STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145699	A. Building B. Wing	09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara of Elgin	1950 Larkin Avenue Elgin, IL 60123

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review, the facility failed to ensure the dignity of a resident was maintained for 1 of 2 residents (R109) reviewed for dignity in the sample of 43.The findings include:On 9/03/2025 at 10:11 AM, during the resident group meeting, R96 said his roommate (R109) had a mess in their bathroom a couple weeks ago. R96 said a housekeeper and a CNA (Certified Nursing Assistant) were going back and forth about whose job it was to clean it up. R96 said he thinks the housekeeper took pictures of the mess in the bathroom. R96 was not able to identify the housekeeper, or the CNA involved in the incident.On 9/3/2025 at 1:18 PM, V1 (Administrator) was asked about the incident regarding a housekeeper and CNA going back and forth in front of residents about whose responsibility it is to clean up a mess in a resident's bathroom. V1 said she was not aware of the incident. At 1:22 PM, V1 and this surveyor went to speak with V5 (Housekeeping Supervisor). V5 said she was told by one of the housekeepers that a CNA would not clean the stool up in a resident's bathroom. V5 said the housekeepers are not responsible for cleaning up feces. V1 (Administrator) said the CNAs are responsible for cleaning up stool, and the housekeepers disinfect the area after the CNAs clean the stool. V5 identified V20 as the housekeeper. V5 said she did not know who the CNA was. V5 said she thinks V20 sent her pictures of the mess. V5 looked through her phone and could not find the pictures, so she called V20. V5 said V20 was going to resend the pictures to her. V20 sent V5 six pictures. The first picture showed the toilet and surrounding area with non-formed, loose stool, on the lid, the seat, the bowl of the toilet, and a large puddle around the base of the toilet. The other pictures showed stool splatter on the wall and floor. V5 showed V1 the pictures V20 sent her. V1 told V5 under no circumstances is it okay for staff to take pictures of a resident or the resident's room. On 9/3/2025 at 2:28 PM, R96 said R109 was in the room when the CNA and housekeeper were going back and forth about whose job it was to clean stool. R96 said he felt bad for (R109). On 9/4/2025 at 8:38 AM, V20 (housekeeper) said she does not recall the exact day it happened, it was sometime near the end of August. V20 said there was a mess in R109's bathroom. Stool was on the toilet and the floor. The CNA came to me and said she needed my help. I asked her what she needed. We went to (R109 and R96's) room and I saw the stool on the floor and toilet. V20 said she told the CNA that the CNAs are responsible for cleaning stool, urine and blood up, then housekeeping will disinfect after it is cleaned. V20 said the CNA pushed back and said it was housekeeping's job to clean. V20 said she and V21 (unknown CNA) did go back and forth regarding who was responsible. V20 said she took pictures to send to her supervisor (V5), to ask who is responsible and to protect herself. V20 said she and V21 should not have had that conversation in front of the residents, and she should not have taken pictures of the residents' bathroom. V20 said It is a dignity issue. On 9/4/2025 at 8:43 AM, R109 said he was in the room when V20 and V21 were going back and forth about who was responsible for cleaning the mess in the bathroom. R109 said he felt down at the time. He was embarrassed because he could not help it. R109 said he got over it though. On 9/04/2025 at 1:21 PM, V1 (Administrator) said she had no idea the incident happened until this surveyor mentioned it. V1 said (V20 and V21) should not have had that conversation in the resident's room at all. they should have talked in a private area where no residents could hear. V1 said discussing that in front of the resident is a dignity issue. V1 said V20 has been written up and she is trying to find out who the CNA (V21) is so she can write them up too. V1 provided a copy of the Disciplinary Notice Form for V20. R109's admission Record, printed by the facility on 9/3/2025, showed he had diagnoses including, but not limited to, Parkinson's disease with dyskinesia (uncontrolled, involuntary muscle movement that can involve one body part, such as an arm or leg, or the entire body), unsteadiness on feet, lack of coordination, gout, depression, hallucinations, weakness, chronic obstructive pulmonary disease, and impingement syndrome of left shoulder (shoulder pain cause by connective tissue-tendon-rubbing on a shoulder blade. The pain may be consistent and increase with lifting or reaching movements).R109's 6/9/2025 facility assessment showed he was cognitively intact, had one-sided range of motion impairment to his upper extremity, required substantial to maximal assistance with toilet hygiene, was dependent on staff for toilet transfers, was frequently incontinent of urine and occasionally incontinent of bowel.The facility's policy and procedure titled Privacy and Dignity, with a revision date of 7/3/2025, showed It is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times. The policy and procedure showed 5. Residents will not be addressed in an undignified manner by staff at all times. 6. Residents' health information will not be shared to anyone who is not involved in resident's care and to anyone whom the alert and oriented resident does not wish to share

