STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145668	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bria of Belleville	150 North 27th Street Belleville, IL 62226

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to prevent abuse in 1 of 3 residents (R31), reviewed for abuse in the sample of 38. Findings include: On 5/13/25 at 11:07 AM, R31 was observed in his room, alert to self only, pleasant and was unable to recall any details of the incident between him and R22. R31 and R22 are in rooms across the hall from one another. R31's Face Sheet, undated, documents R31 has the following diagnoses: Encephalopathy, Altered Mental Status, Slurred Speech, and a Cognitive Communication Deficit. R31's MDS (Minimum Data Set), dated 3/18/25, documents R31 has a BIMS (Brief Interview for Mental Status) score of 6, indicating R31 has severe cognitive impairment. R31's Care Plan, dated 12/23/24, documents R31 is at risk for abuse and neglect related to Encephalopathy and Cognitive Decline. R31 is at risk for complications due to occasional incontinence. He at times forgets where the bathroom is and wanders from room to room looking. R31's Progress Note, dated 5/8/2025 at 11:14 PM, documents the following: This nurse was informed by another res. (resident) that res. was pushed on the floor by another male resident. Upon arrival, res. noted to be trying to get himself off of the floor. ROM (Range of Motion) performed and WNL (Within Normal Limits), vital signs obtained and WNL, no bleeding, hematoma, or bruising noted at this time, res. assisted off the floor using a gait belt via two CNA's (Certified Nursing Assistant). All parties notified, Telehealth Doctor gave orders to monitor for pain and have in house NP (Nurse Practitioner) assess tomorrow morning. On 5/14/25 at 11:48 AM R22 was observed in room in bed with the door closed. R22 stated he didn't have any residents come into his room and he didn't push anyone down, he doesn't do that. R22 and R31 are in rooms right across the hall from one another. R22's Face Sheet, undated, documents R22 has the following diagnoses: Alzheimer's Disease, Traumatic Brain Injury due to Cerebral Infarction, Adjustment Disorder, and Intellectual Disabilities. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R22's MDS, dated [DATE], documents R22 has a BIMS score of 15, which indicates R22 is cognitively intact. R22's Care Plan, dated 5/12/17, documents R22 is at risk for abuse, has a diagnosis of Alzheimer's Disease and may display moods/behaviors such as agitation, aggression, and refusal of care. On 5/8/25, R22 had a physical altercation with another resident. See Nurse's Notes, no injuries. R22's Progress Note, dated 3/17/25 at 6:05 PM, documents the following: Resident has been agitated with behaviors entire shift. Approaching staff members and other residents and cussing at them. Unable to redirect. Resident comes in and out of room constantly wandering halls. R22's Progress Note, dated 5/8/25 at 11:57 PM, documents the following: Nurse was informed that resident pushed another resident down, writer asked resident what was going on, resident stated that other resident entered his room looking for the bathroom. Resident's next of kin was called, no answer, VM (Voice Mail) left, all parties notified. R22's Behavior Tracking was reviewed with the following noted: 4/17/25 & 5/9/25, R22 displayed verbal aggression towards others. R22 and R31's Abuse Investigation Final Report, dated 5/14/25, documents the following: R95 alleged that she saw resident R31 enter R22's room and R22 pushed R31 down. R31 was assessed for injuries with none noted. On 5/8/25 at approximately 10:00 PM, R95 verbally stated that she was leaving the 300 hall shower room, she stopped outside the door of the shower room to take a break because she was getting winded. At that time, she saw the bigger man (R22) pushing the other taller guy (R31) out of his room and the other taller guy (R31) fell. She (R95) yelled for staff, they came running and looked at him (R31) and got him up. V26, LPN (Licensed Practical Nurse), documented and gave a verbal statement that R95 informed her that a resident was pushed by another resident onto the floor. Upon arrival she (V26) noted R31 on the floor in room [ROOM NUMBER] (R22's room). Upon assessment, range of motion was within normal limits, no bleeding, no hematomas or bruising was noted to R31. He (R31) was assisted off of the floor using a gait belt and two aides. The Administrator, DON, residents' responsible parties and Telehealth were notified. When R31 was asked what he was doing, he stated he was looking for the bathroom. When R22 was asked why he pushed R31, he stated The Lord made me do it. The local police were contacted, responded to the facility and took a report. The care plans were updated, and interventions were put into place in an attempt to prevent reoccurrence, including a toileting schedule for R31. There have been no further incidents and neither resident seems to recall the event. On 5/15/25 at 8:15 AM, V24, CNA, stated R31 wanders into other resident rooms and will get into their beds. V24 stated R22, is pretty much with it, stays to himself, sometimes he thinks he works here so he will clean, bark out orders, and says stuff under his breath, like f*** you. On 5/15/25 at 9:14 AM, R95 stated, last week, she was coming out of the shower room on the 300 hallways, was talking to her CNA, and observed the big guy (R22) push R31 and R31 hit the wall and then fell to the ground. R95 stated neither resident had said anything to one another prior to the incident or after the incident. R95 stated she was the only one that saw R22 push R31, her CNA did not witness the incident and she (R95) stated to staff are you going to get him, or do I need to? R95 stated R22 is big, and she thinks he is a bully. