STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145751	A. Building B. Wing	05/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PA Peterson at the Citadel	1311 Parkview Avenue Rockford, IL 61107

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on observation, interview and record review the facility failed to ensure a resident was treated with dignity and respect for 1 of 24 residents (R88) reviewed for resident's rights in the sample of 24. The findings include: R88's facility assessment dated [DATE] documents R88 has no cognitive impairment. On 5/19/25 at 8:45 AM, during the initial tour, R88 said there was one main concern that had been bothering him. R88 said the staff that was taking care of them at midnight does not treat them well. R88 stated one day last week, I requested her to make sure my wheelchair was by me when I am in bed in case, I need my wheelchair in the middle of the night to go to the bathroom, she instead placed the wheelchair across the room, that made me so upset. Another time, I needed help with my covers (blankets) she said, you can do that yourself. R88 said the reason why he was here was he needed help. R88 said he just wanted to be treated right. R88 said they reported all these concerns to V2 (Director of Nursing-DON) On 5/19/25 at 11 AM, V2 (DON) said R88 had brought a concern to her about V10 (Certified Nursing Assistant-CNA) regarding R88 wanting his pants on at night and V10 did not do as what R88 had requested since it was in the middle of the night. V2 said R88 did not report to her about the wheelchair and blanket issues. V2 said R88 was also a fall risk and R88 should put his light on when he needed to go to the bathroom instead of transferring himself. V2 said she will look into those issues. On 5/20/25, at 1 PM, V2 said she had spoken with R88 after this surveyor brought the concerns yesterday. V2 said she had spoken to V10, and education had been provided to V10 also. V10 will not be assigned to R88, and R88 agreed. All residents should be treated with dignity and respect. The facility policy on Dignity (undated) documents, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well- being, level of satisfaction with life feeling of self worth and self esteem.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on interview and record review, the facility failed to ensure as needed anti-anxiety medications had a stop date for two of five residents (R66, R104) reviewed for chemical restraints in the sample of 24. The findings include: 1. R66's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including dementia, major depressive disorder, Alzheimer's disease, anxiety disorder, unspecified psychosis, insomnia, and difficulty walking. R66's Order Summary Report dated May 19, 2025, shows an order for clonazepam 0.5 mg by mouth every eight hours as needed (PRN) for anxiety ordered on December 27, 2024, and an order for lorazepam give 0. 25ml by mouth every four hours as needed for anxiety ordered on January 2, 2025. Neither order has a stop date. 2. R104's Admission Record shows she was admitted to the facility on [DATE], with diagnoses including Alzheimer's disease and insomnia. R104's Order Summary Report dated May 20, 2025, shows an order for lorazepam 0.25ml by mouth every four hours as needed for agitation/restlessness started on May 3, 2025. There is no stop date for this medication. On May 29, 2025, at 10:02 AM, V2 Director of Nursing said as needed psychotropics should have a 14 day stop date. V2 said herself and the Assistant Director of Nursing monitor the psychotropic medications for stop dates. The facility's Psychotropic Medications Policy not dated shows, Chemical restraint-a psychotropic medication that is clinically indicated to treat identified medical symptoms. This medication is usually in PRN form.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review the facility failed to ensure activities of daily living (ADL) assistance was provided for dependent residents for three of 24 residents (R16, R34, R93) reviewed for incontinence care in the sample of 24. The findings include: 1. R16's Admission Record dated May 19, 2025, shows she was admitted to the facility on [DATE], with diagnoses including unspecified psychosis, Meniere's disease, and osteoarthritis. R16's Care Plan initiated March 17, 2025, shows, Clean peri-area with each incontinence episode. Keep skin clean and dry. R16's Minimum Data Set (MDS) dated [DATE], shows she is occasionally incontinent of bladder and frequently incontinent of stool. R16 is dependent on staff for toileting hygiene and mobility. On May 19, 2025, at 9:39 AM, V14 (Certified Nursing Assistant) CNA said that R16 was not cleaned up for the day yet. V14 said that R16 had breakfast in bed. R16's incontinence brief was completely saturated with dark urine. 2. R34's Admission Record dated May 19, 2025, shows she was admitted to the facility on [DATE], with diagnoses including dementia, unspecified psychosis, Alzheimer's disease, and major depressive disorder. R34's Care Plan initiated December 21, 2023, shows R34 has an ADL self-care performance deficit related to activity intolerance. R34's MDS dated [DATE], shows R34 is frequently incontinent of bowel and bladder. R34 requires substantial/maximal staff assistance for toileting hygiene, personal hygiene, and bed mobility. On May 19, 2025, at 9:21 AM, R34 self propelled her wheelchair into her doorway. V14 CNA wheeled R34 back into her room and said she will clean R34 up for the day. V14 said R34 has not been cleaned up for the day yet. There was a strong urine odor in R34's doorway and bathroom. V14 said R34 must have urinated on the floor as there was a liquid noted on the bathroom floor. V14 placed R34 onto the toilet after wiping the liquid from the floor. R34's incontinence brief was completely saturated with dark urine. R34's incontinence pad that was on her bed was damp with a dark urine circle on it. V14 said her pad had urine on it. R34 did not show any aggressive behaviors or refusals while V14 was assisting R34 with toileting and dressing. 