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow their policy for a resident to self-administer medications for 1 of 1 resident (R108) reviewed for self-administration in the sample of 43. The findings include:R108's face sheet printed on 9/3/25 showed diagnoses including but not limited to congestive heart failure, hypertension, diabetes mellitus, cardiomyopathy, and stage three kidney disease. R108's facility assessment dated [DATE] showed moderate cognitive impairment. R108's September 2025 order summary report showed an order start dated 4/23/25 for: Sildenafil citrate (Viagra) oral tablet 100 milligrams. Give 1 tablet by mouth as needed for erectile dysfunction, supervised self-administration daily on an empty stomach. On 9/2/25 at 10:05 AM, R108 was lying in bed and the bedside table had a pill vial with approximately 12 tablets in it. The label showed it was Viagra and to take one tablet one hour prior to intercourse. R108 stated he has been using it for the last two to three months. R108 said he keeps it on the bedside table. The nurses just leave it there for him to take as needed. At 10:13 AM, V17 (Registered Nurse) stated R108 cannot take medications on his own. We have to give all of them to him. On 9/3/25 at 9:05 AM, R108 was sitting in his room and the vial of prescription Viagra was still on the bedside table. R108's medical record had one assessment for the ability to self-administer medications which was dated 4/7/24 (well over one year ago). The assessment was related to the self-use of an inhaler. The same assessment showed a physician order and care plan were needed to self-administer a medication. R108's care plan and physician orders did not reflect any interventions or orders to self-administer the Viagra without supervision. There was no physician order to keep the medication at the bedside. On 9/4/25 at 9:05 AM, V2 (Director of Nurses) stated if a resident requests to self-administer any medication we reach out to the physician first to get approval. There needs to be a doctor's order stating the resident can do it and they can keep it at the bedside. They need to be care planned for it too. An assessment should be done to ensure the ability to do it safely. The assessment tells us the resident is mentally, physically, and visually able to take the medication alone. A return demonstration is needed. The assessment needs to be done before any self-administration and again every quarter. V2 confirmed R108 has had the Viagra since April 2025 and there was no assessment to self-administer. The facility's Self-Administration of Medication policy revision dated 7/3/25 states: 1. The IDT will assign a staff to evaluate resident's ability to safely administer medication. A Self-Administration Evaluation will be filled out to determine capability. A return demonstration will be done to accurately evaluate resident's ability after the health teaching. 2. The resident may store the medication at bedside if there is a physician order to keep it at bedside. 5. The resident's ability to self-administer medication will be assessed regularly by the facility to coincide with MDS assessment or any notable change in status.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to apply compression stockings for 2 of 2 residents (R10,R91) reviewed for quality of care in the sample of 43.The findings include:1) R10's electronic face sheet printed on 9/4/25 showed R10 has diagnoses including but not limited to Parkinson's disease, dementia with behaviors, hypertension, hyperlipidemia, and osteoarthritis. R10's facility assessment dated [DATE] showed R10 has moderate cognitive impairment. R10's physician's orders dated 4/30/24 showed, Compression stockings to bilateral lower extremities. On 9/2/25 at 12:10PM, R10 was up in his wheelchair with no compression stockings on his feet. R10 was unable to recall if he wears them or not. On 9/3/25 at 8:52AM, V6 (Wound Care Nurse) and V13 (Certified Nursing Assistant-CNA) assisted R10 to lay down in bed. V6 removed R10's pants and R10 did not have compression stockings on. V13 stated she was not sure if R10 is supposed to have compressions stockings on or not. V6 stated she is also unaware if (R10) needs compression stockings on or not.R10's treatment administration record for September 2025 showed R10's compression stockings were applied on 9/2/25 and 9/3/25.On 9/4/25 at 12:36PM, V2 (Director of Nursing) stated, Physician's orders should be followed at all times. If a nurse is checking the box on the treatment administration record (TAR), then I would assume they are checking that the compression socks are on otherwise they would put them on and then check the box. They are not following physician's orders if the treatment is not in place.The facility's policy titled, Physician Orders revised 7/3/25 showed, It is the policy of this facility to ensure that all resident/patient medications, treatment, and plan of care must be in accordance