STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145713	A. Building B. Wing	01/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momence Meadows Nursing & Rehab	500 South Walnut Momence, IL 60954

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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 0600 Level of Harm - 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. Based on observation, interview, and record review, the facility failed to ensure a resident remained free from abuse. The facility also failed to keep a resident free from physical abuse, resulting in one resident striking another in the head with his cane and that resident requiring sutures.This applies to 1 out of 6 residents (R29) reviewed for neglect and abuse.The findings include: On 12/31/25 at 12:26 pm, R29 was observed with a bruise to his upper right cheek below the eye, and three sutures on the right eye lid. R29's 12/26/25 6:45 am progress notes showed that R29 was observed with bleeding from below his right eye. The progress note showed that it was reported that another resident hit R29. R29's 12/26/25 hospital report showed that R29 sustained a head injury and a laceration requiring three sutures. The facility's 12/26/25 incident report to Illinois Department of Public Health showed that on 12/26/25, R2 and R29 engaged in inappropriate physical contact. On 1/2/26 at 5:50 pm, V1 Administrator said that it was reported to her that R2 hit R29 in the head with his cane. V1 said that R29 was sent to the hospital and received sutures. R29's 12/24/25 care plan shows a focus for a history of suspected abuse with interventions including assure R29 is in a safe environment.R2's 10/16/25 care plan showed a focus on inappropriate sexual behavior, but did not identify an assessment for the potential for physical abuse against others.The facility's Abuse Prevention Program policy (revised 01/2019) defined physical abuse as hitting, slapping, pinching, kicking, etc. It also includes controlling behavior through corporal punishment. The Policy also showed It is the policy of this facility to prohibit and prevent resident abuse, neglect against a resident in the facility .

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 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 and record review, the facility failed to report allegations of staff to resident abuse and an allegation of resident-to-resident abuse to the Illinois Department of Public Health within the required timeframes. This applies to 3 of 3 residents (R1, R5, R9) reviewed for abuse reporting.The findings include:1.On 1/2/25 at 9:57 am, R5, who was alert and oriented, said that on 12/7/25 she told the staff that R1 had a knife and held it to her neck and threatened her. R5 stated she was scared in the moment. On 12/27/25 at 2:30pm, V4 CNA (Certified Nurse's Assistant) said that 12/7/25 she worked the night of 12/7/25 and she heard R1 threatening R5 with a knife and R1 was standing over R5. V4 said that night, the staff found a knifes, a drill, a hammer, and lighters in R5's room. On 12/31/25 at 11:09 am, V3 CNA said the next day on 12/8/25, V2 DON (Director of Nursing) instructed her to search R1's room after it was reported that R1 had threatened R5. On 12/24/25 at 11:10am, V3 said while searching R1's room, she found a taser and a pocketknife under R1's bed. On 12/17/25 at 9:30 am, a pink and black electric drill, a pink and black hammer, scissors, razor blades, and lighters were present in the medication room. At 3:16 pm V2 DON (Director of Nursing) removed the items and brought them to V1's (Administrator) office. The knife in V1's desk was metal and was like a folding boxcutter or utility knife. Unfolded, it was about 6 inches long, with the top half holding an angled blade.On 1/2/26 at 5:50 pm, V1 Administrator verified the objects found belonged to R1. V1 stated they were confiscated the night R1 went to the hospital and other potentially dangerous items were found and taken the next day. V1 said that she did not report R5's allegation of 12/7/25 to the Illinois Department of Public Health.2. On 12/19/25 at 2:32 pm, R9, who was alert and oriented, said that on 12/14/25 staff ripped his shirt and had their knee on his neck during a verbal altercation between himself and the staff. R9 said that he told the CNA (Certified Nurse's Assistant) that night that they ripped his shirt, and he told the nurse that the CNAs had their knees on his neck. On 12/14/25 at 11:10 am, V5 CNA verified that R9 did tell her and show her that his shirt was ripped during the altercation. V5 said that R9 was sent to the hospital that night for his behaviors and she reported the allegation to the Administrator and the DON. On 1/2/26 at 5:50 pm, V1 said that R9 did report that the staff ripped his shirt and staff was being physically aggressive to him. V1 said that the incident happened on 12/14/25. The facility Initial Report dated 12/23/24 at 8:10 pm (nine days after the incident) to the Illinois Department of Public Health showed that on 12/14/25, at 1:30 PM, R9 alleged that staff engaged in physical contact with him. The incident report did not include the alleged report of staff ripping R9's shirt. 3. On 12/23/25 at 1:59 pm, R5, who was alert and oriented, said that once she was choking and a CNA helped her, but V17 CNA told her that he would have let her choke. R5 said that she reported it to V1 (Administrator). On 12/24/25 at 3pm, V1 said that R5 did report the incident to her but R5 said that it happened right before V1 had started at the facility, so she did not report it to IDPH. The facility's Abuse Prevention Program policy (revised 01/2019) showed that the staff are required to immediately report any incident, allegation or suspicion of potential abuse, neglect, exploitation, misappropriation of residence property, mistreatment or a crime against a resident they observe, her about, or suspect to the Administrator.Complete an incident report immediately. Fax report to IDPH (Illinois Department of Public Health) immediately. The Administrator or the absence of the administrator the DON is then responsible for forwarding a final written report of the results of the investigation and any corrective actions taken to the Department of Public health within 5 working days of the reported incident.