3. R93's Admission Record dated May 19, 2025, shows she was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified psychosis, muscle weakness, unsteadiness on feet, cognitive communication deficit, dementia, and mixed incontinence. R93's Care Plan initiated August 30, 2024, shows R93 is at risk for incontinence related to activity intolerance and to clean peri-area with each incontinence episode. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R93's MDS dated [DATE], shows R93 is always incontinent of urine and frequently incontinent of stool. R93 requires substantial/maximal staff assistance for toileting hygiene. On May 19, 2025, at 10:08 AM, R93 was laying in her bed. At 10:12 AM, V14 CNA said that R93 will need to get cleaned up. At 10:14 AM V14 went into R93's room to provide incontinence care to R93. V14 said incontinence care has not been performed on R93 yet. R93's incontinence brief was saturated with urine. On May 21, 2025, at 10:52 AM, V13 CNA said incontinence care is done at least every two hours or more. On May 20, 2025, at 1:59 PM, V2 Director of Nursing said incontinence care should be done every two hours or more because its best for the residents' skin and it can decrease infection. The facility's Urinary Incontinence Clinical Protocol dated April 2018 shows, As appropriate, based on assessment of the category and causes of incontinence, the staff will provide scheduled toileting, prompted voiding, or other interventions to try to improve the individual's continence status.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to have orders in place for non-pressure wounds, failed to have interventions in place for non-pressure wound healing, and failed to ensure a resident received a specialist consult for vaginal pain for three of 24 residents (R93, R362, R365) reviewed for quality of care in the sample of 24. The findings include: 1. R93's Admission Record dated May 19, 2025, shows she was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified psychosis, muscle weakness, unsteadiness on feet, cognitive communication deficit, dementia, and mixed incontinence. On May 19, 2025, at 10:14 AM, V14 Certified Nursing Assistant provided peri care to R93. R93 complained of a lot of pain when V14 wiped her front peri area. There was some type of growth to R93's peri area. R93 asked V14 to place the cream in a white bottle onto her vaginal area. V14 said there is no cream in a white bottle and all V14 had was Vaseline. R93 said Vaseline does not do anything for her pain. V14 placed Vaseline onto R93's buttocks. No cream was applied to R93's vaginal area. V14 did not ask R93's nurse to come and assess R93 while V14 was providing cares to R93. R93's Order Summary Report dated May 19, 2025, shows an order for A and D ointment to labia three times a day and as needed every two hours entered on December 3, 2024, and an order for lidocaine external cream 4% apply to labia topically three times a day for pain entered on December 10, 2024. R93's Order Summary Report dated May 19, 2025, shows an order for gynecology consult due to labia growth was entered on December 10, 2024. On May 21, 2025, at 9:52 V2 Director of Nursing (DON) said she could not find any evidence to show that R93's gynecology consult was done or followed through. V2 said R93's son is sometimes difficult to get a hold of. V2 said R93 does have something to her labia. V2 said lidocaine cream is scheduled and as needed. V2 said the CNA should have gotten the nurse to put cream onto R93's vaginal area. The Illinois Long Term Care Ombudsman Program Residents' Rights dated November 2018 shows, Your facility must provide equal access to quality care regardless of diagnosis, condition, or payment source. Your facility must provide services to keep your physical and mental health at their highest practical levels. You should receive the services and/or items included in the plan of care. 40798 2. On 5/19/25 at 10:11 AM, R365 had a foam dressing to his right elbow dated 5/12. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R365's Admission Record dated 5/19/25 shows he was most recently admitted to the facility on [DATE]. R365's After Hospital Care Plan dated 5/16/25 shows an order under the heading How Should You Care for your Wound as follows: Right elbow: aquacel AG, allevyn foam. R365's Nursing Admission/Re-admission assessment dated [DATE] at 4:38 PM shows R365 has a skin tear on his right elbow. R365's TAR (treatment administration record) for 5/1/25 to 5/31/25 shows no treatment was initiated for R365's elbow wound until 5/19/25, day four of his admission. 