to the licensed physician's orders. The facility shall ensure to follow physician orders as it is written in the POS (Physician Order Sheet) .2) R91's electronic face sheet printed on 9/4/25 showed R91 has diagnoses including but not limited to metabolic encephalopathy, chronic kidney disease stage 4, Alzheimer's disease, major depressive disorder, and congestive heart failure.R91's facility assessment dated [DATE] showed R91 has severe cognitive impairment.R91's physician's orders dated 5/8/25 showed, Compression socks to bilateral lower extremities, apply every morning and remove at bedtime. On 9/2/25 at 12:33PM, R91 was sitting up in his wheelchair in his room with no compression stockings on. R91 stated he does wear tight socks on his legs, but they did not put them on today. On 9/3/25 at 9:33AM, V23 (CNA) and V24 (CNA Supervisor) assisted R91 out of bed. R91 did not have compression socks on. V22 and V23 were unsure if R91 is still using them. R91 had 2 signs in his room indicating he is to have compression stockings put on in the morning and removed in the evening. On 9/4/25 at 9:43AM, V8 (CNA) assisted R91 with morning cares and dressing assistance. V8 stated he is an agency CNA and is unsure if R91 is supposed to use compression stockings or not.On 9/4/25 at 10:18AM, V14 (CNA) stated, (R91) uses compression socks every day and will usually remind us if we forget so I'm surprised he didn't say anything. He has used them for a few months now.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 implement pressure ulcer prevention measures for 2 of 6 residents (R10,R91) reviewed for pressure ulcers in the sample of 43.The findings include:1) R10's electronic face sheet printed on 9/4/25 showed R10 has diagnoses including but not limited to Parkinson's disease, dementia with behaviors, hypertension, hyperlipidemia, and osteoarthritis. R10's facility assessment dated [DATE] showed R10 has moderate cognitive impairment and is at risk for pressure ulcers. Fall risk evaluation 7/10/25 high risk R10's care plan dated 4/30/24 showed, (R10) has an actual impairment to skin integrity and is at risk for additional skin breakdown related to the following comorbidities but not limited to Parkinson's, unsteadiness on feet, abnormalities of gait and mobility, lack of coordination, hypertension, repeated falls .Interventions: off load heels . R10's skin risk assessment dated [DATE] showed R10 is a high risk for skin breakdown. On 9/3/25 at 8:52AM V23 (Certified Nursing Assistant-CNA) and V24 (Wound Care Nurse) assisted R10 to lay down in bed. R10's heels were resting on the bed and were not elevated off of the mattress. V23 and V24 stated R10's cares were completed and there was nothing else he needed. At 9:32AM, R10 was still lying in bed without his heels elevated. On 9/4/25 at 12:36PM, V2 (Director of Nursing) stated, The expectation is that pressure ulcer prevention will be done per physician's orders and the resident's care plan. If prevention is not done, residents are placed at increased risk for developing pressure ulcers. Someone on hospice is even more prone as they are declining already. The facility's policy titled, Wound Care Guidelines revised 01/24/2024 showed, .The goal of this care guideline is to achieve compliance to regulatory requirements and provide evidence-based recommendations for the prevention and treatment of pressure injuries that can be used by the health professionals in this facility. The purpose of the prevention recommendations is to guide evidence-based care to prevent development of pressure injuries . Procedures .4. Activity, Mobility, and Positioning .g. Resident may be properly positioned in bed using pillows or other supportive devices to help protect bony prominence areas susceptible to pressure .2) R91's electronic face sheet printed on 9/4/25 showed R91 has diagnoses including but not limited to metabolic encephalopathy, chronic kidney disease stage 4, Alzheimer's disease, major depressive disorder, and congestive heart failure. R91's facility assessment dated [DATE] showed R91 has severe cognitive impairment and is at risk for skin breakdown. R91's care plan dated 6/25/24 showed, (R91) has an actual impairment to skin integrity and is at risk for additional skin breakdown related to the following comorbidities but not limited to Alzheimer's, unsteadiness on feet, lack of coordination, history of falling, dementia, depressive disorder, hypertension, heart failure Interventions .off load heels R91's skin risk assessment dated [DATE] showed R91 is at high risk for skin breakdown. On 9/4/25 at 9:43AM, R91 was lying in his bed with his heels resting on the mattress. A pair of offloading boots were sitting in the chair in R91's room. V8 (Certified Nursing Assistant) stated, He needs them on later, not right now. He doesn't need them all the time I don't think. I believe he only needs them in the afternoon when he is taking a nap. On 9/4/25 at 10:18AM, V14 (Certified Nursing Assistant) stated, (R91) is to have his offloading boots on at all times or else we need to elevate his heels with a pillow. There is no reason why we would only offload a resident's heels when they are taking a nap and not overnight, it should be done anytime they are in bed to prevent pressure ulcers.