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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 and record review, the facility failed to investigate reported allegations of resident abuse, and subsequently failed to ensure residents were protected while the reported allegations were investigated. This applies to 3 of 3 residents (R1, R5, R9) reviewed for abuse. The findings include:1. On 12/19/25 at 2:32 pm, R9, who was alert and oriented, said that on 12/14/25, staff ripped his shirt and had their knee on his neck during a verbal altercation between R9 and the staff. R9 said that he told the CNA (Certified Nurse's Assistant) that night that they ripped his shirt, and he told the nurse that the CNAs had their knees on his neck. On 12/14/25 at 11:10 am, V5 CNA verified that R9 did tell her and show her that his shirt was ripped during the altercation. V5 said that R9 was sent to the hospital that night for his behaviors and she reported the incident to the Administrator and the DON. On 1/2/26 at 5:50 pm, V1 (Administrator) said that R9 did report that the staff ripped his shirt and the staff was being physically aggressive to him. V1 said that the incident happened on 12/14/25 and she investigated it on 12/23/25. V1 said that she did not investigate the allegation until after R9 reported it to IDPH (Illinois Department of Public Health). The facility Initial Report dated 12/23/24 at 8:10 pm to the Illinois Department of Public Health showed that on 12/14/25, at 1:30 PM, R9 alleged that staff engaged in physical contact with R9. The facility reported the incident 9 days after the incident. The incident report did not include the alleged report of staff ripping R9's shirt. 2. On 1/2/25 at 9:57 am, R5, who was alert and oriented, said that on 12/7/25 she told the staff that R1 held a knife to her neck and threatened her. R5 stated she was scared in the moment. On 12/27/25 at 2:30pm, V4 CNA (Certified Nurse's Assistant) said that on 12/7/25 she worked that night, and she heard R1 threatening R5 with a knife and R1 was standing over R5. V4 said that night, the staff found a knifes, a drill, a hammer, and lighters in R5's room. On 12/31/25 at 11:09 am, V3 CNA said the next day on 12/8/25, V2 DON (Director of Nursing) instructed her to search R1's room after it was reported that R1 had threatened R5. On 12/24/25 at 11:10am, V3 said while searching R1's room, she found a taser and a pocketknife under R1's bed. On 1/2/25 at 10:48 am, V5 CNA said that on 12/8/25 the following day, R5 reported to her that R1 had a knife in her room and held it to her neck and she was scared. V5 said that the facility found the knife, a hammer and drill. On 1/2/26 at 5:50 pm, V1 Administrator verified the objects found belonged to R1. V1 stated they were confiscated the night R1 went to the hospital and other potentially dangerous items were found and taken the next day. V1 said that she did not investigate R5's abuse allegation of 12/7/25 or report it to the Illinois Department of Public Health (IDPH).3. On 12/23/25 at 1:59 pm, R5, who was alert and oriented, said that once she was choking and a CNA helped her, but V17 CNA told her that he would have let her choke. R5 said that she reported it to V1. On 12/24/25 at 3pm, V1 Administrator said that R5 did report the incident to her but R5 said that it happened right before V1 had started at the facility, so she did not investigate the incident, nor did she report the incident to the Illinois Department of Public Health. The facility's Abuse Prevention Program policy (revised 01/2019) showed .After notification of alleged abuse.the Administrator.shall immediately commence an investigation of the incident reported.If you suspect abuse- separate the alleged perpetrator and assure all residents safety.complete an Incident Report immediately. Under Investigation, the policy showed any incident or allegation involving abuse. against a resident will result in an abuse investigation.