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Abuse Policy and Prevention Program, dated 10/2022, documents the facility affirms the right of our residents to be free from abuse, neglect, exploitation, misappropriation of property, deprivation of goods and services. The facility is committed to protecting our residents from abuse, neglect, exploitation, misappropriation of property and mistreatment by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends, or any other individuals.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, observation and record review, the facility failed to report an injury of unknown origin in 1 of 3 residents (R61), reviewed for abuse in the sample of 38. Findings include: On 5/13/25 at 10:49 AM, R61 was observed with multiple large and small reddish/purple colored bruises and purpura noted to her bilateral forearms and right hand. No s/s (signs or symptoms) of pain or discomfort noted. R61 speaks Spanish but is able to make her needs known with staff. R66, R61's Roommate, stated they did an x-ray yesterday because she (R61) was acting like it (shoulder) hurt and she hadn't noticed her acting like that before. R66 stated she has not seen staff being rough during care or abusive towards R61. R61's Face Sheet, undated, documents R61 has the following diagnoses: Stage 4 CKD (Chronic Kidney Disease), Dementia, HTN (Hypertension), and Dysphagia. R61's MDS (Minimum Data Set), dated 3/6/25, documents R61 has severe cognitive impairment, is dependent on staff with turning in bed and has limitations in range of motion of the bilateral upper and lower extremities. R61's Care Plan, dated 3/15/23, documents R61 is at risk for abuse and neglect due to her anxiety and mood disorder and has a self care deficit in bed mobility related to Dementia. R61's Progress Notes, dated 5/12/25 at 12:14 PM, documents the following: This nurse discovered that resident had a bruise on her lower left arm and complained that her shoulder was hurting. NP (Nurse Practitioner) requested to get an x-ray done. (Mobile X-Ray Company) came and did some scans and stated he doesn't see anything right now but he will have results later. R61's POS (Physician Order Sheet), documents an order dated 5/12/15 for a two view x-ray of the right shoulder and left forearm for complaints of pain and to rule out a fracture. R61's X-Ray Report, dated 5/12/25, documents the following: Right shoulder - examination reveals mild degenerative arthritic changes with limitations of range of movements and possible anterior subluxation (a partial dislocation, where the bones in a joint are still partially touching) of the humeral head with no recent fracture. There was no facility investigation into R61's injury to her right shoulder. On 5/14/25 at 10:45 AM, V1, Administrator, stated they did not complete an investigation on R61's bruise or the right shoulder injury, the staff were able to determine the cause of the bruising was due to R61 lying in bed with her hand/arms pressed against the bed rail, it was after that when R61 began complaining of shoulder pain, the x-ray was obtained and showed degenerative changes and subluxation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 11:40 AM, V2, DON (Director of Nursing), stated the nurse was administering R61 her medications and noticed the bruise to R61 and R61 was complaining of shoulder pain, they did an x-ray and it just showed degenerative changes. V2 stated R61 lays with her hands/arms against the bedrail. V2 stated she has educated the CNAs on positioning R61 in the bed to ensure she is not lying against the bedrail. V2 stated they were also getting R61 and new bed, therapy is going to evaluate her, and the MD ordered labs. The Abuse Policy and Prevention Program, dated 10/2022, documents the following: Internal Investigation: For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because the extent of the injury or location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. If classified as an injury of unknown source, the person gathering the facts will document the injury, the location and time it was observed, any treatment given and notification to the resident's physician, responsible party. The Department of Public Health will be notified. Time frames for reporting and investigating will be followed. The appointed investigator, will