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to supervise 2 residents (R91,R94) during meal times, failed to transfer a resident (R60) with a gait belt, failed to ensure fall precautions were in place for a resident (R16). These failures apply to 4 of 9 residents reviewed for safety/supervision in the sample of 43. The findings include:1) R91's electronic face sheet printed on 9/4/25 showed R91 has diagnoses including but not limited to metabolic encephalopathy, chronic kidney disease stage 4, Alzheimer's disease, major depressive disorder, and congestive heart failure. R91's facility assessment dated [DATE] showed R91 has severe cognitive impairment and requires an altered diet. R91's physician's orders dated 5/7/25 showed, Regular diet, puree texture, nectar thick liquids consistency. R91's speech therapy Discharge summary dated [DATE] showed, diet: puree/nectar thick liquids, 1:1 supervision. On 9/3/25 at 12:33PM, R91 was sitting in his wheelchair in his room feeding himself a pureed diet. No staff were present in R91's room. On 9/4/25 at 10:33AM, V9 (Certified Nursing Assistant) stated, (R91) usually eats out in the activity/dining area so we can at least walk past him every now and again while we are passing trays. I don't think he needs constant supervision but it makes sense for someone on a pureed diet to need supervision. On 9/4/25a at 11:12AM, V12 (Speech Therapist) stated, (R91) is on a pureed diet with nectar thickened liquids. I only discharged him from therapy because he went on hospice. He does have difficulty swallowing and needs constant reminders and cueing. He is a 1:1 supervision at all meals. He cannot be eating alone in his room as he is confused and does not remember to sit upright and doesn't remember the small bites/sips concept. On 9/4/25 at 12:36PM, V2 (Director of Nursing) stated, If speech therapy recommends a resident to be 1:1 supervision, that would just go straight to nursing who would put it in as an order. I wasn't aware that (R91) was eating alone in his room. If speech therapy recommended 1:1 supervision there is obviously a safety concern with his swallowing so we need to be providing that supervision and cueing for (R91). 2) R60's electronic face sheet printed on 9/3/25 showed R60 has diagnoses including but not limited to unsteadiness on feet, lack of coordination, history of falls, anxiety disorder, and congestive heart failure. R60's facility assessment dated [DATE] showed R60 has no cognitive impairment and is a maximum assist for transfers. R60's care plan dated 4/28/25 showed, (R60) is at high risk for falls related to anxiety disorder. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/2/25 at 9:51AM, V11 (Certified Nursing Assistant) was providing hands on assistance to R60 to transfer from her bed to her wheelchair. R60 did not have a gait belt around her waist and V11 was holding underneath R60's arms to provide stability. R60 was shaky during transfer and let out a large sigh as she sat in her wheelchair. After the transfer, V11 stated, She seemed ok during the transfer and didn't need a gait belt. She is a 1 assist most of the time. It just depends on how she's feeling and how tired she is. On 9/3/25 at 9:14AM, R60 stated, They only put the belt around me when they take me to therapy, otherwise they don't ever use it. I'm not sure why they don't use it in my room but the use it in therapy. It doesn't make sense. On 9/3/25 at 12:58PM, V10 (Director of Rehab) stated, On a good day, (R60) is a minimal assist from the edge of the bed. We stand her up at the edge of the bed with a walker and go to the wheelchair. If she's sleepy or not having a good day she could be a maximum assist with 1 assist. Staff are to be using a gait belt at all times for safety with her-no exceptions. She is a high fall risk. and could become weak at any moment during a transfer. The facility's policy titled, Gait Belt revised 6/30/25 showed, The facility will use gait or transfer belts to assist residents needing limited to total assistance during transfers or walking. 3. R94's face sheet printed on 9/3/25 showed diagnoses including but not limited to dementia, right side hemiplegia/hemiparesis(paralysis) following cerebral infarction, traumatic brain injury, and chronic respiratory failure. R94's facility assessment dated [DATE] showed severe cognitive impairment and staff supervision or touching assistance for eating. R94's September 2025 order summary report showed an order start dated 7/9/25 for: Regular diet, pureed texture, nectar thick liquids consistency NO STRAWS. R94's care plan showed a focus area related to nutritional status and a hospitalization 7/1 to 7/9.hospice status. downgraded to puree texture with thickened liquids. R94's re-admission nutrition assessment dated [DATE] shows diagnoses including but not limited to dysphagia (difficulty swallowing) and the diet was downgraded to puree texture in the hospital (authored by V3, Registered Dietician). On 9/2/25 at 12:35 PM, R94 was in bed and eating her lunch alone in the room. R94's bed was furthest from the door and the privacy curtain was pulled around her bed. R94 was not visible from the hallway. R94 had a dietary ticket