STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145806	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Park Health & Living Ctr	6700 North Damen Avenue Chicago, IL 60645

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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 ensure their IDPH (Illinois Department of Public Health) Reportable initial and final Incident Report Form was transmitted correctly for 7 (R20, R28, R45, R50,R82, R86, R121) of 7 residents identified on four (4) Facility Reportable documents reviewed. This failure has the potential to affect 123 residents residing in the facility.Findings Include:On 12/10/25 during review of the facility Reportable Fax Transmittal Form document, it was observed that the facility transmittal sheet document in part: Result: No answer . IDPH did not receive the following reportable of 09/18/25, 10/27/25 (regarding R20 and R28), 10/28/25 (regarding R121), 11/19/25 (regarding R28 and R86), and 9/19/25 regarding R50, R45 and R82.On 12/10/25 at 10:23 AM V1 (Administrator) stated that is the number (referring to the fax number on the Result Report) that we have been submitting the reportable to since I have been here. I have worked here for 10 years but I have been submitting it for 2 years. The receipt of confirmation, that is what that (referring to the Fax Result Report) is and come out after we send/fax the reportable. I am not aware the reportable was not being transmitted correctly. I looked at the result ok and that is what I was accustomed to, so I did not go any further than that. I was given the correct fax number and email. I have not had to send any other reportable in since I was given the correct fax number. V1 was made aware that the facility was being placed in Substandard Quality of Care/Extended Survey and that a plan of correction needs to be put in place at this time.On 12/10/25 at 11:21 AM V1 (Administrator) presented the surveyor with a plan of correction and stated I put a plan together. I updated the reporting form with the new fax number, and I am actively going around to in-service the staff with the new reporting fax number. I will be reviewing all the reportable confirmations for the IDPH (Illinois Department of Public Health) reportable. We will review them in the QAPI (Quality Assurance and Performance Improvement) meeting for compliance. I updated the IDPH Incident Report Form fax number and completed a plan of correction for substandard quality of care.V1 presented the surveyor with an IDPH Incident Report Form with the updated fax number and a sheet with the plan of correction dated 12/10/25 documenting in part: Situation - This plan is to address the facility reporting of incidents to IDPH via fax, to an outdated number. The facility was updated on the new contact information by an IDPH surveyor on 12/06/25 during a complaint investigation. The facility now has current fax and email information to submit reportable incidents to. Plan - The facility Administrator updated the reporting forms to display the updated contact information for IDPH reporting. The staff designees will be in-serviced on the updated reporting information. The facility Administrator will review all fax confirmations r/t (related/to) IDPH reporting for compliance on an ongoing basis. All reportable incidents will be added to QAPI for monitoring of compliance.Policy:Titled Abuse Prevention Program dated 10/22 document in part: Any allegation of abuse of any incident that results in serious bodily injury will be reported to the Illinois Department of Public Health immediately, but no more than two hours of the allegation of abuse. Any incident that does not involve abuse and does not result in serious bodily injury shall be reported within 24 hours. VIII. External Reporting 1. Initial Reporting of Allegations. When an allegation of abuse, exploitation, neglect, mistreatment or misappropriation of resident property has been made, the administrator, or designee, shall notify Department of Public (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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Health's regional office immediately by telephone or fax. Public Health shall be informed that an occurrence of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property has been reported to the administrator and is being investigated. 2. Five-day Final Investigation Report. Within five working days after the report of the occurrence, a complete written report of conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observations, interviews, and record reviews, the facility failed to maintain an effective pest control program. This has the potential to affect all 123 residents residing in the facility.Findings include: On 12/09/2025 at 10:55 AM, R7 was lying in bed. There was a black flying insect flying around in R7's room during the interview. On 12/09/2025 at 11:20 AM, R113 was lying in bed. During interview, there was a black, flying insect flying in the room. R113 stated seeing flies at least once a week. R113 has also seen roaches and spiders in the bedroom. On 12/09/2025 at 12:09 PM, V9 (Ombudsman) stated residents complained about cockroaches in the past and is an ongoing issue. On 12/09/2025 at approximately 2:38 PM, V8 (Maintenance and Housekeeping Director) stated facility contracts a pest control company that comes out weekly and as needed to treat the facility. V8 stated staff occasionally report bugs