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F 0689 Level of Harm - Minimal harm or potential for 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 maintain a safe resident environment after a resident was able to obtain objects that could be used to threaten others. This applies to 2 residents (R1, R5) reviewed for safe environment. The findings include:On 1/2/25 at 9:57 am, R5, who was alert and oriented, said that on 12/7/25 she told the staff that R1 had a knife and held it to her neck and threatened her. R5 stated she was scared in the moment. On 12/27/25 at 2:30pm, V4 CNA (Certified Nurse's Assistant) said that 12/7/25 she worked the night of 12/7/25 and she heard R1 threatening R5 with a knife and R1 was standing over R5. V4 said that night, the staff found a knifes, a drill, a hammer, and lighters in R5's room. V4 said R1 also threatened to burn down the facility before she was discharged to the hospital that night. V4 said that the facility was trying to send her to jail, but she went to the hospital instead. On 12/31/25 at 11:09 am, V3 CNA said the next day on 12/8/25, V2 DON (Director of Nursing) instructed her to search R1's room after it was reported that R1 had threatened R5. On 12/24/25 at 11:10am, V3 said while searching R1's room, she found a taser and a pocketknife under R1's bed. V3 said that she was instructed by V2 to put the items in the medication room. V3 said the night before after R1 was sent to the hospital, a hammer and drill were also found in R1's room. V3 said that the reason R1 was sent to the hospital on [DATE] was because R1 threatened R5, and after the police arrived, R1 threatened to burn down the facility. On 12/24/25 at 4:51 pm, R1, who was alert and oriented, said that she had kept a hammer, a drill and a pocketknife in her room for her protection.On 12/17/25 at 9:30 am, a pink and black electric drill, a pink and black hammer, scissors, razor blades, and lighters were present in the medication room. At 3:16 pm V2 DON (Director of Nursing) removed the items and brought them to V1's (Administrator) office. The knife in V1's desk was metal and was like a folding boxcutter or utility knife. Unfolded, it was about 6 inches long, with the top half holding an angled blade.On 1/2/26 at 5:50 pm, V1 Administrator verified the objects found belonged to R1. V1 stated they were confiscated the night R1 went to the hospital and other potentially dangerous items were found and taken the next day. V1 said when residents have these types of items in the facility it makes the facility unsafe. R1's 12/7/25 11:55 pm nurses note showed that R1 threatened to burn the facility down and was transferred to the local community hospital for evaluation. R1's 11/13/25 care plan showed that R1 displays maladaptive behaviors that may detrimentally affect others. R1's care plan did not show a focus on any aggressive behaviors or previous possession of objects that could be used as weapons. R5's electronic health records showed on 10/8/25 that her cognition is intact and her 7/31/2025 care plan shows a risk for alteration in mood and psychosocial well-being, with an intervention to provide a calm and positive environment. The facility's 6/20/2023 Guidelines for Homelike Environment policy showed that the facility will ensure that the environment is safe. The policy showed that the furnishings should be safe, clean, and comfortable .