on her bedside table showing puree texture foods and nectar thick liquids were required. A large bright pink sign was on the bedside table stating, Thickened water only. R94 was eating a lunch of puree turkey, mashed potatoes, puree peas, and a thickened dairy beverage. R94 was pleasantly confused and unable to explain why she was receiving pureed meals. On 9/3/25 at 8:28 AM, R94 was in bed and eating her breakfast alone in the room. The privacy curtain was pulled around her bed. The meal was pureed and thickened juice. R94's call light was on and V18 (Registered Nurse) and V19 (Assistant Director of Nurses) entered the room, then exited shortly after. At 8:35 AM, this surveyor re-entered the room and the same foods were still on R94's bedside table while she continued to eat unsupervised. R94's privacy curtain was still drawn around her bed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/4/25 at 9:25 AM, V3 (Registered Dietician) stated R94 was sent to the local hospital in July due to respiratory distress. She had a swallow evaluation done there and went on hospice. The hospital's speech pathologist determined the puree diet and thick liquids were needed. She has dysphagia and poor dentation. She needs softer food to reduce the risk of aspiration and swallow issues. She has a high risk of choking while eating and drinking. The facility speech pathologist will not re-evaluate her unless she is off hospice. Until then, we should be following all recommendations from the hospital evaluation. V3 was asked if it was appropriate for R94 to be eating alone and unsupervised in her room. V3 answered, No. Nursing staff should be observing her at all meals, especially considering her dementia and swallowing problems. On 9/4/25 at 9:36 AM, V2 (Director of Nurses) stated residents with dysphagia have difficulty swallowing and the potential to choke if eating unsupervised. V2 said R94 has not been re-evaluated by the speech department, and it is not safe for her to eat alone. She should be with an aide or nurse to supervise. That is not right for her to be alone in the room at meals. There is the risk of choking or aspiration. The facility's Dysphagia and Aspiration-Clinical Guidelines policy effective dated 7/17/21 states under the monitoring and follow-up section: 1. The staff and physician will monitor the progress of individuals with swallowing difficulties; for example, ease of eating, improvement of symptoms, and resolution of underlying causes. The facility's Clinical Guidelines (food intake) policy review dated 4/5/25 states: 4. Functional assistance with meals will be provided by the nursing personnel in accordance to the MDS and/or restorative nursing assessment. 4. On 9/2/25 at 12:06 PM, R16 was laying on her back in bed with a blanket covering her. R16 had a low bed with padded upper side rails. The door to her room was closed and the blind on the window facing the nurse's station was shut. The TV was on, and her video was not playing. There was a note on the wall next to her doorway that showed for the certified nursing assistants (CNA) to keep the blinds open, place two matts on the floor, check the DVD a lot, and nectar for nectar thick liquids. R16 was awake and when asked questions she would mumble something unintelligible. At 12:27 PM R16's door was shut, and the blinds closed. R16 was sitting up in bed; no one was in the room. At 12:39 PM V14 CNA took R16's food tray into her room to feed R16 lunch. V14 stated R16 was at risk for falls so they put two mattresses on the floor and keep her blind open. V14 stated they close the blind when care is provided and open them when they are done; before they leave the room. V14 stated R16 likes to see what is going on and staff keep them open so they can keep and eye on her. V14 stated R16 does try to crawl out of bed. On 9/3/2025 at 9:08 AM and 11:12 AM, the door to R16's room and blind on the window facing the nurse's station were closed. R16 was alone in her room; no care being provided. R16 was sitting up in bed. On 9/3/25 at 9:15 AM, V14 stated she forgot to open the blind on R16's window that was facing the nurse's station. V14 stated R16 has the mattresses on the floor for safety. The blind is to be kept open for safety and the resident sleeps better with the blind open. V14 stated the list posted next to R16's door is based on what she likes and is for her safety. (continued on next page)

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Avantara of Elgin	1950 Larkin Avenue Elgin, IL 60123

