STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145813	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Metropolis Rehab & Hcc	2299 Metropolis Street Metropolis, IL 62960

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F 0550 Level of Harm - 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** Based on interview and record review, the facility failed to treat residents with dignity and respect related to timely response to requests for assistance, valuing residents' private space, and refraining from practices that have the potential to feel demeaning or intimidating for 6 (R4, R8, R9, R10, R33 and R37) of 6 residents reviewed for resident rights in the sample of 46. This failure resulted in R8 experiencing feeling vulnerable, belittled, and intimidated and would cause a reasonable person to feel frustration and humiliation when R4 was put to bed without the opportunity to toilet and subsequently was incontinent. Findings Include: 1. R8's admission Record documented an admission date of 05/20/25 and included diagnoses of encounter for other orthopedic aftercare, muscle weakness, type 2 diabetes mellitus, sleep apnea, occlusion and stenosis or unspecified cerebral artery, seizures, diverticulitis of intestine, radiculopathy, and dizziness and giddiness. R8's MDS dated [DATE] documents a BIMS score of 15, indicating R8 is cognitively intact. R8's Care Plan includes a focus area related to activity preferences dated 05/28/25 with a corresponding intervention of: R8 likes doing things with groups of people dated 06/03/25. A facility grievance form dated 09/22/25 – 09/29/25 documents the following: The section for Resident Name has Community Complaint (Social Media) handwritten in and beside Grievance From, two boxes are checked indicating the grievance was from Resident and Family. Beside Name, R8's name is handwritten in, with (V21) shared on social media written to the side of R8's name. The grievance documents it was initiated by V1. Under the section where boxes can be checked to define the issue, all boxes are left blank, even though food issue is an option to be checked. The section for Description documents (Name of V21) - son of (name of R8) shared on social media pictures of food that they were not happy with. The next sections indicate they are to be completed by staff. The section titled Investigation documents: (R8) did not address with staff - she told (V2) that she did not mean for (V21) to post on social media. The section titled Summary/Findings documents food was edible – she is more than welcome to something different such as an alternative. Sausage was overcooked but could have received different sausage or substitution. The section titled Recommendations/Action Taken documents Resident (R8) to ask for substitution if she feels food she is receiving is less desirable or does not like what is being served. The date resolved is listed as: 09/29/25 and Person Notified of Resolution has R8's name written in and documents the notification was In Person. V1 signed the form on 9/29/25. On 09/30/25 at 2:30 PM, R8 stated she never filled out any grievance about the food or anything and she never signed any grievance. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 09/30/25 at 3:25 PM, R8 stated the food has not been good here lately and apparently V21 (Family) posted some pictures of her food (on a social media website). R8 stated she didn't know what V21 was doing, but he can do whatever he wants. R8 said about a week ago, she initially didn't know the reason, but they (staff) came and took her away from her card game and took her into a meeting with a bunch of department heads. R8 stated I think they were trying to intimidate me. R8 said they didn't talk to V21, they didn't have one of them come talk to R8 in her room, it was four of them and her in a meeting she didn't know anything about, and it made her very uncomfortable and it was intimidating. On 10/17/25 at 11:10 AM, R8 stated she has talked to the staff about her food concerns and maybe some other residents. R8 said the other residents were eating the same food and saying the same things about the food not being good. R8 said the staff here had a meeting with her because of voicing her concerns and V21 posting some pictures of her food trays. R8 said she was sitting in the dining room playing cards with R29 and V84 (previous Activities Director) when V54 (Social Services Director/SSD) came and got R8 and said V1 (Administrator) wanted to have a meeting with her. R8 stated they didn't ask her if she could meet when they were done playing cards or say they would like to meet with her at a certain time that day, they just came and got her and took her from the card game to the meeting where three more staff were waiting. R8 said she asked why there were four of them and just her and V1 stated it was because they needed a witness, but R8 questioned why there were three witnesses. R8 said she felt it was intimidating, and she was very uncomfortable being brought into this meeting. R8 stated being taken from an activity and brought into a meeting where there are four staff members and you is intimidating. R8 said if they wanted to talk, why didn't V1 come out to the dining room, or just come down to R8's room? R8 stated one of the first things they brought up was the pictures V21 posted on (name of social media website). R8 stated she told them they could go get her phone from her room, she didn't even think the thing took pictures and she did not have a (name of social media website). R8 stated someone in the meeting pulled up the pictures and showed them to her and asked if V21 was related to her. R8 stated he was, and she didn't care what he did on (social media website), he can do whatever he likes. R8 stated all the pictures they showed her were pictures of some of her actual food trays she was given. R8 stated she did not tell V21 to post the pictures, but she didn't care that he did either. R8 said V21 has been at the facility several times during meals. R8 stated she asked V1 (Administrator) to come and see some of the trays they are brought without the kitchen knowing in advance and to try the food they receive. R8 stated V1 never did come see or try a tray. R8 said V1 told her she can ask for a substitution and R8 told V1 she knows, and has done that before, along with R6, and they have been told several times they can't get it, don't have it, don't have time to get it, or if they do get a substitution, it could take a couple hours to receive it. R8 said she felt like the only reason they had that meeting was because those pictures were posted, and they were upset with R8 because it made them look bad. R8 said she believed they wanted to intimidate her, stating why else would they talk to her like that? On 10/22/25 at 1:43 PM, V55 (Public Relations Coordinator) stated they did have a meeting with R8, and the meeting included herself, V1 (Administrator), V2 (Director of Nursing), and V54 (Social Service Director/SSD). V55 said she was in the meeting representing admissions. V55 stated they felt all departments needed to be represented. V55 said she does not know if any other residents had a meeting and stated the meeting was casual. V55 said she does not know who suggested having the meeting, but it was to see if R8 had any concerns. V55 stated V21's (social media) post was brought up in the meeting. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 10/22/25 at 1:58 PM, V54 (SSD) stated she attended the meeting they had with R8 as they wanted to discuss the unhappiness and concerns R8 had, so she went and got R8 from the dining room where she was playing cards. V54 said R8 was a little hesitant when she went to get her for the meeting. At the beginning of the meeting, they went around and introduced everyone to R8. V54 said R8 did not have a family member there as R8's BIMS score is 15. V54 stated she was there to represent R8. V54 stated they did not have any meetings with any other residents and acknowledged there were other residents with dietary concerns. V54 said the meeting was not only because of V21's (social media) post, R8 wasn't happy with the meals, had specific concerns, and R8 was vocal. V54 said they did tell R8 they would put referrals out to other facilities for her if she chose for them to do that and R8 told them she would wait for after her doctor's appointment to decide. V54 stated she could see where that meeting could have felt intimidating to R8. V54 said R8 wondered why there was four people in the meeting and did ask about that at the beginning of the meeting. V54 stated it was brought up in the facility's morning meeting to have a meeting with R8, but there was never a specific date. V54 stated she was not sure why R8 did not have a family member with her in the meeting or why one was not invited. V54 stated she does not remember who brought up having the meeting with R8. On 10/22/25 at 2:12 PM, V2 (DON) stated they did have a meeting with R8, and herself, V1, V55, and V54 were present. V2 said V1 asked her to set up the meeting with R8 and said it was to see if there was anything they could do to make R8 happier. V2 stated originally, V2 did not realize she was intended to be part of the meeting. V2 stated she did not say much during the meeting. V2 stated R8 did say she did not like to be talked to by a lot of people at once. V2 said V21's (social media) posts were brought up in the meeting. V2 confirmed that R8 wanted V1 to come down to her room and look at one of her food trays without the kitchen staff knowing in advance. V2 stated she doesn't think the intention of the meeting was to intimidate R8, but she could see where it could be intimidating. V2 stated she is not sure why they only had a meeting with R8 and no other residents when other residents had dietary concerns at the time. V2 stated they had never discussed holding a similar meeting like a care meeting and inviting a family member to be present. On 10/22/25 at 2:28 PM, V1 (Administrator) stated the facility had a meeting with R8 because R8 had concerns with the food. They wanted to let R8 know there were other options out there for her to eat, they had substitutions R8 could ask for. V1 stated herself V55, V2, and V54 were present in the meeting with R8. V1 stated there were four department heads in the meeting so R8 could address any concerns she might have had. V1 stated they did not ask R8 if she wanted a family member in the meeting due to it being a last-minute meeting. V1 stated she could see where it could be intimidating being brought into a meeting last minute with four of the department heads without knowing what it was about, but that was not the intention. V1 stated they did not have a meeting with any other residents. V1 said they only had the meeting with R8 as she was the one talking loudly to other residents and staff about the concerns she had. V1 stated the meeting had nothing to do with the posts on V21's (social media) page. However, the (social media) post was part of the concern. R8 had been talking about the food, saying she was not going to eat it, and they were concerned. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 09/30/25 at 6:05 PM, V21 (Family) stated he did take pictures of R8's food and post them to his (social media) page and doesn't know why he would not be allowed to do that. V21 stated V1 never said anything to him about any of the pictures he posted. V21 stated R8 called him and told him about the meeting facility staff had with her. V21 stated he does not think that is right as R8 was uncomfortable and felt intimidated in that meeting. V21 said R8 was upset about it when she called him. V21 said if they had a problem with the pictures, they should have talked to him about them because he is at the facility regularly but instead, they try to intimidate R8. V21 stated, how would that not be the intention by pulling one resident from playing cards and bringing one resident into a meeting with four of them? The undated facility policy titled, Resident Rights documents: Employees shall treat all residents with kindness, respect, and dignity. Residents are entitled to exercise their rights and privileges to the fullest extent possible. Our facility will make every effort to assist each resident in exercising his or her rights to assure that the resident is always treated with respect, kindness, and dignity. The section titled, resident rights documents: federal code section 483.10 focuses on ways that the rights, dignity, and privacy of long-term care residents are maintained. There are many specific regulations that our facility must follow. In addition to federal requirements, there are also state regulations that we must follow. 2. R4's admission Record with a print date of 10/01/25 documents an admission date of 7/14/21 and included diagnoses of pressure ulcer, acute kidney failure, dementia, osteoporosis, chronic kidney disease, hypertension, glaucoma, muscle weakness, and reduced mobility. R4's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 03, indicating R4 has severe cognitive impairment. This same MDS documented R4 is dependent on staff for toileting hygiene and requires substantial/maximal assistance for transfers. R4's current Care Plan documents a Focus area of (R4) has bladder incontinence with a date initiated of 01/22/2025. Corresponding interventions initiated on 1/22/25 included Brief Use: the resident uses disposable briefs; Encourage fluids during the day to promote prompted voiding responses; Incontinent: Check the resident as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes; Monitor/document for s/sx (signs/symptoms) UTI (urinary tract infection). R4's Care Plan also documented a Focus area of (R4) has an ADL (activities of daily living) Self Care Performance Deficit Impaired Balance with a date initiated of 01/22/2025. Corresponding interventions initiated on 1/22/25 included Toilet Use: The resident requires 1 staff participation to use toilet; Transfer: The resident requires 1 staff participation with transfers. On 10/20/25 at 12:28 PM, V7 (Caregiver) stated she sits with R4 from 7 AM to 1 PM and from 5PM to 7 PM. R4 was sleeping in her chair at the time this interview started. R4 woke up during the interview and stated she didn't get to go to the bathroom before she went to bed on 10/19/25. R4 stated the CNA (Certified Nursing Assistant) told her to just go to bed because she couldn't take her to the bathroom by herself and there wasn't anyone else to help. R4 stated the CNA didn't even try to take her to the bathroom. V7 stated R4 was soaking wet this morning (referring to 10/20/25). V7 stated R4's clothes were drenched up her back and her whole bed was wet. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 10/20/25 at 12:57 PM, V14 (CNA) stated she worked as a CNA and provided care to R4 on the morning of 10/20/25. V14 stated she arrived to work at 6 AM on 10/20/25 and R4 was in bed and dry when she checked her a little after 6 AM. V14 stated she did not get R4 out of bed that morning and she wasn't sure who did. On 10/20/25 at 2:21 PM, V65 (CNA) stated she worked night shift beginning on 10/19/25 and ending on the morning of 10/20/25. V65 stated she was R4's CNA from 6 PM to 10 PM and was the CNA who assisted R4 to bed. V65 stated she told R4 they didn't have staff to take her to the bathroom before going to bed. V65 stated her partner was on break and she couldn't find anyone else to assist her and it takes two staff to take R4 to the bathroom. V65 stated she told R4 she could wait about thirty minutes, but R4 wanted to go to bed. V65 stated she thought this occurred around 6 PM on the evening of 10/19/25. V65 said they had seven CNA's working at the time (from 6 PM to 10 PM), explaining there were 2 CNA's per hall except for the rehab hall, which had one CNA. V65 stated R4 is normally incontinent but had recently started wanting to use the toilet. V65 stated if R4 wants to go to the toilet and they have the staff available to assist her, V65 will take her to the toilet. V65 stated R4 was not a resident she was responsible for doing bed checks on from 10 PM to 6 AM as the staffing level changed to three CNA's during that time, with a fourth CNA who was orientating. V65 stated she was not the CNA who assisted R4 up on the morning of 10/20/25 prior to leaving the facility for the day. On 10/22/25 at 1:36 PM, V7 (Caregiver) stated when she got to the facility on the morning of 10/20/25, R4 was sitting in her chair with a blanket over her wearing her pajama top and an incontinence brief. V7 stated R4's incontinence brief and pajama top were both wet. V7 stated she found R4's pajama bottoms in the dirty clothes inside out and saturated with urine. V7 stated the bottoms were so wet she had to put them in a plastic bag. V7 stated R4 told V7 she needed to change her bed, and V7 told R4 the bed was already made. V7 stated R4 told her the bed was wet, so V7 pulled the covers back on the made bed and the sheet and bed pad were both visibly saturated with urine. V7 stated she didn't report it to anyone because she used to report incidents that occurred, but it never did any good. V7 stated when there is only one staff on the hall, she expects the care will be lacking because it is hard for the staff to keep up. V7 stated she is just glad she is there to assist R4 but feels for the other residents on the hall who don't have a (private) care giver. On 10/21/25 at 2:38 PM, this surveyor spoke to V2 (Director of Nurses/DON) regarding R4 not being toileted prior to bed on 10/19/25 and her clothes and bed being saturated on the morning of 10/20/25. V2 stated that was unacceptable and she expected the licensed nurses to assist the CNA's with providing care to the residents when needed. 3. R9's admission Record with a print date of 10/07/25 documented an admission date of 3/26/25 and included diagnoses of end stage renal disease, absence of right leg above the knee, osteomyelitis, heart failure, and muscle weakness. R9's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R9 is cognitively intact. This same MDS documents R9 requires substantial/maximal assistance of staff for toileting. R9's current Care Plan documents a Focus area of, (R9) has an ADL (activities of daily living) Self Care Performance Deficit Fatigue. Date Initiated: 03/30/2025. This Focus area includes the following intervention, Toilet Use: the resident requires 1 staff participation to use toilet. Date Initiated: 03/30/2025. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	A facility Grievance Form dated 8/6/25 documents R9 filed a grievance related to an issue of Nursing Care. Under Description the form documents, Call light is not getting answered in a timely manner. Under Investigation the form documents, Call light audit done 8-4-25 - 8-8-25. Nursing met with resident and addressed concerns. Resident states he understands during certain times it takes longer to answer and he appreciates everything the staff does. Under Recommendations/Action Taken the form documents, Staff educated to continue answering call lights as promptly as possible. On 10/23/25 at 12:30 PM, R9 stated if the regular staff is working his call light gets answered timely. R9 stated some agency staff are ok, some are not. R9 stated it has taken up to an hour and ten minutes. R9 stated two nights ago he had to sit in feces and wait for assistance. 4. R10's admission Record with a print date of 10/22/25 documented an admission date of 5/22/25 and included diagnoses of diabetes, anemia, heart failure, muscle weakness, reduced mobility, and atrial fibrillation. R10's MDS dated [DATE] documents a BIMS score of 11, which indicates a moderate cognitive deficit. This same MDS documents R10 is dependent on staff for toileting. R10's current Care Plan documents a Focus area of, (R10) has bladder incontinence. Date Initiated: 07/15/2025. This Focus area includes an intervention of, Brief Use: the resident uses (Size) disposable briefs. Check & (and) change Q2 (every 2 hours) and prn (as needed). On 10/15/25 at 6:20 PM, R10 stated it takes a long time for them to answer the call lights, and she's had incontinent episodes while waiting for staff to assist her. 5. R37's admission Record with a print date of 10/22/25 documented an admission date of 7/7/22 and included diagnoses of osteoarthritis, hypertension, atrial fibrillation, pain, muscle weakness, and reduced mobility. R37's MDS dated [DATE] documents a BIMS score of 10, indicating R37 has a moderate cognitive deficit. R37's current Care Plan documents a Focus area of, (R37) has frequent bladder incontinence. Date Initiated: 09/25/2024. This Focus area included an intervention of, Incontinent: Check the resident Q2 (every 2 hours) and as required for incontinence. Date Initiated: 09/25/2024. On 10/15/25 at 6:18 PM, R37 stated they don't usually have enough staff to meet her needs timely. R37 stated it can take up to two hours for them to answer the call lights. R37 stated she's had incontinent episodes while waiting for staff to assist her. On 10/16/25 at 2:56 PM, V51 (Certified Nurse Aide/CNA) stated they sometimes have enough staff to meet the needs of the residents timely but most of the time they are really short staffed. V51 stated he works the 2-10 pm shift, and they are supposed to have two CNA's on the main halls and one CNA on the rehabilitation hall. V51 stated sometimes they only have one on each hall. V51 stated sometimes people have incontinence episodes because they can't assist them as quickly. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 10/20/25 at 11:44 AM, V62 (CNA) stated she works night shift 10 pm to 6 am. V62 stated they have 70-80 residents and work with only three CNA's on night shift. V62 stated, I am not able to provide quality care. V62 stated on 10/19/25 she was responsible for 26 residents, seven of them required two staff to assist them and 21 required assistance with incontinence care. When asked if there was any negative outcome related to staffing, V62 stated residents have incontinence episodes because they have to wait on us, they have had to sit in urine/feces longer than they should. On 10/20/25 at 12:54 PM, V32 (Licensed Practical Nurse/LPN) stated he didn't feel like one CNA on each hall was enough to meet the needs of the residents timely. V32 stated two CNA's for each hall is more effective. V32 stated with one CNA per hall, residents have to wait a long time and have incontinent episodes. On 10/21/25 at 2:01 PM, V13 (CNA) stated they don't always have enough staff to meet the needs of the residents. V13 stated when there are call in's they don't really try to get anyone to help. V13 stated residents have incontinent episodes due to how long it takes them to answer the call light. On 10/30/25 at 2:48 PM, V2 (Director of Nurses/DON) stated she expected call lights to be answered as soon as possible. The facility was unable to provide this surveyor with a policy regarding call lights. 6. R33's admission Record dated 10/22/25 documented an admission date of 10/22/20 and included diagnoses of vascular dementia, chronic kidney disease, dysphagia, psychosis, and cognitive communication deficit. R33's Care Plan documented a focus area of R33 has impaired cognitive function/dementia or impaired thought processes dated 10/22/20. One of the interventions listed is to break tasks into small sub tasks to support short term memory deficits. Another focus area on R33's care plan documents R33 is at risk for burns from hot liquids dated 4/4/24. R33's MDS dated [DATE] documented a BIMS score of 11, indicating R33 is moderate cognitive impairment. On 10/20/25 at 9:35 AM, R33 stated CNA staff often put their energy drinks in his room while they are working. R33 stated he doesn't like it because he's worried the drinks will spill on his clothes. R33 named V47, and V48 (both CNA's) as staff who put their personal drinks in his room. On 10/20/25 at approximately 10:00 AM, V17 (CAN) stated other CNA staff put their personal drinks or their personal bags on the top shelf of a resident's closet. V17 stated she had witnessed V47 put personal items in a resident's room. V17 stated it was R33's room. V17 showed this surveyor the closet in R33's room where she had witnessed V47 put her personal belongings. At this time of observation there were no other belongings in R33's closet besides his own. On 10/22/25 at 11:33 AM, V48 (CNA) stated she does keep her personal drink and lunch bag in the closet of R33's room. V48 stated she has asked R33 in the past if he minds if she puts her personal things in his closet and R33 reportedly told her it was fine. V48 stated there is a break room where staff may place their personal belongings. (continued on next page)