in the laundry room. On 12/10/2025 at 10:08 AM, R121 was in the basement dining room. During interview, there was a black flying insect in the dining room. In the far end of the dining room near the north wall, there was a brown bug crawling on the floor. R121 mentioned roaches being around the vending machines. On 12/10/2025 at 11:22 AM, R11 was lying in bed. There was a rodent glue trap under heater vent. R11 stated maintenance staff put the trap a while ago but it doesn't work because R11 saw a small mouse last night. On 12/10/2025 at 11:23 AM, R27 stated seeing a cockroach on the third-floor hallway a couple of weeks ago. On 12/10/2025 at 11:24 AM V11 (Housekeeping) stated there are roaches in the residents' bedrooms. V11 stated seeing them in the corners of bedrooms or in the residents' bathrooms. V11 stated seeing a roach downstairs in the women's locker room that morning. V11 stated to be honest they're everywhere. V11 also stated seeing a mouse in R120's room last week. V11 stated the activity room in the basement also has a lot of pest and rodent activity. V11 stated pest control comes out weekly but staff and residents continue to see pests and rodents. V11 stated It's just not working. On 12/10/2025 at 11:28 AM, R120 stated seeing a roach here and there. R120 declined to talk about rodents but mentioned needing to request a personal fridge to protect R120's snacks from the rodents. On 12/10/2025 at 11:33 AM, V12 (Housekeeping/Floor Tech) was moping the second-floor hallway. V12 stated usually seeing a cockroach in the vending machine room (dining room) in the basement. On 12/10/2025 at 11:34 AM, R41 stated seeing mice in the bedroom three days ago. R41 also sees water bugs and roaches in the bedroom. R41 stated last sighting was three to four days ago. On 12/11/2025 at 10:35 AM, V2 (Director of Nursing) stated pest control company comes to service the building weekly and as needed. V2 stated staff are to report all sightings in the communication dashboard in the electronic system. V2 stated if staff and residents continue to see pests and rodents then the interventions are not effective. V2 stated the facility needs to see what else they can do to prevent and get rid of the pests and rodents. Facility's ?Service Inspection Reports' from their contracted pest control company document in part that a mouse was found in the kitchen dry storage area on 11/21/2025, a resident's room was attracting flies and roaches on 10/15/2025, and there were German roaches in the kitchen dish room on 10/06/2025. Facility's undated Policy on Pest Control documents in part: It is the policy of the facility will be free of pest/rodents. Facility's admission Packet contains the Illinois Long-Term Care Ombudsman Program's Resident Rights for People in Long-Term Care Facilities. It documents in part that residents have the right to have a safe, clean, comfortable, and homelike environment.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interviews and review of record the facility failed to maintain toilet rails inside the shower in safe working condition and they also failed to ensure that there is a shower head and shower curtain that covers entire shower area for all residents living on the 2nd floor. These failures have the potential to affect fifty-five (55) residents on their safety and comfort when using the shower room.Findings include: On 12/09/2025 at 12:11 PM, With V9 (State Ombudsman) inside shower room, left and right rails of the toilet are not properly attached to the floor (wobble like about to detach when pressure applied). Screws on both left and right rails are missing and full of rust. Missing shower head was found inside one of the shower areas. Also the shower curtain has a tear on the part where it attaches to the 3 rings unable to cover shower area when fully expand. At 12:25 PM, V8 (Maintenance Director) went inside the shower room stated that rails on the toilet are not properly attached on the floor and there are many missing screws that it wobbles wide when moved. V8 stated it looks as it has been for a while due to the rust showing on the metal part of the rails. V8 stated that residents are at risk for fall if it detached on the floor while using the rails on the toilet. On 12/10/2025 at 10:00 AM, V1 (Administrator) was informed about rails on the toilet inside the shower room. V1 stated that she was not aware about the problem. On 12/11/2025 at 12:33 PM, V8 (Maintenance Director) stated that he did not have any record on maintaining or checking shower areas. And that was the first time he knew about the rails problem on the shower room second floor. Maintenance Policy dated 12/2019: To ensure the facility is maintained in proper repair and equipment is functioning appropriately. The maintenance staff will have designated assignments to ensure the facility remains in proper repair on a daily basis and PRN (as needed). Maintenance will be alerted of any ill repair or concerns that need to be addressed as related to the environment upkeep. Maintenance will communicate with the Administration any facility needs that are identified to ensure a safe well-maintained environment at all times.