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/4/25 at 8:36 AM, V2 Director of Nursing (DON) stated R16 is alert but unable to express herself. R16 is a fall risk, and it is the expectation that the blind on her window be left open when personal care is not being provided. V2 stated the blind should be open to monitor the resident. The Nurses Note dated 8/2/25 at 6:09 PM for R16 showed at about 3:15 PM R16 was observed lying prone on the floor mat next to her bed. R16 had a small laceration above her left eye with swelling and some bleeding present. R16 was evaluated in the local emergency room. The Face Sheet dated 9/4/25 for R16 showed diagnoses including traumatic brain injury, lack of coordination, abnormal posture, cognitive communication deficit, history of falling, major depressive disorder, ataxia, and generalized anxiety disorder. The Care Plan dated 7/11/25 for R16 showed she is at high risk for falls related to spastic movements due to traumatic brain injury. R16's fall on 8/2/25 was not listed on the care plan or that the care plan was reviewed and/or revised afterwards. The facility's Fall Prevention Program Guidelines policy (12/5/2021) showed safety interventions shall be initiated and implemented for each resident identified at risk for fall. All assigned nursing personnel and facility staff shall be responsible for ensuring ongoing precautions are put into place and consistently maintained.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review the facility failed to provide catheter care, ensure a drainage bag is not laying on the floor, and kept below the level of the bladder for 4 of 5 residents (R6, R13, R58, & R91) reviewed for catheters in the sample of 43.The findings include:1. On 9/2/25 at 10:01 AM, R13 was sitting up in her bed and her indwelling urinary drainage bag was on a hook on her nightstand. R13 was asked what kind of catheter care the facility staff provided and she stated they empty the drainage bag three times a day. They change her catheter for her. R13 stated she does not receive peri care and cleaning of her catheter tubing every day. R13 stated that it is done sometimes by the staff but not daily. R13 stated she does not clean her peri area daily and does not clean the catheter tubing. R13 stated she tries to clean her peri area twice a week when she has a shower. R13 stated she was willing to receive catheter care education. On 9/3/25 at 1:08 PM, V16 stated the catheter care that he provides for R13 is the emptying of her drainage bag and cleaning the bag off after it is emptied. V16 stated peri care and the cleaning of her catheter tubing is done by the resident herself. On 9/4/2025 at 8:36 AM, V2 Director of Nursing (DON) stated, catheter care is done once daily by staff. V2 stated it is done with activities of daily living. The catheter tubing is to be wiped down. V2 stated catheter care is done to prevent any infection. The Face Sheet dated 9/4/25 for R13 showed diagnoses including multiple sclerosis, obesity, chronic kidney disease, hypertension, hyperlipidemia, anxiety disorder, major depression, and neuromuscular dysfunction of the bladder. The Minimum Data Set, dated [DATE] showed no cognitive impairment; substantial/maximal assistance needed for toileting hygiene; and partial/moderate assistance needed for personal hygiene. The Care Plan dated 6/27/25 for R13 showed on 8/29/25 the care plan was updated because she was on antibiotic therapy for a urinary tract infection. The facility's Urinary Catheter Care policy (7/3/25) showed to wash the resident's genitalia and perineum thoroughly with soap and water; rinse the area well and towel dry. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately 4 inches outward. 2. On 9/2/25 at 10:35 AM, R58 had a mechanical lift sling behind him and was sitting in a recliner in his room. R58's catheter drainage bag was laying on the floor. On 9/3/25 at 11:07 AM, V15 Registered Nurse (RN) stated the catheter bag should not be on the floor for infection control reasons. On 9/4/25 at 8:36 AM, V2 Director of Nursing (DON) stated the drainage bag should not touch floor because of infection control. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Face Sheet dated 9/4/25 for R58 showed diagnoses including Parkinson's disease, Alzheimer's disease, and obstructive and reflux uropathy. The Care Plan dated 8/1/25 for R58 showed he has a potential for infection due to the urinary catheter. The facility's Urinary Catheter Care policy (7/3/25) showed, Infection control: Be sure the catheter tubing and drainage bag are kept off the floor. 3. R91's electronic face sheet printed on 9/4/25 showed R91 has diagnoses including but not limited to metabolic encephalopathy, chronic kidney disease stage 4, Alzheimer's disease, major depressive disorder, and congestive heart failure. R91's facility assessment dated [DATE] showed R91 has an indwelling catheter. R91's care plan dated 1/11/25 showed, (R91) has potential for infection related to (indwelling catheter) . initiate proper precautions per facility policy. On 9/3/25 at 9:33AM, V23 (Certified Nursing Assistant-CNA) and V24 (CNA Supervisor) transferred R91 using a full body mechanical lift. V24 hooked R91's urinary drainage bag on R91's mechanical lift sling above the level of R91's bladder. V23 then took R91's catheter drainage bag and placed it on his lap after he was seated in the wheelchair. V23 and V24 stated that urinary drainage bags should always be kept below the level of the bladder to prevent urine from backflowing into the tubing and back into a resident's bladder. On 9/4/25 at 9:43AM, V8 (CNA) was preparing to empty R91's catheter drainage bag when he held the drainage bag approximately 2 feet above R91's bladder to look into the bag to see how much urine was in it. Urine was observed backflowing in the tubing towards R91's catheter insertion site. V8 continued the remainder of R91's personal cares without ever removing R91's incontinence brief to provide catheter care. V8 stated he did not need to remove the brief because the other shift does cares. On 9/4/25 at 10:33AM, V14 (CNA) stated, When residents are receiving morning care they should get their brief changed even if they have a catheter because they may have had a bowel movement or their catheter could be leaking. This is also the time when we provide catheter care because it's provided at least once per shift. 