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F 0550 Level of Harm - Actual harm Residents Affected - Few	On 10/22/25 at 11:45 AM, V47 (CNA) stated she does store her personal drink and lunch box in the top of R33's closet in his room. V47 stated the staff do have a break room where they can store their personal belongings but stated if a staff leaves it in there someone will mess with your lunch or even eat it. V47 referenced R33's room as where she usually keeps her drink and lunch bag stored while on shift. V47 stated she has asked R33 in the past if he minds if she stores her personal items in his room, and he had reportedly told her he doesn't mind. On 10/22/25 at 12:07 PM, R33 stated he did not remember giving permission to any staff member to store their personal items in his room or closet. R33 stated he does not want them to because he is worried it will spill on his clothes. On 10/22/25 at 12:13 PM, V2 (DON) stated the staff have lockers in the break room they can put their drinks and lunch bags in. They are welcome to bring their own locks to use if they are concerned about theft. V2 stated the facility also has a refrigerator in the lunchroom for lunch boxes. V2 stated she would not expect staff members to store their personal items in a resident's closet. V2 stated she did not consider it appropriate for staff to store their personal items in resident's closets or rooms. On 10/22/25 at 12:29 PM, V1 (Administrator) stated she would expect staff members to store their personal belongings in the locker rooms or in the break room. V1 stated she would not expect for staff to store their personal items in a resident's closet. V1 stated she does not believe it is right for staff members to store their personal items in a resident's room. On 10/22/25 at 12:45 PM, the men's and women's locker rooms were observed to have lockers for use by staff members that could be locked. The facility's undated Residents' Rights policy documents a resident has the right to make personal decisions, right to privacy, and the right to be treated with consideration, respect, and dignity. The Ombudsman's Residents' Rights pamphlet with a revised date of 11/18 documents the resident has a general right to privacy and confidentiality. The pamphlet states a resident has a right to keep and use their own property.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide needed incontinence supplies for 3 of 4 (R1, R7, R38) incontinent, dependent residents reviewed for supplies in the sample of 46.Findings include: 1.R7's admission Record dated 10/7/25 documents an admission date of 7/10/24. Same face sheet documents the following diagnosis including but not limited to muscle weakness, unsteadiness on feet, other reduced mobility.R7's care plan dated 10/7/25 documents a focus area stating R7 has bladder incontinence dated revised 9/22/25. Interventions for this focus area include but are not limited to R7 uses disposable briefs dated revised 7/10/24; check R7 every two hours and as required for incontinence; wash, rinse, and dry perineum and change clothing as needed after incontinence episodes dated 7/10/24. Another focus area from same care plan documents R7 has bowel incontinence dated revised 7/10/24. Interventions for this focus area include but are not limited to check resident every two hours and assist with toileting as needed dated 7/10/24; and provide peri care after each incontinent episode dated 7/10/24.R7's minimum data set (MDS) dated [DATE] documents R7 has a brief interview for mental status (BIMS) of 15 indicating R7 is cognitively intact. Same MDS documents R7 is completely dependent upon staff for toileting hygiene. Same MDS documents R7 is always incontinent of bowel and bladder.On 10/15/25 at 10:35 A.M., R7 stated facility staff told her towards the first of the month of October the facility had run out of her size of incontinence briefs. R7 stated the facility staff would use a smaller size on her. R7 stated they did work, but they were somewhat uncomfortable compared to wearing the correct size. R7 stated she would prefer to wear the correct size.2. On 10/22/25 at 2:55 PM, V73 (R1 and R38's Family Member) stated there have been times she has asked for washcloths and the Certified Nursing Assistants (CNA) have stated they do not have any, they are in the laundry or something.R1's admission Record with a print date of 10/23/25 documents R1 was admitted to the facility on [DATE] with diagnoses that include neurocognitive disorder with Lewy bodies, altered mental status, abnormal posture, muscle weakness, and unspecified psychosis.R1's MDS dated [DATE] documents a BIMS score of 00, indicating R1 has a severe cognitive deficit. This same MDS documents R1 is dependent on staff for toileting hygiene and requires substantial/maximal assistance for toilet transfer.R1's current Care Plan documents a Focus area of, (R1) has bladder incontinence. Has dx (diagnosis) of BPH (benign prostatic hyperplasia). Date Initiated: 09/30/2021. This Focus area includes the following interventions, Brief Use: Us (sic) adult incontinent briefs when up for dignity reasons. Date Initiated: 09/30/2021. Incontinent: Check approximately every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes. Date Initiated: 09/30/2021. Offer and assist (R1) to toilet. Date Initiated: 09/30/2021. This same Care Plan documents a Focus Area of (R1) has bowel incontinence Date Initiated: 07/08/2024. This Focus Area includes interventions of, Provide loose fitting, easy to remove clothing. Date Initiated: 07/08/2024. Provide pericare after each incontinent episode. Date Initiated: 07/08/2024.R38's admission Record with a print date of 10/23/25 documents R38 was admitted to the facility on [DATE] with diagnoses that include syncope and collapse, dementia, heart disease, atrial fibrillation, unsteadiness on feet, and repeated falls.R38's MDS dated [DATE] documents a BIMS score of 07, indicating a severe cognitive deficit. This same MDS documents R38 requires substantial/maximal assistance for toilet hygiene.R38's current Care Plan documents a Focus area of, (R38) has bladder incontinence. Date Initiated: 04/25/2025. This Focus area includes the following interventions, Brief Use: the residents use disposable briefs. Date Initiated: 04/25/2025. Incontinent: Check the resident Q2 (every 2 hours) and as required for incontinence.Date Initiated: 04/25/2025.On 09/30/25 at 11:40 AM, V10 (Certified Nurse Aide/CNA) stated they ran out of supplies last week. V10 stated they didn't have wipes for incontinence care, so they were told to use wash cloths. V10 stated then laundry couldn't keep up with washing the washcloths. V10 stated then they ran out of briefs. V10 stated they only had size small in briefs to use.On 10/15/25 at 1:00 P.M., V17, CNA stated they ran out of incontinence care wipes. V17 stated she reported it to V2, Director of Nurses (DON).On 10/15/25 at 1:11P.M., V31, CNA stated one week they were out of two different sizes of incontinence briefs.On 10/15/25 at 1:34 P.M., V30, Licensed Practical Nurse (LPN) stated there's been a couple days where the facility was out of a few different sizes of incontinence briefs. V30 stated when it happened the staff would use the next most appropriate size.On 10/15/25 at 1:40 P.M., V28 (CNA) stated they ran out of double extra-large and extra-large briefs. V28 stated when they run out they use the next most appropriate size.On 10/15/25 at

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to keep residents warm after showering and failed to provide nail care upon request for 6 of 7 residents (R3, R4, R6, R10, R25, R38) reviewed for self-determination in the sample of 46. Findings include:On 10/22/25 at 9:20 AM both shower rooms located on the 300 Hall were observed to contain split unit heating sources, each unit in each room has a note attached to the units stating, do not change thermostat - Administration.On 10/22/25 at 9:20 AM the temperature of the shower room on the right side of the hall was measured with an infrared thermometer gun on the 3 walls not including the wall the heating unit was located on. The temperatures measured 71.2 degrees Fahrenheit (F). The shower room on the left side of the hall was measured with an infrared thermometer gun on the 3 walls not including the wall the heating unit was located on. The temperatures measured 71.0 degrees F. Neither heating unit displayed a room temperature. On 10/22/25 at 1:40 PM the temperature of the shower room on the right side of the hall was measured with an infrared thermometer gun on the 3 walls not including the wall the heating unit was located on. The temperatures measured 71.1 degrees F. The shower room on the left side of the hall was measured with an infrared thermometer gun on the 3 walls not including the wall the heating unit was located on. The temperatures measured 71.1 degrees F. Neither heating unit displayed a room temperature.On 10/23/25 at 8:40 AM the temperature of the shower room on the right side of the hall was measured with an infrared thermometer gun on the 3 walls not including the wall the heating unit was located on. The temperatures measured 71.2degrees F. The shower room on the left side of the hall was measured with an infrared thermometer gun on the 3 walls not including the wall the heating unit was located on. The temperatures measured 71.1 degrees F. Neither heating unit displayed a room temperature.On 10/23/25 at 2:35 PM the temperature of the shower room on the right side of the hall was measured with an infrared thermometer gun on the 3 walls not including the wall the heating unit was located on. The temperatures measured 71.0 degrees F. The shower room on the left side of the hall was measured with an infrared thermometer gun on the 3 walls not including the wall the heating unit was located on. The temperatures measured 71.0 degrees F. Neither heating unit displayed a room temperature.1. R4's admission Record documents an admission date of 7/14/21 with diagnoses including: encephalopathy, pressure ulcer of sacral region stage 4, dysphagia, metabolic encephalopathy, acute kidney failure, hypercalcemia, dementia, restless legs syndrome, polyneuropathy, diaphragmatic hernia without obstruction or gangrene, osteoarthritis, are related osteoporosis, chronic kidney disease, edema, hypertension, glaucoma, gastro-esophageal reflux disease, diverticulosis of intestine, muscle weakness, cognitive communication deficit, weakness, anorexia, reduced mobility, and unspecified severe protein calorie malnutrition.R4's care plan documents a focus area of: care/ADL (activities of daily living) preferences dated 01/23/25 documenting: (R4) prefers to have her room at a warmer temperature dated 01/23/25. R4's care plan documents a focus area of: (R4) has an ADL self care performance deficit impaired balance dated 01/22/25 with an intervention of: bathing: the resident requires one staff participation with bathing dated 02/25/25.R4's MDS dated [DATE] documents a BIMS score of 03 indicating R4 is severely cognitively impaired.On 09/29/25 at 10:04 AM, V7 (Family Assistant) stated, R4 is alert and can answer questions, she is just hard of hearing, so you have to make sure she can hear you properly.On 09/29/25 at 10:05 AM, R4 who was alert to person, place and time stated, a week or so ago she got a cold shower at 9:00 PM at night. R4 stated, it was her last shower that was cold. R4 stated, they got soap in her eyes, the soar on her bottom was bleeding and it hurt. R4 stated, they did not dry her hair and she was cold going down the hall because she had no clothes on and was only covered by a towel and her hair was dripping. R4 stated, she was yelling and screaming because she was cold and the sore hurt. R4 stated, they treated her awful. R4 stated, they told her to shut up and quit yelling and they were going to take her call light away. R4 stated, her feet were cold. R4 stated, she felt like she was getting punished. R4 stated, she should not be treated like that. R4 stated, she does not typically get her shower that late, she is in bed by then. R4 stated, what they did should be abuse.On 09/29/25 at 10:18 AM, V7 (Family Assistant) stated, R4 has told her in the last month or so that she was given cold showers. V7 stated she believes it was last Friday or so that R4 received the last cold shower. V7 stated that R4 was given a shower in the evening, and they did not dry her hair or anything and R4 was cold all night. V7 stated, this is not the first time she and R4 have told them about R4 being cold because of the showers and the shower room being cold. On 09/30/25 at 12:05 PM, when R4 was again

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F 0584 Level of Harm - Potential for minimal harm Residents Affected - Many	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 observation, interview and record review, the facility failed to maintain floors in a clean and sanitary manner. This has the potential to affect all 74 residents living in the facility.Findings include:The facility Resident Matrix dated 10/15/25 documents 74 residents reside at the facility.On 10/15/25 at 9:09 A.M. , noted dried, dark colored spills the length of hall floors of 100 and 200 halls with a concentrated area of dark, dried spills near the nurses' station and a few clear liquid spills not yet dried on floors. There are also noted scattered bits of what appear to be torn paper, toilet paper and possibly what appears to be food particles on 100 and 200 halls. On 10/15/25 at 3:39 P.M., the same dark colored, dried spills noted on the floor of 100 and 200 halls near the nurse's station at the beginning of the hallway. The floors have not been cleaned yet. On 10/16/25 at 8:45 A.M., on 100 hall there are the same dried, dark spills of an unknown substance noted near the nurse's station that was first noted yesterday morning at 9:09 A.M.A resident grievance form dated 9/11/25 on behalf of R3 complaining of dirty floors in R3's room.On 10/15/25 at 9:31 A. M., V22 (Family Member) stated the dining room floors have been very dirty over the past couple of months when she comes to visit her family member who is a resident at the facility. V22 stated it is not only immediately after a meal she notices the dirty floors in the large dining room. V22 states the housekeeping staff had plenty of time to clean the floors of the dining room. V22 described the dirtiness of the dining room floor being in the form of sticky substances on the floor and unidentified, dried spills on the floor. V22 stated she has also noticed the floor around the nurse's station of 100 hall is frequently sticky and it appears not to have been cleaned recently either.On 10/15/25 at 2:14P.M., V26 (Housekeeping Supervisor) stated the facility was down about two housekeepers about one to two weeks ago causing them to be short of staff. V26 stated the hallway floors and other common area floors were being neglected due to short staffing. V26 stated during this time the common area floors like hallways were being cleaned every other day instead of daily which was the normal expectation.On 10/15/25 at 3:37 P.M., V80 (Regional Director of Operations) stated the facility's floor cleaning machine has been down for a while, and the facility has not been able to clean the floors as thoroughly as needed, V80 stated the facility has ordered a new floor cleaning machine and it should be here next week sometime.On 10/15/25 at 3:50 P.M., V81 (District Manager) for housekeeping services company contracted for facility stated between the middle to end of September the facility lost a housekeeping and laundry staff causing the routine cleaning to fall behind.On 10/22/25 at 9:47A. M., V17 (Certified Nurses' Aide/CNA) stated the hallway floors have been dirtier over the past one to two months than when she first started working here. V17 believed the reason for the floors not being as clean as they had been in the past was because the facility was short on housekeeping staff.On 10/22/25 at 11:33 A. M., V48 (CNA) stated the hallway floors have recently been dirtier than in the past. V48 stated the facility has been short on housekeeping staff in the past one to two months.On 10/22/25 at 9:49 A.M., V50 (Housekeeper) stated over the last one to two months the hallway floors were not being cleaned as frequently as they had in the past because some housekeeping staff had quit, and the remainder of the housekeeping staff were trying to focus on some of the more important areas like resident bathrooms, resident rooms, and shower rooms.On 10/22/25 at 9:55 A.M., V1 (Administrator) stated the hallway floors have not been cleaned as frequently as needed over the past one to two months and have been dirtier than in the past due to being short on housekeeping staff. V1 stated there is no housekeeping policy for the facility. Review of facility's written housekeeping routes A, B, C, and D indicate all floors should be swept and mopped daily.

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F 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure residents were free from staff abuse for 2 of 3 residents (R6 and R19) reviewed for abuse in the sample of 46. This failure resulted in R19 being spat in the face by a staff member which would cause a reasonable person to experience feelings of humiliation, anger and fear and resulted in staff verbally abusing R6 causing R6 to be visibility upset and fearful.Findings Include:1. The facility Final Reportable for R19 dated 10/02/25 documents under Complete Description of Occurrence: Initial Report: Initial: Abuse Coordinator was notified on 10/2/2025 at around 10:30pm about an alleged incident that took place between a staff member and resident, (R19). Staff were immediately suspended. Police, Family Representative and Physician were notified. Immediate investigation was initiated. Final: A thorough investigation was conducted between October 2, 2025, and October 8, 2025. Interview Statements: Resident, (R19) was unable to state what happened: (R19) has a BIM score of 7. (V65), C.N.A. (Certified Nursing Assistant) - (R19) was at the nurse's station on front hall where she was reaching and feeling for things (d/t (due to) her blindness and hard of hearing) She proceeded to grab (V56), LPN's (Licensed Practical Nurse) lunch bag. (V56) told (R19) to stop reaching for things and to stop yelling because she was disturbing other residents. (R19) continued behavior, (V56) then grabbed her hands and told her to Stop! (R19) then grabbed (V56) hands and started to pull and bend her fingers. (V56) claimed that (R19) hurt her left thumb. (R19) started shouting, stop touching me, leave me alone. (R19) was near (V56) face during the shouting. (V56) then leaned into (R19) face and yelled, How do you like it? (R19) then said she needed to go to the sink and spit. (V56) told her, Swallow it. (R19) replied, I'll spit on you. (V56) replied, if you spit on me, I will spit on you. (R19) replied, no you won't. (R19), spit on (V56)! (V56) in turn spit on (R19). (V56) placed (R19) in the large dining room to roam around. I then brought (R19) to the T.V. (television) room o 200 halls. (V56) asked if I would vouch for her, if she were to deny the claims made against her. I replied to (V56), You did spit on her, we saw you. (V56) became upset and went outside to smoke. Incident Analysis: Based on the consistent accounts of the staff interview statements, the incident of resident abuse was substantiated. Correction actions and Prevention Plan: Based on the investigation, the following actions have been implemented to protect (R19) and all other residents. No change in Psychosocial baseline since incident occurred. Employee, (V56), LPN was immediately suspended at time of incident. Employee, (V56), LPN will be terminated with a Do Not Rehire. Employee, (V56), LPN, all information will be sent to IDFPR (Illinois Department of Professional Regulation). Updated findings will be sent to (name of local police department) . Resolution and Conclusion: the investigation concluded that (V56), LPN, was upset that (R19) spit on her, which in turn she then spit on (R19). All necessary medical and physical assessments were completed. Corrective measures and care plan updates have been put in place. Inservice: Abuse and neglect training provided.R19's admission Record with a print date of 10/22/25 documents R19 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction, encephalopathy, diabetes, legal blindness, lack of coordination, muscle weakness, difficulty in walking, major depressive disorder, and anxiety disorder.R19's MDS (Minimum Data Set) dated 9/2/25 documents a BIMS (Brief Interview for Mental Status) score of 07, indicating a severe cognitive deficit. This surveyor attempted to speak with R19 several times throughout the survey process. R19 did not respond to questions.R19's current Care Plan includes the Focus area, (R19) has a behavior problem 1. (R19) startles easily due to blindness & (and) will strike out at others in response. The interventions for this Focus area include, Behavior #1 Physical aggression: Hitting/yelling at staff and roommate. 1. Offer activities to (R19). 2. Offer to call (R19's) sister.3. Offer to take (R19) to a different area to calm down. Date Initiated: 07/09/2025. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 12/19/2024. Minimize potential for the resident's disruptive behaviors by helping (R19) out of areas that are crowded with a lot of people such as hallways and the dining room. Date Initiated: 12/19/2024.R19's Progress Notes dated 10/03/25 documents the following Telehealth note, Per RN (Registered Nurse), allegedly the patient was yelling at a (sic) one of the nurses, grabbed her hand and threatened to spit on her but the nurse told her not to and then the nurse ing (sic) staff spit on the patient. No other physical altercation happened. Admin (administrator) notified and nursing staff responsible was sent home. There is no other documentation in R19's progress notes related to the incident. On 10/15/25 at 6:24 PM, V40 (CNA/Certified Nursing Assistant) stated she was working the night the