3. On 5/19/25 at 9:17 AM, R362 had a foam dressing (undated) to his bottom. R362's Admission record dated 5/19/25 shows he was admitted to the facility on [DATE]. R362's After Hospital Care Plan dated 5/16/25 shows an order under the heading How Should You Care for your Wound as follows: Gluteal cleft MASD (moisture associated skin damage, healed- clean with moisture barrier wipes and gently pat dry, apply zinc cream two times a day and as needed. Leave open to air, can cover with ABD if needed, but do not cover cream with allevyn foam as this can trap moisture and create further skin breakdown. Groin/abdomen/breast folds MASD-clean with moisture barrier wipes and gently pat dry, apply Interdry Ag to folds and change out daily. R362's Nursing: Admission/Re-admission assessment dated [DATE] at 11:53 AM shows R362 has a skin tear to his abdomen and vascular wounds of his right and left inner ankles. No MASD is noted on the assessment. R362's Order Summary Report dated 5/20/25 shows no wound treatment orders and R362's TAR for 5/1/25 to 5/31/25 shows R362's gluteal cleft and MASD of R362's abdomen did not have any treatment until the evening of 5/20/25 (day five of his admission). On 5/20/25 at 1:32 PM, V4, Wound Care Nurse, said when a resident is admitted the floor nurse does the full head to toe body assessment and includes any skin alteration. The wound care nurse will assess the wound(s) within 24 hours. V4 said the wound care nurse's assessment includes the site, type of wound with sub-classification, location, tissue type, amount and type of exudate, measurements (length, width, and depth), pain, description of the peri-wound, if there is odor, and if tunneling or undermining is present. V4 said all wound care assessments are in Wound Rounds in the patient's EMR (electronic medical record). V4 said upon arrival to the facility any skin alterations are to be treated with the orders that came with the patient and treatment begins that day. V4 said she has no wound assessment available for R365, she does not know what kind of wound he has. V4 said she just saw R362 today. On 5/19/25 at 12:33 PM, V6, Registered Nurse said when a resident is admitted the floor nurse will do the assessment and if the resident has wounds, they inform the wound care nurse. V6 said a new admission would come from the hospital with discharge orders for wound treatments. V6 said wound care treatment would begin on the day of admission or the next day and the wound care treatment is documented on the TAR (treatment administration record). The facility's Pressure/Non-Pressure Skin Breakdown Clinical Protocol (effective January 2024) shows, The nurse shall assess and document/report the following: Full assessment of skin condition .and current treatments . The facility's Admission/Re-Admission Checklist dated 7/24/24 shows physician orders must be transcribed onto the TAR within one hour of admission for every admit/readmit. 35178

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40798 Based on interview and record review, the facility failed to assess and implement treatment interventions for pressure wounds, and failed to ensure pressure relieving interventions were in place for 3 of 8 residents (R77, R365, R362), reviewed for pressure wounds in the sample of 24. The findings include: R365's Admission Record dated 5/19/25 shows he was most recently admitted to the facility on [DATE]. R365's After Hospital Care Plan dated 5/16/25 shows an order under the heading How Should You Care for your Wound as follows: Buttocks: zinc paste apply daily and as needed. R365's Nursing Admission/Re-admission assessment dated [DATE] at 4:38 PM shows R365 has a pressure wound of his sacrum. R365's TAR (treatment administration record) for 5/1/25 to 5/31/25 shows no treatment was initiated for R365's sacral wound as of 5/21/25. R365's Order Summary Report dated 5/19/25 shows no wound treatment/care orders for R365's sacrum. R362's Admission record dated 5/19/25 shows he was admitted to the facility on [DATE]. R362's After Hospital Care Plan dated 5/16/25 shows an order under the heading How Should You Care for your Wound as follows: Left posterior thigh healing stage 3 pressure ulcer- clean with saline wound wash and pat dry, cover wound with cut to fit aquacel Ag, secure with allevyn foam, change Tuesday, Thursday, Saturday and Right posterior thigh healed- leave open to air. R362's Nursing: Admission/Re-admission assessment dated [DATE] at 11:53 AM shows R362 has a pressure wound to his groin, sacrum, and right and left posterior thighs. R362's Order Summary Report dated 5/20/25 shows no wound treatment orders and R362's TAR for 5/1/25 to 5/31/25 shows R362's thighs had no treatment initiated until 5/21/25 (day six of his admission). R362's groin and sacrum were not addressed on the TAR. On 5/20/25 at 1:32 PM, V4, Wound Care Nurse, said when a resident is admitted the floor nurse does the full head to toe body assessment and includes any skin alteration. The wound care nurse will then assess the wound(s) within 24 hours. V4 said the wound care nurse's assessment includes the site, type of wound with sub-classification, location, tissue type, amount and type of exudate, measurements (length, width, and depth), pain, description of the peri-wound, if there is odor, and if tunneling or undermining is present. V4 said all wound care assessments are in Wound Rounds in the patient's EMR (electronic medical record). V4 said upon arrival to the facility any skin alterations are to be treated with the orders that came with the patient and treatment begins that day. V4 said she has no wound assessment available for R365, she does not know what kind of wound he has. V4 said she just saw R362 today. On 5/19/25 at 12:33 PM, V6, Registered Nurse said when a resident is admitted the floor nurse will do the assessment and if the resident has wounds, they inform the wound care nurse. V6 said a new admission would come from the hospital with discharge orders for wound treatments. V6 