STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145719	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Village Healthcare	2202 North Kickapoo Street Lincoln, IL 62656

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 31285 Based on observation, interview and record review, the facility failed to respond to resident call lights in a timely manner for seven of seven residents (R2, R3, R4, R6, R8, R9 and R10) reviewed for call light response time in the sample of 24. Findings include: The facility's 'Answering the Call Light' policy (dated August 2008) documents the following: The purpose of this procedure is to respond to the resident's requests and needs; General Guidelines: 8. Answer the resident's call light as soon as possible; Steps in the Procedure: 4. Do what the resident asks of you, if permitted; and, 5. If you have promised the resident you will return .do so promptly. The Facility Assessment (reviewed 07/30/24) goes on to document: The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required by the (State agency). The facility's Grievance Log (dated 03/12/25 - 05/12/25) documents the following grievances filed: R9 reported a grievance on 3/27/25, documenting R9, Wants CNAs (Certified Nursing Assistants) to round more and answer call lights faster. R10 also filed a grievance dated 5/6/25, documenting: R10, Wants response time to (call) lights to be more timely. On 5/13/25 at 10:08 AM, V9 (Certified Nursing Assistant) stated, I feel terrible because these residents have to wait, and sometimes it can be several minutes. We try our best, but there just isn't enough help. On 05/13/25 at 10:11 AM, V14 (CNA/Certified Nursing Assistant) stated that there are not enough CNAs scheduled to answer call lights timely. V14 stated, It's very overwhelming and sometimes we cannot get all of our showers completed. If we do not get the missed showers made up the next day, we get written up. I work as hard as I can to get to the call lights as soon as possible, but there is only one of me and I cannot be in two places at once. (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 - Some	On 05/13/25 at 01:35 PM, R2 was sitting in a wheelchair in her room watching television. R2 stated, I have been here for several years. It's gotten really bad lately. They need more CNAs. It takes them forever to answer a call light. The other day I sat and waited to get changed (after an episode of incontinence) for an hour and a half. On 05/13/25 at 01:38 PM, R3 was sitting in her wheelchair conversing with her roommate. R3 stated her biggest concern is the lack of CNAs that the facility schedules. R3 stated, There are only three of them and there used to be more. It can take over an hour for someone to answer a call light. Some CNAs are better than others. On 5/13/25 at 1:55 PM, R6 was seated in a recliner in her room, alert and awake. R6 activated her call light at 1:58 PM. R6's call light was noted to be in working order and lit up above her door. The call light was also activated at the Nurses Station's call light indicator display board. At 2:19 PM, V3 (RN/Registered Nurse) verified R6's call light had been activated and went to R6's room to answer the call light. R6's call light went unanswered for 21 minutes, from 1:58 PM to 2:19 PM, when this surveyor notified V3, the RN on duty. R8 communicated using hand gestures in response to this surveyor's inquiries. On 5/13/25 at approximately 1:50 PM, R8 indicated sometimes her call light is answered timely and she receives the care she needed and sometimes there is a long wait for response to her call light. On 5/13/25 at 1:55 PM, V19 (R8's family member) stated they often have to wait long periods for staff to answer R8's call light. V19 stated, They are very busy. On 5/13/25, R8's call light was activated at 2:00 PM. R8's call light went unanswered for 10 minutes, until this surveyor notified V5 (LPN/Licensed Practical Nurse) at 2:10 PM that R8's call light was on, and she needed incontinence care. On 05/14/25 at 10:00 AM, R4 was sitting in a recliner in her room watching television. When asked about falling in the facility, R4 stated the following: My legs are weak, so I do fall a lot. I'm supposed to ask for help and wait for them to come after I use my call light, but it usually takes too long. There're times I've had an accident in my pants waiting for help to go to the bathroom. I feel like this happens constantly. It takes a really long time for someone to answer the call light at nighttime. I've waited several hours. They try to get to you during the day, but at times, you wait 30 to 45 minutes. They definitely need to schedule more nurses and CNAs. On 5/14/25 at 4:00 PM, R9 stated the facility is, short-staffed, with the, extra CNAs, listed on the daily schedules sent home. R9 stated call lights are left unanswered for long periods and sometimes her requests are not met, stating the CNAs state they, will be back, and do not return. On 5/14/25 at approximately 10:00 AM, V1, Administrator, stated call lights are to be answered, in five to ten minutes. V1 stated it was unacceptable to leave a call light unanswered for 20 minutes or more.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 31283 Based on interview and record review, the facility failed to implement all components of their abuse policy for one of four residents (R1) reviewed for abuse in the sample of 24. Findings include: The facility's Abuse Prevention Policy (undated) documents the following Investigation Procedures: 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 submitted documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. R1's Abuse Investigation (dated 04/21/25) documents an abuse investigation was initiated after R1 verbalized an allegation of physical abuse to V15 (R1's wife). This investigation did not include documentation of any interviews obtained from residents who receive assistance from the same caretakers who provide care to R1. On 05/14/25 at 03:45 PM, V1 (Administrator) stated she was out of the facility when R1's 04/21/25 Abuse Investigation was conducted, and the investigation was conducted by the individual appointed in her absence. V1 confirmed that all components of the facility's Abuse Policy were not implemented when R1's 04/21/25 Abuse Investigation was conducted and stated resident interviews should have been obtained during the investigation.