at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. Based on interview, observation and record review, the facility failed to investigate an injury of unknown origin in 1 of 3 residents (R61), reviewed for abuse in the sample of 38. Findings include: On 5/13/25 at 10:49 AM, R61 was observed with multiple large and small reddish/purple colored bruises and purpura noted to her bilateral forearms and right hand. No s/s (signs or symptoms) of pain or discomfort noted. R61 speaks Spanish but is able to make her needs known with staff. R66, R61's Roommate, stated they did an x-ray yesterday because she (R61) was acting like it (shoulder) hurt and she hadn't noticed her acting like that before. R66 stated she has not seen staff being rough during care or abusive towards R61. R61's Face Sheet, undated, documents R61 has the following diagnoses: Stage 4 CKD (Chronic Kidney Disease), Dementia, HTN (Hypertension), and Dysphagia. R61's MDS (Minimum Data Set), dated 3/6/25, documents R61 has severe cognitive impairment, is dependent on staff with turning in bed and has limitations in range of motion of the bilateral upper and lower extremities. R61's Care Plan, dated 3/15/23, documents R61 is at risk for abuse and neglect due to her anxiety and mood disorder and has a self care deficit in bed mobility related to Dementia. R61's Progress Notes, dated 5/12/25 at 12:14 PM, documents the following: This nurse discovered that resident had a bruise on her lower left arm and complained that her shoulder was hurting. NP (Nurse Practitioner) requested to get an x-ray done. (Mobile X-Ray Company) came and did some scans and stated he doesn't see anything right now, but he will have results later. R61's POS (Physician Order Sheet), documents an order dated 5/12/15 for a two view x-ray of the right shoulder and left forearm for complaints of pain and to rule out a fracture. R61's X-Ray Report, dated 5/12/25, documents the following: Right shoulder - examination reveals mild degenerative arthritic changes with limitations of range of movements and possible anterior subluxation (a partial dislocation, where the bones in a joint are still partially touching) of the humeral head with no recent fracture. There was no facility investigation into R61's injury to her right shoulder. On 5/14/25 at 10:45 AM, V1, Administrator, stated they did not complete an investigation on R61's bruise or the right shoulder injury, the staff were able to determine the cause of the bruising was due to R61 lying in bed with her hand/arms pressed against the bed rail, it was after that when R61 began complaining of shoulder pain, the x-ray was obtained and showed degenerative changes and subluxation. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/14/25 at 11:40 AM, V2, DON (Director of Nursing), stated the nurse was administering R61 her medications and noticed the bruise to R61 and R61 was complaining of shoulder pain, they did an x-ray and it just showed degenerative changes. V2 stated R61 lays with her hands/arms against the bedrail. V2 stated she has educated the CNAs on positioning R61 in the bed to ensure she is not lying against the bedrail. V2 stated they were also getting R61 and new bed, therapy is going to evaluate her and the MD ordered labs. The Abuse Policy and Prevention Program, dated 10/2022, documents the following: Internal Investigation: For resident injuries not involving an allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an injury of unknown source. An injury should be classified as an injury of unknown source when both of the following conditions are met: The source of the injury was not observed by any person or the source of the injury could not be explained by the resident; and the injury is suspicious because the extent of the injury or location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time. If classified as an injury of unknown source, the person gathering the facts will document the injury, the location and time it was observed, any treatment given and notification to the resident's physician, responsible party. The Department of Public Health will be notified. Time frames for reporting and investigating will be followed. The appointed investigator, will at a minimum, attempt to interview the person who reported the incident, anyone likely to have direct knowledge of the incident and the resident, if interviewable. Any written statements that have been submitted will be reviewed, along with any pertinent medical records or other documents.