said wound care treatment would begin on the day of admission or the next day and the wound care treatment is documented on the TAR (treatment administration record). The facility was unable to provide wound care nurse assessments for R362 and R365 which were completed prior to 5/20/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Pressure/Non-Pressure Skin Breakdown Clinical Protocol (effective January 2024) shows, The nurse shall assess and document/report the following: Full assessment of skin condition .and current treatments . The facility's Admission/Re-Admission Checklist dated 7/24/24 shows physician orders must be transcribed onto the TAR within one hour of admission for every admit/readmit. On 05/19/25 at 12:55PM, R77 was lying in bed on her back. R77 looked like she was sleeping. R77 had a wound vacuum on the floor by the foot of her bed. The tubing extended from the vacuum to the dressing on her LEFT heel. R77 had a pressure reduction boot on her RIGHT foot. Another pressure reduction boot was on a chair in her room. R77's left heel was resting on the bed. On 05/19/25 at 1:04 PM, V12 CNA-Certified Nursing Assistant said, R77 has a wound vacuum to her left heel. The pressure reduction boot is only applied to one foot. R77 current Physicians Order on 05/19/25 at 1:24 PM, shows, offload heels. R77 current Care Plan on 05/19/2025 shows, put protective boots on when in bed. On 05/20/25 at 2:18PM, R77 was sitting up in bed. R77's left heel was resting on the bed. R77's pressure reduction boot was in the dresser drawer. On 05/20/25 at 2:18 PM, R77 stated, I have 2 boots, I do not know why I only have one on. On 05/20/25 at 2:23 PM, V22 RN-Registered Nurse said, the pressure reduction boot keeps pressure off the heel. On 05/20/25 at 2:45 PM, V4 Wound Care Nurse said, it is a standard of care to off load heels to ensure the heel does not have direct pressure with a surface. If there are heel boots, they should be used, if no heel boots, we should use a pillow or wedge to off load the heels. The facility Pressure/Non-Pressure Skin Breakdown policy effective January 2024 shows, the physician will authorize pertinent orders related to wound treatments, including pressure redistribution surfaces .

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 33760 Based on observation, interview and record review the facility failed to ensure splints were in place for residents with contractures for 2 of 5 residents (R30, R12) reviewed for limited range of motion in the sample of 24. The findings include: 1. R30's Physician Order Sheet (POS) show R30 has diagnoses of stroke with left sided paralysis. R30's facility assessment dated [DATE] show R30 is alert and able to verbalize his needs. R30 has limited range of motion due to history of CVA (stroke). The same assessment show R30 has no behaviors of rejection of care. On 5/19/25 at 10 am, R30 was sitting in his wheelchair in his room. R30's contracted left hand- (fingers were all curled/clenched towards the palm) was in his lap. R30 said no one does anything to his left hand, then used his right hand to lift his contracted left hand to show this surveyor. R30 said he has a splint that no one applies. R30 said no one exercises his contracted left arm. At 1:12 PM, R30 was sitting in his wheelchair in his room watching TV. R30 had no splint to his left hand. On 5/20/21 at 8AM, R30 was in the dining room just finished his breakfast. R30 had no splint to his contracted left hand. R30's care plan dated 5/20/21 documents-The resident has limited physical mobility r/t contracted left hand. R30 has left side hemiplegia, due to recent CVA with intervention of, Splint to be worn on Left hand daily as tolerated. On 5/20/25 at 9:44 AM, V2 (Director of Nursing-DON) said she is also the Restorative Nurse at this time. R30 had stroke so he has left hand contractures. R30 should wear his left hand splint as ordered. The splint is to prevent further contractures. If R30 refused to wear his splint, the refusals should be documented in progress notes, if there was no documentation, that means that it was not done. V2 (DON) said R30 will be referred to therapy. R30's progress notes as confirmed by V2 DON did not document that R30 had refused wearing his left hand splint. R30's tasks (for Certified Nursing Assistant-CNA) that show application of splint to be done for the month of May (2025) was also blank as confirmed by V2. On 5/20/25 at 1PM, V11 (Occupational Therapy-OT) said R30 was referred for therapy today (5/20/25) due to R30's contractures and splint need. 34506 (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R12's Admission Record dated April 4, 2025, shows R12 was admitted to the facility on [DATE], with diagnoses including hemiplegia and hemiparesis following cerebral infarction affecting left non dominant side and reduced mobility. R12's Order Summary Report dated May 19, 2025, does not include any orders for splint placement to R12's left arm. R12's Care Plan initiated August 9, 2024, shows R12 refuses to wear splint sometimes. Remind resident on importance to wear splint. Approach again if resident refuses splint. There is no other documentation found to reflect R12's refusals. R12 Minimum Data Set (MDS) dated [DATE], shows R12 did not have any behaviors of rejecting evaluation or care that is necessary to achieve the resident's goals for health and wellbeing. R12's MDS shows he received brace or splint assistance three days of the last seven days. R12's MDS also shows that he has no impairment to either upper extremity for functional range