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident with a gastrostomy tube feeding received care and services to maintain his weight. This failure resulted in a resident experiencing significant weight loss of 13.49% in less than 39 days. This applies to 1 of 2 residents (R12) reviewed for gastrostomy tube use.The findings include:R12 is a [AGE] year-old male admitted to the facility on [DATE]th, 2022, with diagnoses including brain damage from a lightning strike, functional quadriplegia, dysphagia, cognitive communication deficit, and gastrostomy status for tube feeding. R12's December Physician Orders show he takes no food orally and receives nutrition from a gastrostomy tube feeding only. On 12/26/25 at 12:17 PM, R12 was in a wheelchair in his room. R12 appeared very thin and frail. R12 was alert and oriented and communicated using a communication board. R12 communicated that he frequently does not get fed and frequently does not get his medications. R12 communicated that when he does get fed, it is often late. R12 communicated that he is always depressed because of the care he is receiving at the facility. On 12/24/25 at 11:10 AM, V3 CNA (Certified Nurse's Assistant) said that R12 has told her that he is hungry. V3 said that she tells R12's nurse and they will tell her that they will get to it or that it is next on their list. V3 said that R12 has lost a lot of weight. V3 said that the nurses tell R12's family that R12 was fed when he has not been fed. V3 said that she works 6:00 AM to 2:00 PM and she had never seen R12 get a 6:00 AM feeding until the family started complaining about it. On 12/26/25 at 10:20 AM, V15 (CNA) said that R12 has told her that he was hungry. V15 said He has lost tons of weight and looks like a skeleton. He cannot get out of bed and relies on staff to feed him. He should not look like a skeleton.On 12/24/25 at 11:10 AM, V5 (CNA/Restorative Aide) also said that R12 has communicated to her that he is hungry, and she has let the nurse know. On 12/27/25 at 2:30 PM, V4 (CNA) said that she works the 10:00 PM to 6:00 AM shift. V4 said that she noticed R12 has been losing weight and she has never seen him be fed on the night shift. V4 said that sometimes on the night shift the residents don't get fed or don't get their medications because there is only one nurse in the facility. R12's electronic health records showed his weight was 114.2 pounds on 11/19/25. On 12/26/25 at 12:35 PM, R12 was weighed at the facility again and his weight was 98.8 pounds, a 13.49% weight loss in 38 days. R12's December 24, 2025, hospital Discharge Summary listed a diagnosis of severe protein calorie malnutrition, and comments under the physical exam described his appearance as cachectic (extremely thin and frail due to severe unintentional weight loss, primarily from muscle and fat). R12's Summary further showed Weight: 30% weight loss in less than one year. Muscle mass severe loss to clavicular and temporalis muscle areas. Malnutrition: severe.R12's December 2025 Medication Administration Record (MAR) showed R12's order as Enteral Feed Order every 6 hours for Diet- Jevity 1.2, 300 [milliliters] every 6 hours. R12's MAR had the feedings scheduled four times daily at 12:00 AM, 6:00 AM, 12:00 PM, and 6:00 PM. Up to December 20, 2025, R12's December 2025 MAR had every box checked as though the tube feeding was administered as scheduled except four times, which are 12/1 at 6:00 AM and 6:00 PM, on 12/16 at 6:00 AM, and 12/19 at 6:00 PM, and those were left blank. On 12/23/25 at 4:13 PM, V2 (Director of Nursing) said that if there is nothing documented in the EMAR, the medications or feedings were not given.R12's December 2025 Medication Administration Audit Report showed the times when the remaining entries were actually signed off as administered:On 12/2/2025, R12's 12:00 AM and 6:00 AM feedings were both signed off as given at 6:55 AM.On 12/5/2025, R12's 12:00 AM and 6:00 AM feedings were both signed off by V2 (Director of Nursing), two days later, on 12/8/2025 at 2:26 PM.On 12/6/2025, R12's 12:00 AM and 6:00 AM feedings were both signed off at 7:16 AM.On 12/8/2025, R12's 6:00 AM feeding was signed off by V2 at 8:52 PM.On 12/14/2025, R12's (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	12:00 AM feeding was signed off at 5:27 AM, and his 6:00 AM feeding was signed off at 5:19 PM. R12's 12:00 PM and 6:00 PM feedings were both signed off as given at 6:04 PM. On 12/15/2025, R12's 12:00 AM feeding was signed off at 8:44 AM, his 6:00 AM was signed off at 8:45 AM, and his 12:00 PM was signed off at 5:28 PM.On 12/17/2025, R12's 12:00 AM feeding was somehow signed off at 12:30 