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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** Based on interview and record review the facility failed to revise and updated care plans with progressive interventions following falls for 1 of 6 (R57) residents investigated for accidents in a sample of 38. Findings include: R47's EMR (Electronic Medical Record) undated documented that the resident was admitted to the facility on [DATE]. R47's EMR dated 9/13/18 documents a diagnosis of repeated falls. R47's EMR dated 12/15/18 documents a diagnosis of hemiplegia, unspecified affecting left nondominant side. R47's EMR dated 12/10/20 documents a diagnosis of difficulty in walking, not elsewhere classified. R47's MDS (Minimum Data Set) dated 4/4/25 documents a BIMS (Brief Interview for Mental Status) score of 5 out of 15. The MDS documents that the resident requires supervision or touching assistance for roll left and right. The MDS documents that the resident requires substantial/maximal assistance for sit to lying and sit to stand. The MDS document that the resident requires partial/moderate assistance for lying to sitting on side of bed, chair/bed to chair transfer, and toilet transfer. R47's Care Plan dated 6/7/23 documents FALL: (R47) is at high risk for falls Cognitive deficits, Functional Deficits, History of Falls, Poor Balance. (R47) has a tendency to visits with other residents late in the evening. R47's Nurses Notes dated 9/20/24 at 7:26 AM documents during rounds found resident on floor resident stated he fell tryna (sic) get urinal ROM performed vs wnl (within normal limits) resident complained of pain to right leg. No intervention documents on the care plan for this fall. R47's Nurses Notes dated 9/25/24 at 6:24 AM documents res found sitting on the floor in the bathroom, this nurse asked what happened, res stated he lost his balance when transferring to the toilet and he lowered himself to the floor, res stated he did not hit his head, res assed for injuries, no injuries noted, vs taken, res assisted from floor to chair, md made aware, no c/o pain or discomfort, res in w/c in room, call light in reach. No intervention documented on the care plan for this fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R47's Nurses Notes dated 9/29/24 at 2:56 PM documents This nurse was notified by CNA that she was walking pass and seen res fall coming out of the restroom. When this nurse arrived, res noted to be laying on the floor, res stated that he was walking out the restroom and his left leg gave out, res stated that he did not hit his head and that he caught himself with his hands. This nurse and CNA helped res off of the floor into the wheelchair using a gait belt. ROM and vital signs were all WNL, res did complain of mild pain in right knee, res states that it hurt all the time, res stated that he had a knee replacement. This nurse educated res on the importance of asking for assistance to prevent injuries, res started smiling and said I know, I know, this nurse contacted Telehealth doctor, NNO at this time, Res POA/Wife notified, No questions or concerns at this time. Intervention: educated res on the importance of asking for assistance to prevent injuries. R47's Nurses Notes dated 4/9/25 at 7:03 AM documents CNA (Certified Nursing Assistant) made writer aware that resident was on the floor upon arrival resident was found sitting upright on the floor resident stated he slid out of chair denies hitting his head no complaints of pain range of motion performed vs wnl all parties made aware. Intervention: Dycem placed in wheelchair. R47's Nurses Notes dated 4/10/25 at 11:24 AM documents This nurse was made aware by housekeeper res was about to be on the floor. When I entered the room res was trying to hold on to the chair so he wouldn't fall. Res was lower to the floor on his bottom. Res stated he forgot to lock his right wheel and the chair rolled while he was transferring himself from bed to wheelchair. Vitals B/P (blood pressure) :120/64 R (respirations) :18 T (temperature) :97.8 o2 (oxygen saturation) :97%ra (room air) P (pulse):98. Np (Nurse Practitioner) (V22) made aware. Intervention: wc (wheelchair) brakes inspected for proper functioning, res shown how to lock brakes. Continue to encourage compliance. R47's Nurses Notes dated 4/21/25 at 10:00 PM documents Resident had unwitnessed fall. Resident was found on floor. Bathroom seat is broken. Vital signs assessed. VS (vital signs) WNL. Resident state he didn't hit his head. no complaints of pain or discomfort. resident was instructed to use call light and wait for assistance when ambulating or doing Adls (activities of daily living). Intervention: visual cue reminder placed in room. R47's Nurses Notes dated 4/24/25 at 4:32 AM documents Resident was observed on floor by CNA. Resident was in side (sic) lying position. Resident did not verbalize need for help. Scattered items observed on floor believed to have aided in fall. Possible decline in self-help has also aided in fall. Resident did not verbalize or show any signs of pain. Immediate intervention- resident educated on importance of using call light and asking for help. Resident was assisted in bed with call light in reach. Intervention: mx (monitor) for acute change in condition, obtain labs. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R47's Nurses Notes dated 4/29/25 at 1:05 PM documents This nurse was notified by aid res was on the floor. When I entered the room res was on the floor on his bottom. res stated he was ok he slipped while transferring himself to the wheelchair. ROM was performed and all extremities were able to move. Vitals B/p:132/76 R:20 T:98.0 o2:97%ra. DON and niece were made aware. Intervention: dycem replaced, staff educated to remove wc from room when not in use. R47's Nurses Notes dated 5/7/25 at 2:24 PM documents This nurse was notified by the aid res was on the floor. When entering the room res was on the floor on his bottom in front of his wheelchair. Res stated he was transferring himself from the toilet to his wheelchair. ROM was performed and res complained of no pain. This nurse encouraged res to start asking for assistance and he got upset stating he doesn't need no help. Vitals B/P:120/75 R:20 P:90 T:98.0 02:98%RA. NP (V22) made aware and (V23). Intervention: care plan meeting to be to noncompliance, positive reinforcement, and get family/resident input. On 5/15/25 at 3:15 PM, V3, ADON (Assistant Director of Nursing) stated that she would expect to have a new intervention added to a resident's care plan following every fall. Facility's policy Comprehensive Care Plan dated 3/2024 documents The facility must develop a comprehensive person-centered care plan for each resident. 2. The care plan will include a focus, measurable goal, and interventions specific to the resident's medical, nursing, mental, and psychosocial needs. Facility's policy Fall Prevention and Management dated 8/2024 documents This facility is committed to maximizing each resident's physical, mental, and psychosocial well-being. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. All resident falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed. 4. Care plan to be updated with a new intervention based on root cause analysis after each fall occurrence.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to turn and reposition 1 (R14) of 8 residents investigated for pressure ulcers in the sample of 38. This failure resulted in R14 having re-opened pressure ulcers and new in house acquired pressure ulcers. Findings include: R14's Facesheet documents an admission date of 6/23/2024. Diagnosis include Syringomyelia and Syringobulbia, Ulcerative Colitis, Chronic Embolism, Crohn's Disease, Dorsalgia. R14's Minimum Data Set, MDS, dated [DATE] documents R14 has no cognitive deficits. R14 is dependent for mobility and transfers. R14's care plan with a revision date of 2/10/2025 documents R14 SKIN: R14 has developed a stage III pressure wound to his right back. Interventions include Assist and encourage resident to turn and reposition every one to two hours and PRN. Ensure proper body alignment. R14's admission Nursing assessment dated [DATE] documents R14's skin intact. No wounds documented. R14's progress notes dated 11/7/2024 at 1:08PM documents V19 (Wound Care Nurse Practitioner) present to assess right buttock with area having a stage II pressure wound with new order of cleanse right buttock with wound cleanser then apply collagen hydrogel mixed with collagen particles to wound bed and cover with calcium alginate then cover with dry dressing daily. R14's progress notes dated 2/10/2025 at 11:53AM Writer summoned to R14's room by CNA. Upon assessment, observed that R14 has developed an unstageable wound to his right back and an abrasion to his right buttock. Call placed to V19 with new orders of cleanse areas with wound cleanser then apply medi-honey to wound bed cover with calcium alginate and silicone bordered super absorbent dressing daily. R14 notified. R14's progress notes dated 4/2/2025 at 8:10AM documents V14 (Registered Nurse) was present to assess wound with no new orders yet did observe a re-opened stage III pressure wound to right buttock with new order of cleanse right buttock wound with wound cleanser then apply collagen hydrogel mixed with collagen particles then apply to wound bed cover with silicone boarded super absorbent dressing daily. R14 notified. R14's progress notes dated 5/6/2025 at 2:52PM documents V19 present to assess wound with new order of SSD cream to treatment. R14 notified. R14's Skin and Wound Evaluation dated 11/29/2024 documents pressure wound to right gluteal, unstageable, in house acquired. Exact date of discovery 11/7/2024. Slow to heal. R14's Skin and Wound Evaluation dated 3/6/2025 documents new stage 3 pressure ulcer to right gluteal. In house acquired. Exact date of discovery 2/10/2025. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R14's Skin and Wound Evaluation dated 4/17/2025 documents new stage 3 pressure ulcer to right gluteal. In house acquired. Exact date of discovery 4/1/2025. R14's Skin and Wound Evaluation dated 5/13/2025 documents stage 3 pressure ulcer right lower back. In house acquired. Exact date of discovery 2/10/2025. On 5/14/2025 at 11:00AM R14 stated I am never turned or pulled up. I have been like this all morning. My care is poor. I haven't been up in a chair in months. I am afraid to get up because I am afraid, they will not put me back to bed and I will be stuck there in pain. My sore on my back was bleeding a lot last night. On 5/14/2025 at 1:55PM V9, Wound Nurse, provided wound care to R14 with assist of V21, Licensed Practical Nurse, LPN. R14's wound draining dark brown fluid and bright red fluid on bandage and on gauze used to clean wound. R14 in same position he was in at 11:00AM and was incontinent at this time. V9 stated R14 refuses a pressure reducing mattress. He can turn himself a little. His wound is healing slowly. The staff try to get him to turn. Facility policy with a revision date of 9/2023 states To prevent or reduce the incident of pressure injuries, standards of practice should be implemented. A pressure injury may be defined as any lesions cause by unrelieved pressure that results in damage to the underlying tissue. Although friction and shear are not primary causes of pressure injuries friction and shear are important contributing factors to the development of pressure injuries.