conditions are not appropriately institutionalized or marginalized; to make sure that every individual receives the services and supports that will optimize their success in the least restrictive setting; Residents with these specific types of disabilities are admitted or allowed to remain in the facility, only if the facility can provide them with the services they need . 5) Signification Change in Condition: a. Additional Resident Reviews will be performed whenever there is: i. Resident with a previously negative level I screen who demonstrates new symptoms or possible mental illness, intellectual disability, or related condition. b. The facility will respond to a significant change in condition, or onset of new symptoms indicated by doing the following within 14 days: i. Notifying the PASRR authority .

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303 Based on interview and record review, the facility failed to follow their policy to complete an accurate PASRR (Preadmission Screening and Resident Review) for a newly admitted resident. The facility also failed to have a qualified healthcare professional complete a resident's level I PASRR. This applies to 1 of 2 residents (R19) reviewed for PASRR in the sample of 18. The findings include: The EMR (Electronic Medical Record) showed R19 was admitted to the facility on [DATE], with admitting diagnoses including major depressive disorder, anxiety disorder, and seizures. R19's Order Summary Report for the period of October 13, 2023, to October 24, 2023, showed R19 had the following medication orders for that time period: sertraline (antidepressant) oral tablet 50 mg (milligrams), give one tablet orally one time a day or depression; olanzapine (antipsychotic) oral tablet 10 mg, give one tablet orally one time a day for antipsychotic; and venlafaxine extended-release 150 mg, give one capsule orally one time a day for depression. On April 9, 2025, at 8:50 AM, V26 (Admissions Coordinator) said she is responsible for completing the Level I PASRRs for residents who did not have a Level I PASRR submitted prior to admission to the facility. V26 said she submitted R19's Level I PASRR and said she submitted whatever diagnoses were present on R19's facesheet at that time. V26 continued to say she did not submit any of R19's mental health medications because she was instructed by the previous admissions coordinator to not submit resident's mental health medications on the Level I PASRR. V26 said she has not submitted a resident for a rescreening of their PASRR. On April 11, 2025, at 6:29 PM, V26 said she has an associate degree in medical coding. V26 continued to say she was not a nurse or she does not have a degree in social work. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R19's Notice of PASRR Level I Screen Outcome dated October 23, 2023, completed by V26 (Admissions Coordinator) showed .Diagnoses: Mental Health Diagnoses: Check any or all of the following mental health conditions that are diagnosed or suspected for this individual now or in the past: No mental health diagnosis is known or suspected . Mental Health Medications: list any antidepressants, mood stabilizers, antipsychotics, or other mental health medications prescribed currently or other mental health medications prescribed currently or within the past six months: No medications . Level I Attestation and Signature: By checking this box, I attest that I have reviewed all information contained herein and that I take responsibility for the completeness and accuracy of information reported throughout this submission. I attest that I am a health care professional working in a clinical capacity for this provider. I understand that approved submitters include clinical professionals such as nurses, LPNs (Licensed Practical Nurses), social workers (with a Bachelor's of Science degree or higher), physicians, or home health agency clinical staff. Social service staff are not required to be licensed to submit information. I understand that administrative staff are not permitted to submit clinical information to Ascend. I understand that Illinois PASRR considers knowingly submitting inaccurate, incomplete or misleading Level I information to be Medicaid fraud, and I have completed this form to the best of my knowledge. Name: [V26] Date: October 23, 2023, . Ascend Outcome: Level I Outcome: No Level II Required- No Serious Mental Illness/Intellectual Disabilities/Related Conditions. Rationale: The Level I screen indicates that a PASSR disability is not present because of the following reason: There is no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. The facility's undated policy titled Long-term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASRR) Policy, showed .Policy: The organization observes preadmission screening requirements to ensure that: Medicaid-eligible individuals meet required level of care criteria for Long-term Services and Supports; People with known or suspected mental illness, intellectual disabilities, and/pr related conditions are not appropriately institutionalized or marginalized; to make sure that every individual receives the services and supports that will optimize their success in the least restrictive setting; Residents with these specific types of disabilities are admitted or allowed to remain in the facility, only if the facility can provide them with the services they need . PASRR: 1) Level 1 Screening: .b. If the resident is not Medicaid or Medicaid eligible by way of application, the nursing facility will be responsible for completion of the Level 1 screening .

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on observation, interview and record review, the facility failed to ensure each resident had a comprehensive care plan that outlined each residents' care needs accurately. This applies to 4 of 18 residents (R26, R27, R29, and R59) reviewed for care plans in the sample of 18. The Findings include: 1. R27's admission record showed R27 was admitted to the facility on [DATE], with multiple diagnosis including chronic atrial fibrillation, morbid obesity, sepsis unspecified organism, and benign prostatic hyperplasia with lower urinary tract symptoms. R27's MDS (Minimum Data Set) dated February 5, 2025, showed R27 was moderately cognitively impaired, and was dependent on staff assistance for toileting, bathing, dressing, bed mobility and transfer and had an indwelling urinary catheter and always incontinent of bowel. On April 7, 2025, at 11:03 AM, R27 was observed with urinary catheter tubing draining into a drainage bag. On April 9, 2025, V31 (Staffing Coordinator) provided a list of residents who needed 2 staff assist for incontinence care. R27's name was on that list. R27's care plan initiated on November 8, 2024, and revised on December 7, 2024, showed that R27 focus continence showed the resident is occasionally incontinent of bladder and continent of bowels due to which was left blank. The continence care plan intervention dated November 24, 2024, showed empty urinal as needed. There was no care plan for the use of, care for, maintenance or prevention of infection for R27's indwelling urinary catheter. There was no care plan to address R27's dependence on staff assistance for ADL care for bathing, dressing, bed mobility and transfer. 35267 2. R59's Face sheet, dated April 9, 2025, shows R59 was admitted to the facility on [DATE], and her diagnoses included pulmonary embolism, malignant neoplasm of bronchus or lung, weakness, diabetes, protein-calorie malnutrition, vascular dementia, congestive heart failure, chronic kidney disease, and need for assistance with personal care. On April 8, 2025, at 12:37 PM, V12 (Wound Nurse) stated R59 had a facility-acquired pressure injury that was assessed as an unstageable right plantar DTI (Deep Tissue Injury). V12 stated R59 had the pressure injury for months which was caused by her sitting position in her chair. V12 stated R59 was being treated with betadine and a gauze island twice a week. On April 8, 2025, at 12:33 PM, V10 (Licensed Practical Nurse) stated she was unaware of any pressure ulcer related to R59. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Initial Wound Evaluation & Management Summary, dated February 25, 2025, shows R59 was identified to have a wound on her right plantar foot. Wound Evaluation & Management Summary, dated April 8, 2025, shows R59's pressure ulcer measured 1.8 cm by 2 cm and the depth was not measurable. The wound was described as an unstageable DTI with intact skin with no exudates. The plan of care recommendations show R59's wound was to be off-loaded. POS (Physician Order Sheet), dated January 1, 2025, to April 30, 2025, shows R59's physician orders included: - Offload boots to be worn while in chair and during bedtime three times a day for DTI (ordered February 26, 2025) - Bottom lateral foot: Monitor and cleanse wound with NSS (Normal Saline Solution), apply betadine and cover with dry dressing two times a week one time a day every Tues, Fri for wound care (ordered February 18, 2025, and revised February 26, 2025) - Right plantar foot: Cleanse wound with NSS, apply betadine and cover with dry dressing two times a week. One time a day every Tuesday, Friday for wound care (ordered February 26, 2025, and revised April 5, 2025) - Infection precautions enhanced barrier secondary to wounds (ordered March 27, 2025) Care plan, initiated October 11, 2024, and reviewed April 8, 2025, showed R59 had the potential for impairment to skin integrity related to incontinence, the diagnosis of diabetes, and impaired mobility. R59's intervention, dated October 11, 2024, included providing a pressure reducing mattress on bed. The care plan fails to show any pressure relieving interventions implemented to prevent the development of a pressure injury on her lower extremities while sitting in her chair. The care plan also failed to show interventions for her diagnosed pressure injury, or the implementation of enhanced barrier precautions related to her wound. Pressure Injury Prevention and Management Policy, undated, shows, Care Plans: 1. A resident centered care plan will be developed and implemented to address the resident's risk for development of a pressure ulcer/injury and to promote healing if the resident has a pressure ulcer/injury 3. Face sheet, dated April 9, 2025, shows R29 was admitted on [DATE], and R29's diagnoses includes bipolar disorder and major depressive disorder. Psychiatric note, dated January 23, 2025, shows R29 had diagnoses include major depressive disorder, bipolar disorder, insomnia, and unspecified psychosis. The psychiatric plan showed R29 was to continue current management utilizing clonazepam, lurasidone, Seroquel, melatonin and quetiapine. POS, dated April 9, 2025, shows R29 was receiving Seroquel, Lyrica, Clonazepam, melatonin and Quetiapine daily. On April 9, 2025, at 11:32 AM, V41 (Psychiatric Nurse Practitioner) stated R29 was prescribed lurasidone for his bipolar disorder, Seroquel for his depression and bipolar, and clonazepam for seizures and anxiety. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Care plan initiated/revised March 21, 2025, shows R29's no care plans addressing R29's diagnoses of bipolar disorder, depression, anxiety, or his use of psychotropic medications. 