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview, and record review the facility failed to ensure allegations of abuse were reported to the Administrator/Abuse Coordinator for 1 of 3 (R6) residents reviewed for abuse in the sample of 46.Findings Include:R6's admission Record with a print date of 10/01/2025 documents R6 was admitted to the facility 2/6/25 with diagnoses that include acute respiratory failure, heart failure, chronic obstructive pulmonary disease, aortic valve stenosis, dementia, anxiety disorder, major depressive disorder, and cognitive communication deficit.R6's MDS (Minimum Data Set) dated 8/15/25 documents R6 is independent with making consistent/reasonable decisions, with no cognitive impairment documented.R6's current Care Plan was reviewed with no Focus area related to abuse and/or behaviors documented.On 10/15/25 at 10:31 PM, V59 (CNA/Certified Nursing Assistant) stated R6 reported V56 (Licensed Practical Nurse/LPN) told R6 she was ridiculous and yelled in her face. V59 stated R6 was really upset and crying when she reported it to her. V59 stated she told R6 she needed to tell V1 (Administrator) when she came to work the next day. V59 stated she did not report the allegation to V1 since she didn't witness it.On 10/16/25 at 10:16 AM, R6 stated she had issues with V56. R6 stated she was short of breath and scared and V56 didn't help her. R6 stated she wrote down the things V56 said to her during that time. R6 showed this surveyor a piece of paper on her bedside table, and it listed these items with no times or dates listed next to them, choke on that, it's all in your head, you can breathe if you try, you are crazy. R6 stated it happened on a couple of different dates and she reported it to other unknown staff. R6 was visibly upset when speaking to this surveyor regarding V56.On 10/16/25 at 2:56 PM, V51 (CNA) stated R6 reported to her quite a few times (unknown dates), V56 (LPN) told her she was crazy. V51 stated R6 reported V56 was verbally mean to her, and she was afraid of V56. V51 stated she reported the allegation to V1 (Administrator) and V2 (Director of Nurses). On 10/20/25 at 12:09 PM, V2 (Director of Nurses) stated she was unaware of any allegations of verbal abuse regarding V56 and R6.On 10/21/25 at 11:35 AM, V1 (Administrator) stated she wasn't aware of any reports of allegations of V56 being verbally abusive towards R6. V1 stated it should have been reported immediately. V2 (Director of Nurses) who was in this same interview stated she did have staff report R6 was upset with a staff member but when she talked to R6 she told V2 she didn't want anyone to get in trouble.On 10/22/25 at 3:23 PM, this surveyor reviewed the allegation of abuse regarding V56 and R6 with V1 (Administrator) and she stated she had started an investigation and spoke with R6's power of attorney who reported to her R6 had an issue with a nurse telling her she was ridiculous.The Investigation V1 was referring to titled (name of state survey agency) documents under Initial Report: Initial: On 10/21/2025 at around 1:00 p.m., (initials of state survey agency) surveyor reported to Abuse Coordinator (V1) and Director of Nursing (V2) that resident and staff reported that (V56) was verbally abusive towards (R6). Date and time of incident uncertain. Investigation immediately initiated. (V56) has been discharged since 10-2-2025 and (R6) was discharged on 10-17-2025 .The facility Abuse, Prevention and Prohibition Policy dated 03/2025 documents under Investigation: Resident abuse must be reported immediately to the Administrator.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review the facility failed to ensure allegations of abuse were thoroughly investigated for 1 of 3 (R6) residents reviewed for abuse in the sample of 46.Findings Include:R6's admission Record with a print date of 10/01/2025 documents R6 was admitted to the facility 2/6/25 with diagnoses that include acute respiratory failure, heart failure, chronic obstructive pulmonary disease, aortic valve stenosis, dementia, anxiety disorder, major depressive disorder, and cognitive communication deficit.R6's MDS (Minimum Data Set) dated 8/15/25 documents R6 is independent with making consistent/reasonable decisions, with no cognitive impairment documented.R6's current Care Plan was reviewed with no Focus area related to abuse and/or behaviors documented.On 10/15/25 at 10:31 PM, V59 (CNA/Certified Nursing Assistant) stated R6 reported V56 (LPN/Licensed Practical Nurse) told R6 she was ridiculous and yelled in her face. V59 stated R6 was really upset and crying when she reported it to her. V59 stated she told R6 she needed to tell V1 (Administrator) when she came to work the next day. V59 stated she did not report the allegation to V1 since she didn't witness it.On 10/16/25 at 10:16 AM, R6 stated she had issues with V56. R6 stated she was short of breath and scared and V56 didn't help her. R6 stated she wrote down the things V56 said to her during that time. R6 showed this surveyor a piece of paper on her bedside table, and it listed these items with no times or dates listed next to them, choke on that, it's all in your head, you can breathe if you try, you are crazy. R6 stated it happened on a couple of different dates and she reported it to other unknown staff. R6 was visibly upset when speaking to this surveyor regarding V56.On 10/16/25 at 2:56 PM, V51 (CNA) stated R6 reported to her quite a few times (unknown dates), V56 (LPN) told her she was crazy. V51 stated R6 reported V56 was verbally mean to her, and she was afraid of V56. V51 stated she reported the allegation to V1 (Administrator) and V2 (Director of Nurses). On 10/20/25 at 12:09 PM, V2 (Director of Nurses) stated she was unaware of any allegations of verbal abuse regarding V56 and R6.On 10/21/25 at 11:35 AM, V1 (Administrator) stated she wasn't aware of any reports of allegations of V56 being verbally abusive towards R6. V1 stated it should have been reported immediately. V2 (Director of Nurses) who was in this same interview stated she did have staff report R6 was upset with a staff member but when she talked to R6 she told V2 she didn't want anyone to get in trouble.On 10/21/25 at 1:01 PM, V31 (CNA) stated R6 and R8 (roommates) had reported allegations of inappropriate staff behavior to her. V31 stated R6 was crying and told her a nurse was being mean to her, calling her names, and saying awful things. V31 stated she told R6 she could speak with V2 (Director of Nurses). V31 stated she reported the allegations to V2 (Director of Nurses). V31 stated V2 spoke with R6 and R8 and after speaking with them, V2 told V31 since the residents would not give her the name of facility staff member, she could not do anything more about it. V31 stated the residents told her (V31) it was V56, and it was reported to V2, but because R6 and R8 wouldn't tell V2 who it was she was unable to investigate it further. On 10/24/25 at 10:11 AM, R8 who was alert to person, place and time stated, a nurse whose name sounded like V56's was mean to R6. R8 stated V56 would tell R6 she was crazy and ridiculous. R8 stated V56 would tell R6 she was watching her when R6 wasn't aware, and she could breathe just fine. R8 stated she reported this to she believed V32 (LPN) who she thought reported it to administration.On 10/27/25 at 5:10 PM, V32 (LPN) stated he did not remember R6 and/or R8 reporting any allegations to him.On 10/21/25 at 2:38 PM, V2 (Director of Nurses) was asked to tell this surveyor about the time R6 reported a staff member was mean to her. V2 stated she wasn't sure which staff member reported it to her. V2 stated they told her R6 was upset after morning meeting and V1 (Administrator) told her and the Social Services Director (V27) to talk with R6. V2 stated the CNA (who reported it and V2 couldn't remember who it was) told her something was wrong but reported not knowing why R6 was upset. This surveyor reviewed with V2, V31's interview where she stated she reported the allegation and the name of the alleged perpetrator (V56) to V2. V2 stated that was not accurate. V2 stated she was not told who R6 was upset with or what she was upset about. V2 stated R6 told her she didn't want anyone to get in trouble.On 10/22/25 at 1:23 PM, V27 (LPN/SSD) stated she did write a grievance for R6, but she couldn't remember what the details were. When asked if R6 ever reported anything concerning V56, V27 stated that was probably what the grievance was about but R6 would not tell her who the staff member was. V27 stated R6 would never say who it was and didn't report it as abuse just that someone wasn't very nice to her. V27 stated she didn't have information about a CNA reporting the allegation.The facility Grievance Form dated 7/28/25 documents R6 filed a grievance which included a check mark next to Staff Concern. This same form documents under Description: (R6) feels as though staff member had poor customer service with her. There are no specific

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview and record review the facility failed to ensure incontinence care was provided timely and residents who required assistance with showering/bathing received showers for 6 (R1, R4, R5, R7, R22 and R38) of 6 residents reviewed for activities of daily living (ADL's) in the sample of 46.Findings Include:1. R1's admission Record with a print date of 10/23/25 document an admission date of 9/28/21 and included diagnoses of neurocognitive disorder with Lewy bodies, altered mental status, abnormal posture, muscle weakness, and unspecified psychosis. R1's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 00, indicating R1 has a severe cognitive deficit. This same MDS documents R1 is dependent on staff for toileting hygiene and requires substantial/maximal assistance for toilet transfer. R1's current Care Plan documents a Focus area of (R1) has bladder incontinence. Has dx (diagnosis) of BPH (benign prostatic hyperplasia) with a date initiated of 09/30/2021. Corresponding interventions initiated on 9/30/21 included Brief Use: Us (sic) adult incontinent briefs when up for dignity reasons; Incontinent: Check approximately every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes; Offer and assist (R1) to toilet. R4's Care Plan also documented a Focus Area of (R1) has bowel incontinence with a date initiated of 07/08/2024. Corresponding interventions initiated on 07/08/24 included Provide loose fitting, easy to remove clothing; Provide peri care after each incontinent episode. 2. R38's admission Record with a print date of 10/23/25 documents an admission date of 9/28/21 and included diagnoses of syncope and collapse, dementia, heart disease, atrial fibrillation, unsteadiness on feet, and repeated falls. R38's MDS dated [DATE] documented a BIMS score of 07, indicating severe cognitive impairment. This same MDS documented R38 requires substantial/maximal assistance for toilet hygiene. R38's current Care Plan documents a Focus area of (R38) has bladder incontinence with a date initiated of 04/25/2025. Corresponding interventions initiated on 04/25/25 included Brief Use: the residents use disposable briefs; Incontinent: Check the resident Q2 (every 2 hours) and as required for incontinence. On 10/16/25 at 1:13 PM, V73 (Family Member of both R1 and R38) stated she regularly visits with R1 and R38 three to five days a week, and when asked if the facility had enough staff to meet residents' needs V73 stated, Absolutely not. V73 stated they used to have two CNA's (Certified Nursing Assistants) per hall and now they usually only have one. V73 stated she can't remember the exact date, but recently R1 had to sit in feces in the dining room because they didn't have enough staff to take him from the dining room, use the mechanical lift, and change him. V73 stated there was also a time there was only a nurse (V15 - Licensed Practical Nurse/LPN) and R38 had a bowel movement and had feces all over her. V73 stated V15 told her there were no CNA's to assist. V73 stated V15 did the best she could but she didn't have any help. V73 stated this also occurred recently but she could not recall the exact date or time of occurrence. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/22/25 at 1:02 PM, V15 (LPN) stated she sometimes had to work as a CNA in the morning when the CNA's were late getting to work. V15 stated they had staff calling in and other staff quitting this past weekend, so that made it hard. V15 stated she couldn't recall a specific date or incident where she was covering as a CNA and R38 had to wait for care. On 10/15/25 at 10:31 PM, V59 (CNA) stated she didn't think they had enough staff to meet the needs of the residents timely. When asked if they were able to complete every two-hour bed check through the night, V59 stated, It may be more than two hours. On 10/15/25 at 10:44 PM, V61 (CNA) stated they don't have enough staff to meet the needs of the residents timely. V61 stated they do bed checks, but it takes longer than two hours. On 10/16/25 at 2:56 PM, V51 (CNA) stated they sometimes have enough staff to meet the needs of the residents timely but most of the time they are really short staffed. V51 stated sometimes people have incontinence episodes because they can't assist them as quickly. On 10/20/25 at 11:44 AM, V62 (CNA) stated she works night shift 10 PM to 6 AM. V62 stated they have 70-80 residents and work with only three CNA's on night shift. V62 stated, I am not able to provide quality care. When asked if there was any negative outcome related to staffing, V62 stated residents have incontinence episodes because they have to wait on us and they have had to sit in urine/feces longer than they should. On 10/30/25 at 2:48 PM, V2 (Director of Nurses) stated she expected incontinence care to be provided every two hours and as needed. V2 stated she did not believe the facility had a policy regarding incontinence care. 3. R4's admission Record with a print date of 10/01/25 documented an admission date of 7/14/21 and included diagnoses of pressure ulcer, acute kidney failure, dementia, osteoporosis, chronic kidney disease, hypertension, generalized osteoarthritis, glaucoma, muscle weakness, and reduced mobility. R4's MDS dated [DATE] documented a BIMS score of 03, indicating R4 has severe cognitive impairment. This same MDS documented R4 is dependent on staff for toileting hygiene and requires substantial/maximal assistance for transfers, shower/bathing and assist for tub/shower transfers. R4's current Care Plan documents a Focus area of (R4) has bladder incontinence with a date initiated of 01/22/2025. Corresponding interventions initiated on 1/22/25 included Brief Use: the resident uses disposable briefs; Encourage fluids during the day to promote prompted voiding responses; Incontinent: Check the resident as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes; Monitor/document for s/sx (signs/symptoms) UTI (urinary tract infection). R4's Care Plan also documented a Focus area that R4 has an Activities of Daily Living (ADL) Self Care Performance Deficit due to Impaired Balance with a date initiated of 01/22/2025. Corresponding interventions initiated on 1/22/25 included Toilet Use: The resident requires 1 staff participation to use toilet; Transfer: The resident requires 1 staff participation with transfers; R4 requires one staff assist with bathing; and R4 requires one staff assist to dress. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/20/25 at 12:28 PM, V7 (Caregiver) stated she sits with R4 from 7 AM to 1 PM and from 5PM to 7 PM. R4 was sleeping in her chair at the time this interview started. R4 woke up during the interview and stated she didn't get to go to the bathroom before she went to bed on 10/19/25. R4 stated the CNA (Certified Nursing Assistant) told her to just go to bed because she couldn't take her to the bathroom by herself and there wasn't anyone else to help. R4 stated the CNA didn't even try to take her to the bathroom. V7 stated R4 was soaking wet this morning (referring to 10/20/25). V7 stated R4's clothes were drenched up her back and her whole bed was wet. On 10/20/25 at 12:57 PM, V14 (CNA) stated she worked as a CNA and provided care to R4 on the morning of 10/20/25. V14 stated she arrived to work at 6 AM on 10/20/25 and R4 was in bed and dry when she checked her a little after 6 AM. V14 stated she did not get R4 out of bed that morning and she wasn't sure who did. On 10/20/25 at 2:21 PM, V65 (CNA) stated she worked night shift beginning on 10/19/25 and ending on the morning of 10/20/25. V65 stated she was R4's CNA from 6 PM to 10 PM and was the CNA who assisted R4 to bed. V65 stated she told R4 they didn't have staff to take her to the bathroom before going to bed. V65 stated her partner was on break and she couldn't find anyone else to assist her and it takes two staff to take R4 to the bathroom. V65 stated she told R4 she could wait about thirty minutes, but R4 wanted to go to bed. V65 stated this occurred around 6 PM on the evening of 10/19/25. V65 said they had seven CNA's working at the time (from 6 PM to 10 PM), explaining there were 2 CNA's per hall except for the rehab hall, which had one CNA. V65 stated R4 is normally incontinent but had recently started wanting to use the toilet. V65 stated if R4 wants to go to the toilet and they have the staff available to assist her, V65 will take her to the toilet. V65 stated R4 was not a resident she was responsible for doing bed checks on from 10 PM to 6 AM as the staffing level changed to three CNA's during that time, with a fourth CNA who was orientating. V65 stated she was not the CNA who assisted R4 up on the morning of 10/20/25 prior to leaving the facility for the day. On 10/22/25 at 1:36 PM, V7 (Caregiver) stated when she got to the facility on the morning of 10/20/25, R4 was sitting in her chair with a blanket over her wearing her pajama top and an incontinence brief. V7 stated R4's incontinence brief and pajama top were both wet. V7 stated she found R4's pajama bottoms in the dirty clothes inside out and saturated with urine. V7 stated the bottoms were so wet she had to put them in a plastic bag. V7 stated R4 told V7 she needed to change her bed, and V7 told R4 the bed was already made. V7 stated R4 told her the bed was wet, so V7 pulled the covers back on the made bed and the sheet and bed pad were both visibly saturated with urine. V7 stated she didn't report it to anyone because she used to report incidents that occurred, but it never did any good. V7 stated when there is only one staff on the hall, she expects the care will be lacking because it is hard for the staff to keep up. V7 stated she is just glad she is there to assist R4 but feels for the other residents on the hall who don't have a (private) care giver. On 10/21/25 at 2:38 PM, this surveyor spoke to V2 (DON) regarding R4 not being toileted prior to bed on 10/19/25 and her clothes and bed being saturated on the morning of 10/20/25. V2 stated that was unacceptable and she expected the licensed nurses to assist the CNA's with providing care to the residents when needed (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R4's shower records for the months of September through mid-October of 2025 from electronic health record as well as paper documentation shows R4 refused a shower on 9/9/25 and received showers on 9/19/25 and 9/26/25. There were four 6-day periods from 9/3/25 - 9/8/25, 9/10/25 - 9/15/25, 9/20/25 - 9/25/25, and 10/4/25 - 10/9/25 in which a shower is not documented as offered or provided to R4. There was no documentation of R4 refusing to shower/bathe during these four 6-day periods. On 10/16/25 8:53 AM, V2 (Director of Nurses/DON) stated shower sheets are kept in binders, documented on paper as well as documented in residents' electronic health record. On 10/16/25 at 10:15 AM, V2 stated showers for residents are given on two shifts: 6 AM-2 PM and 2 PM-10 PM. V2 stated R4's electronic health record shows documentation that R4 refused a shower on 10/7/25. This surveyor pointed out in the tasks section of the electronic health record it doesn't state refused, but rather the activity did not occur. V2 was unable to explain in the electronic health record why it stated the activity did not happen, and there was no documentation or indication the shower was refused. V2 could not explain the gaps in showers/bed baths for R4 between the dates of 9/9/25, 9/19/25, and 9/26/25. V2 was also unable to explain the gaps of time in R4's shower records for the four 6-day periods from 9/3/25 - 9/8/25, 9/10/25 - 9/15/25, 9/20/25 - 9/25/25, and 10/4/25 - 10/9/25 in which the documentation does not show evidence of R4 being showered/bathed or offered to shower/bathe. 4. R7's admission Record dated 10/7/25 documented an admission date of 7/10/24 and included diagnoses of chronic obstructive pulmonary disorder, congestive heart failure, muscle weakness, and unsteadiness on feet. R7's MDS dated [DATE] documented R7 has a BIMS score of 15, indicating R7 is cognitively intact. The same MDS documents R7 is a substantial/maximal assistance for showering/bathing and completely dependent for tub/shower transfer. R7's Care Plan dated 10/7/25 documents a Focus Area for ADL Self-Care Performance Deficit dated 7/10/24. Corresponding interventions include R7 requires one staff participation for bathing and dressing (both dated 7/10/24), R7 requires two staff participation for transfers (dated 4/3/25), and R7 requires mechanical aid sling for transfers (dated revised 7/16/24). On 10/15/25 at 10:35 AM, R7 was alert and oriented and stated she preferred a bed bath to a shower. R7 stated she had only had one bed bath this month. R7 stated she has made it clear to staff she wants a bed bath and not a shower. R7 stated she has also not been able to get her hair washed routinely because of low staffing. R7's shower/bathing documentation from the electronic health record as well as those documented on paper revealed no evidence of R7 receiving or being offered a shower/bath from 9/2/25 – 9/10/25 (9 days) and from 9/12/25 – 9/21/25 (10 days). On 10/16/25 at 10:15 AM, V2 was unable to explain the gaps between baths/showers for R7 on the dates of 9/2/25 - 9/10/25 and 9/12/25 – 9/21/25. 5. R5's admission Record dated 10/1/25 documented an admission date of 1/26/20 and included diagnoses of cerebral infarction, congestive heart failure, lack of coordination, contracture of muscle right lower leg, hemiplegia and hemiparesis of right side. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R5's MDS 7/17/25 documents a BIMS of 15, indicating R5 is cognitively intact. The same MDS documents R5 is a partial to moderate assist with showering. Same MDS documents R5 is completely dependent for shower/tub transfer. R5's Care Plan dated 10/1/25 documented R5 has an activity of ADL Self-Care Performance Deficit, activity intolerance due to hemiplegia dated 5/31/22. Corresponding interventions include R5 requires one staff assist with bathing and dressing (both dated 5/31/22) and R5 requires two staff participation with transfers (dated 2/27/24). R5's shower/bathing documentation from both the electronic health record and documentation on paper show there was a six-day gap between 9/18/25-9/23/25 where R5 was not offered or provided a shower/bath, and there was no documentation of R5 refusing a shower/bath for that period of time. Shower documentation for 10/11/25 shows no evidence of R5 receiving or refusing a shower, and documentation for 10/4/25 documents R5 received a shower. On 10/15/25 at 11:08 AM, R5 stated she doesn't get her showers like she should. R5 stated she is supposed to have her showers on Wednesdays and Saturdays. R5 stated agency staff CNA's didn't offer her routine shower last Saturday 10/11/25. R5 stated she also missed her shower the Saturday before on 10/4/25 because of low staffing. On 10/16/25 at 10:15 AM, V2 was unable to explain the gap of six days between 9/18/25 - 9/23/25 and other missing documentation to show R5 was offered or provided a shower/bath, and there was no documentation of R5 refusing a shower/bath for those dates. 6. R22's admission Record dated 10/29/25 documented an admission date of 3/4/22 and included diagnoses of cerebral infarction, muscle weakness, reduced mobility, and unsteadiness on feet. R22's MDS dated [DATE] documented a BIMS score of 10, indicating R22 has moderate cognitive impairment. The same MDS documented R22 is a partial to moderate assist for bathing and for tub shower/transfers. R22's Care Plan dated 10/29/25 documented a Focus Area of ADL Self-Care Performance Deficit dated 3/4/22. Corresponding interventions include R22 requires assist of one staff for bathing and dressing (dated 3/4/22) one assist with transfers. On 10/15/25 11:50 AM, R22 stated she only gets a shower once per week to once every one and a half weeks. R22's shower documentation in R22's electronic health record and on paper for the months of September and October 2025 reveal a period from 9/25/25 - 10/10/25 in which there was no evidence that R22 was provided or offered a shower/bath. There was no documentation of refusals for those dates either. (continued on next page)

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Metropolis Rehab & Hcc	2299 Metropolis Street Metropolis, IL 62960