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow and implement progressive interventions and perform appropriate supervision to prevent falls for 1 (R24) of 6 residents in the sample of 38. This failure resulted R24 falling and R24 sustaining a fracture. Findings include: R24's Face sheet documents an admission date of 2/7/2024. Diagnosis include Metabolic Encephalopathy, Adult Hypertrophic Pyloric Stenosis, Hypertension, Radiculopathy. R24's Minimum Data Set, MDS, dated [DATE] documents R24 is severely cognitively impaired. R24 requires partial to moderate assist with mobility and transfers. R24's mode of transportation is walker and/or wheelchair. R24's care plan updated 3/28/2025 documents Fall: R24 is at risk for falls Cognitive deficits, Functional Deficits, History of Falls, Poor Balance. Interventions include: 1/10/25 prompt or assist for change in position, toileting, offer fluids, and ensure R24 is warm and dry. Encourage staff to anticipate needs. 6/28/24 Educate R24 to use the call light and wait for staff assist to walk to the bathroom. Fall risk assessment quarterly and as needed. R24's admission fall risk assessments dated 6/28/2024 documents R24 is at high risk for falls. R24's progress notes dated 6/28/2024 at 8:02PM document R24 was found in R24's bathroom on the floor at 7:11pm. This nurse and night nurse with CNA helped R24 up from floor to toilet. R24 had bowel movement. R24 stated I need to go to the bathroom this nurse asked what is hurting, R24 pointed to left side of head. R24 noted with red water left eye. this nurse contacted V28 (Physician) over telehealth, V28 recommended this nurse to ask family if they want R24 to be monitored. Contacted V27 (Family). V27 requested for bed alarms and for R24 to be closer to nurse's station. This nurse voiced concerns to V2 (Director of Nursing). Neuros started. R24's fall investigation dated 6/28/2024 at 7:38PM stated Interdisciplinary meeting to discuss fall from 6/28/2024. R24 alert and oriented x2-3. Brief Interview for Mental Status, BIMS, 00. R24 requires 1-2-person physical assist with ADLs and transfers. R24 is incontinent of bowel and bladder at times. RCA, root cause analysis: Attempted to self transfer to toilet and fell onto floor. All previous fall interventions in place adding reeducating R24 to call and await assistance. All parties agree with plan of care. Care Plan reviewed and updated. R24's progress notes dated 1/10/2025 at 6:22AM documents CNA came to this nurse stating that R24 was on the floor when she walked into R24's room to give R24 care and get R24 up for the day. This nurse assessed R24 and noted no open areas or any bleeding and R24 stated she was not in any pain. This nurse and CNA carefully got R24 up on the bed and after talking to R24 she stated she would like to get dressed and get into her chair. This nurse told CNA that R24 was able to get dressed and get into her chair. R24's family (V27), V1 (Administrator), V2, V3 (Assistant Director of Nursing), and V28 were notified. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R24's progress notes dated 1/11/2025 at 9:48AM documents Continue monitoring related to fall. R24 x-ray of left hip came back new fracture of left inferior pubis ramus. Contacted V28. New order for outpatient ortho appointment related to fracture. Notified V27, V1, V2, V3. R24's 1/10/25's fall investigation dated 1/11/2025 at 6:22AM documents Root Cause Analysis, R24 got up to use the bathroom and R24 thought she should get up and get ready also. New inventions: Frequent rounding and prompt or assist R24 in position change, toileting, offer fluids and ensure R24 is warm or dry. Obtain labs to rule out acute change in condition. Neurology consults to monitor disease progression. Care plan updated as appropriate. R24's radiology report dated 1/10/2025 documents Fracture of the left inferior pubic ramus. On 5/14/2025 at 10:00AM R24 sitting at nurse's station. R24's room at end of the hall away from nurse's station. On 5/14/2025 at 2:00PM V20, Certified Nursing Assistant, CNA, assisted R24 from wheelchair to bed. R24 was not toileted prior to going to bed. R24 stated I wasn't working in January when R24 fell and hurt herself. She can stand but that's it. We try to have her at the nurse's desk during the day. She is in her room right now because she is ready for a nap. Facility policy with a revision date of 7/2024 states This facility is committed to maximizing each resident's physical, mental, and psychosocial wellbeing. While preventing all falls is not possible, the facility will identify and evaluate those residents at risk for falls, plan for preventative strategies, and facilitate as safe an environment as possible. All residents' falls shall be reviewed, and the resident's existing plan of care shall be evaluated and modified as needed.