AM the day before, and his 12/17 6:00 AM was also signed off the day before at 5:56 AM. R12's 6:00 PM feeding was signed off at 10:49 PM.On 12/18/2025, R12's 12:00 AM feeding was signed off at 4:54 AM, his 6:00 AM was signed at 6:04 AM, and his 6:00 PM was signed at 8:54 PM.On 12/19.2025, R12's 12:00 AM and 6:00 AM were both signed off as administered at 6:16 AM, and his 12:00 PM was signed off as administered at 4:51 PM.In addition to what is already outlined, R12's Audit Report for 12/1-12/20 also showed ten times where his feeding administration times were signed off as administered more than three hours later than scheduled: on 12/1 for the 12:00 AM feeding, 12/6 for the 12:00 PM, 12/7 for the 12:00 AM, 12/9 for the 12:00 AM and the 12:00 PM, 12/10 for the 12:00 AM, 6:00 AM, and 12:00 PM, and 12/13 for the 12:00 AM and 6:00 AM feedings. Additionally, there are three times where R12's scheduled feedings were signed off more than four hours past their scheduled administration times: on 12/4 for the 12:00 AM feeding, on 12/8 for the 12:00 PM feeding, and 12/12 for the 12:00 AM feeding.On 12/30/25 at 10:29 AM, V7 (R12's Primary Care Physician) said that he was not made aware of R12's weight loss or that he was not getting his feedings as ordered. V7 said that he was also unaware of R12 asking for food. V7 said that he had just examined R12 and there was nothing wrong with R12 medically that would cause him to lose weight. V7 said that if R12 is losing weight, it would only be from him not being fed. On 12/30/25 at 11:09 AM, V16 (R12's Registered Dietician) said that if R12 was getting his feedings as ordered, he would not have lost any weight because his feedings were exceeding his needs. V16 said the only reason for R12's weight loss is that he is not getting enough feedings. On 1/2/26 at 5:50 PM, V1 (Administrator) said that it is her expectation that the residents get their tube feeding as ordered. V1 said that she does not expect R12 to be losing weight because he is to be feed as ordered. V1 said that she is aware of R12 not being fed and that he is malnourished, and it is not acceptable.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to have enough licensed nursing staff to pass medications in a timely manner and to consistently provide a resident's gastrostomy tube feeding as ordered.This applies to 15 residents (R1, R10, R12, R18-R29) reviewed for licensed nurse staffing. The findings include:On December 31, 2025, at 11:00 AM, R19 was still in bed and was restless. R19 asked for his medications and stated he did not get his morning medications. R19 stated he goes a lot of nights without getting his 9:00 PM medications until around midnight, adding he also goes a lot of days without getting his morning meds until around 11 or 12:00 PM, too. R19 stated I need them- I am very sick and me not getting my medications on time is making me sicker. R19's October 10, 2025, MDS (Minimum Data Set) showed R19 is cognitively intact.On December 31, 2025, at 11:05 AM, V20 LPN (Licensed Practical Nurse) was at his medication cart, passing medications using the facility's EMR (Electronic Medical Record). The computer screen showed the eMAR (electronic Medication Administration Record) in pink for residents whose medications had not been passed. V20 verified that the pink color for the residents showing meant that there were overdue medications and that there were 14 total residents on the hall who had overdue medications, including R1, R10, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, and R29. V20 stated there was only one nurse down here on this side and there are supposed to be two. V20 stated he did not know if someone had called off or why there was only one nurse. V20 stated nurses work 12-hour shifts and he had worked the overnight shift as well. On December 31, 2025, at 12:00 PM, V26 RN (Registered Nurse) prepared R20's late 9:00 AM medications. V26 stated she just started passing medications around 11:00 AM because she had been working on the other side with another nurse because she's new. V26 stated she had been at the facility since the previous evening at 11:00 PM. V26 stated she was about to take R20's blood pressure. The Medication Administration Audit Report for December 31, 2025, showed R20's two 9:00 AM hypertension medications with blood pressure parameters for dosing were administered late on December 31, 2025, at 12:09 and 12:11 PM. R12's Face Sheet showed he was admitted to the facility on [DATE]th, 2022, with diagnoses including functional quadriplegia, dysphagia, and gastrostomy status for tube feeding. R12's December Physician Orders show he takes no