of motion. On May 19, 2025, at 10:29 AM, R12 was sitting in his room. R12 left arm was out of his long sleeve zip up shirt and was pressed against his abdomen. R12 said he wears a splint sometimes. R12 said it is too hard for him to put it on and if staff would help him, he would wear it. R12 did not have a splint to his left hand or arm. R12's Certified Nursing Assistant tasks in the electronic charting does not contain a task for the CNAs to apply R12's splint. On May 20, 2025, at 9:44 AM, V2 Director of Nursing/Restorative nurse said R12 has a brace that staff put on and take off to his left arm/hand. V2 said R12 wears the splint everyday and sometimes takes it off at mealtimes. V2 said staff put the splint on. V2 said she does not know if there is an actual time limit for having the splint on. V2 said R12 should wear it for at least one hour per day. V2 said splints are used for residents with contractures. Splints help the limbs from contracting, it can help keep the shape of the limb, and helps the contractures from getting worse as long as the splints are worn. V2 said staff document under the tasks tab and in the medication administration record or the treatment administration record. Refusals are documented by the nurse in a progress note. V2 said if there is no documentation that a splint is applied, then it means it was not done. The facility's Application of Splints policy dated November 2023 shows, Purpose: To properly apply a splint for support, comfort, or aid in contractures prevention. Equipment: Physician's order, specific splint for the resident. Note the time the splint was applied, and time splint is to be removed per physician order.

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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** 34506 Based on observation, interview, and record review, the facility failed to ensure a resident was transferred safely for 1 (R66) of 24 residents reviewed for safety/supervision in the sample of 24. The findings include: R66's Admission Record dated May 19, 2025, shows R66 was admitted to the facility on [DATE], with diagnoses including dementia, major depressive disorder, primary generalized osteoarthritis, Alzheimer's disease, anxiety disorder, fatigue, displaced right femur fracture, difficulty walking, and non displaced fracture of right and left little finger. R66's Fall Scale dated March 17, 2025; shows she is a high risk for falling. R66's Care Plan last revised on April 12, 2022, shows R66 has an activities of daily living (ADL) self-care performance deficit related to impaired mobility, impaired cognition. R66's care plan shows R66 requires a limited one assist for bed mobility and transferring. R66's Minimum Data Set (MDS) dated [DATE], shows R66 requires substantial/maximal assistance for transferring and sit to lying. On May 19, 2025, at 12:53 PM, V13 and V14 Certified Nursing Assistants (CNAs) transferred R66 from her chair to her bed by holding her underneath her arms and by holding onto the waistband of her pants. R66 did not bear any weight to her legs. On May 20, 2025, at 1:59 PM, V2 Director of Nursing said if a resident is being transferred with two staff members, then the staff should use a gait belt and stand on each side of the resident. If the resident is not standing, then they could give the resident a break and try again. Otherwise, staff could use a mechanical lift. If a resident is transferred using their arms and waist bands, then the resident could be injured. On May 21, 2025, at 10:52 AM, V13 CNA said a gait belt should be used when transferring a resident. If the resident is not standing, then the resident should be transferred via a mechanical lift. The facility's Gait Belt/Transfer Guideline revised February 2023 shows, A gait belt is a safety device made of cloth that buckles securely around a resident's waist. The device provides a secure grasping surface to aid during transfer and ambulation. Commonly used for resident who are at risk for falls and those who require assistance during transfer. Securely apply the gait belt around the resident waist positioning the buckle on the anterior side of the resident over the top of the clothing. Assist residents to stand and allow them to gain balance. If the resident is morbidly obese and cannot bear weight, consider using lift equipment to transfer the resident instead of a gait belt to ensure safety and prevent caregiver injury.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 35178 Based on observation, interview, and record review the facility failed to ensure R44's steel oxygen cylinders were stored to prevent damage to the cylinders for 1 of 5 residents (R44) reviewed for respiratory services in the sample of 24. The findings include: On 05/19/25 at 12:04 PM, R44 was lying in bed. There was an oxygen tank leaning against the wall in her closet area. The oxygen tank was not secured to keep the cylinder upright. Leaning against the bedside table, near the head of R44's bed, was a second oxygen tank. The oxygen tank was not secured to keep the cylinder upright. On 05/19/25 at 12:05PM, V8 LPN-Licensed Practical Nurse said, when R44 is up in her wheelchair the oxygen tank is attached to the back of the wheelchair. When the oxygen tank is not in use it should be stored in the oxygen cylinder storage room. The facility's Oxygen Safety Policy effective date February 2019 shows, all oxygen cylinders must be stored in racks with chains, sturdy portable carts, or approved stands and never left free-standing or in any resident room or living area.