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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 - Some	On 10/16/25 at 10:15 AM, V2 stated she wasn't sure why R22 didn't get a shower for the 2-week period between 9/25/25 and 10/10/25. V2 stated there were refusals documented in R22's electronic health record in tasks for the dates of 9/24/25 and 9/27/25. This surveyor pointed out in the tasks section on the electronic health record it doesn't state refused but rather the activity did not occur. This surveyor also pointed out there were no refusal forms completed for those dates of 9/24/25 and 9/27/25. V2 stated she could not explain why refusals were not completed for the dates of 9/24/25 and 9/27/25 if R22 did refuse. V2 stated she could not explain the gap with no showers documented for R22 at all between 9/25/25 to 10/10/25. On 10/15/25 1:00 PM, V17 (CNA) stated the facility was short on CNA staffing about four to five weeks ago. V17 stated being short on CNA staff lasted about 2 weeks. V17 stated for those 2 weeks there was only one CNA on each hall most every day. V17 stated the CNA staff were having difficulty getting showers done due to short staff. On 10/21/25 at approximately 1:20 PM, V8 (CNA) stated she had to work the 300 hall by herself one evening a couple of months ago due to short staffing. V8 stated she was only able to do two out of the four showers that were scheduled for her to complete that evening. On 10/21/25 at 1:39 PM, V10 (CNA) stated there were four to five times in the past month where she was unable to complete showers on the residents that had a shower scheduled. V10 stated she tries to do a bed bath in place of a shower if unable to do the shower, but sometimes she is unable to do the showers all together. On 10/21/25 at 1:39 PM, V14 (CNA) stated there have been times she was unable to complete showers over the past 2 months because she's been the only CNA on the hall and unable to leave the hall to do showers. On 10/16/25 at 10:15 AM, V2 stated two weeks was too long of a period between showers. V2 stated all residents should have a shower or bed bath at least two times per week at the minimum. V2 said the facility staff may have forgotten to document the showers for the residents listed above for the time periods pointed out but confirmed there was no proof of them receiving showers/baths and no evidence of refusals for those time periods. V2 stated there was no facility policy for showers. On 10/29/25 at 8:11 AM, V1 (Administrator) stated she was unable to explain the gaps in showers for residents R4, R5, R7, and R22. V1 did state R7 frequently refused bed baths but was unable to explain why there was no documentation of bathing or refusal of bathing for R7 in the gaps with no documentation of showering or refusal of one. V1 stated she believes those residents were at least offered the opportunity to bathe and facility staff were not documenting the attempts of showering/bathing, but she agreed if there was no documentation then the attempts of or actual showers could not be verified. V1 stated 6 days was too long to go between showering/bathing for the residents. V1 stated residents should at least be offered the opportunity to shower/bathe twice per week at the minimum. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility Grievance Form dated 8/6/25 documents, .Description: Staff have not had towels for showers for two mornings. Below To Be Completed By Staff, Investigation: I found some bath towels (and) washcloths in (name of resident) old room yesterday. Summary/Findings: I found some washcloths in the room between big n (sic) small shower rooms. Then I also found some washcloths in room [ROOM NUMBER]B closet earlier. I found a bath towel (and) another washcloth in 402A bed (and) bathroom when I deep cleaned. Recommendations/Action Taken: Spoke with (name of Laundry Supervisor) to ensure laundry is being completed in the evening as scheduled. New towels (and) washcloths ordered. Date Resolved: 8/7/25. Person Notified of Resolution: Staff.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician orders were accurate and implemented for recommended changes in treatment after a hospitalization and a fall, and failed to assess and treat lymphedema/wounds per physicians orders for 3 of 3 residents (R6, R7, R20) reviewed for quality of care/treatment in a sample of 46. This failure resulted in R6 struggling to breathe, causing anxiety, sleep disturbance, and significant discomfort due to recommended medications changes not being administered/implemented to treat newly diagnosed congestive heart failure. This failure also resulted in R7's developing redness, increased swelling, tenderness, and altered mental status and R7's subsequent hospitalization with a diagnosis of cellulitis and septic shock.Findings include:1. R6's admission Record documented an admission date of 02/06/25 and included diagnoses of acute respiratory failure with hypercapnia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, heart failure, dementia, anxiety disorder, major depressive disorder, dysphagia, type 2 diabetes mellitus with diabetic nephropathy, and acute kidney failure. R6's Minimum Data Set (MDS) dated [DATE] documents a BIMS score of 15, indicating cognitively intact. R6's Care Plan documented a focus area of oxygen therapy dated 05/20/25, with interventions including: give medications as ordered by physician, monitor/document side effects and effectiveness; monitor for signs or symptoms of respiratory distress and report to medical doctor PRN (as needed): respirations, pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, and skin color; position resident to facilitate ventilation/perfusion matching, use upright high Fowlers position whenever possible to allow for optimal diaphragm, when on side the good side should be down (e.g., damaged lung should be up) all dated 02/06/25 and oxygen settings; the resident has O2 (oxygen) via nasal prongs dated 02/11/25. R6's care plan documents a focus area of R6 has SOB (shortness of breath) while lying flat r/t (related to) respiratory failure dated 02/11/25 with interventions listed of: administer PRN medications as ordered dated 02/06/25 and elevate HOB (head of bed) dated 02/06/25. R6's June 2025 Medication Administration Record (MAR) documents an order for albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083%, 3 ml inhale orally via nebulizer every 4 hours as needed for shortness of breath with a start date of 04/02/25 at 10:44 AM and a D/C (discontinue) date of 08/20/25 at 9:15 AM and an order for furosemide oral tablet 40 mg, give one tablet by mouth every 24 hours as needed for edema/swelling with a start date of 02/06/25 at 2:30 PM and a D/C date of 08/20/25 at 9:15 AM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R6's hospital records with an admission date of 08/15/25 document: history of present illness: [AGE] year old female with past medical history of hypertension, COPD (Chronic Obstructive Pulmonary Disease), on 2-3 liters (oxygen) per NC (nasal cannula) anxiety, and depression presented to the ER (emergency room) from (facility name) with respiratory distress. Nursing staff at (facility name) noticed her in respiratory distress sometime yesterday evening. No mention of cough, fever, or other symptoms. On EMS (emergency medical service) arrival, O2 (oxygen) saturation was 70%. Her oxygen was increased and albuterol nebulizer was given en route. Chest x-ray showed bilateral pleural effusions BNP (B-type natriuretic peptide) 10,000, pH 7. 27, pCO2 (partial pressure of carbon dioxide) 83. She was given duoneb, Lasix, and placed on BIPAP (bilevel positive airway pressure), ABG (arterial blood gas) improved after 1 hour on BIPAP. admitted to med/surg inpatient. The section titled, patient visit information; activity restrictions or additional instructions: discharge to skilled nursing facility; follow up with PCP (primary care physician) in 3 days, recommend repeat blood work to monitor HGB/BUN (hemoglobin/blood urea nitrogen), continue good bowel regimen, DX (diagnosis): ileus, EKG (electrocardiogram) changes, CHF (congestive heart failure); prescriptions (in part): furosemide (Lasix) 40 mg (milligrams) oral daily #30 tablet. Additional documents given: patient health summary and home medications list. The home medication list includes furosemide (Lasix) 40 mg tablet, stop taking: 40 mg oral daily as needed, start taking: 40 mg oral daily. The section titled problems documents active problems: acute exacerbation of CHF. Under the section titled, discharge plan documents in part: dx: ileus, EKG changes, CHF. Prescriptions: changed: furosemide (Lasix) 40 mg tablet, 40 mg PO (per oral) daily. Under the continued medications listed: albuterol sulfate 2.5mg/3ml (milliliters) solution for nebulization, 2.5 mg inhalation Q (every) 4 hours PRN (reason: shortness of breath or wheezing). R6's hospital discharge records dated 08/21/25 documented to follow up with primary care physician in 3 days, recommend repeat blood work to monitor hemoglobin and blood urea nitrogen. R6's Dietary Progress Note dated 08/25/25 documented in part, Dietitian chart review for RA (recent admission). August weight: 143.7# (pounds) 08/12/25 weight recorded (prior to hospitalization).some varied history but overall stable. Sent to hospital 08/15/25 with diagnosis: acute respiratory failure, BLE (bilateral lower extremities) increased swelling. Diagnosis: new onset of CHF (congestive heart failure) use of Lasix 20mg (milligrams) Q (every) 8 hours and 1800 ml fluid restriction with hospital weight recorded: 131.34 pounds RA (recent admission) here 08/21.Continue diet order of NAS (no added salt) as least restrictive therapeutic intervention. Monitor weight, lab and consumption with new order for Lasix 40mg QD (every day) may see fluid shifts affecting weight patterns. Record weekly weight or 4 weeks, follow up as needed with new concerns. R6's Medication Review Report documents an active order with a start date of 8/21/25 documenting furosemide oral tablet 40 mg, give 1 tablet by mouth every 24 hours as needed for edema/swelling. This document does not show the order change implemented at the hospital from furosemide 40mg tablet daily as needed to furosemide 40mg tablet daily. This report also documented an active order with a start date of 8/21/25 documenting albuterol sulfate inhalation nebulization solution 2.5mg/0.5ml (milliliter); 1 vial inhale orally every 4 hours as needed for COPD. This order does not match the hospital record's continued medications of albuterol sulfate 2.5mg/3ml solution for nebulization. R6's Progress Note dated 10/15/25 at 1:16 AM documented R6 complained of shortness of breath and O2 (oxygen) sats (saturation) at 94% on 3L (liters)/NC (nasal cannula). PRN (as needed) medications administered per MD (Medical Doctor) orders. R6's October 2025 MAR documented an albuterol sulfate inhalation nebulization solution 2.5mg/0.5ml treatment was given on 10/15/25 at 1:15 AM. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R6's Progress Note dated 10/15/25 at 2:20 AM by V53 (Licensed Practical Nurse/LPN) documented: resident continues to c/o (complain of) SOB (shortness of breath) and unable to breath. Nurse explained to resident that she needed to go to ER (emergency room) and get checked out. Resident refused and said she would make it. This nurse requested (V78/Registered Nurse-RN) to come and evaluate resident. Resident also told V78 that she was not going to the hospital, and she would just wait. X-ray ordered and (x-ray company) called to schedule. R6's Progress Note dated 10/15/25 at 7:00 AM by V77 (Nurse Practitioner/NP) documented, Visit Type: Telehealth: the nurse reported dyspnea accompanied by low oxygen saturation and abnormal lung sounds with crackles. A chest x-ray was requested, along with adjustments to the respiratory treatment plan. Ordered chest x-ray and a one-time PRN dose of 2 ml albuterol sulfate neb (nebulizer) treatment. Rounding to follow up. R6's October 2025 MAR showed no administration of a one-time dose of 2ml albuterol sulfate neb treatment ordered by V77 as documented in the progress note above for the corresponding time of 7:00AM. On 10/15/25 at 10:29 AM, R6 was sitting on her bed with an anxious facial expression. R6 appeared to be struggling to breathe with loud crackles heard. At this time, R6 was alert and oriented and stated she was having a hard time breathing. R6 said she would make it if she could have a breathing treatment and would not have to go to the hospital. R6 stated she had not had one since about 1:00 AM this morning. R6 stated she asked the nurse for a breathing treatment earlier but was not given a treatment. R6 said the nurse was not nice to her and told her just to spit it out. R6 stated, she can't, and her breathing is getting worse. On 10/15/25 at 10:34 AM, V27 (Licensed Practical Nurse/LPN) was at the nurse's station when surveyor requested V27 to go check on R6. V27 stated R6's SPO2 (saturation of peripheral oxygen) was fine, R6 has an x-ray ordered, and she is fine. V27 did not go assess R6 at this time. On 10/15/25 at 10:35 AM, another surveyor entered R6's room and immediately noticed R6 displaying symptoms of anxiety due to respiratory difficulty including trying to sit up straight, use of accessory muscles, and gasping and anxious/fearful facial expression. There were noted audible crackles that could be heard without a stethoscope while standing next to R6. On 10/15/25 at 10:36 AM, V2 (Director of Nursing/DON) stated R6 is having trouble breathing, R6 definitely should get a breathing treatment. V2 stated V27 (LPN) should have come down to visually assess R6. V2 stated there could be more going on than what SPO2 percentages can show. V2 stated R6 should have received a breathing treatment when she had asked for one earlier, it is not appropriate for the nurse just to tell her to spit it out. V2 stated R6 knows when she needs a breathing treatment and should be given one when she asks. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R6's Progress Note dated 10/15/25 at 10:54 AM by V27 (LPN) documented: reported to this nurse that resident had an acute change in condition. This nurse entered resident's room and resident was noted to be sitting on edge of bed. No new onset shortness of breath noted, resident did not appear to be in distress, cognition continues to be baseline. No complaints of pain, No audible wheezing present. VS (Vital Signs) as follows: BP (blood pressure) 112/56, P (pulse) 81, R (respirations) 20, O2 (oxygen) 99% via NC (nasal cannula). Temperature 98.0. Resident has received scheduled nebulizer treatments this AM, this nurse asked resident if she felt as if she needed to go to the hospital and she refuses at this time stating she would like to wait and have her in house chest x-ray. I informed resident that chest x-ray has been scheduled but she can still go to hospital if she feels she needs to. Resident verbalized understanding at this time. On 10/15/25 at 10:55 AM, V2 (DON) administered a breathing treatment of albuterol sulfate nebulization solution 2.5mg/0.5ml to R6. At this time, R6 asked why there was barely any medication in there anymore (while shaking the nebulizing chamber in her hand). R6 took a couple breaths and stated, look it is gone already. R6's Progress Note dated 10/15/25 at 11:27 AM by V2 documented: after PRN breathing treatment resident stated she was still SOB. Lung sounds audible and crackles could be heard. Residents current O2 sat is 99% on 2 L NC. Resident wanted another treatment and denied going to hospital for evaluation. This nurse called on call NP, (V77) and obtained order for a one-time PRN dose of 2ml albuterol sulfate neb treatment. Treatment given at this time. On 10/15/25 at 11:45 AM, V2 administered the one-time dose of 2ml albuterol sulfate neb treatment ordered by V77. R6's October MAR documents administration of albuterol sulfate inhalation nebulization solution 2.5mg/0.5ml at 10:59AM and a subsequent administration of albuterol sulfate inhalation nebulization solution 0.63mg/3ml (Albuterol Sulfate), give 2ml inhale orally via nebulizer one time only for SOB for 1 day at 11:45 AM. R6's MAR shows no administration of albuterol sulfate inhalation nebulization treatment after the 10/15/25 1:15 AM administration until the 10:59 AM and 11:45 AM administrations. On 10/16/25 at 9:19 AM, V2 (DON) was questioned about R6's Progress Note entry dated 10/15/25 by V27 and why it did not match observations of R6's condition on that date and time. V2 stated V27 put in the change in condition progress note because V2 asked her to. V2 stated what V27 documented was not an accurate assessment of R6 at the time. R6's Progress Note dated 10/16/25 at 7:00 AM by V82 (Physician Assistant) documents: visit type: telehealth: resident chest x-ray showed signs of pulmonary edema and the patient complains of dyspnea and cough, no fevers. She is Lasix 40mg prn, will change to Lasix 40mg daily for 5 days and then add potassium 10mEq (milliequivalents) daily for 5 days as well. Rounding to assess. On 10/16/25 at 10:15 AM, R6 was again struggling to breathe, was tearful and anxious. At this time, R6 stated she is still having trouble breathing. R6 stated she did not get a breathing treatment last night or this morning and she asked for one. R6 stated she is just so tired because she could not sleep because she couldn't breathe. R6's October MAR documents no further administrations of albuterol sulfate inhalation nebulization treatments after 10/15/25. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R6's October MAR documents an order for furosemide oral tablet 40 mg, give 1 tablet by mouth one time a day for CHF for 5 days with a start date of 10/17/25 at 8:00 AM. R6's MAR documents furosemide 40 mg given on 10/17/25 at 8:00 AM. On 10/16/25 at 11:01 AM, V2 (DON) stated R6 is still having trouble breathing, she should have received a breathing treatment last night and/or early this morning. V2 stated R6 knows when she needs a breathing treatment. R6's Progress Note dated 10/17/25 at 5:53 AM by V74 (Nurse Practitioner) documented in SOAP (Subjective, Objective, Assessment, and Plan) format included: note text: S-dyspnea with anxiety; O-review of CXR (chest X-Ray): initial was incomplete not viewing lung bases. Repeat on 10/16 showed worsening of bilateral opacities with edema, possible pneumonia, COPD-end stage on supplemental oxygen. Currently on multiple medications for this. Newly diagnosed CHF (congestive heart failure) in August 2025 with PRN Lasix. See new orders from on-call (V78). A-COPD exacerbation. Community acquired pneumonia. CHF exacerbation. P-1. See plan for Lasix/KCL (potassium chloride), recommend new facility draw BMP Monday, 2 augmentin, 3 prednisone, 4 check if (brand name) inhaler will be covered by insurance to replace current ICS/[NAME] (inhaled corticosteroid/long-acting beta-agonist), 5 recommend referral to pulmonologist. R6's October 2025 MAR documents furosemide oral tablet 40mg; give one tablet by mouth every 24 hours as needed for edema and swelling with documentation noting it was administered on 10/08/25 at 7:38 AM and 10/16/25 at 7:38 PM. These are the only two administrations of furosemide documented for the whole month of October. R6's Discharge Summary documents discharge from the facility on 10/17/25 to another nursing facility in a neighboring town. R6's Progress Notes dated 10/17/25 at 10:43 AM documented receiving facility here to transport resident. On 10/22/25 at 7:40 AM, R6 was observed in her new facility. R6 stated she still has some problems breathing but it is some better. R6 said after she returned from the hospital last time at the end of August, she kept telling the nurses she was supposed to have another medication that she was given in the hospital but the nurses either said she was crazy, or they said they did not have any new orders for medication for her. R6 still appeared to have some difficulty with breathing but did not appear to be in respiratory distress, was not anxious during this observation and no crackling sounds were heard during the visit. On 10/22/25 at 1:32 PM, V2 (DON) stated she does not see a physician follow up appointment that was set up for R6, but she will provide one if she can find one. V2 said she does not know why the diagnosis of CHF was not added to R6's diagnosis list after her hospital visit. V2 said she does not know why the order for the furosemide was not changed to daily for R6. V2 stated she can see in the hospital paperwork where R6 was given a diagnosis for CHF and R6's order for Lasix was changed to daily from as needed. V2 said she does not see where there have been any notes from any doctors for the furosemide not to be changed to daily. V2 also stated she does not see where or why R6's order was changed from the albuterol sulfate 2.5mg/3ml to the 0.5ml dosage after she returned from the hospital. On 10/23/25 R6's electronic health record (EHR) did not contain any documentation of a follow up visit with a physician after R6's hospital visit. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 10/23/25 at 9:40 AM, V2 stated she had not found any other documentation for R6 from after her hospital visit. On 10/24/25 at 10:11 AM, R8 (R6's previous roommate) stated when R6 returned from the hospital in August, R6 kept telling the nurses she was supposed to have another medication from the hospital, but some nurses told her she was crazy and some just stated R6 did not have any new medications. On 10/28/25 at 1:05 PM, V74 (Nurse Practitioner) stated she was not aware of the medication changes of the Lasix or the albuterol nebulizer treatment after 08/21/25 when R6 was discharged from the hospital. V74 said she was unaware of the updated diagnosis of congestive heart failure for R6. V74 said she has told the facility several times she can only see the records in (EHR company name), therefore when residents return from the hospital with new medications or diagnoses she either needs to be sent the hospital records or the resident's medical record needs to be updated so she can be notified and be aware of what is going on with the resident. V74 stated a diagnosis of CHF and medications changed to Lasix daily could make a significant difference to a resident. V74 stated she was not notified of any of the information and if it was not put into (name of EHR company) she would not know. On 10/29/25 at 2:22 PM, V75 (Nurse Practitioner) stated, he has seen R6 for her anxiety. V75 stated R6 does get more anxious when she cannot breathe. On 10/29/25 at 2:48 PM, V79 (Hospital Nurse Practitioner) stated R6 was given a diagnosis of CHF while in the hospital from 08/15 – 08/21/25 and upon discharge from the hospital, R6's Lasix was changed from as needed to daily. V79 stated would have expected R6 to have CHF added to her diagnoses and the Lasix to be given daily as prescribed at the hospital, upon discharge to the facility. V79 stated she can see on R6's discharge paperwork from the hospital they did not change her albuterol nebulizer dosage. V79 stated R6 should have had a follow up appointment with her primary care physician as in her discharge paperwork from the hospital. The facility's Medication Administration Policy documents Adherence to this Medication Administration Policy is essential to ensure the well-being and safety of our residents. All staff members are expected to follow these guidelines strictly and to repot any issues or deviations from the policy. Continuous improvement and open communication are encouraged to uphold best practices in medication administration. The policy further documents that it applies to all staff members involved in the administration of medication, including nurses. Under Guidelines, Medication Orders and Documentation: 1. All medication orders must be prescribed by a licensed healthcare professional and documented accurately in the resident's medical records. 2. Written, verbal, or telephone orders may only be received and transcribed by an LPN or RN. 3. Any changes in medication orders must be documented in the resident's medical record. 4. Medication administration records (MARs) should be maintained for each resident and must be up-to-date and easily accessible. On 11/06/25 at 10:31 AM, V2 (Director of Nurses) stated she was unable to locate a significant change in condition policy. 2. R7's admission Record dated 10/7/25 documents an admission date of 7/10/24. R7's face sheet documents the following diagnoses including but not limited to lymphedema, reduced mobility, localized edema, and congestive heart failure. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	R7's MDS dated [DATE] documented a BIMS score of 15, indicating R7 is cognitively intact. R7's MDS documents R7 is a substantial/maximum assist for all mobility needs including repositioning in bed and is at risk for pressure ulcers/injuries. R7's Care Plan dated 10/7/25 documents R7 has a focus area for potential/actual impairment to skin integrity related to decreased mobility and lymphedema to left lower leg dated revised on 4/23/24. R7's care plan documents interventions for the above focus area includes but is not limited to administer treatments as ordered and monitor for effectiveness dated 7/10/24; float heels while in bed as tolerated dated 7/10/24; for dry and flaky skin use high quality moisturizers to rehydrate skin dated 7/10/24; monitor pressure areas for changes in color, sensation, temperature and report any change to nurse dated 7/10/24. R7's physician's orders sheet dated 10/7/25 documents physician's orders including but not limited to ace wrap for compression to bilateral lower extremities related to edema. Change daily. Wrap leg with ace wrap from foot to knee every day shift with a start date of 6/8/25. R7's physician's order from same physician's order sheet documents cleanse left lower extremity with wound cleanser, apply puracol cut to fit open areas and wrap with kerlix (gauze wrap) every day and night shift for wound care with a start date of 6/27/25. R7's physician's order from same form documents another order for a low air loss mattress with a start date of 5/1/25. R7's physician's order documents an order for lymphedema pump to be used three times weekly times three weeks with a start date of 6/26/25. R7 has skin/wound assessments for dates 6/3, 6/10, 6/17, 6/25, 7/2, 7/8, 7/16, 8/18, 8/25, 9/1, 10/14, and 10/16. There were no skin/wound assessments for the weeks of 7/20-7/26, 7/27-8/2, 8/3-8/9, 8/10-8/16, 9/7-9/13, 9/14-9/20, 9/21-9/27, 9/28-10/4, 10/5-10/1, and 10/19-10/25. R7's skin/wound assessments fail to document the circumference of R7's legs indicating the amount of lymphedema being monitored. R7's skin/wound assessments fail to document on the dates completed what type of wounds R7 has, where the wounds are located on the left lower extremity, size of the wounds, how many wounds, and/or if any exudate from wounds. There is also no mention of monitoring of R7's weights to aid in monitoring R7's lymphedema. The most descriptive assessment dated [DATE] given for any of the dates skin/wound assessments were completed documents R7's left lower leg has lymphedema present with wounds, and treatments are in place. R7's progress notes from June – October 2025 including dieticians, nurse practitioners, medical doctors, and all nursing staff progress notes do not document R7's lymphedema was being measured/monitored for increase/decrease in size/amount, that medical doctor was being notified of R7's frequent refusals of dressing changes, or that R7 wanted a different treatment to left lower extremity wounds. R7's progress note dated 10/28/25 at 9:19 A.M., documents R7 was sent to local hospital for left lower extremity being red, warm to touch, having altered mental status, and increased left sided facial drooping. (continued on next page)