food orally and receives nutrition from a gastrostomy tube feeding only. R12's electronic health records showed his weight was 114.2 pounds on 11/19/25. On 12/26/25 at 12:35 PM, R12 was weighed at the facility again and his weight was 98.8 pounds. On 12/30/25 at 10:29 AM, V7 (R12's Primary Care Physician) stated that he had just examined R12 and there was nothing wrong with R12 medically that would cause him to lose weight. V7 said that if R12 is losing weight, it would only be from him not being fed.On 1/2/25 at 3:51pm, V9 ADON (Assistant Director of Nursing) said that the facility's minimum for nurses is 3 on day shift and 2 on night shift. The shifts are twelve-hour shifts scheduled from 7am to 7pm, and 7pm to 7am. V9 was reviewed the facility's November 2025 and December 2025 daily floor assignment sheets, the daily staffing sheets, and the staff time sheets. V9 confirmed the following information to be true:On Nov. 17th, 2025, there was only 1 nurse on from 7pm to 7am.On 11/22/25 there was 1 nurse on from 7pm - 7am. On 11/29/25 there were 2 nurses 2 on from 7am - 7pm. On 12/3/25 there was 1 nurse from 9pm - 7am. On 12/13/25 there were 2 nurses from 7am - 7pm and only 1 nurse from 12am to 7am. On 2/14/25 there was 1 nurse from 7am - 4:30pm, and only 2 nurses from 4:30pm to 7pm.On 12/17/25 there were 2 nurses from 7am - 815am.On 12/18/25 there were 2 nurses from 2pm until 7pm, and only 1 nurse from 11pm - 7am. On 12/19/25 there were 2 nurses from 7am - 1045 am and only 1 nurse from 8:45 pm to 7am. On 12/22/25 there were 2 nurses from 7am - 845 am. On 12/23/25 there was 1 nurse from 7am - 745 am.On 12/25/25 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Momence Meadows Nursing & Rehab	500 South Walnut Momence, IL 60954

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	there were 2 nurses from 7am - 730am, and only 1 nurse from 830pm - 7am. On 12/30/25 there were only 2 nurses from 7am - 7 pm.On 12/31/25 there were 2 nurses from 7am - 7pm, and only 1 nurse from 10pm to 7am. V9 (ADON) continued and said that her expectations for staffing are for the facility to meet the minimum requirements. V9 said, if not, it affects the care that should be provided, such as passing medications and tube feedings given on time.On 12/31/2025 at 2:55 PM, V20 (LPN) stated he thought the facility was short on nurses.On 12/26/25 at 2:34 pm, R3, who was alert and oriented, said there is not enough staff at the facility. R3 said that some nights there is no nurse on duty, and he does not get his medications. R3 said that he has had to yell for his medications and threaten to call 911. R3 said that sometimes he is unable to sleep because he hasn't gotten his pain medications that night. On 12/26/25 at 2:48 pm, R15, who was alert and oriented said that some nights there are no nurses on the floor, and she does not get her pain medications. R15 said that she has threatened to call the state about it. On 12/26/25 at 2:45 pm, R16 who was alert and oriented, said that sometimes he is unable to sleep at night because he has not gotten his medications to help him sleep. On 12/26/25 at 2:55pm, R17, who was alert and oriented, said that he does not get his medications at night, including his medications to help him sleep. On 1/2/26 at 5:50 pm, V1 (Administrator) said that her expectations are that the minimum number of staff work to provide care. V1 said that it is not acceptable to have just one nurse on the floor. V1 acknowledged that it is not safe for only one nurse to have the whole facility, and it happens. On 12/23/25 at 4:13 pm, V2 DON (Director of Nursing) said that the minimum of nurses on at night shift is 2. V2 said that on 12/14/25 at 1:17 am, she was aware that there was only 1 nurse working in the facility. On 12/24/25 at 11:10 am V3 CNA (Certified Nurses Assistant) said that there are not enough nurses. V3 said that some residents don't get their medications and their G-tube feedings, and some residents must wait to get their medications. On 12/27/25 at 2:30 pm, V4 CNA said that there are times that there is only 1 nurse working on the floor and she has made V2 aware of it. V4 said that she has seen residents begging for their medications and threatening to call 911 to get their medications. On 12/26/25 at 10:20 am, V15 CNA said that on 12/14/25 at 9:18 am, V15 sent a text to V1 and V2 telling them that there was only 1 nurse on the floor and there were residents waiting on medications. V15 said the text also informed V1 and V2 that there were resident behaviors happening. V15 said that neither V1 nor V2 replied to her text. The facility's Strategies to Mitigate Staffing Shortages policy dated 5/1/2020 showed that Maintaining staffing is essential to provide a safe work environment for healthcare professionals and safe patient care.The facility Assessment Tool dated 11/17/2025 showed the Staffing Plan with the total number of licensed nurses providing direct care needs to be 3 on days and 2 on nights. The Staffing Plan also showed that the facility had zero for average number of residents for the category, behavioral symptoms and cognitive performance.