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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. 34506 Based on observation, interview, and record review, the facility failed to ensure an adequate amount of staff were scheduled to meet the needs of residents. This failure has the potential to affect all 36 residents residing on the third floor of the facility. The findings include: The facility roster that was provided by the facility on May 19, 2025, shows there was 36 residents residing on the third floor of the facility. On May 19, 2025, at 9:02 AM, there were two CNAs working with 36 residents on the third floor. V17 LPN (Licensed Practical Nurse) said that is quite a bit of residents for two CNAs to work. V13 and V14 CNAs said the third CNA got pulled from the third floor to work on another floor because the other floor was short. Incontinence care was observed on R34 at 9:21 AM. R34's incontinence brief was saturated, and V14 CNA said this was the first time peri care was provided for R34 on day shift. Incontinence care was observed on R16 at 9:39 AM. R16's incontinence brief was saturated. This was the first time incontinence care was provided to R16 on the day shift. Incontinence care was observed on R93 at 10:14 AM. R93's incontinence brief was saturated. On May 19, 2025, at 9:15 AM, V13 CNA said CNAs are not able to get everything done when there are only two CNAs on the unit. V13 said there are four showers scheduled for that day and only two have been done. V14 CNA said there are still some residents in bed that usually get up for breakfast. On May 21, 2025, at 11:00 AM V19 Staffing Scheduler said the third Certified Nursing Assistant (CNA) was pulled from the third floor on May 19, 2025, because there was a call off on the first floor. The facility tries to staff the ground floor with four CNAs, the first floor two CNAs, the second floor three CNAs, and the third floor three CNAs. V19 said the third floor will work with two CNAs at times. On May 20, 2025, at 10:30 AM during the resident meeting that occurred during the facility's annual certification survey, R42 (attends the resident council meetings regularly) said many residents complain of waiting one-two hours for staff to answer call lights. R88 (attends the resident council meetings regularly) said he has had the staff shut off his call light and never ask what he needs. R56 Resident council president said she has sat by the nurse's station and has seen staff shut the call lights off at the nurse's station. R56 said staff can ask what the residents need through the call light system at the nurses' station. R56 said there is a note above the call light system that says do not talk to the residents over the call light system. Staff are to go to the residents' rooms. R56 said there are days when there are two CNAs working when there should be four. R56 said ice water is not passed everyday. Most of the time you have to ask for ice water. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On May 21, 2025, at 10:23 AM, V14 CNA said there are times that she works a double shift. V14 said if there is a call off and no staff pick up the extra shift then only two CNAs work. V14 said showers cannot get done and some residents cannot get up for breakfast. At 10:32 AM, V17 LPN said she helps the CNAs when she can. It is hard to care for all the residents when the unit runs with two CNAs. The CNAs are able to be more attentive when there are three CNAs. At 10:38 AM, V18 Unit Manager said staffing depends on the day. V18 said the facility tries to run the unit with one nurse and three CNAs for 36 residents. V18 said there are times when there are call offs and the unit has two CNAs for 36 residents if the facility cannot replace the call off. V18 said she helps when she can. At 10:52 AM, V13 CNA said staffing is up and down. V13 said when the unit is staffed with three CNAs, the workload is comfortable. V13 said they have ran the unit with two CNAs. V13 said the day shift is harder because the staff doesn't know right away if there is going to be two CNAs or three CNAs. V13 said it is difficult to get all the showers done, get residents up, and toilet all the residents. On May 21, 2025, at 11:25 AM, V15, R74's Daughter said the unit needs more CNAs. V15 said there are times when residents are yelling and there's no staff around. At 11:26 AM, V16, R80's spouse said there is not enough staff in the facility. V16 said there are times when he calls the unit, and no one answers the phone and there are times when there are residents in the dining room and there are no staff in the dining room. At 11:39 AM, R10 said there are times when her bed is not made. R10 said the unit could use an extra CNA. R10 said the CNAs run around a lot. The facility's Working staff schedule dated May 5, 2025, shows the second and third floor had one CNA on the night shift. On May 8, 2025, there were two CNAs on the second shift for the third floor. May 9, 2025, there were two CNAs on the schedule for third floor second shift and one CNA for third shift on the third