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Metropolis Rehab & Hcc	2299 Metropolis Street Metropolis, IL 62960

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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 - Actual harm Residents Affected - Few	R7's hospital records dated 11/5/25 documents R7 was admitted to local hospital from [DATE] – 11/3/25. R7's hospital records documents on page 8, R7 was started on broad spectrum antibiotics intravenously to treat her diagnosis of septic shock and cellulitis of left lower extremity. R7's hospital records documented no treatment of left lower extremity regarding how and what type of dressing was being done, except left lower extremity was not being wrapped for compression due to severe swelling. R7's same hospital records documents R7 went to local hospital emergency room on [DATE] for altered mental status, fever, leg pain and swelling. Page 17 of same hospital records documents R7's admitting diagnosis was septic shock secondary to lower extremity cellulitis. Page 18 documents from medical doctor's notes R7 is at high risk of recurrence due to underlying lymphedema and poor wound care. On 10/15/25 at 10:35 A.M., R7, who was alert and oriented, stated the nurses frequently do not do her dressing changes or at least all her dressing change. R7 stated her legs are to be wrapped with ace wraps every day, but frequently the staff tell her they do not have ace wraps, or they simply don't do the dressing change. R7 stated she doesn't know and/or has not asked why they weren't done. R7 stated she feels concern for her legs because the cracked, open, bleeding, and weeping skin on her legs could cause infections. At this time, R7's legs were not currently wrapped in ace wraps. There was noted gauze wrap to left lower leg with some light-yellow staining of the gauze in multiple areas from what appears to be weeping and/or serosanguineous drainage from wounds. R7's left leg was extremely swollen with edema. Unable to visualize skin due to gauze wrap. R7's right leg also had severe edema noted but is less than the left leg. There were also no lymphedema pumps noted at R7's bedside. On 10/16/25 at 1:29 P.M., observed the dressing change and treatment of R7's wounds and lymphedema of both lower extremities. V30, (Licensed Practical Nurse/LPN) was the nurse performing the treatment with V2, (Director of Nursing/DON) and V31, (Certified Nursing Assistant/CNA) assisting. Upon entering room the V30 brought the treatment cart into R7's room to perform dressing. V30, V2, and V31 were all wearing gloves, but no one had donned a disposable gown before beginning wound care. V30 performed hand hygiene and then donned gloves. V30 removed the old dressing which was only the gauze wrap using scissors. Upon removal of R7's old dressing R7's left leg skin was cracked and peeling with numerous open cracks that were not actively weeping but appeared to be moist with serosanguineous fluid and/or blood. The skin was very tight in appearance also. There were also what appeared to be blister like formations near the posterior region of the left knee above and below the knee joint. The lesions were intact and not currently open or draining. R7's right leg was also severely swollen with edema, but the skin had not started to crack, peel and open like the left leg. Skin to right leg was intact and appeared healthier than the left leg's skin condition overall. V30 then performed hand hygiene and donned new set of gloves. V30 washed both legs with soap and water changing gloves and performing hand hygiene according to current standards of practice. R7's left leg was rinsed with water and washcloths. Left leg was dried, then lotion applied. There was no medicated creams or ointments applied to R7's open areas on her left leg. Then gauze wrap was applied from toes to knee on the left foot and then two four-inch ace wraps applied to left leg. Right leg was then completed with lotion being applied and two four-inch ace wraps applied. On 10/16/25 at 11:01 A.M., V32, LPN stated as far as treatment/dressing supplies the facility is frequently out of ace wraps. V32 stated the trouble with obtaining wound supplies has been ongoing for about the last two months periodically. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 11/6/25 at 12:12 P.M., V32, LPN stated when he realized on the incidents, he was out of ace wraps to do R7's dressing changes with he would notify V2. V32 couldn't say how frequently he was out of ace wraps, but did mention it was more than once. V32 stated he would notify V2 the same day because he worked day shift, and she was usually in the building. V2 stated as far as he is aware administration did not go to a local store and pick any ace wraps up that same day. V32 stated administration would tell him the ace wraps were on back order or delayed. V32 stated he did not notify the medical doctor when R7 would frequently refuse her dressing changes. V32 stated R7 frequently refused her dressing changes because he would not do it the way she wanted but only do it according to doctor's orders, or R7 would state she was too tired or wanted to sleep at that particular time. V32 stated because he would only do the dressing according to doctor's orders she would refuse it. V32 stated he thought notifying the wound care nurse V30, LPN and V2 would be sufficient. On 11/5/25 at 1:32P.M., V32, LPN stated R7 frequently wanted him to put Nystatin powder in her open wounds because she said that was what healed them. V32 stated on 9/9/25 when it was documented in R7's treatment administration records that she refused the treatment that day it was because he refused to do the dressing like R7 wanted it done versus how the dressing and treatment were ordered. V32 stated he did notify the nurse practitioner of R7's refusal that day on 9/9/25. V32 stated when he notified V74, nurse practitioner that day, he stated he received no new orders from V74 regarding R7's treatments to wounds or lymphedema. R7's only progress note dated 9/9/25 documents there was no notification to V74 of R7's refusal of dressing change. On 11/5/25 at 1:36 P.M. V29, LPN stated R7 would frequently refuse her dressing changes to her left lower leg because the nursing staff wouldn't put Nystatin powder on the open wounds and/or sometimes R7 would tell the nursing staff she was just too tired or hurting. V29 stated she would notify V2, DON of her refusal of dressing changes, but does not remember notifying the medical doctor or nurse practitioner. V29 stated R7 would refuse the entire treatment including wrapping her legs with the ace wraps when V29 refused to put the nystatin powder on them when it wasn't what the doctor ordered. V29 stated looking back on R7's refusals she should have notified the doctor or nurse practitioner if and/or when R7 refused her treatments. On 11/5/25 at 5:30 P.M. V53, LPN stated she could not remember the exact dates or date R7 had refused her dressing changes to her legs including application of the ace wraps, but remembered it was frequently R7 did refuse. V53 stated the reason given from R7 for frequently refusing her dressing changes was because she wanted the nursing staff to do it a certain way including rubbing nystatin powder or cream into her open wounds on her legs and then dressing them. V53 stated she explained to R7 couldn't do that because it wasn't the doctor's orders. V53 stated when she would explain this to R7 she would then refuse the dressing all together. V53 stated she did not notify the medical doctor when R7 would refuse her dressing changes because it was in the evening and R7 refused frequently. V53 stated there were shifts she was working when there were no ace wraps in the building she knew of. V53 stated she would not notify V2, DON or the wound nurse immediately, but would leave a note on the shift report in the electronic health record system and let them know that way. V53 stated she would expect them to find the notificat

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide the prescribed diets, nutritional supplements and the appropriate portion sizes according to the approved menus for 7 of 7 residents (R2, R3, R13, R15, R18, R19 and R42) reviewed for weight loss in a sample of 46. This failure further contributes to continued harm to R3 and R18, who are currently considered severely thin and underweight. Findings include:1. R3's admission Record documents an admission date of 05/14/24 with diagnoses including: Alzheimer's disease with late onset, dementia, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, pleural effusion, abnormal posture, and body mass index 19.9 or less.R3's Minimum Data Set (MDS) dated [DATE] documents a dash for the question, should brief interview for mental status (BIMS) be conducted? and a dash for the BIMS summary score. R3's MDS section L documents none of the above were present with the boxes included B. no natural teeth or tooth fragments and F. mouth or facial pain, discomfort or difficulty with chewing. R3's MDS section GG documents R3's eating ability requires supervision or touching assistance indicating helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently.R3's Order Summary Report documents a dietary order for a regular diet with regular consistency and minced meats for nutrition with an order date of 01/28/25 and an order status of active. R3's order summary report documents a dietary supplement order of fortified foods with an order date of 07/15/24 with an order status of active.R3's Care Plan documents a focus area of R3 has a nutritional problem or potential nutritional problem dated 07/01/25 and interventions listed as: provide and serve diet as ordered and registered dietician to evaluate and make diet change recommendations as needed with a date initiated 05/30/24. R3's care plan documents a focus area of R3 has an ADL (Activities of Daily Living) self care performance deficit related to dementia dated 05/14/24 with an intervention listed as: eating: the resident requires 1 staff participation to eat dated 05/14/24.R3's weight summary documents weights as follows: 08/02/25 as 69.7 pounds, 09/01/25 as 69.5 pounds, 10/02/25 as 68.9 pounds. R3's weight summary documents that R3 is 62 inches tall, has a BMI (Body Mass Index) of 12.6 and her IBW (Ideal Body Weight) Range is 131.0-159.0 pounds.On 11/13/25 at 10:04 AM, R3 was in the dining room in her wheelchair, she appeared thin, R3 was assisted to stand on scale by V35 (Certified Nurse Aide/CNA), R3's weight was 68.0 pounds.According to the Adult BMI Calculator on the CDC (Centers for Disease Control) website at https://www.cdc.gov/bmi/adult-calculator/index.html, R3 has a BMI of 12.4 and is considered underweight. According to the World Health Organization at https://apps.who.int/nutrition/landscape/help.aspx?menu=0&helpid=420#:~:text=Moderate%20and%20severe%20thinness%20%E2%80%93%20A, population%20has%20a%20BMI%20%3C18.5, a BMI of less than 17.0 indicates moderate and severe thinness. According to the WHO the consequences and implications of moderate and severe thinness: A BMI < 17.0 indicates moderate and severe thinness in adult populations. It has been linked to clear-cut increases in illness in adults studied in three continents and is therefore a further reasonable value to choose as a cut-off point for moderate risk. A BMI < 16.0 is known to be associated with a markedly increased risk for ill health, poor physical performance, lethargy and even death; this cut-off point is therefore a valid extreme limit.R3's dietician nutrition assessment dated [DATE] at 2:46 PM documents: R3 has a regular diet with fortified foods, nutritional drink at 120 ml (milliliters) two times a day with varied intakes at review of available records since 08/16/25. R3's height is 62 inches dated 05/16/24 at 6:21 PM by method of standing with a weight on 08/02/25 at 1:51 PM of 69.7 pounds with a BMI of 12.7 %. R3's usual body weight is listed as 69.5 pounds. R3's goal weight is listed as 110 pounds and the comment section documents: R3 is at base weight and stable, her weight is low with low BMI but usual.R3's most current dietary note dated 04/09/25 at 1:36 PM documents: dietitian weight review for loss at 3 months. April weight is 69.2 pounds with a body mass index of 12.7%, R3 has a weight loss of 8.7 % over the last 3 months. R3 appears to have fluid related/CHF (Congestive Heart Failure) family wanted no further evaluation, use of Lasix noted. R3 has no wounds and has wound preventative in place. May give R3's medications in pudding if accepted. R3's lab review on 04/05 notes R3 is nutritionally stable except BUN (blood urea nitrogen) which is elevated at 33. R3's diet order is regular diet with regular texture with fortified food, boost 120 ml (milliliters) twice a day on 01/28/25. Meal consumption at review of available records since 03/27/25 is 26-100% with no refusals which is baseline. Although low body weight is stable with interventions. Continue per orders and follow up as needed with new

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide pain medications for pain management for 3 of 3 residents (R4, R5, and R31) reviewed for pain in the sample of 46. This failure resulted in R4 and R31 not having the medications available used to treat their pain resulting in uncontrolled pain. Findings Include:1. R4's admission Record with a print date of 10/01/25 documents R4 was admitted to the facility on [DATE] with diagnoses that includes polyneuropathy.R4's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 03, indicating R4 has a severe cognitive deficit.R4's current Care Plan documents a Focus area of (R4) has pain. Date Initiated: 01/22/2025. This Focus area includes the intervention of, Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Date Initiated 01/22/2025.R4's Order Summary Report dated 10/01/2025 documents a physician order for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligrams) give 1 tablet by mouth every 6 hours as needed for pain with an order date of 7/30/25.R4's Medication Administration Record (MAR) dated 9/1/25 to 9/30/25 documents a physician order for Hydrocodone-acetaminophen 5-325 mg give one tablet every 6 hours as needed for pain. This same MAR documents R4 is routinely administered the hydrocodone from 9/1/25 until 9/20/25. There is no documentation R4 was administered hydrocodone from 9/21/25 through 9/30/25. This MAR documents the following pain scale assessments using a 0-10 pain scale for R4: 9/22- night shift-2, 9/23-night shift-4, 9/24- night shift- 4, 9/26- evening shift- 4, 9/29/25 - night shit- 5. This MAR documents the physician order for acetaminophen 650 mg every four hours as needed was administered on 9/25 at 2:20 PM, 9/26 at 6:57 PM, 9/27 at 7:28 PM, and 9/28/25 at 6:46 PM. This indicates R4's pain was not treated with the physician ordered hydrocodone from 9/21 to 9/30/25 and was not treated with any pain-relieving medication on 9/23, 9/24, and 9/29 when she was assessed with pain scales of 4 and 5.R4's MAR dated 10/01/25 to 10/31/25 documents a physician order for hydrocodone-acetaminophen 5-325 mg give one tablet every 6 hours as needed for pain. This same MAR documents R4 is routinely administered hydrocodone from 10/09/25 until 10/31/25. There is no documentation of the hydrocodone and/or acetaminophen being administered from 10/01 through 10/8/25. This MAR documents the following pain scale assessments using a 0-10 pain scale: 10/01 - night shift- 5, 10/02 - night shift- 3, 10/03 - day shift - 3, 10/05 - night shift - 4, 10/6 - night shift - 3, 10/07 - night shift - 3, 10/08- night shift- 4. This indicates R4's pain was not treated with pain relieving medications from 10/01 to 10/8/25 when she was assessed as having pain at a scale of 3-5.On 10/20/25 at 12:28 PM, V7 (Caregiver) stated R4 currently had pain medications but she was out of them the end of September, and it took about a week and a half to get it in. V7 stated R4 would cry in pain after her lunch time nap. V7 stated the facility staff offered her Tylenol but it didn't relieve the pain. V7 stated she didn't know why the medications weren't available.On 10/20/25 at 12:54 PM, V32 (LPN/Licensed Practical Nurse) stated they run out of controlled substances (pain medications) at times. When asked why, V32 stated the NP (Nurse Practitioner), it's hard. V32 stated when a resident needs a new prescription, they let the physician know and then the facility staff call the pharmacy to get it and the pharmacy reports they don't have the prescription. V32 stated R4 was out of her pain medications about three weeks ago for four to five days. V32 stated R4 had an increase in pain, they tried Tylenol to control it, but it didn't work. 2. R31's admission Record with a print date of 10/22/25 documents R31 was admitted to the facility on [DATE] with diagnoses that include multiple sclerosis, stiffness, and polyosteoarthritis.R31's MDS dated [DATE] documents a BIMS score of 09, indicating R31 has moderate cognitive impairment.R31's current Care Plan documents a Focus area of, (R31) has potential for pain. Date Initiated: 10/15/2019. This Focus area includes the intervention of, Administer analgesia as per ordered. Date Initiated: 08/17/2020. R31's Order Summary Report dated 10/22/2025 documents a physician order for Gabapentin Oral Capsule give 900 mg by mouth at bedtime for Multiple Sclerosis with an order date of 09/28/2025.R31's Medication Administration Record dated 10/01/25 to 10/31/25 documents a 6 for the dates of 10/07/25-10/13/25 for the order of Gabapentin. Under the Chart Codes the MAR documents 6=Other-See Progress Notes. This same MAR documents R31's pain level, using a 0-10 pain scale, at 0 (indicating no pain) each shift from 10/1/25 to 10/22/25 except for the following dates: 10/09- and 10/17-night shift and 10/20/25 day shift, R31's pain is assessed as a 1. On 10/7 and 10/13/25, R1's pain level is assessed at a 3.On 10/15/25 at 7:01 PM, V53 (LPN) stated R31 had been without her gabapentin for about a week. V53 stated R31 would cry at night