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observations, interviews, and record reviews, the facility failed to provide a home-like environment for three residents (R9, R133, and R134) out of a total sample of 26 residents. Findings include: On 12/09/2025 at 11:34 AM, R9 was oriented to self, place, and year. R9 stated there is a hole in the wall behind the bed. R9 stated it was there when R9 moved into the room. R9 requested facility to fix it but maintenance has not done it. Surveyor observed large break in the wall that was greater than R9's breakfast plate. Multiple pieces of the drywall are caved in. Multiple smaller pieces are on the floor below the hole. R9's ?Census List' documents in part that R9 has been in the room since 11/19/2025. On 12/09/2025 at 11:38 AM, R134 was oriented to self, place, and date. R134 stated previous roommate made a hole in the wall behind bedroom door. There was a crescent-shaped hole in the drywall that was about a foot long and eight inches high. R134 stated requesting facility to fix it but maintenance has not done it. R134 stated being scared that pests or rodents would come out from the hole. On 12/09/2025 at 11:40 AM, R133 (R134's current roommate) stated hole in the wall was there when R133 moved in. R133 stated informing staff about it as well but facility hasn't got to it. R133 also stated there were holes on the floor near R133's bed that needed to be fixed but facility hasn't done it. R133 showed surveyor a missing part of the flooring tile near the bottom right side of the bed and another tile near the left side of the bed. R133's ?Census List' documents in part that R133 has been in the room since 9/09/2025. On 12/09/2025 at 2:35 PM, V8 (Maintenance Director) and surveyor conducted a walk-through of R9, R133, and R134's rooms. V8 stated was not aware of the holes in the walls. V8 stated the holes in the wall could be fixed right away but staff did not communicate it to V8. V8 also stated that the floor is linoleum and that V8 was not aware there were holes near R133's bed. On 12/11/2025 at 10:35 AM, V2 (Director of Nursing) stated the staff are supposed to report all maintenance issues on the communication dashboard in the electronic system. Facility's undated [Company Name Omitted] Preventative Maintenance and Work Order Policy documents in part: Purpose: To track Life Safety Tasks, Manage Assets, Schedule Maintenance Services and Work Order Repairs. All employees and/or family members should report an issue. It also documents in part that the work order needs to be filled out in a timely manner. Facility's admission Packet contains the Illinois Long-Term Care Ombudsman Program's Resident Rights for People in Long-Term Care Facilities. It documents in part that residents have the right to have a safe, clean, comfortable, and homelike environment.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Level II PASARR (Preadmission Screening and Annual Resident Review) yearly review was completed for 1 of 2 residents reviewed for PASARR in a sample of 26.Findings Include: R41 has diagnosis not limited to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Ulcerative Colitis, Morbid (Severe) Obesity due to Excess Calories, Abnormalities of Gait and Mobility, Insomnia, Overactive Bladder, Age-Related Osteoporosis, Mood [Affective] Disorder, Solitary Pulmonary Nodule Right lower lobe Lung Nodule, Bilateral Primary Osteoarthritis of Knee, Bipolar Disorder, Pulmonary Embolism and Infarction, Heart Failure, Congestive Heart Failure, Idiopathic Scoliosis, Atherosclerotic Heart Disease of Native Coronary Artery, Hyperlipidemia and Essential (Primary) Hypertension. R41's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response.R41's Medication Review Report document in part: Citalopram Hydrobromide Tablet 20 MG (milligram) Daily for depression, Lorazepam Oral Tablet 2 MG three times a day related to Unspecified Mood [Affective] Disorder and Trazodone HCl Oral Tablet 150 MG at bedtime related to bipolar disorder.R41's Care Plan document in part: Focus: SMI (Severe Mental Illness) Individualized Care Plan. R41 is in need of supportive counseling and/or psychotherapeutic services secondary to: (X) mental illness diagnosis of Bi-Polar Disorder (MI). (X) Signs and symptoms of clinical depression. (x) Observable medical/psychiatric/cognitive conditions that may require on-going assessment, consultation and intervention. Date Initiated: 10/14/25. Interventions: Staff will encourage the resident to follow mental health treatment plans to the best of capability in accordance with age and medical condition. Explain the benefits of continued mental health involvement and potential negative consequences from abstaining from treatment. Utilize assessment data (i.e., PASARR, MDS, Psychiatric Evaluation, Level of Functioning and Psychosocial History) to help determine the resident's present needs, deficits, abilities, strengths. Date Initiated: 10/14/25.During review of R41's Electronic Medical records, R41does not have a current PASRR (Preadmission Screening and Resident Review). R41's OBRA (Omnibus Budget Reconciliation Act) Screen dated 07/21/1992 document in part: There is a reasonable basis for suspecting DD (Developmental Disability) or severe MI (Mental Illness) as severe Mental Illness (SMI). R41 was originally admitted to the facility on [DATE] with a readmission date of 10/14/16. Electronic Medical Records document on 06/05/15 a diagnosis of bipolar disorder and on 10/27/17 a diagnosis of Unspecified Mood [Affective] Disorder. On 12/10/25 at 09:16 AM V3 (Social Service Director) stated The whole social service department is responsible for the PASARR (Preadmission Screening and Resident Review).On 