45303 4. The EMR (Electronic Medical Record) showed R26 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's disease, ventricular tachycardia, and arthritis. R26's MDS (Minimum Data Set) dated March 7, 2025, showed R26 had moderate cognitive impairment. As of April 9, 2025, at 9:32 AM, R26's care plan did not include a care plan for Alzheimer's disease or dementia care including R26's dementia care needs or individualized interventions related to R26's symptomology. On April 9, 2025, at 9:36 AM, V24 (Social Services Director) said he conducts care plan meetings along with nursing and therapy. V24 said R26's comprehensive care plan was completed on March 14, 2025. V24 said R26's Alzheimer's disease diagnosis should have been discussed at the care plan meeting. V24 said R26's care plan should have included an Alzheimer's disease care plan. The facility's undated policy titled Care Planning- Comprehensive Person-Centered showed, Policy: A baseline care plan to meet the resident's immediate needs shall be developed for each resident within forty-eight hours of admission. A person-centered comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs shall be developed for each resident. To the extent practicable, the resident/resident representative will be provided with opportunities to participate in the care planning process . Specific Procedures/Guidance: .2. The facility will develop and implement a comprehensive person-centered care plan for each resident, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified throughout the comprehensive Resident Assessment Instrument process . 13. The comprehensive care plan will: a. Incorporate identified problem areas; b. Incorporate risk factors associated with identified problems; c. Build on the resident's strengths; d. Be culturally competent and trauma-informed as applicable; e. Reflect treatment goals, timetables and objectives in measurable outcomes; f. Identify the professional services that are responsible for each element of care; g. Aid in preventing or reducing declines in the resident's functional status and/or functional levels; h. Promote resident safety; i. Enhance the optimal functioning of the resident by focusing on a rehabilitative program; and j. Reflect currently recognized standards of practice for problem areas and conditions .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on observation, interview, and record review, the facility failed to timely revise the care plan with specific fall-prevention interventions for a cognitively impaired resident that required staff assistance. This applies to 1 of 1 resident (R34) reviewed for fall-related accidents in a sample of 18. The findings include: The EMR (Electronic Medical Record) shows that R34, a [AGE] year-old with diagnoses of dementia, psychosis, anxiety disorder, major depressive disorder, age related physical debility, repeated falls, unsteadiness of feet, difficulty walking, need of assistance with care, hyperlipidemia, Vitamin D deficiency, hypothyroidism, and chronic kidney disease. R1 was admitted to the facility on [DATE]. The MDS (Minimum Data Set) assessment dated [DATE] showed that R34's cognition was severely impaired with BIMS (Brief Interview Mental Status) score of 0/15. The MDS documents that R34 required substantial to maximum assistance from staff during wheelchair transport in the corridor or similar places. On April 7, 2025 at 10:30 A.M., R34 was seated in her wheelchair in the corridor. R34 was observed with a dark blue bruise on the forehead, entire right side of her face and lower orbital area of the right eye. R34 was not interviewable and not able to verbalize how she acquired the bruise. R34 noted to be anxious and was pacing back and forth from outside and inside her room. V10 (LPN/Licensed Practical Nurse) was present during this time. V24 said that R34 sustained the bruise from a fall incident that occurred on March 15, 2025, while being transported by CNA using a wheelchair without the use of wheelchair leg rests. V24 also said that R34 was anxious and must not be feeling comfortable from the facial bruise. The facility's incident report dated March 15, 2025 showed: CNA (Certified Nurse Assistant) was transporting (R34) to the dining room, for lunch when (R34) foot got caught underneath the wheelchair, (R34) slid out of the wheelchair and landed on her side hitting her head .911 called . hematoma forehead. The nurse's progress notes March 15 ,2025 at 1:19 P.M., showed CNA was transporting (R34) to the dining room for lunch when (R34) foot got caught underneath the wheelchair, (R34) slid out the wheelchair and landed on her right side hitting her head.BP 102/58 HR 103 R 18 T 96.9. NOD (Nurse on Duty) help CNA assist (R34) back to wheelchair and to her room. 911 called and .transport (R34) to .hospital for evaluation. Review of R34's EMR including the fall incidents and care plan-initiated February 23, 2023 showed prior falls on February 23, May 26, July 5, July 26, September 20, and September 27, 2024. Despite this history, the care plan lacked specific, updated interventions and no root cause analysis was conducted after each fall to address contributing factors. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 9, 2025, the Acting Director of Nursing (V2) validated that the March 15, 2025, fall had not prompted a care plan revision and that no root cause analysis or targeted prevention measures had been implemented.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. 35267 Based on interview and record review, the facility failed to provide restorative services to a resident per facility policy. This applies to 1 of 1 resident (R29) reviewed for restorative services in the sample of 18. The findings include: On April 7, 2025, R29 stated he did not receive restorative therapy and would like to be receiving it. On April 8, 2025, at 12:13 PM V10 (Licensed Practical Nurse) stated she had not seen R29 receiving any restorative therapy. On April 8, 2025, V11 (Rehabilitation Manager) stated R29 was not receiving skilled therapy services because during his initial assessment R29 was evaluated to be at his prior level of functioning. R11 stated the therapy department did recommend R29 receive restorative therapy to be provided by the facility. V11 stated a referral was provided to V2 (Director of Nursing) for R29 to receive restorative therapy. On April 8, 2025, at 3:16 PM, V2 (Director of Nursing) stated she was not aware R29 was provided a referral for restorative therapy and R29 was not receiving restorative therapy. V2 also stated when the facility did not have enough staff, the facility CNAs (Certified Nursing Assistants) did not provide restorative therapy. Rehabilitation and Restorative Nursing Program document shows It is the policy of this facility that all residents will be screened for restorative care: 1. As terminated off active therapy, 2. When there is a significant change in status, 3. Quarterly with assessment progress, 4. On referral from nursing on therapy.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on observation and interview, the facility failed to provide nail care to residents who are dependent on staff assistance with ADLs (Activities of Daily Living). This applies to 3 of 3 residents (R44, R47, R485) in the sample of 18. The findings include: 1. R485's admission record showed R485 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis of left dominant side following cerebral infarction, cardiomegaly and dysphagia. R485's MDS (Minimum Data Set) showed R485 was moderately cognitively impaired and needed assistance with ADL's including supervision/light touch assistance with eating and oral hygiene, substantial assistance with bed mobility and dependent on staff for personal hygiene, bathing, toileting, dressing and transfer. R485 had mobility impairment to her left arm and left hand. On April 8, 2025, at 12:05 PM, R485's right hand was observed with all fingernails long and black/brown/yellow colored debris underneath the nails. R485 stated she would like her nails to be cleaned and trimmed. V28 (LPN) made aware of R485 request for nail care. 15845 2. On April 4, 2024 at 10:30 A.M., R44 was seated in his wheelchair in the main dining room. R44 was in the group of activities that was ongoing. R44 was observed with long, jagged edge fingernails. The fingernails were embedded to R44's inner palm of his contracted left hand. The same observation was observed regarding R44' fingernails on April 8, 2025 at 1:07 P.M. During this time of observation, V3 (LPN/Licensed Practical Nurse) was present. The care plan that was initiated on December 31,2024 showed that R44 was identified with self-care deficit due to left hemiplegia, due to CVA (cerebral vascular accident) depression, ADHD (attention deficit hyperactivity disorder), anxiety, hypothyroidism, and hypertension. The care plan also showed that R44 required total assistance from staff for ADLs (Activities of daily Living) such as hygiene and personal care. 3. On April 4, 2024 at 11:00 A.M., R47 was seated in his wheelchair in his room. R47 was observed with long, jagged edge fingernails. The fingernails were embedded to R47's inner palm of his contracted left hand. During this observation, V4 (RN/Registered Nurse) was present. On April 8, 2025 at 11:30 A.M., R47 was sitting in his wheelchair in his room. R47's fingernails remained long, jagged edges with black substance under the nails. V3 was present during this observation. The care plan that was initiated on July 30, 2022 showed that R47 was identified with self-care deficit due to left hemiplegia, left hemiparesis due to CVA, diabetes mellitus, and anxiety disorder. The care plan also showed that R47 required total assistance from staff for ADLs (Activities of Daily Living) such as hygiene and personal care. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Both residents had care plans identifying self-care deficits related to left hemiplegia from cerebrovascular accidents and other medical conditions. Each required total staff assistance with hygiene and personal care, yet their fingernails were untrimmed, compromising comfort and hygiene. The facility's undated policy regarding Fingernails/Toenails showed: The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. 1. Routine nail care must be performed by nursing staff and or qualified activity team members. 3. Nail care includes daily cleaning and regular trimming. 4. Proper nail care can aid in the prevention of skin problems around nail bed. 7. Trimmed and smooth nails to prevent the resident from accidentally scratching and injuring his or her skin.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35267 Based on observation, interview, and record review, the facility failed to implement interventions to prevent and treat a pressure injury per facility policy. This failure resulted in the development of a DTI (Deep Tissue Injury) for a resident at moderate risk for the development of pressure injuries. This applies to 1 of 4 residents (R59) reviewed for pressure injuries in the sample of 18. The findings include: Face sheet, dated April 9, 2025, shows R59 was admitted to the facility on [DATE], and her diagnoses included pulmonary embolism, malignant neoplasm of bronchus or lung, weakness, diabetes, protein-calorie malnutrition, vascular dementia, congestive heart failure, chronic kidney disease, and need for assistance with personal care. MDS (Minimum Data Set), dated January 15, 2025, shows R59's cognition was severely compromised and R59 required substantial / maximal assistance from staff for rolling left and right. Skin Observation Weekly, dated October 10, 2024, shows R59's skin was normal with no open areas. Braden scale, dated October 9, 2024, shows R59 was at high risk for pressure injuries because she was completely immobile, was bedfast, and did not make even slight changes in body or extremity position without assistance. Braden scale, dated February 6, 2025, shows R59 was assessed to only be at moderate risk for pressure injuries, was chairfast, had very limited mobility and made occasional slight changes in body or extremity position but was unable to make frequent or significant changes independently. The assessment also shows R59 had very limited sensory perception. On April 8, 2025, at 12:33 PM, V10 (Licensed Practical Nurse) stated she was unaware of any pressure ulcer related to R59. On April 8, 2025, at 12:37 PM V12 (Wound Nurse) stated R59 had a facility-acquired pressure injury that was assessed as an unstageable right plantar DTI. V12 stated R59 had the pressure injury for months which was caused by her sitting position in her chair. V12 stated R59 was being treated with betadine and a gauze island twice a week. On April 8, 2025, at 12:39 PM, V12 (Wound Nurse) walked into R59's room and pulled back the sheets to observe R59's feet. V12 stated, that's not quite offloaded. R59 had black socks on both feet, both feet were resting on a pillow and R59's lateral plantar side of right foot touching pillow. R59's green pressure-relieving boots were on the counter across from her bed and not on her feet. V12 stated R59's pillow under her lower extremities should be placed back under her calves to give her a boost and so her feet were not touching anything. V12 stated R59's pillow should not have been placed under her feet. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On April 8, 2025, at 2:07 PM, R59 was lying in bed with offload boots and V13 (CNA/Certified Nursing Assistant) took off the sock on the right foot. There was a dressing present. At 2:10 PM, V12 took off the dressing and R59 had a blackened area with raised edges on her right sole. This area was approximately 2.5 cm (centimeters) in diameter with redness in the surrounding area. V12 was asked to describe the area, and she said it was a deep tissue injury, which was unstageable due to necrotic tissue. Initial Wound Evaluation & Management Summary, dated February 25, 2025, shows R59 was identified to have a wound on her right plantar foot. The assessment shows R59 had a pressure ulcer identified as an unstageable DTI with intact skin greater than 7 days in duration measuring 2 centimeters (cm) by 2.5 cm and the depth was not measurable. The skin was assessed as intact with purple/maroon discoloration. The evaluation's dressing recommendations included betadine and silicone foam with border twice a week and as needed. The evaluation's intervention recommendations include offloading the wound, use of a pressure off-loading boot, and repositioning R59 per facility protocol. Care plan, initiated October 11, 2024, and reviewed April 8, 2025, showed R59 had the potential for impairment to skin integrity related to incontinence, the diagnosis of diabetes, and impaired mobility. R59's intervention, dated October 11, 2024, included providing a pressure reducing mattress on bed. The care plan fails to show any pressure relieving interventions implemented to prevent the development of a pressure injury on her lower extremities while sitting in her chair. The care plan also failed to show interventions for her diagnosed pressure injury, or the implementation of enhanced barrier precautions related to her wound. POS (Physician Order Sheet), dated January 1, 2025, to April 30, 2025, shows R59's physician orders included: - Offload boots to be worn while in chair and during bedtime three times a day for DTI (ordered February 26, 2025) - Bottom lateral foot: Monitor and cleanse wound with NSS (Normal Saline Solution), apply betadine and cover with dry dressing two times a week one time a day every Tues, Fri for wound care (ordered February 18, 2025, and revised February 26, 2025) - Right plantar foot: Cleanse wound with NSS, apply betadine and cover with dry dressing two times a week. One time a day every Tuesday, Friday for wound care (ordered February 26, 2025, and revised April 5, 2025) - Infection precautions enhanced barrier secondary to wounds (ordered March 27, 2025) On April 9, 2025, at 1:08 PM, V22 (Physician) stated usually on admission at the facility the wound care team assesses and recommends pressure injury prevention interventions for residents at risk for pressure injuries. V22 stated usually the interventions including repositioning, floating heels and use of pressure relieving boots is part of the resident's care plan as preventative measures the facility should be doing if a resident was identified as someone that requires those measures. V22 stated it was certainly possible that the lack of interventions could have caused R59's DTI. V22 stated the facility either did not conduct a proper assessment or if they were providing the interventions they did not document them. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On April 9, 2025, at 12:25 PM, V38 (Physician) stated R59 should have interventions in place based on the facility protocol. V38 stated R59's pillow should be behind her heel and R59 should have both offloading boots on when in bed. Wound Evaluation and Management Summary, dated April 1, 2025, shows R59 had a pressure injury that was described as an unstageable DTI for greater than 40 days measuring 1.8 cm by 2 cm with a depth unmeasurable. The assessment was no exudate, and the skin was intact with purple/maroon discoloration. The treatment plan shows apply betadine twice a week and as needed for 22 days in addition to a gauze island with boarder to be applied twice a week and as needed for 22 days. The plan of care (reviewed and addressed) shows R59's wounds were to be off-loaded and R59 was to be repositioned per facility protocol. Wound Evaluation & Management Summary, dated April 8, 2025, shows R59's pressure ulcer measured 1.8 cm by 2 cm and the depth was not measurable. The wound was described as an unstageable DTI with intact skin with no exudate. The plan of care recommendations show R59's wound was to be off-loaded. Pressure Injury Prevention and Management Policy, undated, shows, The intent of this organization is to develop and maintain systems and pr\processes to ensure that the resident does not develop pressure ulcers/injuries (PU/PI) unless clinically unavoidable and that the facility provides care and services consistent with professional standards of practice to: Promote the prevention of pressure ulcer/injury development; Promote the healing of existing pressure ulcers/injuries (including prevention of infection to the extent possible); and Prevent development of additional pressure ulcer/injury Avoidable means that the resident developed a pressure ulcer/injury and that one or more of the following was not completed Evaluation of the resident's clinical condition and risk factors; Definition or implementation of interventions that are consistent with resident needs, resident goals, and professional standards of practice; Monitoring or evaluation of the impact of the interventions or Revision of the interventions as appropriate Risk Assessments 4. Findings from the pressure ulcer/injury risk assessment will be incorporated into the resident's plan of care Preventive Measures 1. Preventive interventions will be implemented based on the pressure ulcer/injury risk assessment, other related factors, and resident preferences. Such interventions may include: .c. Use of pressure reducing/relieving support surfaces or devices that assist with pressure redistribution and tissue load Care Plans: 1. A resident centered care plan will be developed and implemented to address the resident's risk for development of a pressure ulcer/injury and to promote healing if the resident has a pressure ulcer/injury

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on observation, interview, and record review, the facility failed to provide interventions, and failed to prevent further decrease in ROM (Range of Motion) and failed to provide positioning device for residents with hand contractures. This applies to 2 of 5 residents (R67 and R485) reviewed for limited range of motion in the sample of 18. The findings include: 1. R67 admission record showed R67 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis following non traumatic intracerebral hemorrhage affecting the left non dominant side, dysphagia, unspecified mood disorder, neuralgia and neuritis, and gastrostomy status. R67's MDS (Minimum Data Set) dated January 7, 2025, showed that R67 was cognitively intact and was dependent on staff assistance for eating through a feeding tube, bathing, toileting, dressing, bed mobility and transfer. On April 8, 2025, at 1:27 PM, R67 was lying in bed and her left hand was contracted in flexion. R67 wrote on her paper with her right hand, I have a splint when asked about the positioning for her left hand. V28 (LPN) was present and looked for the splint in R67's room but did not find a splint for R67's left hand. R67 demonstrated using her right hand she could only partially extend her thumb, index and middle finger and the 4th and 5th digit were difficult to extend. V11 (Rehabilitation Director) provided R67's Physical Therapy discharge recommendations dated August 15, 2024, for date of service range from July 5, 2024, through August 15, 2024. V11 stated R67 did not receive any Occupational Therapy while in the facility. The Physical Therapy discharge recommendation showed only a restorative transfer program using a full mechanical lift was recommended. R67's care plan dated January 29, 2025, for functional maintenance identified R67 had limited range of motion on her left side however interventions did not specify which joints would need either PROM, (Passive Range of Motion), or AAROM (Active Assisted Range of Motion) or how many repetitions of exercise each joint should receive or what positioning device should be used for R67's left hand to prevent further contractures. 2. R485's admission record showed R485 was admitted to the facility on [DATE], with multiple diagnoses including hemiplegia and hemiparesis of left dominant side following cerebral infarction, cardiomegaly and dysphagia. R485's MDS (Minimum Data Set) dated showed R485 was moderately cognitively impaired and needed assistance with ADL's including supervision/light touch assistance with eating and oral hygiene, substantial assistance with bed mobility and dependent on staff for personal hygiene, bathing, toileting, dressing and transfer. R485 had mobility impairment to her left arm and left hand. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 7, 2025, R485 was lying in bed and her left hand was noted with a flexion contracture. R485 stated she was supposed to have a splint in her left hand, but she doesn't have one. R485's OT (Occupational Therapy) Evaluation and Plan of Treatment dated March 26, 2025, showed R485's LUE (Left Upper Extremity) had a contracture. The OT Evaluation showed No, OT will not treat to address contracture and showed Nursing is managing the contracture. R485's care plan initiated on March 20, 2025, did not address any intervention for decreased range of motion and need for positioning device for the left-hand contracture. On April 8, 2025, at 3:03 PM, V1 (Administrator) stated they have a functional maintenance program, instead of a restorative program and that V2 is responsible to oversee that program. On April 8, 2025, at 3:23 PM, V2 (DON) stated R67 and R485 should have positioning devices or splinst to prevent further contractures and would refer them to therapy for an evaluation. The facility's policy titled Resident Mobility and Range of Motion undated, showed Policy 1. Residents will not experience an avoidable reduction in range of motion ROM .2. Residents with limited range of motion will receive treatment and services to increase and/or prevent a further decrease in ROM .3. Residents with limited range of motion will receive the appropriate services, equipment, and assistance to maintain or improve mobility unless reduction in mobility is unavoidable .Specific Procedures .1. As part of the resident's comprehensive assessment the licensed nurse may identify the residents .c. limitations in movement or mobility .2. As part of the comprehensive assessment the licensed nurse may also identify conditions that may place the resident at risk for complications .including .e. contractures .4. The care plan will be developed by the interdisciplinary team based on comprehensive assessment .6. Interventions may include therapies, the provision of necessary equipment, and/or exercises and will be based on professional standards of practice .