4. R6's admission Record (Face Sheet) showed and admission date of 5/9/25 with diagnoses to include but not limited to central pain syndrome (pain due to nervous system damage), diabetes type 2, and left sided paralysis. R6's Care Plan showed she had an indwelling urinary catheter. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/03/2025 at 9:40 AM, V6 Wound Care Nurse and V7 Wound Care Technician provide wound care for R6. R6's catheter bag was attached to the right side of her bed frame. R6 was supine on her back at the start of the wound care. During wound care, R6 was repositioned to her left side. V7 assisted with the repositioning of R6 as well as the repositioning of R6's catheter bag. While moving R6's catheter bag, V7 held the bag a foot over the bladder, which cause the urine in the tubing to flow back towards R6. When R6 was repositioned to her back, V7 held R6's catheter bag above her bladder, which caused the urine in the catheter tubing to flow back towards R6. On 9/04/2025 at 8:36 AM, V2 Director of Nursing stated, catheter bags should always be kept below the level of the bladder to ensure proper drainage and prevent backflow of urine. V2 said, this is done to prevent potential infections or other effects of improper drainage of urine. The facility's Urinary Catheter Care policy (revised 7/3/25) showed, The purpose of this procedure is to prevent catheter-associated urinary tract infections.The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure physician prescribed medications were administered as ordered for 1 of 1 resident (R3) reviewed for medication administration in the sample of 43. The findings include: R3's face sheet printed on 9/3/25 showed diagnoses including but not limited to cellulitis of right lower leg, cognitive communication deficit, chronic kidney disease, edema (swelling caused by excess fluid in tissues), and paranoid schizophrenia. R3's September 2025 order summary report showed an order start dated 7/10/25 for: Bumetanide (Bumex/diuretic) tablet 2 milligrams. Give one tablet by mouth in the morning for fluid retention. R3's September 2025 medication administration report (MAR) showed the Bumex medication scheduled to be given at 6 AM daily. The same report showed documentation it was given on 9/2/25 at the scheduled time. On 9/2/25 at 12:25 PM, R3 was seated in a chair in his room. R3 was alert and talkative. A plastic medication cup was on the bedside table next to R3. The cup held a white tablet that had been split in half. R3 stated that was his water pill. He only takes half of it at a time. R3 said if I take the whole thing I am peeing like crazy. I snap it in half and take the rest of it later, when I feel like it. On 9/4/25 at 10:45 AM, V6 (Wound Care Nurse) stated R3 has poor circulation and chronic venous ulcers on his lower legs. He has Bumex prescribed daily to help with the fluid retention. It is an ongoing problem. On 9/4/25 at 9:15 AM, V2 (Director of Nurses) stated nurses should verify medication orders then bring them directly to the resident. Nurses should remain with the resident until it is taken. They need to ensure it is swallowed. R3 should not be taking the Bumex in two separate doses. It should be taken as ordered. There is the potential of underdosage and not treating the condition it was ordered for. There is the potential for R3's fluid retention to worsen if he isn't getting the medicine as ordered. The facility's Medication Pass policy revision dated 7/2/25 states under the PO (by mouth) section: 7. PO meds -e. After medication is administered to each resident, sign MAR that it was given. The facility was unable to provide any other policy related to proper medication administration.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, interview and record review, the facility failed to ensure residents on a pureed diet received a pureed dinner roll during the lunch meal for 8 of 8 residents (R16, R18, R68, R69, R72, R79, R91, and R94) reviewed for pureed diets in the sample of 43.The findings include:On 9/2/2025 at 10:22 AM, an initial tour of the kitchen was conducted. V4 (Dietary Manager) said the residents lunch meal on that day included herbed turkey, California blend vegetables, mashed potatoes and gravy, cookies, and dinner rolls. At 11:27 AM, dietary staff were observed preparing the trays for the lunch meal service. No pureed dinner rolls were observed being provided to the residents on a pureed diet. At 12:55 PM, V22 (Cook) was not in the kitchen at the time. V4 was asked about the pureed dinner rolls not being served to the residents with pureed diets. V4 said she would ask V22 if he put it in with the pureed turkey. On 9/2/2025 at 1:53 PM, V3 (Registered Dietitian-RD) said the dinner rolls should have been served at lunch to