12/10/25 at 12:59 PM V3 (Social Service Director) stated R41 have never left the facility. I only have to submit for the PASARR it if the residents are going to a different facility. There has not been a change to R41's mental illness not that I am aware of. Surveyor asked V3 if there is any documentation that she (V3) does not have to submit for a PASARR. V3 responded, where do you document that? I had a call with the help line.On 12/11/25 at 11:14 AM V3 (Social Service Director) stated R41 does not have a PASARR. R41 has the old OBRA because she was here prior to 2022. I don't have here original diagnosis.On 12/11/25 at 11:21 AM V18 (Psychotropic Nurse/Care Plan Coordinator) stated I am not the one who normally does the PASARR. Surveyor asked V18 to provide documentation that indicated R41 had diagnosis of Mood [Affective] Disorder and Bipolar Disorder prior to her initial admission date of 03/10/10.On 12/11/25 an undated typed document was presented to the surveyor from the facility via e mail that document in part: R41 was admitted in 2010 with diagnosis of bipolar disorder. After a hospital stay in 2017 a diagnosis of Mood Disorder was added to her list of diagnosis. There was no new PASARR completed as Mood disorder is an umbrella term for conditions where a primary disturbance of mood is central. All Bipolar Disorders are Mood Disorders. But not all Mood Disorders are bipolar disorders. And her (R41) added (continued on next page)

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	diagnosis was unspecified mood disorder. That did not warrant a new screening.Policy:Titled admission Criteria revised 03/22 document in part; Policy Statement: Our facility admits only residents whose medical and nursing care needs can be met. 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorder per Medicaid Pre-admission Screening and Resident Review (PASARR) process.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observations, interviews, and record reviews the facility failed to follow their Change in Condition Policy to promptly notify the physician of skin rashes for three [R23, R97, R113] residents reviewed in a sample of 26. This failure resulted in a delay of treatment. Findings include, On 12/9/25 at 9:30 AM, during the facility's tour, several residents expressed concern in reference to their body rashes. On 12/9/25 at 9:42 AM, V30 [Certified Nurse Assistant] stated, There are a few residents I noticed with a body rash over the past month. R23, R46 and R113. The nurse was made aware. On 12/9/25 at 10:20 AM, R23 stated, I have been itching for a month. The rash started on my feet, between my toes, then moved to my lower legs, stomach, back, and under my breast. I showed V14 a few times and they are not doing anything about my rashes. R23 gave V14 [Registered Nurse] and surveyor permission to observe her rashes and noted red and black bumps some with crust on top, other bumps have a tiny whole in the middle. The rash was noted from R23's feet, ankles, lower legs, buttocks, back of thigh, back, stomach and underneath the breast areas. V14 stated, I notified one of the nurse practitioners, but I do not remember who I told or when. On 12/9/25 at 11:42 AM, R97 stated, My feet, legs and my butt won't stop itching. I been itching for a long time. On 12/9/25 at 11:45 AM, V28 [Certified Nurse Assistant], V13 [Licensed Practical Nurse] and surveyor observed R97's skin. Observed R97's feet, lower legs, buttocks, stomach, and arms with red and black bumps some with crust on top, other bumps have a tiny whole in the middle. V28 stated, I noticed R97's rash about two weeks ago. I did notify the nurse, but I cannot remember who it was. V13 stated, I thought R97 had skin cream ordered for his rash, it looks like it has spread. On 12/10/25 at 1:00 PM, V2 [Director of Nursing] stated, Once certified nurse assistants note a change in a resident's skin, they must report the change to the nurse immediately. The nurse must document the change in condition and notify the physician or nurse practitioner timely. If the nurse fails to notify the physician regarding a change in condition, it could potentially delay prompt treatment and worsening of a medical condition. A delay in treatment could potentially cause harm to the resident. Policy documented in part: Change in Condition or Status dated 5/2026. Our facility shall promptly notify the resident attending physician of changes of condition. The nurse will notify the physician for [in part]: Adverse reactions to medications, significant change in resident's physical, emotional, or mental (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	conditions. Refusal of treatment or medications. Significant change of condition is a condition that will not normally resolve itself without intervention by staff or my implementing standard disease related clinical interventions. Findings include: On 12/09/2025 at 11:20 AM, R113 stated had rash to left hip for the past two weeks. R113 stated it itches. R113 stated getting it from the linen at this facility. On 12/09/2025 at 11:22 AM, V7 (Nurse) came into R113's room to look at the rash. V7 stated new to the facility and was not aware of R113's rash. R113 stated informing another nurse about the rash. R113 pulled down pants and pointed to legs. R113's skin was dry with multiple raised bumps up and down both legs from hip down to lower legs. Some bumps with indentation in the middle. V7 stated R113's skin was dry and scaly.