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to communicate and collaborate with the outpatient dialysis center and monitor the dialysis access site for 1 of 3 residents (R318) reviewed for hemodialysis in the sample of 38. Findings include: R318's Face Sheet documents R318 was admitted to the facility on [DATE] with diagnoses including end stage renal disease. R318's Minimum Data Set (MDS) dated [DATE] documented R318 was cognitively intact, dependent with mobility and received dialysis. R318's Care Plan initiated 5/15/25 documents R318 has impaired renal function related to end stage renal disease. R318's Physician Order dated 4/30/25 documents check for thrill (vibration or buzzing sensation felt when palpating the skin over a hemodialysis fistula or graft) and bruit (whooshing sound heard when listening to an arteriovenous fistula, a surgical connection between an artery and a vein used for hemodialysis) every day and night shift. R318's Treatment Administration Record (TAR) for May 2025 does not document R318's thrill and bruit were checked twice daily on 5/2/25-5/5/25 or 5/9/25-5/11/25. R318's Physician Order dated 4/30/25 documents check dialysis access site dressing for signs and symptoms of infection every day and night shift. R318's TAR for May 2025 does not document R318's dialysis access was checked twice daily on 5/2/25-5/5/25 or 5/9/25-5/11/25. On 5/15/25 at 10:35 AM, V3, Assistant Director of Nursing (ADON), stated the purpose of checking the thrill and bruit is to make sure the access is still working and should be checked every shift or per MD order. She stated she will check and see if there is any other documentation thrill and bruit were checked for R318. (Outpatient Dialysis) is supposed to be sending treatment documentation back with R318 after each treatment, so she will also look for that. On 5/15/25 at V3, ADON, stated she was not able to locate any additional documentation for R318. On 5/15/25 at 12:58 PM, V1, Administrator, stated she expects staff to follow all Facility policies. The Facility's Dialysis Protocol Policy revised 9/2021 documents the dialysis site will be checked every shift for signs and symptoms of infection or bleeding. The dialysis site will be monitored every shift for thrill and bruit. The Dialysis Communication form will be completed and sent with the resident with each treatment and reviewed upon the resident's return.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and observation the facility failed to display clearly and in a visible place for residents, staff, and visitors the daily nurse staffing information. This failure has the potential to affect the entire facility. Findings include: On 5/15/25 at 11:00 AM, during a tour of the facility, the daily nurse staffing information was not visibly posted anywhere to see. On 5/15/25 at 11:07 AM, V29, Receptionist stated that the daily nursing staff schedule is in the nurse's station. She stated that the daily nursing staff schedule is not posted where the public can see it. Facility's policy Posting Direct Care Daily Staffing Number undated documents Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents. 1. Within two (2) hours of the beginning of each shift, the number of Licensed Nurses (RNs, LPNs, and LVNs) and the number of unlicensed nursing personnel (CNAs) directly responsible for resident care will be posted in a prominent location (accessible to residents and visitors) and in a clear and readable format. The Long-Term Care Facility Application for Medicare and Medicaid dated 5/13/25 documents a census of 108 residents.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide food that accommodates food allergies for 1 of 2 residents (R95) reviewed for food and nutrition services in the sample of 38. Findings include: R95's Face Sheet documents R95 was admitted to the facility on [DATE]. R95's Minimum Data Set (MDS) dated [DATE] documented R95 was cognitively intact. R95's Physician Order dated 4/16/25 documents R95 is on a regular diet. R95's Allergy Report created 4/24/24 documents R95 has a cinnamon allergy. R95's Diet Card from Breakfast documents R95 has an allergy to cinnamon and lists dislike as Allergic to Cinnamon (in bold, capitalized print). The Facility's Menu for 5/13/25 documented raisin toast would be served for breakfast. On 5/13/25 at 8:48 AM, V7, Dietary Aid, was plating food from the steam table, then handing the plates to Certified Nursing Assistants (CNAs). He stated the CNAs look at the resident's meal tickets and tell us what to serve on the plate. On 5/13/25 at 8:50 AM, V5, CNA, took a standard plate containing scrambled eggs and