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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. 31283 Based on interview and record review, the facility failed to thoroughly investigate an allegation of physical abuse for one of four residents (R1) reviewed for abuse in the sample of 24. Findings include: The facility's Abuse Prevention Policy (undated) documents the following Investigation Procedures: 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 submitted documents. Residents to whom the accused has regularly provided care, and employees with whom the accused has regularly worked, will be interviewed. R1's current care plan documents the following focus: (R1) is an adult living with chronic health conditions, challenges, and co-morbidities and symptomatologic factors that require monitoring that put him at risk for abuse. This same care plan also documents the following focus: (R1) displays deficits in cognition, a BIMS (Brief Interview of Mental Status) score of 00. R1's Abuse Investigation (dated 04/21/25) documents, On 04/21/25, (V15, R1's wife) relayed she was concerned about discoloration to (R1's) eye area. (V15) also stated that (R1) said a man came in his room and did that to him. (V15) added that (R1) was 'trying to get her (V15) out of a locked room' and that is what caused the fall. Investigation was immediately initiated. Staff from night of 04/15/25 were interviewed and did not see any male enter (R1's) room. This same investigation does not include any interviews of residents who reside near R1's room and receive care from the same staff members. On 05/13/25 at 10:30 AM, V15 (R1's wife) stated, I am a retired nurse, which makes me a mandated reported. He had such a terrible bruise to his eye that it just did not seem consistent with a fall. One day while I was visiting, I asked him how he managed to get a black eye, and he told me that a man had come into his room and hit him. He couldn't tell me exactly when, but it made me concerned. I felt like I had to report it after he said that. On 05/14/25 at 11:15 AM, V2 (Director of Nursing) stated that R1 is typically confused, but can have moments of lucidity. V2 stated that besides R1, no other residents whose room is located near R1's and receive assistance from the same caregivers were interviewed during R1's 04/21/25 abuse investigation. V2 verified R1's abuse investigation was not thoroughly investigated and stated, Some of the interviewable residents in (R1's) hallway should have been interviewed and those interviews included in the investigation.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 31283 Based on interview, observation and record review, the facility failed to provide supervision and implement fall prevention interventions to prevent resident falls for two of three residents (R1 and R4) reviewed for falls in the sample of 24. These failures resulted in R1 falling and sustaining an injury to right eyelid and R4 falling and experiencing left hip pain. Findings include: The facility's Fall Reduction Program (revised April 2019) documents the following: It is the policy of this facility to have a Fall Reduction Program that promotes the safety of residents in the facility. The program's intent is to assist clinical staff in determining the needs of each resident through the use of standard assessments, the identification of each resident's individual risks, and the implementation of appropriate interventions, supervision, and/or assistive devices deemed appropriate. Quality Assurance will monitor the program to assure ongoing effectiveness. This same policy documents, Safety interventions will be determined and implemented based on the assessed, individualized risks and in accordance with standards of care; interventions to be documented in the resident's care plan. This policy also documents, Examples of Standard Fall/Safety Precautions that May be Applicable: Call lights answered in a timely manner; Supervision of residents who require staff assistance with bathing, showering, or toileting. If resident is not able to maintain proper sitting balance, staff shall remain with resident allowing as much privacy as is safe for the resident. 