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure sufficient staff were available to meet the needs of residents in a timely manner. This has the potential to affect all 74 residents residing at the facility.Findings Include:1. R4's admission Record with a print date of [DATE] documents an admission date of [DATE] and included diagnoses of pressure ulcer, acute kidney failure, dementia, osteoporosis, chronic kidney disease, hypertension, glaucoma, muscle weakness, and reduced mobility. R4's Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 03, indicating R4 has severe cognitive impairment. This same MDS documented R4 is dependent on staff for toileting hygiene and requires substantial/maximal assistance for transfers. R4's current Care Plan documents a Focus area of (R4) has bladder incontinence with a date initiated of [DATE]. Corresponding interventions initiated on [DATE] included Brief Use: the resident uses disposable briefs; Encourage fluids during the day to promote prompted voiding responses; Incontinent: Check the resident as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN (as needed) after incontinence episodes; Monitor/document for s/sx (signs/symptoms) UTI (urinary tract infection). R4's Care Plan also documented a Focus area of (R4) has an ADL (activities of daily living) Self Care Performance Deficit Impaired Balance with a date initiated of [DATE]. Corresponding interventions initiated on [DATE] included Toilet Use: The resident requires 1 staff participation to use toilet; Transfer: The resident requires 1 staff participation with transfers. On [DATE] at 12:28 PM, V7 (Caregiver) stated she sits with R4 from 7 AM to 1 PM and from 5PM to 7 PM. R4 was sleeping in her chair at the time this interview started. R4 woke up during the interview and stated she didn't get to go to the bathroom before she went to bed on [DATE]. R4 stated the CNA (Certified Nursing Assistant) told her to just go to bed because she couldn't take her to the bathroom by herself and there wasn't anyone else to help. R4 stated the CNA didn't even try to take her to the bathroom. V7 stated R4 was soaking wet this morning (referring to [DATE]). V7 stated R4's clothes were drenched up her back and her whole bed was wet. On [DATE] at 12:57 PM, V14 (CNA) stated she worked as a CNA and provided care to R4 on the morning of [DATE]. V14 stated she arrived to work at 6 AM on [DATE] and R4 was in bed and dry when she checked her a little after 6 AM. V14 stated she did not get R4 out of bed that morning and she wasn't sure who did. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 2:21 PM, V65 (CNA) stated she worked night shift beginning on [DATE] and ending on the morning of [DATE]. V65 stated she was R4's CNA from 6 PM to 10 PM and was the CNA who assisted R4 to bed. V65 stated she told R4 they didn't have staff to take her to the bathroom before going to bed. V65 stated her partner was on break and she couldn't find anyone else to assist her and it takes two staff to take R4 to the bathroom. V65 stated she told R4 she could wait about thirty minutes, but R4 wanted to go to bed. V65 stated this occurred around 6 PM on the evening of [DATE]. V65 said they had seven CNA's working at the time (from 6 PM to 10 PM), explaining there were 2 CNA's per hall except for the rehab hall, which had one CNA. V65 stated R4 is normally incontinent but had recently started wanting to use the toilet. V65 stated if R4 wants to go to the toilet and they have the staff available to assist her, V65 will take her to the toilet. V65 stated R4 was not a resident she was responsible for doing bed checks on from 10 PM to 6 AM as the staffing level changed to three CNA's during that time, with a fourth CNA who was orientating. V65 stated she was not the CNA who assisted R4 up on the morning of [DATE] prior to leaving the facility for the day. On [DATE] at 1:36 PM, V7 (Caregiver) stated when she got to the facility on the morning of [DATE], R4 was sitting in her chair with a blanket over her wearing her pajama top and an incontinence brief. V7 stated R4's incontinence brief and pajama top were both wet. V7 stated she found R4's pajama bottoms in the dirty clothes inside out and saturated with urine. V7 stated the bottoms were so wet she had to put them in a plastic bag. V7 stated R4 told V7 she needed to change her bed, and V7 told R4 the bed was already made. V7 stated R4 told her the bed was wet, so V7 pulled the covers back on the made bed and the sheet and bed pad were both visibly saturated with urine. V7 stated she didn't report it to anyone because she used to report incidents that occurred, but it never did any good. V7 stated when there is only one staff on the hall, she expects the care will be lacking because it is hard for the staff to keep up. V7 stated she is just glad she is there to assist R4 but feels for the other residents on the hall who don't have a (private) care giver. On [DATE] at 2:38 PM, this surveyor spoke to V2 (Director of Nurses/DON) regarding R4 not being toileted prior to bed on [DATE] and her clothes and bed being saturated on the morning of [DATE]. V2 stated that was unacceptable and she expected the licensed nurses to assist the CNA's with providing care to the residents when needed. 2. R1's admission Record with a print date of [DATE] documents an admission date of [DATE] and included diagnoses of neurocognitive disorder with Lewy bodies, altered mental status, abnormal posture, muscle weakness, and unspecified psychosis. R1's MDS dated [DATE] documented a BIMS score of 00, indicating R1 has severe cognitive impairment. This same MDS documents R1 is dependent on staff for toileting hygiene and requires substantial/maximal assistance for toilet transfer. R1's current Care Plan documents a Focus area of (R1) has bladder incontinence. Has dx (diagnosis) of BPH (benign prostatic hyperplasia) with a date initiated of [DATE]. Corresponding interventions initiated on [DATE] included Brief Use: Us (sic) adult incontinent briefs when up for dignity reasons; Incontinent: Check approximately every 2 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes; Offer and assist (R1) to toilet. R4's Care Plan also documented a Focus Area of (R1) has bowel incontinence with a date initiated of [DATE]. Corresponding interventions initiated on [DATE] included Provide loose fitting, easy to remove clothing; Provide peri care after each incontinent episode. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R38's admission Record with a print date of [DATE] documents an admission date of [DATE] and included diagnoses of syncope and collapse, dementia, heart disease, atrial fibrillation, unsteadiness on feet, and repeated falls. R38's MDS dated [DATE] documented a BIMS score of 07, indicating severe cognitive impairment. This same MDS documented R38 requires substantial/maximal assistance for toilet hygiene. R38's current Care Plan documents a Focus area of (R38) has bladder incontinence with a date initiated of [DATE]. Corresponding interventions initiated on [DATE] included Brief Use: the residents use disposable briefs; Incontinent: Check the resident Q2 (every 2 hours) and as required for incontinence. On [DATE] at 1:13 PM, V73 (Family Member of both R1 and R38) stated she regularly visits with R1 and R38 three to five days a week, and when asked if the facility had enough staff to meet residents' needs V73 stated, Absolutely not. V73 stated they used to have two CNA's per hall and now they usually only have one. V73 stated she can't remember the exact date, but recently R1 had to sit in feces in the dining room because they didn't have enough staff to take him from the dining room, use the mechanical lift, and change him. V73 stated there was also a time there was only a nurse (V15 - Licensed Practical Nurse/LPN) and R38 had a bowel movement and had feces all over her. V73 stated V15 told her there were no CNA's to assist. V73 stated V15 did the best she could but she didn't have any help. V73 stated this also occurred recently but she could not recall the exact date or time of occurrence. On [DATE] at 1:02 PM, V15 (LPN) stated she sometimes had to work as a CNA in the morning when the CNA's were late getting to work. V15 stated they had staff calling in and other staff quitting this past weekend, so that made it hard. V15 stated she couldn't recall a specific date or incident where she was covering as a CNA and R38 had to wait for care. 3. R9's admission Record with a print date of [DATE] documents an admission date of [DATE] and included diagnoses of end stage renal disease, absence of right leg above the knee, osteomyelitis, heart failure, and muscle weakness. R9's MDS dated [DATE] documented a BIMS score of 15, indicating R9 is cognitively intact. This same MDS documents R9 requires substantial/maximal assistance of staff for toileting. R9's current Care Plan documents a Focus area of (R9) has an ADL (activities of daily living) Self Care Performance Deficit Fatigue with a date initiated of [DATE]. Corresponding interventions initiated on [DATE] included Toilet Use: the resident requires 1 staff participation to use toilet. The facility Grievance Form dated [DATE] documents R9 filed a grievance related to an issue of Nursing Care. Under Description the form documents, Call light is not getting answered in a timely manner. Under Investigation the form documents, Call light audit done 8-4-25 - 8-8-25. Nursing met with resident and addressed concerns. Resident states he understands during certain times it takes longer to answer and he appreciates everything the staff does. Under Recommendations/Action Taken the form documents, Staff educated to continue answering call lights as promptly as possible. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:30 PM, R9 stated if the regular staff is working his call light get answered timely. R9 stated some agency staff are ok, some are not. R9 stated it has taken up to an hour and ten minutes. R9 stated two nights ago he had to sit in feces and wait for assistance for a long time. 4. R10's admission Record with a print date of [DATE] documented an admission date of [DATE] and included diagnoses of diabetes, anemia, heart failure, muscle weakness, reduced mobility, and atrial fibrillation. R10's MDS dated [DATE] documented a BIMS score of 11, indicating R10 has moderate cognitive impairment. This same MDS documents R10 is dependent on staff for toileting. R10's current Care Plan documents a Focus area of (R10) has bladder incontinence with a date initiated of [DATE]. Corresponding interventions included Brief Use: the resident uses (Size) disposable briefs. Check & (and) change Q2 (every 2 hours) and prn (as needed). On [DATE] at 6:20 PM, R10 stated it takes a long time for them to answer the call lights, and she's had incontinent episodes while waiting for staff to assist her. 5. R37's admission Record with a print date of [DATE] documented an admission date of [DATE] and included diagnoses of osteoarthritis, hypertension, atrial fibrillation, pain, muscle weakness, and reduced mobility. R37's MDS dated [DATE] documented a BIMS score of 10, indicating R37 has a moderate cognitive deficit. R37's current Care Plan documents a Focus area of (R37) has frequent bladder incontinence with an initiation date of [DATE]. Corresponding interventions initiated on [DATE] included Incontinent: Check the resident Q2 (every 2 hours) and as required for incontinence. On [DATE] at 6:18 PM, R37 stated they don't usually have enough staff to meet her needs timely. R37 stated it can take up to two hours for them to answer the call lights. R37 stated she's had incontinent episodes while waiting for staff to assist her. On [DATE] at 6:31 PM, V10 (CNA) stated they don't have enough staff to meet the needs of the residents timely. V10 stated it sometimes takes a while to get another staff to assist them when they need help with a resident. On [DATE] at 6:40 PM, V46 (CNA) stated they don't have enough staff to meet the needs of the residents timely. V46 stated they usually only have one CNA on each hall on the 2- 10 PM shift. V46 stated she usually works the 100 hall, and they have 3-4 residents who require assist of two staff on that hall. V46 stated when they need assistance, she gets someone from another hall to assist her. V46 stated residents have had incontinence episodes and falls because of this. On [DATE] at 7:27 PM, V45 (CNA) stated they absolutely didn't have enough staff to meet the needs of the residents timely. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:31 PM, V59 (CNA) stated she didn't think they had enough staff to meet the needs of the residents timely. When asked if they were able to complete every two-hour bed checks through the night, V59 stated, It may be more than two hours. On [DATE] at 10:44 PM, V61 (CNA) stated they don't have enough staff to meet the needs of the residents timely. V61 stated they do bed checks, but it takes longer than two hours. On [DATE] at 2:56 PM, V51 (CNA) stated they sometimes have enough staff to meet the needs of the residents timely but most of the time they are really short staffed. V51 stated he works the 2-10 PM shift, and they are supposed to have two CNA's on the main halls and one CNA on the rehabilitation hall. V51 stated sometimes they only have one (CNA) on each hall. V51 stated sometimes people have incontinence episodes because they can't assist them as quickly. On [DATE] at 11:44 AM, V62 (CNA) stated she works night shift 10 PM to 6 AM. V62 stated they have 70-80 residents and work with only three CNA's on night shift. V62 stated, I am not able to provide quality care. V62 stated on [DATE] she was responsible for 26 residents, seven of which required two staff to assist them and 21 who required assistance with incontinence care. When asked if there was any negative outcome related to staffing, V62 stated residents have incontinence episodes because they have to wait on us, they have had to sit in urine/feces longer than they should. On [DATE] at 12:54 PM, V32 (LPN) stated he didn't feel like one CNA on each hall was enough to meet the needs of the residents timely. V32 stated two CNA's for each hall is more effective. V32 stated with one CNA per hall, residents have to wait a long time and have incontinent episodes. On [DATE] at 2:01 PM, V13 (CNA) stated they don't always have enough staff to meet the needs of the residents. V13 stated when there are call-in's, they don't really try to get anyone to help. V13 stated residents have incontinent episodes due to how long it takes them to answer the call lights. On [DATE] at 1:08 PM, V67 (anonymous) stated they didn't have enough staff to meet the needs of the residents timely. V67 stated they can't get the residents who require assist of two out of bed, they don't get showers done as they should, and there isn't enough time to provide activities of daily living like they should. V67 stated, Like the (mechanical lift) for example. With it going around on (name of social media site) about the CNA in California getting charged with manslaughter because a resident fell out of a (name of mechanical lift) and died. If I don't have a partner, I am not doing the (mechanical lift) by myself. V67 stated she usually works on a hall by herself five times a month. V67 stated she works day shift now, but she used to work 2-10 PM shift, and it was worse in the evenings than it is during the day shift. 6. R5's admission Record with a print date of [DATE] documented an admission date of [DATE] and included diagnoses of cerebral infarct, heart failure, anemia, chronic obstructive pulmonary disease, adult failure to thrive, diabetes, and neuropathy. R5's MDS dated [DATE] documented a BIMS score of 15, indicating R5 is cognitively intact. R5's current Care Plan documents a Focus area of (R5) has Diabetes Mellitus and (R5) is non-compliant with her diet with an initiation date of [DATE]. Corresponding interventions initiated on [DATE] included Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R5's Order Summary Report dated [DATE] included the following physician orders, Furosemide.20 mg (milligrams) Give 1 tablet by mouth one time a day for diuretics.glyburide.5 mg.Give 1 tablet by mouth one time a day for antidiabetics.Jardiance.25 mg.Give 1 tablet by mouth one time a day for antidiabetics.Lantus. 100 unit/ml (milliliter).Inject 10 unit subcutaneously at bedtime for antidiabetics.Levothyroxine.50 mcg (micrograms).Give 1 tablet by mouth one time a day for thyroid agents.Lyrica.50 mg.Give 1 capsule by mouth every morning and at bedtime for Anticonvulsants.Metformin.500 mg Give 2 tablet by mouth one time a day for Antidiabetics.Potassium Chloride ER.20 meq (milliequivalents) Give 1 tablet by mouth every morning and at bedtime for Minerals & (and) electrolytes.Tradjenta.5 mg.Give 1 tablet by mouth one time a day for Antidiabetics. R5's Medication Admin Audit Report dated [DATE] to [DATE] documented the following medications were administered late. Lyrica 50 mg on 10/03, 10/15, 10/18, and 10/19; Potassium Chloride 10 meq on 10/03, 10/07, 10/19, and 10/19; Lantus 10 units on 10/03, 10/10, 10/15, and 10/19; Glyburide 5 mg, Jardiance 25 mg, Tradjenta 5 mg, Metformin 500 mg, Levothyroxine 50 mcg, and Furosemide 20 mg on 10/07 and 10/19. Lantus 10 units on 10/10, 10/15, and [DATE]. R5's Medication Admin Audit Report dated [DATE] to [DATE] documents V32 (LPN) signed off administering R5's medications late on [DATE]. On [DATE] at 12:54 PM, V32 (LPN) stated he can administer his medications timely. On [DATE] at 11:34 AM, R5 stated she is a diabetic and takes insulin. When asked if her medications were ever administered late, R5 stated, Yes, all medications are late when the agency nurse is working. R5 stated she sometimes doesn't get her medications that are due at 8:00 PM until 11:00 PM, including her insulin. 7. R19's admission Record with a print date of [DATE] documented an admission date of [DATE] and included diagnoses of cerebral infarction, diabetes, dementia, and hypertension. R19's MDS dated [DATE] documented a BIMS score of 07, indicating R19 has a severe cognitive deficit. R19's current Care Plan documents a Focus area of (R19) has Diabetes Mellitus with an initiation date of [DATE]. Corresponding interventions initiated on [DATE] included Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. R19's Order Summary Report dated [DATE] included the following physician orders. Humalog.Inject 10 unit subcutaneously with meals for Hyperglycemia.Lantus.Inject 12 unit subcutaneously at bedtime for elevated blood glucose . R19's Medication Admin Audit Report dated [DATE] to [DATE] documents the following medications were administered late: Humalog 10 units on 9/11, 9/26, 10/04, and [DATE]. 8. R35's admission Record with a print date of [DATE] documented an admission date of [DATE] and included diagnoses of repeated falls, chronic obstructive pulmonary disease, chronic kidney disease, and obstructive sleep apnea. R35's MDS dated [DATE] documented a BIMS score of 14, indicating R35 is cognitively intact. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R35's current Care Plan does not document a Focus area with interventions that include medication administration. R35's Order Summary Report dated [DATE] includes the following physician orders: Gabapentin Oral Capsule.Give 1 capsule by mouth two times a day for nerve pain.Order Date [DATE].Quetiapine Fumarate Tablet 25 mg (Seroquel) give 1 tablet by mouth at bedtime for Insomnia .Oder Date [DATE]. R35's Medication Admin Audit Report dated [DATE] to [DATE] documents the following medications were administered late. Gabapentin 100 mg on 10/04, 10/06, 10/07, 10/12, and 10/15 and Seroquel 25 mg on [DATE]. On [DATE] at 12:28 PM, V33 (Registered Nurse/RN) stated she is late administering medications at times because she will pause her medication pass to feed residents. On [DATE] at 12:23 PM, when asked why she administered medications late to the residents at times, V49 (RN) stated she was an agency nurse and she had to make sure she was administering the correct medication to the correct resident, and she also had to stop her medication pass at times and provide care to the residents. On [DATE] at 1:13 PM, V70 (RN) stated medications were administered late at times in part due to the workload. V70 stated when you have so many medications to give including patches, eye drops, and nasal sprays, it gets delayed. V70 stated when you have 35 residents to administer medications to and multiple things that need to be done and you give the residents the attention they need, medication administration is late. On [DATE] at 2:01 PM, V71 (RN) stated she is very late administering medications at times. V71 stated it has happened more than once, but not every time she administers medications. V71 stated unusual weather causes the computer to shut down and that impacts medication administration times. V71 stated she also spends a lot of time trying to locate missing items including medications and that causes her medication administration to be late. V71 stated the residents on the hall she usually works on are a higher level of care and that causes her medication administration to be late. V71 stated she only worked at the facility as needed and that could also be part of the reason the medications were administered late. On [DATE] at 4:56 PM, V53 (LPN) stated she was able to pass her medications timely if everything went ok but if something happened, the medications would be administered late. V53 stated she administers medications to approximately 40 residents each shift. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 2:38 PM, V2 (Director of Nurses) stated they currently have 71 residents in the facility. V2 stated they have two CNA's each on the three long term care halls and one on the rehabilitation hall on day shift and evening shift, then they have three CNA's (total) on night shift. When asked how many residents require assist of two and how many were incontinent, V2 stated she would have to look. When asked if she had enough staff to meet the needs of the residents timely, V2 stated, Yes, if they are doing what they are supposed to. When asked how three CNA's were able to provide care to 71 residents on night shift, V2 stated she expected the licensed nurses to assist them. When asked why medications were administered late, V2 stated she didn't know. V2 stated she has passed medications and didn't have any problem getting them administered timely unless she had another problem, such as if there were a fall, or if she had to send someone out, then getting the medications administered timely would be an issue. This surveyor reviewed with V2 the circumstances of R4's incident in which staff was unable to find help to assist R4 to the bathroom prior to assisting her to bed (on[DATE]). This surveyor asked V2 if this incident would have occurred during a time the licensed nurse was administering the evening medications and V2 clarified it would have been during that time and confirmed this was a lengthier medication pass. This surveyor then asked V2 if she were to pass evening medications and had to stop and help CNA's transfer residents, did she believe she would be able to administer the medications timely? V2 stated, I see your point. The facility Time Detail Reports and (name of staffing agency) time reports were reviewed for [DATE] to [DATE] and document two CNA's working in the facility from 10 PM to 6 AM on [DATE] and [DATE], and three CNA's working from 10 PM to 6 AM on 10/1 through 10/12, 10/14, and 10/15. The untitled facility daily staffing sheets document three CNA's working 10 PM to 6 AM on [DATE] and [DATE]. On [DATE] at 10:27 AM, V2 (DON) verified there were only two CNA's working in the facility from 10 PM to 6 AM on [DATE] and [DATE]. V2 stated the daily staffing sheets were not accurate and she didn't know why they didn't reflect the correct number of staff working on those days. On [DATE] at 2:15 PM, V46 (CNA) stated she had witnessed at least 2 agency CNA staff leave and stay gone for up to one hour without notifying anyone. V46 stated she doesn't remember the exact date or day, but it happened in the last 2 months. On [DATE] at 2:20 PM, V45 (CNA) stated she has witnessed agency staff leave and stay gone while they should be working on shift in the building. V45 stated it happened about 2 weeks ago. V45 stated she was working 300 hall and there were 2 agency CNAs that left at approximately 8:40 PM and did not return until it was time to clock out at 10pm. On [DATE] at 3:23 PM, V1 (Administrator) stated they have agency staff working to cover staff call-in's. V1 stated they should always have three CNA's working night shift and they are meeting the minimum staffing ratios. The Posting Direct Care Daily Staffing policy dated 12/2024 documents, Policy: 1. The facility will post the staffing on a daily basis at the beginning of each shift. The actual hours worked per position and the total number of hours worked will be posted. The facility Resident Matrix dated [DATE] documents 74 residents reside at the facility.