floor. On May 10, 2025, there was no one written in the working staff schedules that was provided by the facility. On May 11, 2025, there were two CNAs on the schedule for the third floor and one CNA for the second floor for day shift and second shift. On May 16, 2025, there was two CNAs for the third floor during day shift on the third floor. The facility's Resident Council minutes dated December 11, 2024, shows, Call lights not being answered in a timely manner. February 12, 2025, one resident stated on the night of February 11, 2025, her roommates' call light was on for over two hours before a nurse or CNA came into her room. Two other residents stated their beds have not been made in two days. March 12, 2025, Residents are still concerned about the delay in answering call lights. Two residents reported their beds not being made. April 9, 2025, Residents state that they believe they sometimes have to wait longer than they would like when they need assistance. May 14, 2025, Residents state that they believe they sometimes have to wait longer than they would like when they need assistance. No specific situation was brought up, infrequent, but annoying.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 33760 Based observation, interview and record review the facility failed to ensure medications were legibly labeled and dated when opened for 2 of 2 residents (R24 R18) reviewed for medication storage in the sample of 24. The findings include: On [DATE] at 8:10 AM, this surveyor and V8 (License Practical Nurse-LPN) checked the medication cart on the east ground floor. R24's pain medication-Morphine Sulfate 100 mg/5 ml was opened but not dated when it was opened. The controlled drug receipt shows R24's date of delivery from the pharmacy was [DATE]. V8 said R24 is on palliative care and needs the morphine for pain. V8 said she will call R24's physician and reorder R24's Morphine. At 8:20 AM, this surveyor and V9 (LPN) checked the medcart on the west ground floor. R18 had a medication of Diazepam 1 ml (5mg) every 10 minutes for seizure. The label of the medication was not legible and was almost falling off. The medication was opened but not dated when it was opened. The medication expiration date was [DATE]. (approximately 4 months ago.) The Controlled drug receipt show the medication delivery date was [DATE] (almost 2 years ago). V9 (LPN) said R18's has seizures and needs the medication and V9 will update R18's physician to renew the medication. V2 (Director of Nursing) who was also on the ground floor said the medication should have been dated when it was opened. All medications labels should be legible. Expired meds should be renewed. The morphine and diazepam were both outdated. V2 said R24's physician will be updated to renew R24's pain medication. R18's physician will be updated to renew R18's anti seizure medications

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on observation, interview, and record review, the facility failed to don personal protective equipment (PPE) for residents on Enhanced Barrier Precautions (EBP) and failed to change gloves and perform hand hygiene in a manner to prevent cross contamination for five of 24 residents (R66, R93, R34 R16, R362) reviewed for infection control in the sample of 24. The findings include: 1. R66's Admission Record dated May 19, 2025, shows R66 was admitted to the facility on [DATE], with diagnoses including dementia, major depressive disorder, primary generalized osteoarthritis, Alzheimer's disease, anxiety disorder, fatigue, displaced right femur fracture, difficulty walking, and non displaced fracture of right and left little finger. R66's Order Summary Report dated May 21, 2025, shows an order for EBP related to wounds ordered on February 17, 2025. On May 19, 2025, at 12:53 PM, the was a sign on R66's door that showed R66 was on enhanced barrier precautions. V14 Certified Nursing Assistant (CNA) performed incontinence care on R66. There was urine and stool in R66's incontinence brief. V14 wiped R66's front peri area, helped R66 turn onto her side, wiped the small amount of stool from R66's buttocks, placed the clean brief underneath R66 and then helped R66 turn back onto her back. V14 did not perform hand hygiene nor change her gloves when going from dirty to clean surfaces. V14 did not wear a gown during these cares. 2. R93's Admission Record dated May 19, 2025, shows she was admitted to the facility on [DATE], with diagnoses including epilepsy, unspecified psychosis, muscle weakness, unsteadiness on feet, cognitive communication deficit, dementia, and mixed incontinence. On May 19, 2025, at 10:15 AM, V14 performed incontinence care to R93. R93's incontinence brief was saturated with dark urine. R93's vaginal area was reddened. V14 wiped R93's front peri area, helped R93 to turn onto her right side, wiped R93's buttocks, place the clean incontinence brief and helped R93 turn back onto her back. V14 did not change her gloves or perform hand hygiene. 