1. R1's Fall Risk Observation (dated 05/09/25) documents a score of 20, indicating R1 is at high risk for falls. R1's current Fall Prevention Care Plan documents the following: (R1) is at risk for falling related to polyneuropathy, generalized muscle weakness and cognitive deficit related to progression of Parkinson's. R1's current Functional Status Care Plan documents the following focus: (R1) requires extensive assistance with bed mobility due to weakness related to Parkinson's. R1's Functional Status Care Plan also documents the following intervention currently in place: Never leave (R1) in a position that is unsafe or uncomfortable to him. R1's Minimum Data Set Assessments (dated 02/11/25 and 05/09/25) document in Section GG, R1 is dependent (helper does all of the effort, or the assistance of two or more helpers is required) in the following areas: Roll left and right, Sit to lying, and Lying to sitting on bed. R1's Fall Investigation (dated 04/15/25) documents, IDT (Interdisciplinary Team) met to discuss alleged fall. (R1) was receiving cares in bed when CNA (Certified Nursing Assistant) turned away and (R1) rolled out of bed and onto the floor. (R1) has discoloration to right eyelid. Neurological checks initiated. (R1) not complaining of pain at this time. All notifications made, care plan updated. Root cause: Extensive assistance needed for all cares provided while in bed. Intervention: Two staff present during cares in bed at all times. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 05/14/25 at 11:15 AM, V2 (Director of Nursing) stated that V16 (former Certified Nursing Assistant), Was the only one in with (R1) at the time of his fall. (V16) walked away and left (R1) unattended in his bed to obtain supplies while she was providing cares to him, and he fell out of his bed while he was unattended. (R1) ended up with a black eye. (V16) should not have walked away from (R1) at any time. She knew better than that. She was terminated and no longer works at the facility. 2. R4's current Fall Prevention Care Plan documents the following: (R4) is at risk for falling and repeat falls related to spinal stenosis, generalized edema, history of falls, generalized muscle weakness accompanied by poor safety awareness. This same care plan documents the following fall prevention interventions in place: CNAs (Certified Nursing Assistants) will assist (R4) to the bathroom and back using a wheelchair; Staff will frequently check on (R4) and anticipate her needs. R4's Fall Investigation (dated 03/14/25) documents the following: (R4) stated she needed to use the bathroom and was in a hurry, so she attempted to get up alone. She lost balance and lowered herself to her knees. (R1) stayed on her knees until CNA (Certified Nursing Assistant) and Nurse entered room and were able to transfer resident back into the bed. No injury. This same investigation documents that R4's call light was on at the time of R4's fall. On 05/14/25 at 10:00 AM, R4 was sitting in a recliner in her room watching television. When asked about falling in the facility, R4 stated the following: My legs are weak, so I do fall a lot. I'm supposed to ask for help and wait for them to come, but it usually takes too long. There're times I've had an accident in my pants waiting for help to go to the bathroom. I feel like this happens constantly. It takes a really long time for someone to answer the call light at nighttime. I've waited several hours. They try to get to you during the day, but at times you wait 30 to 45 minutes. They definitely need to schedule more nurses and CNAs. R4 was able to recall her 03/14/25 fall and stated the following: I needed to use the bathroom, and I had my call light on. I waited and waited, and no one ever came, so I attempted to get up by myself. That was a mistake because I fell on to my knees. I stayed on my knees for several minutes until someone finally came to help. On 05/14/25 at 11:25 AM, V2 (Director of Nursing) verified that R4's call light was on at the time of her 03/14/25 fall, and stated staff should be checking on R4 frequently, especially since she is a high risk for falls. R4's Fall Investigation (dated 04/10/25) documents the following: Resident experienced an unwitnessed fall around 07:30 AM. After the fall, she stated she had left hip pain, and she stated she hit her head. Writer assessed resident after falling. No bleeding, resident alert, neuro (neurological) check done and normal, MD (Medical Doctor) and POA (Power of Attorney) notified. Resident is being sent to ED (emergency department) to be evaluated. This same investigation documents: Resident statement of what happened: I was trying to use the bathroom. This investigation also documents the following conclusion: Root cause: Staff did not follow plan intervention. Staff education and discipline. On 05/14/25 at 11:30 AM, V2 (Director of Nursing) stated, After (R4's) fall on 04/10/25, (V18, Certified Nursing Assistant) received discipline because she did not check on (R4) frequently. I watched the camera that records the entrance to (R4's) room, and it was an extended period of time before (V18) checked on (R4) since she had last been checked. (R4) is supposed to be checked on frequently, at least every 15 minutes.