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 15845 Based on observation, interview, and record review, the facility failed to ensure safe wheelchair transport for a cognitively impaired resident (R34) that required staff assistance. As a result, R34 sustained pain and significant bruising to the right side of the face, forehead and orbital area to the right eye. This applies to 1 of 1 resident (R34) reviewed for fall-related accidents in the sample of 18. The findings include: The EMR (Electronic Medical Record) shows that R34, is a [AGE] year-old with diagnoses of dementia, psychosis, anxiety disorder, major depressive disorder, age related physical debility, repeated falls, unsteadiness of feet, difficulty walking, need of assistance with care, hyperlipidemia, Vitamin D deficiency, hypothyroidism, and chronic kidney disease. R1 was admitted to the facility on [DATE]. The MDS (Minimum Data Set) assessment dated [DATE], showed that R34's cognition was severely impaired with a BIMS (Brief Interview Mental Status) score of 0/15. The MDS documents that R34 required substantial to maximum assistance from staff during wheelchair transport in the corridor or similar places. On April 7, 2025, at 10:30 A.M., R34 was seated in her wheelchair in the corridor. R34 was observed with a dark blue bruise on the forehead, entire right side of her face and lower orbital area of the right eye. R34 was not interviewable and not able to verbalize how she acquired the bruise. R34 was noted to be anxious and was pacing back and forth from the outside and inside her room. V10 (LPN/Licensed Practical Nurse) was present during this time. V24 said that R34 sustained the bruise from a fall incident that occurred on March 15, 2025, while being transported by CNA using wheelchair without the use of wheelchair leg rests. V24 also said that R34 was anxious and must not be feeling comfortable from the facial bruise. The facility's incident report dated March 15, 2025, showed: CNA (Certified Nurse Assistant) was transporting (R34) to the dining room, for lunch when (R34's) foot got caught underneath the wheelchair, (R34) slid out of the wheelchair and landed on her side hitting her head .911 called . hematoma forehead. The nurse's progress notes March 15, 2025, at 1:19 P.M., showed CNA was transporting (R34) to the dining room for lunch when (R34) foot got caught underneath the wheelchair, (R34) slid out the wheelchair and landed on her right side hitting her head.BP 102/58 HR 103 R 18 T 96.9. NOD (Nurse on Duty) help CNA assist (R34) back to wheelchair and to her room. 911 called and .transport (R34) to .hospital for evaluation. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On April 9, 2025, at 12:10 P.M., V17 (LPN/Nurse Supervisor on March 15,2025) said that R34 had fell forward while seated in her wheelchair and being transported and propelled by (V16/CNA). V17 said that R34's feet were caught underneath the wheelchair that caused the fall. V17 also said that the fall could have been prevented if leg rests were used. V17 added that during the fall incident on March 15, 2025, R34's leg rest were not used during transport and assisted by V16. On April 9,2025 at 12:17 P.M., V19 (CNA) said that R34 did not have the leg rests attached to the wheelchair when transported by V16 and R34 legs were caught and caused the fall. V19 said she saw V16 (CNA) propel R34 in a wheelchair and R34 fell forward. Multiple attempts made for an interview with V16 (CNA) during survey but to no avail. On April 9, 2025, at 12:19 P.M., V18 (LPN, on duty on March 15, 2025, Day shift) said that (V16) had propelled and assisted (R34) to dining room for lunch, (R34) fell forward, there were no leg rests used, (R34's legs/feet) were caught under the wheelchair. On April 9, 2025, at 11:42 AM, V2 (Acting Director of Nursing) said that V16 was supposed to use leg rests when assisting and transporting R34 to ensure safe transport. On April 9, 2025, at 12:06 P.M., V11 (Director of Skilled Rehabilitation/ Physical Therapist) stated that leg rests must be used to ensure safe transport using a wheelchair and being propelled by staff. V11 added this would prevent legs/feet being caught under the wheelchair during transport and would prevent fall accident. On April 9, 2025, at 12:40 P.M. V20 (CNA), said yes, (R34) has pain due to the bruise, she might not be able to say it but with the bruise that big, she must be in pain. On April 9,2025 at 12:42 P.M., V21 (RN) said that R34 has facial pain due to the large bruise. On April 9, 2025, at 11:00 A.M., V14 (Regional Nurse Consultant) said the facility must implement safe transport via wheelchair. V14 also said that facility has no policy for safe transport, but skilled therapy department practice was to be implemented to ensure safe transport for resident while being transported using a wheelchair.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on observation, interview and record review the facility failed to document justification for continued use of an indwelling urinary catheter for a resident who experienced a urinary tract infection. This applies to 1 of 4 residents (R27) reviewed for catheter use in the sample of 18. The findings include: 1.R27's admission record showed R27 was admitted to the facility on [DATE], with multiple diagnosis including chronic atrial fibrillation, morbid obesity, sepsis unspecified organism, and benign prostatic hyperplasia with lower urinary tract symptoms. R27's MDS (Minimum Data Set) dated February 5, 2025, showed R27 was moderately cognitively impaired, and was dependent on staff assistance for toileting, bathing, dressing, bed mobility and transfer and had an indwelling urinary catheter and was always incontinent of bowel. R27's admission assessment dated [DATE], under genitourinary section showed R27 was incontinent of urine and did not identify the use of an indwelling urinary catheter. R27's physician order dated November 8, 2024, showed Foley catheter 16 Fr (French) and the order was revised on November 24, 2024, to add Monitor Foley Cath output Q (every) shift. The order did not include the reason for the indwelling urinary catheter, or the care and maintenance of the catheter to prevent urinary tract infection. On April 7, 2025, at 11:03 AM, R27 was observed with a urinary catheter tubing draining into a drainage bag. The facility did not provide any documentation that identified the reason for continuous indwelling urinary catheter use or evaluation of symptoms that resulted in the justification of indwelling urinary catheter use upon request. R27's care plan initiated on November 8, 2024, did not include the presence of the indwelling catheter or identify interventions for prevention of infection or reason for indwelling urinary catheter use. R27's urine culture obtained on March 12, 2025, grew Klebsiella pneumoniae ESBL (Extended Spectrum Beta Lactamase) greater than 100,000 colonies. R27 received antibiotic treatment from March 17 through March 24, 2025, for the urinary tract infection. On April 9, 2025, at 12:31 PM, V2 (Acting DON) stated there was no documentation or evaluation to justify the reason for continued catheter use and she wasn't sure if the indwelling catheter was being used for BPH (Benign Prostatic Hypertrophy) or due to wounds on the buttocks. V2 stated there was no policy regarding the evaluation for justification of indwelling urinary catheter use.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on interview and record review the facility failed to provide sufficient number of Nursing staff to ensure call lights are answered timely and assistance with ADL care is given as needed. This has the potential to affect all 83 residents who reside in the facility. The findings include: During the resident meeting on April 8, 2025, at 10:00 AM, 4 of the 7 residents in attendance, R6, R13, R36 and R58, all stated they experienced extended wait time for call light response during the evening and overnight shift. R33's name was on the list to attend the resident meeting, but did not attend, there was a note on the list next to his name that showed CNA did not get him up. On April 7, 2025, at 10:53 AM, R487 said she gets anxious during the overnight shift and sometimes the evening shift because she has to wait for a response to her call light 2 or 3 hours. R487 said she puts her call light on when she needs incontinence care or when she gets chest pressure and needs her PRN (as needed) medication from the Nurse. On April 8, 2025, at 12:39 PM, R33 was in his bed eating his lunch and stated he wanted to go to the resident meeting, but the CNA did not get him up because it was not his scheduled day to get up. R33 stated he wants to get up at least 3 days a week and wants to attend BINGO on Tuesday and Saturdays and wants to be dressed in his own clothes when he goes out of his room. R33's request was made known to V28 (R33's LPN) On April 9, 2025, at 2:40 PM, R13, stated almost every overnight she waits an extended amount of time to receive care for incontinence and stated it was uncomfortable to wait in a wet brief for it to be changed. On April 9, 2025, at 2;35 PM, R 36 stated during the day she uses the bathroom but during the night she uses the incontinence brief because the wait for call light response doesn't give her enough time to get to the bathroom without soiling the brief. On April 9, 2025, at 2:35 PM, R58 stated he listens at night and hears the call lights activated and sounding for 30 minutes or more without being turned off. R58 stated this occurs every overnight shift. The Resident Council Meeting minutes dated December 27, 2024, showed the residents raised concerns regarding extended call light response times on the evening, overnight shifts and during the weekends. Residents also identified a concern with medications that are scheduled to be given in the morning are not given until the afternoon. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Resident Council meeting minutes dated January 29, 2025, showed the meeting was attended by V35 (Ombudsman) and two family members. The family members raised concern regarding residents not receiving care on the weekends as they observe residents in bed wearing gowns in the afternoon. shaving of facial hair not being done, and residents are consistently soiled. Residents again raised the concern that medications scheduled to be given in the morning are not administered until the afternoon. Resident also stated staff will turn off a call light, not respond to the need, stating they will return, and staff do not come back. The Resident Council meeting minutes dated February 26, 2025, showed the residents again raised the concern regarding extended call light response times, during the evening and overnight shift. The Residents also raised a concern of not being able to get up out of bed before breakfast due to staffing. The Resident Council Meeting Minutes dated March 26, 2025, showed residents raised the concern regarding extended call light response times especially on the evening and overnight shifts. The residents reported that staff are complaining to them that there is short staffing. On April 9, 2025, at 9:46 AM, V1(Administrator) stated an evaluation of resident care needs in relation to number of CNA staff was not reviewed in response to the Resident Council Meeting concerns. V1 also explained that the Facility Assessment, dated August 8, 2024, showed in a 24-hour period direct care Nurses would be 4 RNs and 5 LPNs, and 30 CNAs. On April 9, 2025, at 10:30 AM, V31 (Staffing Coordinator/CNA) provided daily assignments for April 7-10, 2025, and a list of residents who need 2 staff assists with ADL care. Based on the list of residents, who need 2 staff assists, Unit 1 had 5 of 14 residents who needed 2 staff assists with ADL care. The Daily Assignment sheet for April 7, 2025. showed there was 1 CNA staff on Unit 1 for both the evening and the night shift. The daily assignment sheet for April 8, 9, and 10 showed there was 1 CNA on the overnight shift each day. Unit 2 had 10 of 23 residents who needed 2 staff assists with ADL Care. The Daily Assignment sheet showed on April 7, 8, 9, and 10, there was 1 CNA scheduled for Unit 2 on the overnight shift each day. Unit 3 had 15 of 43 residents who required 2 staff assists with ADL care. The Daily Assignment sheet for April 7, 8, 9, and 10, showed 2 CNA on Unit 3 on the overnight shift each day. R6 and R33 reside on Unit 2. R13, R36, R58, and R487 reside on Unit 3. V31 stated when the residents need 2 staff assists and there is only 1 assigned CNA, the Nurse could help the CNAs provide care for a resident if the nurse was not busy. V31 stated a CNA could come from another Unit to help give care for those residents who need 2 assists for care, which could potentially leave no CNA on a Unit while the CNA assists on another Unit. The Facility assessment dated [DATE], showed 30 CNA staff were needed to provide care in a 24-hour period based on resident care profile. The Daily Assignment sheets dated April 8 through 10, showed there were 20 CNAs who worked in each 24-hour period.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303 Based on interview and record review, the facility failed to develop a person-centered care plan to support a resident's dementia care needs. This applies to 1 of 2 residents (R26) reviewed for dementia care in the sample of 18. The findings include: The EMR (Electronic Medical Record) showed R26 was admitted to the facility on [DATE], with multiple diagnoses including Alzheimer's disease, ventricular tachycardia, and arthritis. R26's MDS (Minimum Data Set) dated March 7, 2025, showed R26 had moderate cognitive impairment. As of April 9, 2025, at 9:32 AM, R26's care plan did not include a care plan for Alzheimer's disease or dementia care including R26's dementia care needs or individualized interventions related to R26's symptomology. On April 9, 2025, at 9:36 AM, V24 (Social Services Director) said he conducts care plan meetings along with nursing and therapy. V24 said R26's comprehensive care plan was completed on March 14, 2025. V24 said R26's Alzheimer's disease diagnosis should have been discussed at the care plan meeting. V24 said R26's care plan should have included an Alzheimer's disease care plan.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. 35267 Based on interview and record review, the facility failed to employ a qualified food service manager. This applies to all 83 residents residing in the facility. The findings include: Long Term Care Facility Application for Medicare and Medicaid, dated April 7, 2025, shows the facility census was 83 residents. On April 9, 2025, at 9:32 AM, V5 (Food Service Manager) stated she had not enrolled in the dietary manager course and did not take the course in the past. V5 stated she was sent the link for the class registration recently and needed to enroll in the class. V5 stated she had a Serve Safe Sanitation certification but no other certifications as the Food Service Manager. On April 8, 2025, at 9:30 AM, the facility provided a ServSafe certificate for V5 dated 11/22/24 and expiring November 22, 2029. As of April 10, 2025, at 4:20 PM, the facility failed to provide documentation regarding V5's qualification as the Food Service Manager.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35267 Based on observation, interview, and record review, the facility failed to prepare and serve food to residents as per their planned and dietitian-approved facility menu and per facility policy. This applies to all 82 residents residing in the facility receiving oral diets. The findings include: Long Term Care Facility Application for Medicare and Medicaid, dated April 7, 2025, shows the facility census was 83 residents. Order Listing Report, dated April 8, 2025, shows there was one resident who did not receive an oral diet (R67) and there were 8 residents who received puree diets. Facility Menu Extension, dated April 8, 2025, show all residents on all diets received a hamburger patty (3 ounces) on a bun. The menu shows pureed diets were to receive pureed hamburger on a bun and mechanical diets were to be served a ground hamburger on a bun. Order Listing Report, dated April 8, 2025, shows 18 residents (R1, R4, R7, R16, R22, R23, R26, R33, F34, R35, R38, R39, R49, R53, R59, R60, R61, R70) had physician orders for Mechanical Soft Diets. On April 8, 2025, at 11:47 AM during lunch service, V6 (Dietary Aide) was plating ground meals onto lunch plates. V6 placed a scoop of ground beef, a scoop of ground green beans, and scoop of ground hash browned potatoes onto the Mechanical Soft plates. No bread was served on the mechanical soft lunch trays served to residents receiving Mechanical Soft diets. V6 served hamburger patties with cheese on a bun to regular and to all other diets other than those residents receiving pureed/mechanical soft diets at lunch. The hamburger patty appeared to weigh less than 3 ounces. On April 8, 2025, at 2:28 PM with V5 (Food Service Manager), one beef patty with one slice of cheese from lunch was weighed on a scale provided by V5. The beef patty and cheese weighed a total of 2.6 ounces. V5 stated the beef patty and cheese was expected to weigh 3 ounces total to provide the three ounces good quality protein per the planned/approved facility menu at lunch. V5 stated the egg omelet served in the morning was expected to provide two ounces of good quality protein. V5 stated the kitchen serves 5 raviolis in a serving at dinner which V5 thought would provide 2 ounces of good quality protein. V5 stated the residents served ground diets at lunch were formerly supposed to be served a bun with their ground hamburger patties but that the dietitian instructed the food service not to serve any bread to residents receiving mechanical soft diets. On April 8, 2025, at 10:44 AM, V5 stated she utilized a frozen, pre-made egg/cheese omelet product for breakfast instead of making the item by scratch. V5 provided the egg omelet manufacturing information which showed one omelet weighed 3.5 ounces but only each provided a total of 10 grams of protein per omelet. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Review of facility cheese ravioli manufacturers product information showed a serving size of 9 ravioli only provided a total of 10 grams of protein per serving (including low quality protein from the pasta). Therefore 5 raviolis only provided an approximate total of 5.5 g high and low quality protein in the serving provide to residents. On April 9, 2025, at 10:09 AM, V40 (Dietitian) stated she discussed giving Mechanical Soft diets a soft piece of untoasted bread in replacement of any bread that was planned on the regular menu. V40 stated the residents receiving Mechanical Soft diets should have been served the equivalent of the regular menu bread servings from the hamburger bun which was two slices of bread. V40 stated she reviewed and approved all of the menus for all of the facility diets. V40 stated it was her expectation that a total of six ounces weight of good quality protein was served each day. V40 stated the hamburger patty was expected to provide 3 ounces of cooked good quality protein. V40 stated the manufacturer serving size of 9 ravioli did not appear to provide one total ounce of high quality protein in the serving. V40 stated if the facility only served 5 raviolis, the serving would not meet the equivalent of one ounce of high quality protein at dinner. V40 stated the menu as served on April 8, 2024, including the omelet, hamburger patty, and ravioli, did not provide a total of 6 ounces of high quality protein. Facility Menu policy, dated September 2, 2021, shows Menus are planned in advance and are followed as written to meet the nutritional needs of the residents The Director of Food and Nutrition Services and Registered Dietitian sign and approve the menus. Menus are served as written unless changed due to an unpopular item on the menu, and item could not be procured, or in the event of a special meal Facility Document Meal Pattern, dated September 2, 2021, shows Meat or Meat Alternatives should total to 5. 