3. R34's Admission Record dated May 19, 2025, shows she was admitted to the facility on [DATE], with diagnoses including dementia, unspecified psychosis, Alzheimer's disease, and major depressive disorder. On May 19, 2025, at 9:28 AM, V14 took R34 to the bathroom. R34's incontinence brief was saturated with dark urine. There was a strong urine odor. V14 removed R34's incontinence brief, cleaned R34's front and back peri area, placed and new incontinence brief onto R34, and applied a clean dress onto R34. V14 did not change her gloves or perform hand hygiene. 4. R16's Admission Record dated May 19, 2025, shows she was admitted to the facility on [DATE], with diagnoses including unspecified psychosis, Meniere's disease, and osteoarthritis. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16's Care Plan initiated March 17, 2025, shows, Clean peri-area with each incontinence episode. Keep skin clean and dry. R16's Minimum Data Set (MDS) dated [DATE], shows she is occasionally incontinent of bladder and frequently incontinent of stool. R16 is dependent on staff for toileting hygiene and mobility. On May 19, 2025, at 9:39 AM, V14 performed incontinence care to R16. R16's incontinence brief was saturated with dark urine. V14 wiped R16's front peri area, help her turn onto her side, wiped R16's buttocks, and then placed Vaseline onto R16 buttocks. V14 placed the clean incontinence brief onto R16 and did not change her gloves or perform hand hygiene. On May 21, 2025, at 10:52 AM, V13 CNA said gloves should be changed right after touching soiled items and before touching clean items. On May 20, 2025, at 1:59 PM, V2 Director of Nursing said gloves should be changed after touching dirty items and before touching clean to reduce risk of infection. 40798 5. On 5/19/25 at 9:08 AM R362's room had a sign showing he was on Enhanced Barrier Precautions (EBP). On 5/19/25 at 9:17 AM, V5, Certified Nursing Assistant was in R362's room. With bare hands and no gown, V5 changed R362's gown and said his oxygen tubing was backwards, so she took it out of his nose and turned it around. V5 the applied gloves, but no gown and assisted R362 to turn onto his side. On 5/20/25 at 1:50 PM, V23, Infection Prevention Nurse, said staff need to use EBP for residents with chronic wounds. R362's Nursing: Admission/Re-admission assessment dated [DATE] at 11:53 AM shows R362 has a pressure wound to his groin, sacrum, and right and left posterior thighs. The facility's Enhanced Barrier Precautions Policy (effective 1/20/24) shows it is the practice of the facility to implement EBP for the prevention of transmission of multidrug-resistant organisms (MDRO). EBP refer to the use of gown and gloves for use during high-contact resident care for residents known to be colonized or infected with a MDRO as well as those at increased risk of MDRO acquisition (e.g., residents with wounds or indwelling medical devices). EBP are implemented for residents with wounds (pressure ulcers, diabetic foot ulcers, unhealed surgical wounds and chronic venous stasis ulcers) and/or indwelling medical devices such as urinary catheters. Gowns and gloves are to be available immediately outside of the resident's room. High contact resident care activities include bathing, dressing, providing hygiene and changing briefs/assisting with toileting. The facility's Hand Washing/Hand Hygiene Policy (effective March 2023) shows it is the policy of the facility to assure staff practice recognized hand washing/hygiene procedures as a primary means to prevent the spread of infections. When hands are not visibly soiled, employees may use an alcohol-based hand rub containing at least 60% alcohol before moving from a contaminated body site to a clean body site during resident care.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35174 Based on interview and record review the facility failed to offer a resident the pneumonia vaccination which applies to 1 of 5 residents (R36) reviewed for vaccinations in a sample of 24 The findings include: R36's Facility assessment dated [DATE] showed R36 is a seventy-seven-year-old male resident admitted to the facility on [DATE]. R36's electronic medical record showed R36 refused the pneumococcal polysaccharide vaccine (PPSV) 23 and the pneumococcal conjugate vaccine (PCV) 13 on 6/2/21. On 5/20/25 at 11:20 AM, V25 Infection Control Preventionist (ICP) stated the facility follows the Centers for Disease Control (CDC) guidelines for vaccinations which included the pneumonia vaccine. V25 stated the current pneumonia vaccinations the facility offers is the PCV 20. Residents should be offered immunizations upon admission and when they are eligible to receive a vaccination. V25 stated they had not talked with R36 prior to this interview. The facility did not produce any documentation R36 had been offered a current pneumonia vaccination. The facility's Pneumococcal Vaccine Policy dated 11/2022 showed residents will be offered pneumococcal vaccines admission and when a resident is eligible to receive the pneumococcal vaccine when indicated. This policy showed vaccinations will be made in accordance with current CDC recommendations at the time of the vaccination.