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review, the facility failed to ensure significant medications were administered as ordered.This applies to 6 residents (R10, R12, R18, R19, R20, R28) reviewed for medications.The findings include:1.On December 31, 2025, at 11:00 AM, R19 was still in bed and was restless. R19 asked for his medications and stated he did not get his morning medications. R19 stated he goes a lot of nights without getting his 9:00 PM medications until around midnight, adding he also goes a lot of days without getting his morning meds until around 11 or 12:00 PM, too. R19 stated I need them- I am very sick and me not getting my medications on time is making me sicker. R19's October 10, 2025, MDS (Minimum Data Set) showed R19 is cognitively intact.R19's Face Sheet showed he his diagnoses include malignant lung neoplasm, absence of his right and left legs above the knee, and hydradentis suppurativa (a chronic and painful skin condition that causes recurrent abscess-like lumps). R19's December 31, 2025, Order Summary Report showed Physician Orders for baclofen three times daily for muscle spasms and gabapentin three times daily for muscle spasms. R19's December 2025 MAR (Medication Administration Record) showed the two medications were scheduled to be administered daily at 9:00 AM, 5:00 PM, and 9:00 PM. The Medication Administration Audit Report for December 31, 2025, showed he received his first doses of both medications at 11:24 AM, his 5:00 PM doses at 4:35 PM (five hours later), and his 9:00 PM doses at 8:10 PM (under four hours after that). On December 31, 2025, at 11:05 AM, V20 LPN (Licensed Practical Nurse) was at his medication cart, passing medications using the facility's EMR (Electronic Medical Record). The computer screen showed the eMAR (electronic Medication Administration Record) in pink for residents whose medications had not been passed. V20 verified that the pink color for the residents showing meant that there were overdue medications and that there were 14 total residents on the hall who had overdue medications, including R19, R28, R10, R20, and R18.2. On December 31, 2025, at 11:05 AM, R28's MAR was pink. R28's Face Sheet showed his diagnoses include diabetes with hyperglycemia. R28's December 31, 2025, Order Summary Report showed Physician Orders for 6 units of short-acting insulin injected three times daily for diabetes, and 25 units of long-acting insulin injected once daily. R28's December 2025 MAR showed his short-acting insulin was scheduled for administration before meals at 7:00 AM, 11:00 AM, and 4:00 PM. The same MAR showed his daily dose of long-acting insulin was scheduled for administration at 8:00 PM. The MAR showed the 7:00 AM and 11:00 AM doses of R28's short-acting insulin were administered on December 31, 2025, and the MAR showed both doses were signed off at 11:35 AM, as does R28's Medication Administration Audit Report for December 31, 2025. R28's MAR showed his once daily long-acting insulin scheduled for 8:00 PM was signed off as administered on 12/25, 12/26, 12/27, refused on 12/28, and signed off again on 12/29. R28's December 2025 Medication Administration Audit Report showed the 8:00 PM dose on 12/25 was administered at 6:21 AM on 12/26, his 8:00 PM dose on 12/26 was administered at 5:57 AM on 12/27, his 12/27 8:00 dose was administered 12/28 at 7:08 AM, his 12/28 refused dose at 8:00 PM was administered 12/29 at 6:48 AM. The Audit Report showed his actual 12/29 8:00 PM dose was administered 14 hours later at 8:34 PM.3. On December 31, 2025, at 11:05 AM, R10's MAR was pink. R10's Face Sheet showed her diagnoses include the bi-polar type of schizoaffective disorder, and recurrent major depressive disorder. R10's December 31, 2025, Order Summary Report showed Physician Orders for benztropine mesylate two times daily for Parkinson's, and clozapine every twelve hours and lithium carbonate three times daily, both related to bipolar-type schizoaffective disorder. R10's MAR showed the benztropine and clozapine were both scheduled for administration at 9:00 AM and 9:00 PM, and lithium was scheduled for 9:00 AM, 1:00 PM, and 9:00 PM. The Medication