5 ounces for the day. Facility Portion Control policy/procedure, dated May 15, 2020, shows Portion size is determined by the nutritional needs of the residents, federal and state regulations that specify the food groups, and portion sizes that must be served according to the facility menu `1. Use standardized recipes based on facility census and cycle menus. 2. Serve portions according to the menu spreadsheet 4. Weight or measure ingredients. Weighting is the most accurate 2. Facility Document Meal Pattern, dated September 2, 2021, shows the daily menu should contain 2 or more servings of fruit per day (1/2 cup per serving), 3 or more servings of vegetables per day (raw vegetables must be 1 cup serving), and 6 servings per day of grains/breads. Review of the facility Week 1 menu, approved February 7, 2025, shows the menu was short in food item servings on the following days: Sunday had only a total of 4 grain/bread servings and 2 vegetable servings Monday had only 1 vegetable serving Thursday had only 5 grain/bread servings and 1 vegetable serving Friday had only 3 grain/bread servings (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Saturday had only 5 grain/bread servings and 2 vegetable servings Review of facility Week 2 menu, approved February 6, 2025, shows the menu was short in food item servings on the following days: Monday had only a total of 5 grain/bread servings and 2 vegetable servings Tuesday day had only 1 fruit serving and 4 grain/bread servings Wednesday had only 2 vegetable servings Thursday had only 3 grain/bread servings and 2 vegetable servings Friday had only 2 grain/bread servings and 2 vegetable servings Saturday had only 4 grain bread servings Review of facility Week 3 menu, approved February 20, 2025, shows the menu was short in food item servings on the following days: Sunday had only 4 grain/bread servings and 2 vegetable servings Monday had only 4 grain/bread servings Tuesday had only 5 grain/bread servings Wednesday had only 4 grain/bread servings Thursday had only 4 grain/bread servings Friday had only 4 grain/bread servings Saturday had only 4 grain/bread servings. Review of facility Week 4 menu, approved March 26, 2024, shows the menu was short in food item servings on the following days: Sunday had only 5 grain/bread servings Monday had only 5 grain/bread servings Tuesday had only 2 vegetable servings Wednesday had only 1 fruit serving and 4 grain/bread servings Friday had only 1 fruit serving and 5 grain/bread servings Saturday had only 5 grain/bread servings

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 35267 Based on observation, interview, and record review, the facility failed to perform hand hygiene after touching soiled dishes per facility policy and failed to utilize sanitizing solution at the proper concentration to sanitize food contact services per manufacturer instructions. This applies to all 83 residents living in the facility. The findings include: Long Term Care Facility Application for Medicare and Medicaid, dated April 7, 2025, shows the facility census was 83 residents. Order Listing Report, dated April 8, 2025, shows there was one resident who did not receive an oral diet (R67). On April 8, 2025, at 9:51 AM in the dish machine room, V15 (Dietary Aide) scraped and loaded dirty dishes into the mechanical dish machine. V15 then removed her gloves and without washing her hands or replacing gloves, V15 walked to the clean side of the dish machine and touched clean/sanitized bowls. V15 removed the bowls from the clean/sanitized dish rack and placed the bowls into storage. V15 then put on a new pair of gloves without washing her hands. V15 walked to the dirty side of the dish machine and began touching dirty bowls. Without changing her gloves and/or washing her hands, V15 walked to the clean side of the dish machine and began touching clean/sanitized plate lids, stacked them, and returned them to storage. Without changing her gloves and/or washing her hands, V15 then took clean/sanitized beverage pitchers to storage. Without changing her gloves and/or washing her hands, V15 then stacked clean/sanitized plate lids and placed them into storage. On April 10, 2025, at 3:57 PM, V5 (Food Service Director) stated she expected staff to wash their hands and change their gloves after touching soiled dishes and before touching clean dishes. Facility Policy Use of Disposable Gloves for Food Handling, dated February 27, 2020, shows disposable gloves were to be used appropriately by all employees and hands were to be washed between glove use. Facility policy Safe Food Handling Practices, dated September 23, 2019, shows All work surfaces and equipment are clean and sanitized after each use If the person washing is also going to pull and store the clean dishes, hands must be washed before pulling the clean dishes. Germs/bacteria can be spread to the clean dishes if clean dishes are not pulled with clean hands. Hands must be washed with soap and water Mechanical Ware Washing (Dish Machine) Policy/Procedure, dated September 27, 2018, shows Handwashing is imperative to prevent cross-contamination when the same person washes the dirty dishes and stores the clean dishes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. On April 7, 2025, at 9:40 AM in the kitchen during lunch meal preparation, V6 (Dietary Aide) used a wipe cloth out of red sanitizer bucket at the cook's station to wipe the counter of the cook's station. V7 (Cook) used a quaternary ammonium test strip and measured the sanitizing solution concentration in the red bucket which measured 100 ppm (parts per million). V6 stated the minimum sanitizing solution concentration should measure 155 ppm quaternary ammonium. On April 10, 2025, at 3:57 PM, V5 stated the quaternary ammonium chemical sanitizing solution in the sanitizing wipe buckets should measure 150-400 ppm. Facility chemical manufacturing product information, undated, shows the facility chemical sanitizing solution was to be utilized at 150-400 ppm of active quaternary ammonium.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 45303 Based on observation, interview, and record review, the facility failed to conduct infection surveillance for resident infections in the facility. The facility also failed to have a complete water management program for Legionella. The facility also failed to follow their policy for EBP (Enhanced Barrier Precautions) and hand hygiene. This applies to all 83 residents residing in the facility. The findings include: The facility's Long-Term Care Application for Medicare and Medicaid dated April 7, 2025, showed the facility's census was 83 residents. 1. On April 8, 2025, at 1:04 PM, V2 (DON/Director of Nursing) said she is the Infection Preventionist for the facility. V2 said when a resident shows signs of an infection, the facility staff will notify the physician for orders. V2 said the facility uses McGeer's Criteria when an infection is identified. V2 continued to say V2, or facility staff do not complete a McGeer's Criteria assessment for residents with infections. V2 said when an antibiotic is ordered, the facility completes an assessment titled Antibiotic Timeout. V2 said the assessment does not include the McGeer's Criteria. V2 said she compiles a monthly list of residents who received antibiotics and conducts her infection surveillance from that list. V2 said from the list, V2 tracks infection trends and transmission-based precautions in the facility. The facility's Order Listing Reports for January 2025, February 2025, and March 2025 showed the resident status as current. On April 9, 2025, at 12:40 PM, the Order Listing Reports were reviewed with V2. Upon review of the reports, V2 said the reports were only run for residents who were currently residing in the facility at the time the report was generated. V2 said she should have been reviewing the antibiotic use and infections for all residents residing in the facility for the month. V2 said since she did not review all residents in the facility for the month who received antibiotics, V2 did not have accurate surveillance of infections within the facility. The Order Listing Reports for antibiotic use for all residents in the facility for January 2025, February 2025, and March 2025, dated April 9, 2025, showed in January 2025, 11 anti-infectives were prescribed for infections and no surveillance was completed. The report continued to show in February 2025, 9 anti-infectives were prescribed for infections and no surveillance was completed. The report showed in March 2025, 9 anti-infectives were prescribed and no surveillance was completed. On April 9, 2025, at 3:45 PM, V1 (Administrator) said V2 should be conducting surveillance for all infections identified in the facility. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated policy titled Antibiotic Stewardship Program showed Policy: The organization is committed to providing sufficient resources to establish and maintain systems and processes for a facility-wide system to monitor the use of antibiotics through an interdisciplinary Antibiotic Stewardship Program . The Antibiotic Stewardship team will analyze infection data (including type of infection or symptoms being treated, antibiotic utilization, and adverse outcomes, etc.) monthly and feedback will be provided to the QAPI (Quality Assurance and Performance Improvement) Committee regarding antibiotic stewardship practices . Specific Procedures/Guidance: . 7. Infection and antibiotic therapy usage will be maintained for each unit/neighborhood of the facility monthly. a. A tracking tool will be utilized to capture the following information at a minimum: i. Resident identifier and room location at onset. ii. Type of infection/symptom and if infection met or did not meet established criteria. iii. Antibiotic use (name of antibiotic, dose, frequency, duration of use); if multiple antibiotics are prescribed for the condition, each antibiotic will be tracked. iv. Outcome- resolution of symptoms, presence of adverse outcomes, etc. v. Type of precautions used (including adjustments for person centered care) . 