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 31285 Based on observation, interview and record review, the facility failed to provide adequate staffing to deliver resident cares efficiently and in a timely manner. This failure has to potential to affect all 72 residents currently residing in the facility. Findings include: The Facility Assessment (reviewed 07/30/24) documents the following: The facility assessment must address or include the facility's resident population, including; but not limited to: Both the number of residents and the facility's resident capacity; The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population. The Facility Assessment goes on to document: The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required by the (State agency). Daily Staff Assignment posting sheets dated April 15, 2025, through May 12, 2025 documented six CNAs/Certified Nursing Assistants are consistently scheduled to cover the Day shift (6:00 AM to 6:00 PM) and four CNAs are scheduled to cover the Night shift (6:00 PM to 6:00 AM) to carry out resident cares throughout the facility, with a resident census ranging from 72 to 76 residents during this time. The assignment postings included one Extra Aid on day shift and one Extra Aid on Night shift. These extra CNAs names were crossed out and these forms documented went home or sent home and the extra staff member was not to stay and work the shift. This practice consistently left six CNAs on the Day shift and four CNAs to cover the Night shift. The facility's Grievance Log, dated 2025, documents the following grievances filed: R9 reported a grievance on 3/27/25, documenting R9, Wants CNAs/Certified Nursing Assistants to round more and answer call lights faster. R10 also filed a grievance dated 5/6/25, documenting: R10, Wants response time to lights to be more timely. On 5/13/25 at 1:55 PM, R6 was seated in a recliner in her room, alert and awake. R6 activated her call light at 1:58 PM. R6's call light was noted to be in working order and lit up above her door. The call light was also activated at the Nurses Station's call light indicator display board. At 2:19 PM, V3 (RN/Registered Nurse) verified R6's call light had been activated and went to R6's room to answer the call light. R6's call light went unanswered for 21 minutes, from 1:58 PM to 2:19 PM, when this surveyor notified V3, the RN on duty. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/13/25 at 10:08 AM, V9 CNA/Certified Nursing Assistant) stated the facility does not staff enough CNAs. V9 stated in the hall she is currently assigned, There are several residents that transfer with (full mechanical lifts) and two CNAs are required to be present when transferring, using a (full mechanical lift). There are three CNAs in this area. The middle CNA has to cover their area, and float to the other two areas to assist. There used to be four CNAs scheduled and they have cut the staffing numbers. I feel terrible because these residents have to wait, and sometimes it can be several minutes. We try our best, but there just isn't enough help. On 05/13/25 at 10:11 AM, V14 (CNA/Certified Nursing Assistant) stated that there are not enough CNAs scheduled to answer call lights timely. V14 stated, It's very overwhelming and sometimes we cannot get all of our showers completed. If we do not get the missed showers made up the next day, we get written up. I work as hard as I can to get to the call lights as soon as possible, but there is only one of me and I cannot be in two places at once. On 05/13/25 at 10:30 AM, V15 (R1's spouse) stated the facility needs more staff, They all work very hard. They definitely need a few more CNAs to help out. On 05/13/25 at 01:35 PM, R2 was sitting in a wheelchair in her room watching television. R2 stated, I have been here for several years. It's gotten really bad lately. They need more CNAs. It takes them forever to answer a call light. The other day I sat and waited to get changed (after an episode of incontinence) for an hour and a half. On 05/13/25 at 01:38 PM, R3 was sitting in her wheelchair conversing with her roommate. R3 stated her biggest concern is the lack of CNAs that the facility schedules. R3 stated, There are only three of them and there used to be more. It can take over an hour for someone to answer a call light. Some CNAs are better than others. R8 communicated using hand gestures in response to this surveyor's inquiries. On 5/13/25 at approximately 1:55 PM, R8 indicated sometimes her call light is answered timely and she receives the care she needed and sometimes there is a long wait for response to her call light. On 5/13/25 at approximately 1:55 PM, V19 (R8's family member) was at the bedside and stated (R8) needs to be changed, She's wet. V19 then stated they often have to wait long periods for staff to answer R8's call light. V19 stated, They are very busy. On 5/13/25, R8's call light was activated at 2:00 PM. R8's call light went unanswered for 10 minutes, until this surveyor notified V5 (LPN/Licensed Practical Nurse) at 2:10 PM that R8's call light was on and she needed incontinence care. R8's current Care Plan documents the following interventions to prevent skin issues: Turn and reposition every 2 hours and as needed as tolerated by (R8). Provide incontinence care after each incontinent episode. R4's Fall Investigation (dated 03/14/25) documents the following: (R4) stated she needed to use the bathroom and was in a hurry, so she attempted to get up alone. She lost balance and lowered herself to her knees. (R1) stayed on her knees until CNA (Certified Nursing Assistant) and Nurse entered room and were able to transfer resident back into the bed. No injury. This same investigation documents that R4's call light was on at the time of R4's fall. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/14/25 at 10:00 AM, R4 was sitting in a recliner in her room watching television. When asked about falling in the facility, R4 stated the following: My legs are weak, so I do fall a lot. I'm supposed to ask for help and wait for them to come, but it usually takes too long. There're times I've had an accident in my pants waiting for help to go to the bathroom. I feel like this happens constantly. It takes a really long time for someone to answer the call light at nighttime. I've waited several hours. They try to get to you during the day, but at times you wait 30 to 45 minutes. They definitely need to schedule more nurses and CNAs. R4 was able to recall her 03/14/25 fall and stated the following: I needed to use the bathroom, and I had my call light on. I waited and waited, and no one ever came, so I attempted to get up by myself. That was a mistake because I fell on to my knees. I stayed on my knees for several minutes until someone finally came to help. On 05/14/25 at 11:25 AM, V2 (Director of Nursing) verified that R4's call light was on at the time of her 03/14/25 fall, and stated staff should be checking on R4 frequently, especially since she is a high risk for falls. R4's Fall Investigation (dated 04/10/25) documents the following: Resident experienced an unwitnessed fall around 07:30 AM. After the fall, she stated she had left hip pain, and she stated she hit her head. Writer assessed resident after falling. No bleeding, resident alert, neuro (neurological) check done and normal, MD (Medical Doctor) and POA (Power of Attorney) notified. Resident is being sent to ED (emergency department) to be evaluated. This same investigation documents: Resident statement of what happened: I was trying to use the bathroom. This investigation also documents the following conclusion: Root cause: Staff did not follow plan intervention. Staff education and discipline. On 05/14/25 at 11:30 AM, V2 (Director of Nursing) stated, After (R4's) fall on 04/10/25, (V18, Certified Nursing Assistant) received discipline because she did not check on (R4) frequently. I watched the camera that records the entrance to (R4's) room, and it was an extended period of time before (V18) checked on (R4) since she had last been checked. (R4) is supposed to be checked on frequently, at least every 15 minutes. On 5/14/25 at approximately 10:00 AM, V1, Administrator, stated call lights are to be answered, in five to ten minutes. V1 stated a call light should never be left unanswered for 20 minutes or more, That's absurd. V1 stated the facility is staffed according to census and to meet the State Minimum Requirements. On 5/14/25 at approximately 1:30 PM, V12, CNA, stated he was the CNA for the Respiratory Unit and also assisted the CNA assigned outside of the Respiratory Unit. V12 stated all residents on the Respiratory Unit required full mechanical lift transfers and many residents on each of the other halls required full mechanical lifts, requiring two CNAs to operate and transfer the residents. V12 verified one CNA was assigned to the Respiratory Unit and floated out to assist the other CNAs assigned to a hall outside of the Respiratory Unit. On 5/14/25 at 4:00 PM, R9 stated the facility is, short-staffed, with the, extra CNAs, listed on the daily schedules sent home. R9 stated call lights are left unanswered for long periods and sometimes her requests are not met, stating the CNAs state they, will be back, and do not return. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145719	A. Building B. Wing	05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lincoln Village Healthcare	2202 North Kickapoo Street Lincoln, IL 62656