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review the facility failed to ensure an enteral bolus feeding was administered per physician orders for one (R103) resident with an order of NPO (Nothing by Mouth) reviewed for g-(gastric) tube feedings in a sample of 26.Findings Include:R103 has diagnosis not limited to Chronic Systolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, , Gastrostomy, Essential (Primary) Hypertension and Hyperlipidemia. R103's Medication Review Report document in part: NPO (nothing by mouth) diet. Enteral Feed Order four times a day Enteral feeding G (gastric)-Tube: Jevity 1.2cal, Bolus: 2 cans. Flush g-tube with 120ml (milliliter) of water before & after each bolus feed. Enteral Feed Order one time a day for G-tube Care [Enteral] Change syringe daily. Oral /Enteral Syringe with Enfit Connector 60ml.R103's Care Plan document in part: The resident requires tube feeding r/t (related /to) dysphagia, Swallowing problem. 03/14/24: On Bolus feeding of Jevity 1.2 2 cans 4x/day. NPO TF (Tube feeding).On 12/09/25 at 12:05 PM R103 was observed in bed in a semi-Fowler_position with a left-hand splint in place. V19 (Registered Nurse) was observed administering R103's bolus feeding with a 60 ml (milliliter) syringe via the gastric tube with a short tip allowing some of the gastric feeding to leak onto a blanket that was covering R103's abdomen. V19 aspirated the feeding into the syringe from a plastic cup, placed the short tip of the syringe into the gastric tube, then pushed the feeding into the gastric tube using the plunger. V19 said this is not the right kind of syringe. V19 then flushed the gastric tube with 120 ml of water. 12/11/25 at 09:23 AM V2 (Director of Nursing) stated G-tube feeding, the nurse has to make sure there is an order, check placement, proper position and wash hands. The syringe plunger (piston with a rubber tip/gasket for suction and pushing) should not be used to give a bolus feeding. We use the bolus feeding and the bolus feeding is done by gravity. If the bolus feeding is leaking, there is a potential the resident is not receiving enough feeding according to the order.12/11/25 at 09:45 the surveyor accompanied V2 (Director of Nursing) to the supply room. V2 picked up a syringe from the shelf and stated, the enteral feeding syringe is a flat top piston. V2 proceeded to pick up a g-tube tray that contained a cannister and syringe then stated, this syringe does not work with the kind of g-tubes they are placing.Policy:Titled Enteral Nutrition revised 11/18 document in part: Adequate nutritional support through enteral nutrition is provided to residents as ordered. Policy Interpretation and Implementation. 11. The Nurse confirms that orders for enteral nutrition are complete. Complete orders include: a. The enteral nutrition product; b. Delivery site (tip placement); c. The specific enteral access device (nasogastric, gastric, jejunostomy tube, etc.; d. Administration method (continuous, bolus, intermittent); Central supply is responsible for ordering all tube feeding supplies. The staff may use products from a basic formulary until any specialized products can be delivered.

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	145806	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Warren Park Health & Living Ctr	6700 North Damen Avenue Chicago, IL 60645

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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 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. Based on observation, interview and record review the facility failed to (a.) follow the physician orders for a resident on continuous oxygen, (b.) failed to post oxygen in use signage at the entrance of R41's room, and (c.) failed to label and store oxygen tubing and a nebulizer set-up to prevent contamination for two (R41, R103) residents reviewed for respiratory treatments in a sample of 26.Findings include:R41 has diagnosis not limited to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Morbid (Severe) Obesity due to Excess Calories, Insomnia, Overactive Bladder, Age-Related Osteoporosis, Mood [Affective] Disorder, Bilateral Primary Osteoarthritis of Knee, Bipolar Disorder, Pulmonary Embolism and Infarction, Heart Failure, Congestive Heart Failure, Idiopathic Scoliosis, Atherosclerotic Heart Disease of Native Coronary Artery and Essential (Primary) Hypertension. R41's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response.R41's Medication Review Report document in part: Check pulse oximetry Q (every) Shift & as needed, Call Md (Medical Doctor) below 90% every 24 hours as needed. Continuous O2 (oxygen) Via (NC (nasal cannula)/Mask) at 2 liters per minute. Notified MD if Below 90. every shift for related to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation.R41's Care Plan document in part: Focus: The resident has oxygen therapy r/t (related /to) Respiratory illness. Pulmonary Nodule, Hypoxemia, COPD, Pulmonary Embolism diagnosis. R41 has a plug- in concentrator at the bedside.On 12/09/25 at 01:20 PM R41 was observed near the nurse station in a wheelchair with no oxygen in use. R41 asked to speak to this surveyor. Surveyor proceeded down the hallway and entered the room with R41. R41 said she has been in the facility for 15 years. My oxygen is broke. R41 applied the nasal cannula and turned on the oxygen concentrator that was located at her bedside. The oxygen tubing was