10. Information from each unit/neighborhood will be reported at least monthly to the Director of Nursing and/or infection control preventionist for tracking/trending and analysis in the facility . 2. On April 8, 2025, at 3:56 PM, V23 (Maintenance Director) said for the facility's water management plan for Legionella, V23 will run the water in vacant resident rooms while a visual inspection of the room is being conducted. V23 continued to say V23 will test water temperatures in a resident room in each unit, the shower room, the kitchen, and the laundry room. V23 said he does not document temperatures of the hot water heaters or tanks. V23 said he does not perform chlorine testing of the facility's water. V23 said he is not aware if any of the hot water tanks or heaters have a thermometer on them. On April 9, 2025, at 12:05 PM, V23 said he does not know what the control measures are for the facility's water management plan for Legionella. V23 said he does not know what to do if the control measures are not met. On April 9, 2025, at 1:18 PM, V23 said the facility does not maintain documentation of running the water in vacant resident rooms. As of April 9, 2025, at 3:44 PM, the facility did not have documentation to show a water management plan containing areas at risk for Legionella growth, control measures for at risk areas, ways to respond when control measures are not met, or routine safety logs for control measures. On April 9, 2025, at 3:45 PM, V1 (Administrator) said her expectations are the facility should have a water management plan for Legionella including control measures and the monitoring of control measures. V1 said V23 should be completing documentation of control measure monitoring. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's policy dated November 16, 2023, titled Legionella/Water Management Plan showed Policy: The facility is committed to established and maintaining an effective water management system to minimize the occurrence of Legionnaire's Disease. Definitions: 'Legionnaire's Disease': is a serious type of pneumonia caused by bacteria, called Legionella, that lives in water. Legionella can make people sick when they inhale contaminated water from building water systems that are not adequately maintained. Specific Procedures/Guidance: 1. The facility will develop and maintain a water management program that includes the following elements: . c. Identify areas where Legionella could grow and spread. d. Decide where control measures should be applied, monitor and log compliance quarterly . e. Establish ways to respond when control measures are not met . g. Document all activities (i.e. monitoring, response to variances, etc.): i. Routine safety logs will be maintained . 2. The water management program will be reviewed at least annually and as needed, to include when: a. Data review shows control measures are persistently outside of control limits . 15845 3. On April 8, 2025, between 8:28 A.M. and 9:03 A.M., V28 (Licensed Practical Nurse/LPN) had administered multiple prescribed medications to R67 via the resident's gastric tube. A posted sign outside R67's room clearly instructed staff to wear appropriate Personal Protective Equipment (PPE), including gown and gloves, due to R67's Enhanced Barrier Precautions (EBP) status, which was ordered in response to the resident's gastric tube care. Despite this posted instruction and the documented order on the April 2025 Physician Order Sheet (POS) requiring EBP, V28 failed to don the required PPE gown while administering the medications. Additionally, during the medication administration process, V28 changed soiled gloves but failed to perform hand hygiene before donning a clean pair of gloves, as required by the facility's undated Hand Hygiene policy. This policy documents that glove use is not a substitute for hand hygiene and mandates hand hygiene before and after glove use and before and after direct resident contact. Later that same day, at 1:11 P.M., V28, flushed R67's gastric tube. During this procedure, V26 also failed to wear the required PPE gown, despite engaging in direct contact with R67's gastric tube. This was a procedure/task that explicitly listed under High-Contact Resident Care Activities Requiring EBP in the facility's EBP policy dated March 28, 2024. Additionally, V28 failed to perform hand hygiene both upon entering and leaving R67's room. 4. On April 8, 2025, at 9:15 A.M., the medication administration observation continued with V28, with gloves on V28 performed a blood glucose finger-stick test on R6. Following this procedure, V28 removed the soiled gloves but failed to perform hand hygiene before proceeding to prepare and administer 14 units of Humalog insulin via subcutaneous injection to R6. This was not following the facility's Insulin Administration policy dated October 1, 2021, which requires handwashing before and after insulin administration. Furthermore, while still failing to perform hand hygiene, V28 administered multiple oral medications to R6 and subsequently proceeded to prepare and administer oral medications to R55. During this process, V28 did not perform hand hygiene before donning a new pair of gloves, nor after glove removal, as required by the facility's Hand Hygiene policy. The facility Policies show: Enhanced Barrier Precautions Policy (March 28, 2024): Requires gown and gloves during high-contact resident care activities, including device care or use during gastric feeding/enteral tube management. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Insulin Administration Policy (October 1, 2021): Requires handwashing before and after insulin administration. Hand Hygiene Policy (Undated): Specifies that glove use does not replace hand hygiene and mandates hand hygiene before and after glove use, and before and after direct contact with resident's intact skin. 35267 5. POS (Physician Order Sheet), dated April 9, 2025, shows R29's diagnoses included pressure ulcers, urinary tract status, major depressive disorder, bipolar disorder, paraplegia, epilepsy, osteomyelitis, and infection of intervertebral disc. On April 7, 2025, at 9:56 AM, R29 had no transmission or enhanced barrier precautions outside of his room indicating what type of precautions were required to enter his room or perform care. Inside of R29's room there were two red biohazard disposal bins. There was a PPE (Personal Protective Equipment) dispenser hanging on R29's door holding gloves, gowns and masks. R29 stated he was recently hospitalized for an infection in his blood. R29 had an indwelling urinary catheter hanging on the side of his bed. On April 7, 2025, at 10:03 AM V29 (Social Services) was unable to locate any barrier precautions signage outside R29's door of his room. Red biohazard bins were inside door of room. On April 7, 2025, at 10:06 AM, V10 (Licensed Practical Nurse) stated she just received labs that morning showing R29 had ESBL (Extended-spectrum beta-lactamase) infection in his urine and that R29 had MRSA (Methicillin-Resistant Staphylococcus aureus) infection in his wound. V10 stated she was waiting on two other cultures to come back from the laboratory. Nursing note, dated March 31, 2025, shows R29 had a MRSA infection and pneumonia and contact precautions were required. POS, dated April 9, 2025, shows the following active physician orders for R29: - April 7, 2025, Contact isolation for ESBL in urine - February 22, 2025, Infection precautions - enhanced barrier related to wounds, colostomy, urostomy, every shift for EBP (Enhanced Barrier Precautions) - January 12, 2025, Strict contact isolation for MRSA and C Striatum every shift for wound infection Physician Note, dated April 2, 2025, shows R29 was recently hospitalized at [hospital] January 2-January 12, 2025, for bacteremia, source likely sacral OM (Osteomyelitis), also treated for aspiration PNA (Pneumonia). The note shows R29 was stabilized and discharged back to facility on January 12, 2025, with IV ABT (Intravenous Antibiotic) Vancomycin and Meropenem EOT (End of Treatment) February 14, 2025. (continued on next page)

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	145657	A. Building B. Wing	04/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Downers Grove Rehab & Nursing	3450 Saratoga Avenue Downers Grove, IL 60515

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On April 9, 2025, at 3:47 PM, V2 (Director of Nursing) stated R29 should have had a contact precautions sign hanging on the door of his room. 6. POS, dated (January 1, 2025, to April 30, 2025, shows the following physician orders for R59: - Bottom Lateral foot: Monitor and cleanse wound with NSS, apply betadine and cover with dry dressing two times a week one time a day every Tuesday and Friday for wound care (ordered February 18, 2025, and revised February 26, 2025) - Right plantar foot: Cleanse wound with NSS apply betadine and cover with dry dressing two times a week. One time a day every Tuesday, Fri for wound care. And as needed for soilage and or saturation (ordered April 5, 2025) - Infection precautions enhanced barrier secondary to wounds (ordered March 27, 2025) On April 8, 2025, V10 (Licensed Practical Nurse) stated she was not aware of any pressure injuries regarding R59. On April 8, 2025, at 12:37 PM V12 (Wound Nurse) stated R59 had an unstageable right plantar DTI for months. At 12:39 PM, V12 walked into R59's room with no gown, no gloves, no mask and pulled back the sheets with bare hands to observe R59's feet. With bare hands, V12 pulled off R59's right sock and displayed R59's wound dressing on her foot. There was no isolation precaution sign at the entrance of R59's room and there were no PPE supplies at the entrance to R59's room. On April 8, 2025, at 1:30 PM, V12 (Wound Nurse) stated R59 should have EBP (Enhanced Barrier Precautions) in place for her wound. V12 stated she was unaware of R59's order for EBP. On April 9, 2025, at 12:25 PM V38 (Physician) stated she expected residents to be placed on enhanced barrier precautions for all wounds per Centers for Disease Control guidelines. R59's care plan, reviewed on April 8, 2025, shows no identification of R59's facility acquired pressure injury or need for Enhance Barrier Precautions related to R59's wound. Wound evaluation & Management Summary, dated April 8, 2025, shows R59's pressure ulcer measured 1.8 cm by 2 cm and the depth was not measurable. The wound was described as an unstageable DTI with intact skin with no exudate. The plan of care recommendations show R59's wound was to be off-loaded. Facility Enhanced Barrier Precautions (EBP) Policy, undated, shows EBP will be utilized in conjunction with standard precautions to provide targeted gown and glove use during high-contact resident care activities Enhanced Barrier Precautions refer to the infection control intervention aimed at reducing transmission of MDROs (Multi-Drug Resistant Organisms) through the targeted use of gown and gloves during high-contact resident care activities. 