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F 0755 Level of Harm - 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. (continued on next page)

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F 0755 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to 1. ensure medications were available to be administered as ordered, 2. ensure medications were administered timely, and 3. ensure medications were stored in a secure area for 6 of 6 residents (R4, R5, R19, R31, R35, and R45) reviewed for pharmacy services in the sample of 46. This failure resulted in R4 and R31 not receiving their pain medication and R4 and R31 crying with uncontrolled pain.Findings Include:1(a). R4's admission Record with a print date of 10/01/25 documents R4 was admitted to the facility on [DATE] with diagnoses that includes polyneuropathy. R4's MDS (Minimum Data Set) dated 8/29/25 documents a BIMS (Brief Interview for Mental Status) score of 03, indicating R4 has a severe cognitive deficit.R4's current Care Plan documents a Focus area of (R4) has pain. Date Initiated: 01/22/2025. This Focus area includes the intervention of, Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Date Initiated 01/22/2025.R4's Order Summary Report dated 10/01/2025 documents physician orders for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligrams) give 1 tablet by mouth every 6 hours as needed for pain with an order date of 7/30/25 and Acetaminophen 650 mg by mouth every 4 hours as needed for pain/fever with an order date of 4/18/25.R4's Medication Administration Record (MAR) dated 9/1/25 to 9/30/25 documents a physician order for Hydrocodone-acetaminophen 5-325 mg give one tablet every 6 hours as needed for pain. This same MAR documents R4 is routinely administered the hydrocodone from 9/1/25 until 9/20/25. There is no documentation R4 was administered hydrocodone from 9/21/25 through 9/30/25. This MAR documents the following pain scale assessments for R4: 9/22- night shift-2, 9/23-night shift-4, 9/24- night shift- 4, 9/26- evening shift- 4, 9/29/25 - night shit- 5. This MAR documents the physician order for acetaminophen 650 mg every four hours as needed was administered on 9/25 at 2:20 PM, 9/26 at 657 PM, 9/27 at 7:28 PM, and 9/28/25 at 6:46 PM. This indicates R4's pain was not treated with the physician ordered hydrocodone from 9/21 to 9/30/25 and was not treated with any pain-relieving medication on 9/23, 9/24, and 9/29 when she was assessed with pain scales of 4 and 5.R4's MAR dated 10/01/25 to 10/31/25 documents a physician order for hydrocodone-acetaminophen 5-325 mg give one tablet every 6 hours as needed for pain. This same MAR documents R4 is routinely administered hydrocodone from 10/09/25 until 10/31/25. There is no documentation of the hydrocodone and/or acetaminophen being administered from 10/01 through 10/8/25. This MAR documents the following pain scale assessments: 10/01 - night shift- 5, 10/02 - night shift- 3, 10/03 - day shift - 3, 10/05 - night shift - 4, 10/6 - night shift - 3, 10/07 - night shift - 3, 10/08- night shift- 4. This indicates R4's pain was not treated with pain relieving medications from 10/01 to 10/8/25 when she was assessed as having pain at a scale of 3-5.On 10/20/25 at 12:28 PM, V7 (Caregiver) stated R4 currently had pain medications but she was out of them the end of September, and it took about a week and a half to get it in. V7 stated R4 would cry in pain after her lunch time nap. V7 stated the facility staff offered her Tylenol but it didn't relieve the pain. V7 stated she didn't know why the medications weren't available.On 10/20/25 at 12:54 PM, V32 (LPN/Licensed Practical Nurse) stated they run out of controlled substances (pain medications) at times. When asked why, V32 stated the NP (Nurse Practitioner), it's hard. V32 stated when a resident needs a new prescription, they let the physician know and then the facility staff call the pharmacy to get it and the pharmacy reports they don't have the prescription. V32 stated R4 was out of her pain medications about three weeks ago for four to five days. V32 stated R4 had an increase in pain, they tried Tylenol to control it, but it didn't work.1(b). R31's admission Record with a print date of 10/22/25 documents R31 was admitted to the facility on [DATE] with diagnoses that include multiple sclerosis, stiffness, and polyosteoarthritis.R31's current Care Plan documents a Focus area of, (R31) has potential for pain. Date Initiated: 10/15/2019. This Focus area includes the intervention of, Administer analgesia as per ordered. Date Initiated: 08/17/2020.R31's Order Summary Report dated 10/22/2025 documents a physician order for Gabapentin Oral Capsule 900 mg by mouth at bedtime for Multiple Sclerosis with an order date of 09/28/2025.R31's Medication Administration Record dated 10/01/25 to 10/31/25 documents a 6 for the dates of 10/07/25-10/13/25. Under the Chart Codes the MAR documents 6=Other-See Progress Notes. This same MAR documents R31's pain level, using a 0-10 pain scale, at 0 (indicating no pain) each shift from 10/1/25 to 10/22/25 except for the following dates: 10/09- and 10/17-night shift and 10/20/25 day shift, R31's pain is assessed as a 1. On 10/7 and 10/13/25, R1's pain level is assessed at a 3 On 10/15/25 at 7:01 PM, V53

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure residents were free from significant medication errors for 3 of 3 residents (R5, R19, and R35) reviewed for medication administration in the sample of 46.Findings Include:1.R5's admission Record with a print date of 10/01/25 documents R5 was admitted to the facility on [DATE] with diagnoses that include cerebral infarct, heart failure, anemia, chronic obstructive pulmonary disease, adult failure to thrive, diabetes, and polyneuropathy.R5's Minimum Data Set (MDS) dated [DATE] documents R5 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R5 is cognitively intact. R5's current Care Plan documents a Focus area of, (R5) has Diabetes Mellitus. (R5) is non-compliant with her diet. Date Initiated: 05/31/2022. This Focus area includes the intervention of, Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Date Initiated: 05/31/2022.R5's Order Summary Report dated 10/01/2025 documents the following physician orders: Furosemide 20 mg (milligrams) Give 1 tablet by mouth one time a day for diuretics, Glyburide 5 mg Give 1 tablet by mouth one time a day for antidiabetics, Jardiance 25 mg Give 1 tablet by mouth one time a day for antidiabetics, Lantus 100 unit/ml (milliliter) Inject 10 unit subcutaneously at bedtime for antidiabetics, Levothyroxine 50 mcg (micrograms) Give 1 tablet by mouth one time a day for thyroid agents, Lyrica 50 mg Give 1 capsule by mouth every morning and at bedtime for Anticonvulsants, Metformin 500 mg Give 2 tablet by mouth one time a day for Antidiabetics, Potassium Chloride ER (extended release) 20 mEq (milliequivalents) Give 1 tablet by mouth every morning and at bedtime for Minerals and electrolytes, and Tradjenta 5 mg Give 1 tablet by mouth one time a day for Antidiabetics.R5's Medication Admin Audit Report dated 10/01/2025 to 10/20/2025 documents the following medications were administered late:10/03/25 - Lyrica 50 mg, Potassium Chloride 20 mEq, and Lantus 100 unit/ml (10 units) ordered to be administered at 8:00 pm, documented as administered at 10:16 PM.10/07/25- Lyrica 50 mg, Potassium Chloride 20 mEq, Glyburide 5 mg, Jardiance 25 mg, Tradjenta 5 mg, Metformin 500 mg, Levothyroxine 50 mcg, and Furosemide 20 mg ordered to be administered at 8:00 AM documented as administered at 10:48 AM.10/10/25- Lantus 100 unit/ml (10 units) ordered to be administered at 8:00 PM, documented as administered at 10:37 PM.10/15/25 - Lantus 100 unit/ml (10 units) ordered to be administered at 8:00 PM, documented as administered at 9:44 PM. Lyrica 50 mg ordered to be administered at 8:00 PM, documented as administered at 11:57 PM.10/18/25- Lyrica 50 mg ordered to be administered at 8:00 AM documented as administered at 10:54 AM.10/19/25- Potassium Chloride 20 mEq, glyburide 5 mg, metformin 500 mg, tradjenta 5 mg, Jardiance 25 mg, levothyroxine 50 mcg, and furosemide 20 mg ordered to be administered at 8:00 AM, documented as administered at 9:21 AM. Potassium Chloride 20 mEq, Lyrica 50 mg, and Lantus 100 unit/ml (10 units) ordered to be administered at 8:00 PM, documented as administered at 10:35 PM.On 10/20/25 at 11:34 AM, R5 stated she is a diabetic and takes insulin. When asked if her medications were ever administered late, R5 stated, Yes, all medications are late when the agency nurse is working. R5 stated she sometimes doesn't get her medications that are due at 8:00 PM until 11:00 PM, including her insulin.R5's Weights and Vitals Summary dated 11/05/2025 documents blood sugar results from 10/01/25 to 11/5/25 with no significantly abnormal results noted.2. R19's admission Record with a print date of 10/22/25 documents R19 was admitted to the facility on [DATE] with diagnoses that include cerebral infarction, diabetes, dementia, and hypertension. R19's MDS dated [DATE] documents a BIMS score of 07, indicating a severe cognitive deficit.R19's current Care Plan documents a Focus area of, (R19) has Diabetes Mellitus Date Initiated: 05/17/2022. This Focus area includes the following intervention, Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Date Initiated: 05/17/2022.R19's Order Summary Report dated 10/01/2025 includes the following physician orders: Humalog Inject 10 unit subcutaneously with meals for Hyperglycemia and Lantus Inject 12 unit subcutaneously at bedtime for elevated blood glucose.R19's Medication Admin Audit Report dated 9/1/25 to 10/23/25 documents the following medications were administered late:9/11/25-Humalog 10 units ordered to be administered at 8 AM, documented as administered at 9:25 AM. 9/26/25 - Humalog 10 units ordered to be administered at 12:00 PM, documented as administered at 1:45 PM.10/04/25 Humalog 10 units ordered to be administered at 8:00 AM, documented as administered at 9:37 AM.10/18/25 - Humalog 10 units ordered to be administered at 8:00 AM, documented as administered at 11:08 AM.10/18/25 - Lantus 12 units ordered to be administered at 8:00 PM, documented as administered at 9:30 PM.R19's Weights and Vitals Summary dated 11/05/25 documents blood sugar results from 10/01/25 to

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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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on interview, observation, and record review the facility failed to ensure the facility employed certified dietary staff in the kitchen. This failure has the ability to affect all 74 residents residing at the facility.Findings include: On 09/29/25 at 11:03 AM, V5 (Cook) stated they do not currently have a Dietary Manager. V5 stated, she does not have her food manager certification, and that no one in the kitchen currently does. V5 stated, she has been back for a couple days now, she worked at the facility a while ago.On 09/29/25 at 11:33 AM, V1 (Administrator) stated, there is currently no one in the kitchen that has their food manager certification. V1 stated, they do not currently have a Dietary Manager, the previous one (V4) walked out approximately a couple weeks ago. V1 stated they did not get any of the current staff certified within that time frame. V1 stated, they have someone from the dining services they use doing the ordering and menu but they are not at the facility daily.On 09/29/25 at 11:03 AM there were no certified dietary staff at the facility or working in the kitchen.The facility Resident Matrix dated 10/15/25 documents 74 residents reside at the facility.The facility document dated 07/07 titled, Sanitation Certification documents: policy: The food service manager shall be certified in sanitation. Additional food service staff (usually the cooks) are certified in sanitation thus ensuring that the facility has someone in-house that is certified in sanitation during the hours of operation for the food service department. Procedure: 1 county health departments and local community colleges provide training for management sanitation certification examination. 2 at least one individual in the food service department will be certified for sanitation during the hours of operation for the department. 3 certification will be kept current and renewed as directed.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide sufficient and competent dietary staff to carry out the functions of the food and nutrition service. This failure has the potential to affect all 74 residents residing at the facility. Findings include:An undated facility policy titled, Dining Service Meal Times documents: breakfast at 7:00 AM, Lunch at 12:00 noon (PM), and supper at 5:00 PM.On 09/30/25 at 7:15 AM kitchen staff called out that the cart for the 400 hall was ready for pick up. At 7:37 AM kitchen staff called for the 300 hall was ready for pick up, at 7:43 AM the 300 hall food trays were started to be delivered. At 7:50 AM there were no residents with food on the 100 hall, the large dining room, or the front dining room. At 7:59 AM there were still three trays left to deliver on the 300 hall. At 8:00 AM the food for the small dining room was ready to be delivered. At 8:00 AM there were still 3 trays left to deliver for the 300 hall, at 8:01 AM the trays for the 100 hall was ready to be delivered, at 8:09 AM the 200 hall tray were started to be deliveredOn 09/30/25 at 8:19 AM surveyor a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/_ 2 degrees Fahrenheit. On 09/30/25 at 8:19 AM, R9's breakfast tray was refused and tested by this surveyor. The western eggs were 103 degrees Fahrenheit, the oatmeal was 103 degrees Fahrenheit, the toast was dark brown to black in color, very hard to the touch, and crumbled into pieces when pushed on. There was no jelly, butter, or sugar on the tray. The eggs and oatmeal were cold when tasted, the oatmeal was bland with no sugar or other toppings already on the oatmeal.On 09/30/25 at 12:34 PM the 400 hall lunch cart was ready to be picked up, at 12:45 PM the 300 hall lunch cart was ready to be picked up, at 12:58 PM the 100 and 200 hall cart was ready, at 1:00 PM small dining room still had no food. At 1:00 PM staff were still delivering the 300 hall lunch trays, 1:18 PM halls trays for the 300 hall were still being delivered at 1:18PM. At 1:18 PM the large dining room food was in the process of being delivered.On 09/29/25 at 11:43 AM, R6 stated, the facility did not have dietary staff for a while. R6 stated, she did get a peanut butter and jelly for breakfast one day. R6 stated, the food seems to always be late. Sometimes it was well over an hour late. R6's Minimum Data Set, dated [DATE] documents a BIMS score of 15, indicating cognitively intact. On 09/30/25 at 1:05 PM, R10 who was alert and oriented stated you never know when you are going to receive the meals anymore, they are typically late.On 09/29/25 at 10:32 AM, R7 who was alert and oriented, stated the food was cold yesterday, the eggs are cold, the oatmeal is usually cold, if they have waffles, the waffles are cold, and her hot tea is always cold. R7 stated, if she gets her soup, it is usually cold also. R7 stated, the food on her ticket rarely matches what she receives on her tray.On 09/29/25 at 10:05 AM, R4 who was alert and oriented, stated a couple weeks ago she got peanut butter and jelly for breakfast. R4 stated, they were getting a lot of sandwiches for a bit. R4 stated, the food has not been great.On 09/29/25 at 10:03 AM, V7 (Family Assistant) stated, meals have been late it seems like since the stove has been broke. V7 stated, she is here to assist with eating and other items that need to be done. Lunch has been an hour to an hour and a half late before. Lunch has arrived at 2:00 PM before. V7 stated the food has arrived shortly before she was supposed to leave before and that makes it difficult. There for a bit, they were serving oatmeal all the time. V7 stated, staffing and times for getting help has been worse on nights and weekends.On 09/30/25 at 3:20 PM, V20 (Family) stated, meals have been late, there have been sometimes that it has been over an hour late, the other night it was past 6:00 PM when they received dinner. V20 stated, one time they tried to change the order of the dining service so the family that was at the facility could help the residents.On 09/30/25 at 3:50 PM, V21(Family) stated, meals have been late lately. About a week ago he left the facility about 1:15 PM and R8 still had not received her lunch. He was on the phone with her and she received her lunch at approximately 2:00 PM.On 09/29/25 at 11:33 AM, V1 (Administrator) stated, all the previous dietary staff walked out a couple weeks ago. That morning a couple nurses and CNAs cooked breakfast for that day and the next day. V1 stated, she and some others cooked lunch and dinner the first day and by the second day they were able to get some agency staff in for lunch and dinner time. The residents did get three meals every day, the first day they did get peanut butter and jelly sandwiches and oatmeal. On 09/30/25 at 3:40 PM, V1 stated, meal service has been late sometimes, they are working on it.On 09/30/25 at 11:40 AM, V10 (Certified Nurse Aide/CNA) stated, the kitchen has been struggling to get meals out supposedly due to not having the supplies they need and the staff they need. Meals had been coming out as late as 2:00 PM. The meals have been better but they can still be later than scheduled. V10 stated, it is not uncommon for the

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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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 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to follow the facility menu for 9 (R4, R6, R7, R8, R10, R13, R15, R18, and R42) of 9 residents reviewed for dining in the sample of 46.Findings include:Facility menu: Summer menu 2025, Tuesday, week 1, breakfast, regular documents: 3 ounce western scramble, 6 ounces oatmeal, 1 each sugar, 1 each butter, 0.5 fluid ounces coffee creamer, 1 each jelly, 6 fluid ounces orange juice, 8 fluid ounces 2% milk, 6 fluid ounces coffee. (9/30/25)Facility menu: Summer menu 2025, Tuesday, week 1, breakfast, mechanical soft documents: 3 ounce western scramble, 6 ounces oatmeal, 1 each sugar, 1 each butter, 0.5 fluid ounces coffee creamer, 1 each jelly, 6 fluid ounces orange juice, 8 fluid ounces 2% milk, 6 fluid ounces coffee. (9/30/25)Facility menu: Summer menu 2025, Tuesday, week 1, lunch, general/mechanical soft documents: 2 each corn tortillas, 3 ounces ground taco chicken filling, 2 fluid ounces salsa fresh, 4 ounces Spanish rice, 4 ounces refried beans, 1/2 cup butterscotch pudding, 8 fluid ounces 2% milk, 6 fluid ounces coffee, 1 each butter, 1 each sugar, and 6 fluid ounces hot tea. (9/30/25)1. R15's admission Record documents an admission date of 04/11/25 with diagnoses including: chronic kidney disease, dementia, major depressive disorder, atrial fibrillation, disease of intestine, and hyperglycemia. R15's Order Summary Sheet documents a dietary order of mechanical soft texture and add one fortified food with all meals with an order date of 04/18/25 and no end date listed. The dietary supplements order documents: fortified foods two times a day for breakfast and lunch with an order date of 05/28/25 and no end date listed.R15's Care Plan documents a focus area of: R15 has nutritional problem or potential nutritional problem dated 07/29/25 with an intervention listed as provide and serve diet as ordered dated 05/09/25.R15's Minimum Data Set (MDS) dated [DATE] documents a brief interview of mental status (BIMS) of 03, indicating severely cognitively compromised. R15's eating assistance is listed as: setup or clean up assistance.R15's dining ticket dated 09/30/25 breakfast documents condiment: 1 each butter and 1 each jelly.On 09/30/25 at 8:32 AM, R15 did not receive any butter or jelly with her breakfast.On 09/30/25 at 8:32 AM, R15 who was alert and oriented, stated she would like butter and jelly for her toast, she would probably eat it then.On 09/30/25 at 1:32 PM, R15 did not receive any corn tortilla or any butterscotch pudding with her lunch.On 09/30/25 at 1:32 PM, R15 stated she would like the tortillas and a dessert, the butterscotch pudding would be fine, with her lunch. R15 did not end up receiving these items with her lunch meal. 2. R6's admission Record documents an admission date of 02/06/25 with diagnoses including: acute respiratory failure with hypercapnia, chronic obstructive pulmonary disease with acute exacerbation, heart failure, dementia, anxiety disorder major depressive disorder, dysphagia, type 2 diabetes mellitus with diabetic nephropathy, and acute kidney failure.R6's Order Sheet documents a dietary order of no added salt diet with mechanical soft texture with an order date of 04/24/25 with no end date listed.R6's Care Plan documents a focus area of R6 has a nutritional problem or potential nutritional problem dated 05/09/25 with an intervention of provide and serve diet as ordered dated 05/09/25.R6's MDS dated [DATE] documents a BIMS score of 15, indicating R6 is cognitively intact.R6's dining ticket dated 09/30/25 breakfast: documents condiment: 1 each butter and 1 each jelly.On 09/30/25 at 8:40 AM, R6 did not receive any butter or jelly with her breakfast.On 09/30/25 at 8:40 AM, R6 stated she would like jelly and butter with her toast with breakfast. R6 did not end up receiving these items with her breakfast meal. On 09/30/25 at 1:25 PM, R6 did not receive the 2 corn tortilla or the 1/2 cup butterscotch pudding with her lunch.On 09/30/25 at 1:25 PM, R6 stated, she would like to have the corn tortillas and a dessert, the butterscotch pudding would be nice, with her lunch. R6 did not end up receiving these items with her lunch meal. 3. R13's admission Record documents an admission date of 09/09/25 with diagnoses including: cerebral palsy, type 2 diabetes mellitus with hypoglycemia, epilepsy, dysphagia, disorder of urea cycle metabolism, major depressive disorder, poisoning by other antiepileptic and sedative hypnotic drugs accidental, dysphagia, metabolic encephalopathy, anemia, iron deficiency, intellectual disabilities, atrial fibrillation, and adult failure to thrive.R13's MDS dated [DATE] documented a BIMS score of 00.R13's Order Sheet documents a dietary order of consistent carbohydrate diet of mechanical soft texture with add ice cream at lunch and supper for nutrition with an order date of 07/21/25 and no end date listed.R13's Care Plan documents a focus area of R13 has a potential nutritional problem PEG (percutaneous endoscopic gastrostomy) tube is in place due to history of poor intake and weight loss prior to admission dated 06/25/24 with an intervention of provide and serve diet as ordered dated 06/25/24.On 10/23/25 at 1:40 PM, V15 (Licensed Practical Nurse) stated, R13 does not have a PEG tube