unlabeled and undated. R41 stated V1 (Administrator) has the receipt for my oxygen box but where is my oxygen box. I would like to move around the floor and go to activities, but I feel like a prisoner in my own room. They ordered a battery for the other box, but it did not fit inside. I get nervous and end up with loose stools. I have a doctor appointment on 12/11/25 and have no oxygen tank. When I am out of the room I try to control my breathing. A small rectangular shaped bag was observed attached to the back of R41's wheelchair with a nasal cannula inside of it with no bag to prevent contamination.On 12/09/25 at 03:05 PM V1 (Administrator) stated I ordered a new battery-operated portable oxygen concentrator for R41. There is an oxygen concentrator in R41's room and we have a cannister that we can hook R41 to in the meantime. If the cannister is not working, we send R41 out to her doctor appointment with two oxygen tanks.On 12/10/25 at 8:30AM, surveyor observed R41 sitting in her wheelchair without a supplemental oxygen tank. R41 stated, I have no oxygen again this morning. I have a medical appointment tomorrow and I am afraid to go without oxygen.On 12/10/25 at 01:33 PM R41 was observed sitting by the shower room door near the nurse station with no oxygen in use. R41 said they don't give me oxygen tanks. I am trying to control my breathing. I need my inhaler. I am supposed to be on oxygen all the time. The small rectangular bag was observed on the back of R41's wheelchair with a nasal cannula inside of it with no bag to protect it from contamination. R41 said that is the bag that the oxygen machine goes in. On 12/10/25 at 01:37 PM V14 (Registered Nurse) was made aware by the surveyor the R41 was requesting her inhaler. V14 looked in R41's electronic medical records and said R41 gets prn (as needed) Ventolin. R41 said to V14 I need something to open my airway. V14 asked R41 to return to her room. Upon entering the room R41 placed the nasal cannula on then turned on the oxygen cannula set at 2 liters of oxygen. V14 placed the pulse oximeter on R41's right index finger with a reading of 82%. At 01:42 PM the pulse oximeter reading increased to 86%. At 01:45 PM the pulse oximeter reading was 91%. At 01:45 PM V14 administered 2 puffs of the Ventolin inhaler and at 01:47 the pulse oximeter reading was 95%.On 12/10/25 at 01:48 PM V14 (Registered Nurse) returned to the medication cart. Surveyor asked V14 to check R41's order for oxygen. V14 stated R41 is supposed to be on oxygen continuously. The portable oxygen was faulty that's why R41 do not have oxygen on. We do not have any portable oxygen tanks. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R41's oxygen concentrator has to be plugged up in the dayroom, that's where we plug it up for her.On 12/10/25 at 01:56 PM there was no oxygen in use signage at R41's room entrance or postings in R41's room.12/11/25 at 09:23 AM V2 (Director of Nursing) stated The oxygen tubing is changed every Monday on the night shift. The nebulizer we make sure it is labeled before using it and it is supposed to be inside the bag because you don't want any bacteria or infection. The oxygen nasal cannula should be labeled and stored in a bag when they are not using it to prevent respiratory infection. We have portable oxygen tanks located at the end of the hallway on each floor. The nurses have access to the portable oxygen tanks 24 hours a day and the nurses are aware they have access to the portable oxygen tanks. R41 is always with oxygen, and she has a portable oxygen tank that we have to place it. R41 has an oxygen concentrator in her room. R41 is not supposed to be without her oxygen, she is on continuous oxygen. R41 is going to her doctor's appointment with the portable oxygen tank. R41 is supposed to have a portable oxygen tank on her wheelchair. If R41 does not have her oxygen there is a potential for shortness of breath. The oxygen tubing should not be in the bag on R41's wheelchair and not stored in a bag. If they saw R41 sitting and she is desaturating, they are not following the doctor's order. There should be oxygen signage at the door or at the resident's bedside.R103 has diagnosis not limited to Chronic Systolic (Congestive) Heart Failure, Chronic Obstructive Pulmonary Disease, Asthma, Insomnia, Hypothyroidism, Gastrostomy, Low Back Pain, Suicidal Ideations, Essential (Primary) Hypertension, Hyperlipidemia, Drug Induced Subacute Dyskinesia, Major Depressive Disorder, Atherosclerotic Heart Disease of Native Coronary Artery, Cardiomyopathy, Obstructive Sleep and Schizoaffective Disorder.R103's Medication Review Report document in part: Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG (milligram)/3ML (milliliter) (Ipratropium-Albuterol) 3 ml inhale orally every 4 hours as needed for SOB (Shortness of Breath).R103's Care Plan document in part: Focus: Resident is on respiratory therapy for improvement in pulmonary function. Focus: R41 has altered respiratory status/difficulty breathing r/t (related/to) Sleep Apnea.On 12/09/25 at 12:05 PM R103 was observed in bed in a semi-Fowler_position with a left-hand splint in place. The nebulizer set up mask was observed laying on the bedside table with no bag to prevent contamination. On 12/09/25 at 12:12 PM V19 (Registered Nurse) stated the nebulizer set up mask should be in a bag to protect it from bacteria and germs.Policy:Titled Administering Medications through a Small Volume (Handheld) Nebulizer revised 04/22 document in part: The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. 