the residents on a pureed diet to make sure they get enough carbohydrates. V3 said a larger portion would need to have been served if the pureed dinner rolls were added to the pureed turkey, to ensure residents are getting the correct amount of both bread and turkey. V3 said the dietary staff were going to serve the residents on pureed diets the pureed bread at the dinner meal. V3 was asked if it was not brought to their attention, did she think the residents would be getting the bread at the dinner meal? V3 said she would like to think the dietary staff would have noticed it and served it at the dinner meal. On 9/2/2025 at 1:58 PM, V4 (Dietary Manager) said the dietary staff forgot to make the pureed dinner rolls for the lunch meal. V4 was asked if it was not brought to her attention, would the residents be receiving the pureed bread at dinner? V4 stated, Well like I said, they forgot it. On 9/4/2025 at 12:54 PM, V3 (RD) said the menus are created by (a contracted food service company). V3 said it is important to make sure the menus are followed to support the residents' nutritional needs.The facility's Diet Type Report, printed on 9/2/2025, showed R16, R18, R68, R69, R72, R79, R91, and R94 were the residents in the facility receiving pureed diets.R16, R18, R68, R69, R72, R79, R91, and R94's Order Summary Reports, printed by the facility on 9/3/2025, showed all these residents had an order for pureed diets.The facility's Week at a Glance menu, printed on 9/2/2025, showed dinner roll was listed on the menu to be served on Tuesday 9/2/2025 during the lunch meal.The facility's policy and procedure titled Kitchen, with a revision date of 6/30/2025, showed all food items in the menu and recipe will be followed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to wear personal protective equipment (PPE) during catheter care for a resident (R91) on Enhanced Barrier Precautions, failed to perform glove changes during resident care. This applies to 1 of 1 residents reviewed for infection control in the sample of 43.The findings include:R91's electronic face sheet printed on 9/4/25 showed R91 has diagnoses including but not limited to metabolic encephalopathy, chronic kidney disease stage 4, Alzheimer's disease, major depressive disorder, and congestive heart failure.R91's care plan dated 1/11/25 showed, (R91) is on enhanced barrier precautions .ensure that gown and gloves are used during high-contact resident care activities (like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use for those with central line, urinary catheter, feeding tube, tracheostomy/ventilator, and wound care for any skin opening requiring a dressing) that provide opportunities for transfer of MDROs (Multi-Drug Resistant Organisms) to staff hands and clothing. On 9/4/25 at 9:43AM, R91's doorway had a sign stating, STOP Enhanced Barrier Precautions Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for high-contact resident care activities. Dressing, Bathing/Showering, Transferring, Changing Linens, providing hygiene, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening that requires a dressing . V8 (Certified Nursing Assistant-CNA) entered R91's room to provide catheter care to R91. V8 wore gloves with no gown while emptying R91's catheter drainage bag. V8 then went and touched the shared bathroom door to empty R91's urinal with urine in it. V8 proceeded to touch the shared bathroom door handle, R91's bed remote, and R91's clean clothing with the same gloves on. V8 did not change his gloves throughout the entirety of R91's personal cares. V14 (CNA) called V8 out of R91's room to inform him he needed to put a gown on. V8 then applied a gown to transfer R91 out of bed. V8 stated he needs a gown because there is a sign outside R91's door. V14 stated, (V8) should have used gown and gloves with cares, especially with the catheter because that is why he is on EBP. On 9/4/25 at 12:36PM, V2 (Director of Nursing) stated, Residents on EBP include those with wounds, catheter, etc. All staff providing cares and high-contact activities are to wear a gown and gloves at all times to prevent the transmission of any bacteria from the resident to the staff. After catheter care if provided, gloves should be changed to prevent cross-contamination. These are basic CNA skills at this point. (V8) is an agency CNA but these procedures are across the board for CNA's, not just specific to our facility. The facility's policy titled, Enhanced Barrier Precaution revised 6/30/25 showed, The facility will use EBP to reduce transmission of multi-drug-resistant organisms in the nursing homes. EBP involves the use of gowns and gloves to reduce transmission of resistant organisms during high-contact resident care activities for residents known to be colonized or infected with MDRO's as well as residents with wounds and/or indwelling medical devices .1. EBP will be used for any resident residing in the facility that has indwelling medical devices (E.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of XDRO (Extensively Drug-Resistant Organism) colonization status .3. The EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of XDRO's to staff hands and clothing .g) device care or use of central line, urinary catheter .