Administration Audit Report for December 31, 2025, showed all three 9:00 AM scheduled doses were signed off as administered at 12:58 PM, with the (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	second 1:00 PM scheduled dose of lithium signed off as administered at 12:59 PM. The same Audit Report showed on 12/30/25, R10's 9:00 AM doses of clozapine, lithium, and benztropine were signed off as administered at 2:58 PM, and her 1:00 PM scheduled dose of lithium signed off as administered at 2:20 PM. 4. On December 31, 2025, at 11:05 AM, R20's MAR was pink. R20's Face Sheet showed his diagnoses include diabetes with hyperglycemia and foot ulcer, combined heart failure, and hypertension. R20's December 31, 2025, Order Summary Report showed Physician Orders for amlodipine and lisinopril daily for hypertension with parameters to hold the medications for a systolic blood pressure value under 110, orders for 45 units of long-acting insulin injected at bedtime, and orders for short-acting insulin injected three times daily with a sliding scale.R20's MAR showed to administer the amlodipine and lisinopril at 9:00 AM. On December 31, 2025, at 12:00 PM, V26 RN (Registered Nurse) prepared R20's medications. V26 stated she just began passing medications around 11:00 AM because she had been working on the other side. V26 stated she was about to take R20's blood pressure and it was last taken the day before at 3:03 PM. The Medication Administration Audit Report for December 31, 2025, showed R20's hypertension medications were administered on December 31, 2025, at 12:09 and 12:11 PM. The Medication Administration Audit Report showed for the previous day on December 30, 2025, that R20's 9:00 AM scheduled hypertension medications were administered at 3:00 PM.R20's MAR showed to check his blood glucose and inject short-acting insulin as needed per sliding scale before meals at 6:00 AM, 11:00 AM, and 4:00 PM. R20's MAR showed the 11:00 AM insulin dose on 12/28 was administered at 6:20 PM and the 11:00 AM dose on 12/30 was administered at 2:23 PM. R20's Medication Administration Audit Report for his bedtime dose of long-acting insulin (scheduled for 9:00 PM) showed his 12/26 dose was administered at 6:05 AM on 12/27, his 12/27 dose was administered on 12/28 at 7:11 AM, his 12/28 dose was administered on 12/29 at 6:43 AM, and his 12/29 dose was administered at 8:47 PM, approximately 14 hours later.5. On December 31, 2025, at 11:05 AM, R18's MAR was pink. R18's Face Sheet showed her diagnoses include malignant neoplasm of brain and epileptic seizures. R18's December 31, 2025, Order Summary Report showed Physician Orders for levetiracetam and lacosamide twice daily for seizures. R18's MAR showed both seizure medications were to be administered twelve hours apart at 9:00 AM and 9:00 PM. R18's December Medication Administration Audit Report showed the two 9:00 AM seizure medications were administered on 12/26 at 10:41 and 10:44 AM and the 9:00 PM dose was administered on the next day on 12/27 at 6:03 and 6:04 AM; her 12/27 9:00 AM doses were administered seven hours later at 1:06 PM and her 12/27 9:00 PM doses were administered on 12/28 at 6:52 AM; her 12/28 9:00 AM doses were administered at 6:24 PM and her 9:00 PM doses were administered on 12/29 at 6:30 AM; her 12/29 9:00 AM doses were administered just over seven hours later at 1:45 PM, her 12/29 9:00 PM seizure medications were administered at 8:52 PM, just over seven hours after that, making that a third dose within 15 hours. The Audit Report showed her 12/30 9:00 AM doses were administered at 2:58 PM, with the 12/30 9:00 PM doses not being signed off as administered at all. The same Audit Report showed the 12/31 9:00 AM doses were administered at 1:00 PM, 22 hours later.6. R12's Face Sheet showed his diagnoses include functional quadriplegia, dysphagia, and history of acute respiratory failure and pneumonia. R12's December 24, 2025, hospital Discharge Summary showed Weaned off oxygen successfully. [Intravenous] Zosyn (antibiotic) transitioned to [oral] antibiotic. R12's Transition of care section showed 1. Medication changes: start levofloxacin (antibiotic) 750 mg (milligrams) daily for five days.R12's Order Summary Report had the order transcribed to give levofloxacin 750 mg two times a day via his gastrostomy tube every five days. R12's MAR showed 9:00 AM and 5:00 PM doses were signed off as administered on 12/25 and 12/30, instead of once daily for five straight days. Further, R12's Medication Administration Audit Report showed his 9:00 AM dose on 12/30 was administered at (continued on next page)

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