30. 30. When equipment is completely dry, store in a plastic bag with the resident's name and the date on it. 31. Change equipment and tubing every seven days, or according to facility protocol.Titled Oxygen Administration revised 03/20 document in part: The purpose of this procedure is to provide guidelines for safe oxygen administration. 4. Oxygen tubing and humidification bottles are to be changed weekly and as needed. Tubing and humidification bottles are to be dated at the time they are changed. 5. Oxygen tubing will be covered and stored when not in use. 2. Place an Oxygen in Use sign on the outside of the room entrance door. Close the door. 3. Place an Oxygen in Use sign in a designated place on or over the resident's bed. 5. Label the oxygen tubing with the resident's name and the date administered. Oxygen tubing, bottles and masks are labeled and changes every week on Sunday night shift.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observations, interviews and review of records the facility failed to follow policy on accounting controlled or narcotic medications for residents on the 2nd floor. These failures have the potential to affect 2 residents (R121 and R133) and an unknown resident on inaccurate accounting of controlled or narcotic medication.Findings include: On 12/09/2025 at 09:41 AM, V13 (Licensed Practical Nurse) was reviewing all controlled or narcotic medications inside medication cart. Inside the binder there was a controlled substance record sheet without resident name for Lorazepam - Intensol with instruction to take 0.25 ML (0.5 MG) by mouth or under tongue every 4 hours as needed (PRN). V13 cannot specify to which resident narcotic medication belongs. V13 stated that it may be inside medication room in the refrigerator. V13 went inside the medication room, open refrigerator where a box with R37's name labelled for Haldol/Ativan (Lorazepam). V13 opened the box and there was no Ativan (Lorazepam) medication. V13 cannot find narcotic medication anywhere, said that she did not account Lorazepam medication during change of shift review with the night nurse. On 12/09/2025 at 10:07 AM, V14 (Registered Nurse) was reviewing all controlled or narcotic medications inside medication cart. Per R121's Controlled Substance sheet, R121 has four (4) vials of Lorazepam 2 ML/ML. V14 went inside the medication room, opened refrigerator where a plastic bag with R121's name. After opening the plastic bag there were 4 (four) vials of Lorazepam 2 ML/ML. V14 saw another plastic bag with R121's name. After opening the bag, another 4 vials of Lorazepam 2 ML/ML were seen with Controlled Substance sheet folded inside. V14 stated that the other 4 vials of Lorazepam 2 ML/ML were not accounted and included in the counting during change of shift. V14 stated that it should be the receiving nurse that needs to fill up information to include in the binder to be accounted during change of shift. On 12/09/2025 at 10:35 AM, V7 (Registered Nurse) reviewing all controlled or narcotic medications inside medication cart. Per R133's Controlled Substance sheet for Lorazepam 0.5 MG tablet, it documents that R133 has twenty-eight (28) remaining tablets. After checking the actual bingo cards there were eighty-eight (88) remaining tablets. V7 recorded from eighty-nine (89) tablets to twenty-eight (28) tablets after documenting that 1 tablet was administered. V7 stated that she made a mistake, and all narcotic medication needs to be accounted. Since sixty (60) tablets were not recorded those narcotic medication will not be included in the counting during change of shift. On 12/11/2025 at 08:59 AM, V2 (Director of Nursing) stated that accounting of controlled or narcotic medication needs to be verify by nurse that narcotic medication is intact. The nurse sign and put the amount received. There supposed to be amount of narcotic medication, date when narcotic medicine was received and signature of the nurse that received narcotic medication. All narcotic medications need to be accounted by following proper procedure or else nurses can miss the counting and cannot account for the narcotic medication. Controlled Substances Policy dated December 2024: The facility shall comply with all laws, regulations, and other requirements related to handling, storage, disposal, and documentation of controlled substances. Controlled substances must be counted upon delivery. The nurse receiving the medication, along with person delivering the medication, must count the controlled substances together. Both individuals must sign the designated control substance record. If the count is correct, an individual resident controlled substance record must be made for each resident who will be receiving a controlled substance. This record must contain:A. Name of resident;B. Name and strength of medication;C. Quantity received;D. Number on hand;E. Number of physician;F. Prescription number;G. Name of issuing pharmacy;H. Date and time received;I. Time of administration;J. Method of administration;K. Signature of person receiving medication; andL. Signature of nurse administering medication. Nursing staff must count controlled medications at the end of the shift. The nurse coming on duty and the nurse going off duty must make the count together. They must document and report any discrepancies to the Director of Nursing Services.