raisin toast from V7 and placed it on R95's tray. V5 did not communicate any information from the meal ticket to V7. V5 stated the toast was just raisin bread and did not contain cinnamon, then delivered the tray to R95. On 5/13/25 at 8:52 AM, V4, Dietary Manager, stated she does not think the raisin toast contains cinnamon, but will reach out to her representative and request an ingredients list. On 5/13/25 at 8:55 AM, R95 stated, Every time we have something cinnamon, they give it to me. They think if they take it off my tray it's fine. I have been here for over a year, and it happens all the freaking time. She stated she has to stay on her toes, because the cinnamon affects her asthma and, They don't pay attention because they don't care. On 5/13/25 at 9:25 AM, V4 stated the CNAs will inform dietary staff of any allergies, but she understands R95 not wanting to eat the raisin bread, just in case. The Facility's Product Details for Raisin Bread documents ground cinnamon is an ingredient. On 5/15/25 at 8:45 AM, V25, Registered Dietitian (RD), stated the staff should have communicated that R95 had a food allergy, because you do not know how severe the allergy may be or how it may affect a resident. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/15/25 at 10:35 AM, V3, Assistant Director of Nursing (ADON), stated dietary staff should be checking resident allergies to make sure they are not serving foods containing allergens. The Facility's Undated Food Allergies Policy documents, Individuals with food allergies will be provided with safe foods and fluids, and appropriate substitutions to maintain health.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to ensure food was stored, prepared, and distributed in a manner that prevents foodborne illness. This has the potential to affect all 108 residents living in the Facility. Findings include: On 5/13/25 at 8:10 AM, in the kitchen next to the oven there was a large tub containing light brown colored grains. The tub was not labeled or dated, and the scoop was lying directly on top of the grains inside. There was another large tub containing a white powdery substance that was not labeled or dated. V4, Dietary Manager (DM), stated that was sugar, and the brown grains were oats. She picked up the scoop from the oats and stated the handles always fall out into the grains. She stated she just washed both of the containers and refilled them but has not had a chance to label them. On 5/13/5 at 8:14 AM, in the walk in refrigerator there was a carton of milk and a carton of applesauce lying directly on the floor. There were two boxes of pasteurized shell eggs stored on a shelf directly above two boxes of (Nutritional Shakes). The (Nutritional Shakes) boxes read, Keep Frozen. On 5/15/25 at 8:18 AM, there was a rack next to the walk in freezer holding saucers stored upside down in stacks. Six of the stacks had crumbs and debris on the top plates. On 5/15/25 at 8:20 AM, the dish room floor was covered in food debris. On 5/15/25 at 8:22 AM, V10, Dietary Aid, stated the eggs should not be stored above the shakes, but some people do not know that. On 5/13/25 at 8:50 AM, V4, Dietary Manager, stated she put the eggs back on the bottom shelf where they were supposed to be and cleaned up the food on the floor of the walk in refrigerator. On 5/13/25 at 9:30 AM, the dish machine labeled ES 4000 was running. V4 stated it is a low temperature dish machine. After the cycle was complete, V4 dipped a test strip in the reservoir and pulled it out. The test strip did not change color at all. V4 checked the sanitizer bucket which was empty and stated that is why the test strip did not change colors. On 5/15/25 at 8:45 AM, V25, Registered Dietitian (RD), stated the purpose of storing animal products below other food items it to prevent them from dripping into other items and prevent foodborne illness. On 5/15/25 at 12:58 PM, V1, Administrator, stated she expects staff to adhere to the Facility's food service policies. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility's Undated Food Storage Policy documents food will be stored at appropriate temperatures and by methods designed to prevent contamination or cross contamination. All containers must be legible and accurately labeled and dated. Scoops must be provided for bulk foods and are not to be stored in food containers but are kept covered in a protected area near the containers. For refrigerated foods, cooked foods must be stored above raw foods to prevent contamination. Raw animal foods will be separated from each other and stored on lower shelves (below cooked foods or raw fruits and vegetables) and in drip proof containers. All foods will be stored off the floor. Frozen foods must be maintained at a temperature to keep the food frozen solid. The Facility's Undated Warewashing Policy documents all dishware, serviceware, and utensils will be cleaned and sanitized after each use. The Facility's Long-Term Care Facility Application for Medicare and Medicaid (CMS 671) dated 5/14/25 documents there are 108 residents living in the Facility.