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 5/15/25 at approximately 8:25 AM, V6 (CNA/Certified Nursing Assistant Manager and Scheduler) verified when there is an Extra Aide scheduled on the Daily postings, for the day shift (6:00 AM to 6:00 PM) and for the night shift (6:00 PM to 6:00 AM) shifts, they are sent home if the state minimum staffing is met without the extra CNA staff member. V6 stated she was informed by her Corporate that the census determines she cannot staff more than six CNAs on day shift and four CNAs on the night shift. V6 stated, We used to be able to staff eight CNAs on day shift, but now we have to staff with six CNAs on days. V6 stated the Extra Aids staffed on the Daily Staffing Assignment postings were sent home when the facility's staffing, based on resident census, met the State Minimum Requirements. On 5/15/25 at approximately 10:00 AM, V2 (Director of Nursing) provided a list documenting 31 of 72 residents currently require a full mechanical lift for transfers, and verified the following hallways contain the following amount of residents that utilize a full mechanical lift: five residents residing in the [NAME] Hall; eight residents residing in the Harmony I Hall; eight residents residing in Harmony II Hall; and ten residents residing in the Respiratory Care Unit. V2 stated all of the hallways housing residents who utilize full mechanical lifts are staffed with one CNA, and CNAs assigned to the corresponding halls are expected to assist with a full mechanical lift transfer. V2 stated staffing is based on the facility's census and the facility is staffed to meet and not exceed the State Minimum Requirements. V2 stated that currently, the resident census in the facility is 72, and there are very heavy halls in the facility with the residents requiring a lot of care, including full mechanical lifts. V2 verified the respiratory unit is one of these heavy halls, as well as other halls outside of the respiratory unit. V2 stated most of the residents residing on the respiratory hall are on ventilators and all those residents require full mechanical lifts for transfers. V2 then verified two CNAs are required to safely operate full mechanical lifts. On 5/14/25 at approximately 3:10 PM, V17 (Corporate Regional Representative) verified the facility is staffed to meet and not exceed the State Minimum Staffing Requirements. The facility's Census Sheet (dated 05/12/25) documents 72 residents are currently residing in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31285 Based on interview, observation and record review, the facility failed to remove and discard unlabeled multi-dose insulin vials and multi-dose insulin delivery pens from four active medication carts for 17 of 17 residents (R3 through R6, and R12 through R24) reviewed for insulin usage in the sample of 24. Findings include: The facility's undated Medication Administration policy documents: Medications shall be prepared and administered only to residents for whom they were ordered . The facility's Storage of Medications policy (effective 10/25/14) documents the following: All medications dispensed by the pharmacy are stored in the container with a pharmacy label. On 5/14/25 at 11:35 AM, an unlabeled, multi-dose vial of insulin was stored in the insulin compartment of the top drawer of the active medication cart for Harmony I hall. On 5/14/25 at 11:30 AM, V4 (RN/Registered Nurse) stated she would not use an unlabeled vial of insulin and any insulin pens or vials without an identifying label with the resident's name and the unlabeled, multi-dose should be discarded. On 5/14/25 at 1:00 PM, an unlabeled, multi-dose insulin delivery pen was stored in the insulin compartment of the top drawer of the active medication cart for Harmony II hall. On 5/14/25 at 1:00 PM, V6 (RN/Registered Nurse) stated she would not use any insulin that was not labeled with the specific resident's name. On 5/14/25 at 1:15 PM, an unlabeled, multi-dose insulin delivery pen was stored in the insulin compartment of the top drawer of the medication cart for [NAME] and [NAME] halls. On 5/14/25 at 1:15 PM, V5 (LPN/Licensed Practical Nurse) stated an unlabeled insulin vial or delivery pen should not be used for any resident. On 5/14/25 at 1:25 PM, an unlabeled, multi-dose vial of insulin was stored in the insulin compartment of the top drawer of the medication cart in the respiratory unit. On 5/14/25 at 1:25 PM, V7 (LPN) stated she would not use this vial of insulin, as it was not labeled with a specific resident's name and would discard the vial. On 5/14/25 at 1:01 PM, V2 (DON/Director of Nursing) stated any insulin vials or pens which are not labeled with the resident's name should be immediately discarded and never used for insulin delivery for any resident nor should it be stored in a medication cart. V2 stated each insulin-dependent resident's specific insulin vials and multi-dose insulin delivery pens are labeled with the resident's name by the pharmacy prior to delivery to the facility. V2 stated Nurses are to notify the Pharmacy when a specific resident's insulin needs to be refilled, and Nurses are not to use any other resident's insulin in place of another resident's insulin. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 5/15/25, V2 provided a list of all residents in the facility who currently utilize insulin regularly. This list documents the following residents: R3 through R6, and R12 through R24.