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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** Based on observations, interviews and review of records the facility failed to maintain medication storage free from expired and/or discontinued medications for 1 out of 4 medication carts and 1 out of 2 medication rooms. These failures have the risk that can affect two (2) residents (R38 and R121) on receiving medication that are either expired and/or discontinued.Findings include: On [DATE] at 09:41 AM, with (V13) Licensed Practical Nurse, surveyor observed inside medication cart R38's eye drop (Latanoprost 0.005 %) labeled opened on [DATE]. V13 stated that she does not know when it will expire. V13 said, I am not sure when it will expire, months may be. Facility submitted instruction from pharmacy that reads: Xalatan Ophthalmic Solution (latanoprost) date when opened and discard after 6 weeks. Six (6) weeks from [DATE] opening of eye drop will be [DATE]. Per pharmacy instruction, eye drop needs to be discarded on [DATE]. On [DATE] at 10:07 AM, V14 (Registered Nurse) was reviewing all controlled or narcotic medications inside medication cart. Per R121's Controlled Substance sheet, R121 has four (4) vials of Lorazepam 2 ML/ML. V14 went inside the medication room, open refrigerator where a plastic bag with R121's name. After opening the plastic bag there were 4 (four) vials of Lorazepam 2 ML/ML. V14 saw another plastic bag with R121's name. After opening the bag, another 4 vials of Lorazepam 2 ML/ML were seen with Controlled Substance sheet folded inside. Per R121's physician order, Lorazepam 2 ML/ML was already discontinued on [DATE]. On [DATE] at 08:59 AM, V2 (Director of Nursing) stated that nurses are supposed to give all expired and discontinued medication to her. Medications that are expired or discontinued have the risk of being given or administered even if medication are already expired or discontinued. Storage and Labeling of Medications dated 2001: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interviews and record reviews, the facility failed to follow their Vaccination of Resident Policy. Failed to administer three [R23, R46, R113] residents their Covid Vaccine after consenting for the vaccine reviewed in a sample of 26. Findings includeReviewed the facility's immunization report provided by V27 [Infection Control Preventionist]. Noted R23, R46, and R113 consented for the Covid Vaccination, and was not administered per documentation provided.On 12/10/25 at 10:00 AM, R23 stated, I asked for the Covid Vaccine months ago, and I have not received the vaccine.On 12/10/25 at 10:38AM, R46 stated, I want the Covid Vaccine, but they would not give it to me.On 12/10/25 at 1:40 PM, R113 stated, I told the nurse I wanted the Covid Vaccine, but she never gave it to me.On 12/10/25 at 12:30 PM V27 [Infection Control Preventionist] stated, R23 consented to receive the Covid Vaccine on 2/6/25, R46 consented to receive the Covid Vaccine on 4/4/25, and R113 consented to receive the Covid Vaccine on 5/8/25. R23, R46 and R113 did not receive the Covid Vaccine, because I did not set up a in-house vaccine clinic. The Covid Vaccine potentially aid in preventing the disease from having a worsen outcome.On 12/20/25 at 1:50 PM, V2 [Director of Nursing] stated, All residents are offered the Covid Vaccine upon admission and annually. If a resident consent to receive the vaccine, the nurse should call their physician for an order and administer the vaccine timely.If the resident consented for the Covid Vaccine but did not receive the vaccine, it could potentially cause the resident worse symptoms or infection if contracted Covid.Policy document in part:Vaccination of Residents dated 9/2025All residents will be offered vaccines that aid in preventing infectious disease.Certain vaccines such as influenza, pneumococcal vaccines, herpes zoster, hep B or Covid may be administered per resident's request.