1. Criteria for Implementing EBP: EBP should be employed in the following scenarios: Residents with infection or colonization by a CDC (Centers for Disease Control) -targeted MDRO when contact Precautions are not otherwise applicable. Residents with wounds and/or indwelling medical devices, irrespective of MDRO infection or colonization status . High-Contact Resident Care Activities Requiring EBP: EBP should be utilized during the following activities: Dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 45303 Based on interview and record review, the facility failed to follow their policy for antibiotic stewardship. This applies to all 83 residents residing in the facility. The findings include: The facility's Long-Term Care Application for Medicare and Medicaid dated April 7, 2025, showed the facility's census was 83 residents. On April 8, 2025, at 1:04 PM, V2 (DON/Director of Nursing) said when a resident in the facility has an infection, McGeer's Criteria is supposed to be used. V2 continued to say she had not completed McGeer's Criteria since she started as the Infection Preventionist in November 2024. V2 reviewed antibiotic use for R79 in March 2025. V2 said she did not complete McGeer's criteria for R79 and reviewing McGeer's Criteria now, R79 did not meet criteria for an infection. V2 said R79 was prescribed antibiotics due to laboratory results and R79 did not have any symptoms. V2 said R79's urine culture results showed R79 had a growth of ESBL (Extended-Spectrum Beta-Lactamases) of 50,000 to 100,000 colonies. V2 said R79's laboratory results did not meet McGeer's Criteria. V2 said when an antibiotic is ordered, the facility completes an assessment titled Antibiotic Timeout. V2 said the assessment does not include the McGeer's Criteria. V2 said she compiles a monthly list of residents who received antibiotics. The facility's Order Listing Reports for January 2025, February 2025, and March 2025 showed the resident status as current. On April 9, 2025, at 12:40 PM, the Order Listing Reports were reviewed with V2. Upon review of the reports, V2 said the reports were only run for residents who were currently residing in the facility at the time the report was generated. V2 said she should have been reviewing the antibiotic use for all residents residing in the facility for the month. V2 said since she did not review all residents in the facility for the month who received antibiotics, V2 did not have accurate monitoring of antibiotic use within the facility. The Order Listing Reports for antibiotic use for all residents in the facility for January 2025, February 2025, and March 2025, dated April 9, 2025, showed in January 2025, 11 anti-infectives were prescribed for infections and no surveillance was completed. The report continued to show in February 2025, 9 anti-infectives were prescribed for infections and no surveillance was completed. The report showed in March 2025, 9 anti-infectives were prescribed and no surveillance was completed. On April 9, 2025, at 1:51 PM, V25 (Agency RN/Registered Nurse) said when she suspects a resident has an infection, she calls the provider. V25 said she does not complete a McGeer's criteria when she suspects a resident infection. V25 said she was not instructed by the facility to complete a McGeer's Criteria when assessing a resident for a possible infection. On April 9, 2025, at 1:55 PM, V21 (Agency RN) said she was not instructed by the facility to complete McGeer's Criteria when she suspects a resident has an infection. V21 said she does not know what McGeer's Criteria is or how to complete the assessment. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On April 9, 2025, at 2:01 PM, V27 (RN) said she suspects a resident has a UTI (Urinary Tract Infection) if the resident has symptoms like fever, confusion, lethargy, or a change from their baseline. V27 said she has not been instructed to complete the McGeer's Criteria for a suspected resident infection. V27 said she was unaware what McGeer's Criteria was. The facility did not have documentation to show McGeer's Criteria was performed for suspected resident infections from November 2024, to present. On April 9, 2025, at 3:45 PM, V1 (Administrator) said V2 should be following the facility's policy for antibiotic stewardship and accurately compiling antibiotic use. V1 continued to say V2 should be utilizing McGeer's Criteria to ensure a resident requires antibiotics. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's undated policy titled Antibiotic Stewardship Program showed Policy: The organization is committed to providing sufficient resources to establish and maintain systems and processes for a facility-wide system to monitor the use of antibiotics through an interdisciplinary Antibiotic Stewardship Program. Improving the use of antibiotics in the nursing facility to protect residents and reduce the threat of antibiotic resistance is a priority. The goals of the program include: Ensuring that residents who require an antibiotic, are prescribed the appropriate antibiotic, reducing the risk of adverse events, including the development of antibiotic-resistant organisms, from unnecessary or inappropriate antibiotic use. The Antibiotic Stewardship team will analyze infection data (including type of infection or symptoms being treated, antibiotic utilization, and adverse outcomes, etc.) monthly and feedback will be provided to the QAPI (Quality Assurance and Performance Improvement) Committee regarding antibiotic stewardship practices . Specific Procedures/Guidance: . 2. The Antibiotic Stewardship team will meet monthly to review antimicrobial regimens for appropriate: a. Drug; b. Indication for use (i.e. type of infection, symptom, prophylactic use, etc.); c. Opportunities for elimination of lines or devices; d. Cultures and sensitivities obtained during review period; e. Person centered precautions/isolation status; f. Clinical assessments; g. Resident response to antimicrobial therapy including the development of a secondary infection, allergy, adverse outcomes such as diarrhea, rash, gastritis, etc. 3. The Antibiotic Stewardship Program will review all routes of antibiotics: oral, intramuscular, intravenous, ocular, PEG (Percutaneous Endoscopic Gastrostomy), topical, etc. 4. A standard of criteria for defining various infections, (i.e. McGeer's Criteria) will be adopted and utilized for classifying infections and/or related symptoms. These standards will be approved by the QAPI Committee with input from the Medical Director, consulting pharmacist, Director of Nursing and infection control preventionist. These standards will be communicated and accessible to prescribing physicians/non-physician practitioners, and licensed nursing staff. a. Antibiotic therapy should be based on the following guidelines: (if the infective pathogen is not known) or prophylactic therapy (given to prevent development of an infection), the therapy is prescribed using a narrow spectrum antimicrobial over the shortest duration possible to achieve therapeutic effectiveness. b. If the infective pathogen is known: according to the microbiology results and susceptibilities, when available. c. Consistent with the appropriate dosage, route, and frequency or prescribed antibiotics for the individual as well as the site and type of infection, for the shortest number of days. d. Based on appropriate duration of a specific antibiotic and reviewed routinely to determine clinical effectiveness. i. Single antibiotic therapy should be used in most instances, where clinically appropriate. 5. When symptoms of infection are identified, the clinical team (i.e. nursing, provider, etc.) will complete an evaluation of the resident and communicate findings to the resident's physician for orders related to diagnostic testing and/or treatment. Tracking and surveillance will be initiated for all symptoms and/or infections that require diagnostic testing (i.e. urinalysis, chest x-rays, etc.) and/or with orders for antibiotic therapy. 6. The initial tracking/surveillance tool will be initiated by the infection control preventionist or designated licensed nurse (i. e. unit manager/coordinator, DON/Assistant Director of Nursing, etc.) and will be completed for each resident as applicable. 7. Infection and antibiotic therapy usage will be maintained for each unit/neighborhood of the facility monthly. a. A tracking tool will be utilized to capture the following information at a minimum: i. Resident identifier and room location at onset. ii. Type of infection/symptom and if infection met or did not meet established criteria. iii. Antibiotic use (name of antibiotic, dose, frequency, duration of use); if multiple antibiotics are prescribed for the condition, each antibiotic will be tracked. iv. Outcome- resolution of symptoms, presence of adverse outcomes, etc. v. Type of precautions used (including adjustments for person centered care). 8. The clinical record will be reviewed to validate the presence of absence signs and symptoms of infection, implementation of orders for diagnostic testing or treatment, resident response to treatment, and related diagnostic reports . 12. A summary of the monthly tracking, analysis and actions taken will be communicated to the QAPI Committee for additional oversight and oversight .