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to provide food that was palatable and at an appetizing temperature for 12 (R4, R5, R6, R7, R8, R9, R10, R11, R12, R14, R15, R25) of 12 residents reviewed for food service in a sample of 46.Findings include:On 09/29/25 at 6:50 AM, this surveyor used a digital metal stemmed thermometer used for taking temperatures for this survey, the thermometer was checked for accuracy using the ice-point method and was accurate within +/_ 2 degrees Fahrenheit. 1. On 09/29/25 at 12:50 PM, R8 who was alert and oriented, received her tray and stated the coffee was cold and the French fries were cold and she was not going to eat them and refused the food. At that time R8 asked this surveyor to take the temperature of the coffee and her French fries because she was not eating them. When temped with a metal stemmed thermometer the coffee was 93 degrees Fahrenheit and the French fries were 89 degrees Fahrenheit. On 09/30/25 at 3:50 PM, V21(Family) stated, the food has been burnt and cold lately. The oatmeal has been cold to the point it has gelled together and you can flip the bowl over and it just sticks there. V21 stated, he was there when R8 was served the burnt sausage and it just was not slightly burnt, it was very burnt. It was so burnt he took a picture of it. The coffee has been cold. One-time R8 was served a grilled cheese and there was black stuff on the grilled cheese and the plate. After they sent it back they were told it was chocolate, but why would there be chocolate on the plate and grilled cheese? The black stuff did not look like chocolate either. After the grilled cheese was sent back they were told R8 was going to have to wait awhile before she could get another one, he felt like they were punishing her for sending it back. V21 stated there was a time the oatmeal came out with something red in the center of it.2. On 09/29/25 at 10:32 AM, R7 stated the food was cold yesterday, the eggs are cold, the oatmeal is usually cold, if they have waffles, the waffles are cold, and her hot tea is always cold. R7 stated, if she gets her soup, it is usually cold also. R7's MDS dated [DATE] documents a BIMS score of 15 indicating cognitively intact.3. On 09/29/25 at 11:37 AM, R5 who was alert to person, place and time, stated, dinner was cold last night and is cold at other times also. R5 stated sometimes the sausage doesn't look like it is cooked and sometimes it is burnt. R5 stated the food is lousy. The food was better when the nurses cooked. R5 stated, they do not have enough staff to assist the residents eat, one day it was only V13 (Certified Nurse Aide/CNA) that was available to help the residents. 4. On 09/29/25 at 10:05 AM, R4 who was alert and oriented, stated a couple weeks ago she got peanut butter and jelly for breakfast. R4 stated, they were getting a lot of sandwiches for a bit. R4 stated, the food has not been great and sometimes it is cold.On 09/30/25 at 8:13 AM, Surveyor observed V7 (Family Assistant) attempt to cut through R4's toast, R4's toast was difficult to cut through. R4's toast was hard. R4 took a bite of her toast and stated it was hard and dry. R4 was alert and oriented to person, place and time at time of interview.5. On 09/29/25 at 11:43 AM, R6 stated the food has been cold lately, nights and weekends are the worse. Then there are times it is burnt and hard. R6's Minimum Data Set, dated [DATE] documents a BIMS score of 15, indicating cognitively intact.On 09/30/25 at 8:19 AM surveyor used a digital metal stemmed thermometer used for taking temperatures for this survey, the thermometer was checked for accuracy using the ice-point method and was accurate within +/_ 2 degrees Fahrenheit. 6. On 09/30/25 at 8:19 AM, R9's breakfast tray was refused and tested by this surveyor. The western eggs were 103 degrees Fahrenheit, the oatmeal was 103 degrees Fahrenheit, the toast was dark brown to black in color, very hard to the touch, and crumbled into pieces when pushed on. There was no jelly, butter, or sugar on the tray. The eggs and oatmeal were cold when tasted, the oatmeal was bland with no sugar or other toppings already on the oatmeal.On 09/30/25 at 8:19 AM, R9 who was alert to person, place and time, stated the toast is really hard and it crumbled when he pushed on it and there is no butter or jelly for it and he doesn't have time to wait for anything, he was supposed to be at a doctor's appointment at 8:00 AM but apparently they wrote it down wrong and he is late because no one is ready to take him and he hopes he doesn't miss it all together. 7. On 09/30/25 at 10:36 AM, R12 who was alert to person, place and time stated, breakfast was not that warm today and the toast was kind of burnt. 8. On 09/30/25 at 7:58 AM, R10 stated, the eggs are not warm R10's MDS dated [DATE] documents a BIMS score of 14 indicating, cognitively intact.9. On 09/30/25 at 8:22 AM, R11 picked up her toast, looked at both sides, looked around her tray, tapped the toast on her plate and set it back down without eating any. R11's toast appeared burnt and hard. R11's tray did not contain any butter or jelly.On 10/18/25 at 2:20 PM, R11 was alert to person, place and time, stated they have talked about the food concerns in the resident council meetings including the food being cold or burnt.10. On

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Metropolis Rehab & Hcc	2299 Metropolis Street Metropolis, IL 62960

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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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide preferred items, substitutions, and to follow resident's outlined food preferences for 6 (R3, R5, R6, R8, R10, and R11) of seven residents reviewed for meal preferences and substitutions in a sample of 46.Findings include:1. R6's admission Record documented an admission date of 02/06/25 and included diagnoses of acute respiratory failure with hypercapnia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, heart failure, dementia, anxiety disorder, major depressive disorder, dysphagia, type 2 diabetes mellitus with diabetic nephropathy, and acute kidney failure. R6's Minimum Data Set, dated [DATE] documents a BIMS score of 15, indicating cognitively intact. On 09/29/25 at 11:43 AM, R6 stated, the facility did not have dietary staff for a while. R6 stated, the food she receives is not what is on the ticket. There are always items missing from the what the ticket says. R6 stated, they were not getting substitutions for about the last three weeks or so. The staff would tell you they didn't have it or didn't have time to make it.2. R5's admission record documents an admission date of 05/31/25 with diagnoses including: cerebral infarction, pneumonia, acute respiratory failure with hypoxia, acute on chronic systolic heart failure, hypomagnesemia, and adult failure to thrive. R5's MDS dated [DATE] documents a BIMS score of 15 indicating R5 is cognitively intact.R5's care plan documents a focus area noting: dietary dated 09/05/23 with an interventions listed of: foods (R5) dislike are: tuna, parmesan noodles with meat in them and rice dated 08/12/24.On 09/29/25 at 11:37 AM, R5 stated there are times they do not have any substitutions.On 10/21/25 at 1:50 PM, R5 stated she does not like rice, and she received rice with her lunch today.3. R8's admission record documents an admission date of 05/20/25 with diagnoses including: encounter for other orthopedic aftercare, muscle weakness, type 2 diabetes mellitus, sleep apnea, occlusion and stenosis or unspecified cerebral artery, seizures, diverticulitis of intestine, radiculopathy, and dizziness and giddiness. R8's MDS dated [DATE] documents a BIMS score of 15 indicating R8 is cognitively intact.R8's dietary ticket dated 09/29/25 lunch, document at the bottom of the ticket cranberry juice.On 09/29/25 at 12:50 PM, R8 did not receive the cranberry juice with her lunch meal. At that time, R8 stated she has not received the cranberry juice for a few weeks and most of the time when you ask for a substitution you don't get because they do not have it or they don't have time to make it. Sometimes you may get a grilled cheese or something similar, but it will take well over an hour to receive it. R8's dietary ticket dated 09/30/25 lunch, document at the bottom of the ticket cranberry juice.On 09/30/25 at 1:05 PM, R8 did not receive the cranberry juice with her lunch meal. 4. R10's admission record documents an admission date of 05/22/25 with diagnoses including: type 2 diabetes mellitus with ketoacidosis, malignant neoplasm of left kidney, severe protein calorie malnutrition, nausea, anemia, chronic diastolic heart disease, muscle wasting and atrophy, dysphagia, iron deficiency, obesity, overactive bladder, body mass index of 32.0-32.9%, and long term use of insulin.R10's MDS dated [DATE] documents a BIMS score of 14 indicating R10 is cognitively intact. Section GG documents the eating assistance required by R10 is setup or clean up assistance.R10's dietary ticket dated 09/30/25 lunch documents at the bottom of the ticket, no beans.On 09/30/25 at 1:20 PM, R10 received beans with her lunch. On 09/30/25 at 1:35 PM, R10 stated the dietary ticket stating what they are supposed to receive is rarely what is received. R10 stated, a dessert would be nice, R10 stated, she is not supposed to get beans, but there they are.R10's dietary ticket dated 09/30/25 breakfast documents: milk with all meals, condiments for all meals, cold cereal, raisin bran, scrambled eggs, and banana with meals.On 09/30/25 at 7:58 AM, R10 received her breakfast tray, she did not receive her banana or any raisin bran cereal. R10 stated, she would be ok with toasted oats cereal but she did not receive any cereal. R10 stated, she would like some cereal and a banana.5. R3's admission record documents an admission date of 05/14/24 with diagnoses including: Alzheimer's disease with late onset, dementia, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, pleural effusion, abnormal posture, and body mass index 19.9 or less.R3's minimum data set (MDS) dated [DATE] documents a dash for the question, should brief interview for mental status be conducted? and a dash for the BIMS summary score. R3's MDS section L documents none of the above were present with the boxes included B. no natural teeth or tooth fragments and F. mouth or facial pain, discomfort or difficulty with chewing. R3's dietary ticket dated 09/30/25 breakfast documents at the bottom of the ticket, R3 is to receive a banana and yogurt with breakfast. On 09/30/25 at 8:39 AM, R3 did not receive the banana or yogurt with her breakfast.6. On 10/16/25 at 2:20 PM, R11 who was alert and oriented, stated they have talked about the

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, observation, and record review the facility failed to provide supplements as order for wound healing for one resident (R4) of one resident reviewed for supplements for wound healing in a sample of 46. Findings include: R4's admission Record documents an admission date of 7/14/21 with diagnoses including: encephalopathy, pressure ulcer of sacral region stage 4, dysphagia, metabolic encephalopathy, acute kidney failure, hypercalcemia, dementia, restless legs syndrome, polyneuropathy, diaphragmatic hernia without obstruction or gangrene, osteoarthritis, are related osteoporosis, chronic kidney disease, edema, hypertension, glaucoma, gastro-esophageal reflux disease, diverticulosis of intestine, muscle weakness, cognitive communication deficit, weakness, anorexia, reduced mobility, and unspecified severe protein calorie malnutrition.R4's Order Summary Report documents a dietary order of a regular diet with mechanical soft texture with an order date of 09/18/2025 and an order status of active and a dietary supplement order of fortified foods one time a day for wound healing with an order date of 02/21/25 and an order status of active.R4's Care Plan documents a focus area listing: R4 has nutritional problem or potential nutritional problem dated 01/24/25 with interventions listed of: provide, serve diet as ordered, monitor intake and record every meal, and RD (Registered Dietician) to evaluate and make diet change recommendations as needed dated 05/09/25. R4's care plan documents a focus area listing R4 has potential/actual impairment to skin integrity related to decreased mobility stage 4 pressure to coccyx, right forearm skin tear, and a right shin skin tear dated 08/25/25 with interventions listed as: administer treatments as ordered and monitor for effectiveness, document location of wound, size, amount of drainage, peri-wound area, pain, edema, and circumference measurements, and monitor pressure areas for changes in color, sensation, temperature, and report any change to nurse dated 02/26/25. R4's dietary note dated 10/11/25 at 10:08 AM documents: dietitian chart review for wound updates. R4's October weight is 95.4 pounds which is stable. R4's wound update as of 10/06/25 notes a pressure ulcer stage 4 to the sacrum area, it is noted as improving with treatment and order and nutritional interventions: Remeron 7.5 mg/d (milligrams per day), arginaid, twice a day, prostat 30 ml (milliliters) twice a day, vitamin C, multivitamin and mineral, and boost 120 ml twice a day. R4's diet order is a regular diet with mechanical soft texture and regular liquids, and fortified foods every day. Continue diet order for all wound healing interventions and follow up monthly until resolved.R4's dietary note dated 09/19/25 at 1:36 PM documents: dietitian chart review for wound update. R4's September weight is 96. 4 pounds which is stable with a BMI of 16%. R4's wound's update notes on 09/15 pressure ulcer at a stage 4 to the sacrum is slow to heal but noted as improved at time of review. R4's diet order is regular diet with regular texture and liquids. Fortified food every day, nutritional drink 120 ml twice a day, arginaid twice a day, prostat twice a day and use of multi-vitamin and mineral and vitamin C are noted. Continue all interventions with current trends and follow up monthly until resolved.R4's dietary ticket documents dated 09/30/25 documents breakfast - fortified cereal.On 09/30/25 at 8:10 AM, R4 did not receive any fortified cereal with her breakfast.On 09/30/25 at 1:10 PM, R4 who was alert and oriented, stated, the ticket with her food rarely matches the food she receives.On 09/30/25 at 3:18 PM, V10 (Certified Nurse Aide/CNA) went to the kitchen door and asked for a pudding and ice cream and V18 (Dietary) and V19 (Dietary) shook their heads no and shut the door on her while she was still talking.On 09/30/25 at 3:19 PM, V10 stated, she has noticed when residents are missing items or supplements and she has tried to go to the kitchen and ask the dietary staff for them but most of the time they will not give them to the staff, the dietary staff will say they don't have the item, they don't have time to get them anything, or sometimes they will just say no and shut the door.On 09/30/25 at 3:20 PM, V18 (Dietary) stated, if they have the item such as pudding, they give it, if they do not they don't. On 09/30/25 at 3:21 PM, V19 (Dietary) stated, they do not have time to read the bottom of the tickets.On 09/30/25 at 3:50 PM, V1 (Administrator) stated, she knows the dietary staff were not doing well about reading the bottom of the dietary tickets where the supplements and preferences are listed. V1 stated she will talk to them again.On 10/15/25 at 3:43 PM, V18 stated, they do not have time to read the bottom of the tickets or get items the staff are coming to the dietary door during meal service.On 10/27/25 at 12:45 PM, V72 (Registered Dietician) stated, she would expect all the supplements to be given as she recommended for weight loss and wounds.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure snacks were available and meals were served within the required timeline. This failure has the potential to affect all 74 residents residing at the facility.Findings Include:The facility Resident Matrix dated 10/15/25 documents 74 residents reside at the facility. 1.R21's admission Record with a print date of 10/22/25 documents R21 was admitted to the facility on [DATE] with diagnoses that include diabetes. R21's MDS (Minimum Data Set) dated 8/14/25 documents a BIMS (Brief Interview for Mental Status) score of 09, which indicates a moderate cognitive deficit. R21's current Care Plan documents a Focus area of, .Dietary Date Initiated: 10/22/2025. This Focus area includes the intervention of, .I prefer snacks between meals. I love cheese and crackers. Date Initiated: 10/08/2024. On 10/20/25 at 12:36 PM, R21 stated she is supposed to get bedtime snacks and she is sometimes told they don't have them. 2. R31's admission Record with a print date of 10/22/25 documents R31 was admitted to the facility on [DATE] with diagnoses that include diabetes. R31's Minimum Data Set (MDS) dated [DATE] documents a BIMS score of 09, indicating a moderate cognitive deficit. R31's current Care Plan documents a Focus area of, All About Me- Dietary. Date Initiated 08/17/2017. This Focus area includes the following intervention, I prefer snacks between meals. (R31) will take a snack at times, she likes cookies and chips. Date Initiated: 03/04/2018. R31's Focus area for diabetes does not include an intervention related to snacks. On 10/20/25 at 12:41 PM, R31 stated she doesn't get bedtime snacks provided by the facility. R31 stated she tries to keep something in her room to eat. 3. On 09/29/25 at 2:43 PM R8 stated, they do not receive snacks in the evening anymore and there are times she would really like something. R8 was alert and oriented to person place and time. 4. On 09/29/25 at 2:44 PM, R6 stated she has not been able to get a snack in the evening for a while lately. R6 stated, she will ask for a snack but she is told they don't have any. R6 was alert and oriented to person place and time. 5. On 09/29/25 at 2:48 PM, R7 stated, they do not bring evening snacks anymore. R7 stated, she has asked and they will tell her they do not have any to give anyone. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/30/25 at 2:25 PM, V16 (Family) stated, they have not had snacks lately, probably for about the last two weeks. The staff never pass them, they are usually sitting in a bowl at the nurse's station and residents that are out and about could get one, but the residents that were in their rooms did not get one. But now, no one gets one. On 10/15/25 at 6:40 PM, V46 (CNA/Certified Nursing Assistant) stated bedtime snacks are not left out by dietary for the nursing staff to give to the residents. On 10/15/25 at 7:01 PM, V53 (Licensed Practical Nurse/LPN) stated the kitchen used to leave out drink carts with snacks but they don't do it anymore. V53 stated she does have diabetic resident who need a bedtime snack. On 10/15/25 at 7:27 PM, V45 (CNA) stated the kitchen locks the door after supper so they can't get snacks for the residents. On 10/15/25 at 10:25 PM, V53 (LPN) stated they did not get a drink or snack cart left out for residents bedtime snacks tonight. On 10/15/25 at 10:44 PM, V61 (CNA) stated his main concern at the facility was weight loss. V61 stated the kitchen is locked at night so they can't get snacks and there is no ice available. On 10/20/25 at 11:44 AM, V62 (CNA) stated she works 10 PM to 6 AM. V62 stated half the time they have snacks for the residents, the other time they don't. V62 stated when they have snacks it is oatmeal cream pies and fudge rounds. V62 stated they will sometimes have bananas. V62 stated there are no sandwiches and/or meals left for a resident who may need it. V62 stated they will have peanut butter and jelly sandwiches left out every now and then. On 10/20/25 at 2:21 PM, V65 (CNA) stated they sometimes have bedtimes snacks for the residents. V65 stated when the kitchen leaves out a drink cart for them it will sometimes have drinks only and other times have snacks only. When asked about diabetic residents who are supposed to get a bedtime snack, V65 stated if they don't leave snacks out the residents usually have snacks in their room that them or their family provided. On 10/20/25 at 3:45 PM, V19 (CNA/Dietary Aid) stated she works as agency CNA and Dietary Aid at the facility. V19 stated when she started, she wasn't educated on the facility processes. V19 stated when she first started, they weren't leaving snacks out but now they are. On 10/20/25 at 4:14 PM, V40 (CNA) stated they don't always have bedtime snacks to offer the residents. V40 stated she didn't know why they didn't. V40 stated she works 2 PM to 10 PM and residents ask for them and sometimes they have something to give them and sometimes they don't. On 10/28/25 at 12:27 PM, V74 (Nurse Practitioner/NP) stated not getting a bedtime snack for a resident who has a diagnosis of diabetes can cause significant hypoglycemia. V74 stated if a resident isn't getting a bedtime snack it can cause a hypoglycemic effect and they could die, they could seize in their bed. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/22/25 at 3:23 PM, V1 (Administrator) stated they don't have a snack policy. V1 stated the residents can get a snack whenever they want. V1 stated the kitchen is always unlocked. V1 stated there are always snacks. This surveyor reviewed with V1 the interviews related to no snacks being available for the residents at night, including residents who have diabetes. V1 stated she couldn't say diabetics get a routine snack. 6. The undated facility policy titled, Dining Service Meal Times documents: breakfast at 7:00 AM, Lunch at 12:00 noon (PM), and supper at 5:00 PM. On 09/29/25 at 10:03 AM, V7 (Family Assistant) stated, the food has been late it seems like since the stove has been broke. V7 stated, she is here to assist with eating and other items that need to be done. The lunch has been an hour to an hour and a half late before. The lunch has arrived at 2:00 PM before. V7 stated the food has arrived shortly before she was supposed to leave before and that makes it difficult. There for a bit, they were serving oatmeal all the time. V7 stated, staffing and times for getting help has been worse on nights and weekends. On 09/29/25 at 11:43 AM R6 stated, R6 stated, the food seems to always be late. Sometimes it was well over an hour late. R6's admission record documents an admission date of 02/06/25 with diagnoses including: acute respiratory failure with hypercapnia, chronic obstructive pulmonary disease with acute exacerbation, heart failure, dementia, anxiety disorder major depressive disorder, dysphagia, type 2 diabetes mellitus with diabetic nephropathy, and acute kidney failure. R6's Minimum Data Set, dated [DATE] documents a BIMS score of 15, indicating cognitively intact. On 09/30/25 at 7:15 AM the kitchen called the cart for the 400 hall was ready for pick up. At 7:37 AM the kitchen called for the 300 hall was ready for pick up, at 7:43 AM the 300 hall food trays were started to be delivered. At 7:50 AM there were no residents with food on the 100 hall, the large dining room, or the front dining room. At 7:59 AM there were still three trays left to deliver on the 300 hall. At 8:00 AM the food for the small dining room was ready to be delivered. at 8:00 AM there were still 3 trays left to deliver for the 300 hall, at 8:01 AM the trays for the 100 hall was ready to be delivered, at 8:09 AM the 200 hall tray were started to be delivered On 09/30/25 at 11:40 AM, V10 (Certified Nurse Aide/CNA) stated, the kitchen has been struggling to get meals out supposedly due to not having the supplies they need and the staff they need. Meals had been coming out as late as 2:00 PM. The meals have been better but they can still be later then scheduled. On 09/30/25 at 3:20 PM, V20 (Family) stated the food has been late, there has been sometimes that it has been over an hour late, the other night it was past 6:00 PM when they received dinner. V20 stated, one time they tried to change the order of the dining service so the family that was at the facility could help the residents. On 09/30/25 at 12:34 PM the 400 hall lunch cart was ready to be picked up, at 12:45 PM the 300 hall lunch cart was ready to be picked up, at 12:58 PM the 100 and 200 hall cart was ready, at 1:00 PM small dining room still had no food. At 1:00 PM still delivering the 300 hall lunch trays, 1:18 PM halls trays for the 300 hall are still being delivered, at 1:18 PM the large dining room food is in the process of being delivered. (continued on next page)

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/30/25 at 3:50 PM, V21(Family) stated the food has been late lately. About a week ago he left the facility about 1:15 PM and R8 still had not received her lunch. He was on the phone with her and she received her lunch at approximately 2:00 PM. On 09/30/25 at 1:05 PM, R10 stated you never know when you are going to receive the meals anymore, they are typically late. On 10/15/25 at 3:43 PM, V18 stated they do not have time to read the bottom of the tickets or get items the staff are coming to the dietary door during meal service and get. Meals will be served no more than 30 minutes after the scheduled meal times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145813	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Metropolis Rehab & Hcc	2299 Metropolis Street Metropolis, IL 62960

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview, observation, and record review the facility failed to keep equipment functioning properly to ensure sanitation of dishware. This failure has the potential to affect all 74 resident residing at the facility. Findings include:On 09/29/25 at 11:07 AM, V6 (Dishwasher) stated, he has only worked at the facility for a few days, he worked at the facility years ago. V6 stated, he does not know where the strips to check the sanitizer in the dish machine are. V6 stated, he does not know when it was checked last. On 09/29/25 at 11:14 AM chlorine test strips to check the sanitizer in the dish machine were found, the strips did not perform any color change when utilized, indicating no sanitizer was reading on the strip.On 09/29/25 at 11:14 AM there was no liquid in the line running from the sanitizer container to the dish machine. V6 tried purging the sanitizer line to pull sanitizer from the container of sanitizer to the dish machine, and no sanitizer was observed moving in the line to the dish machine.On 09/29/25 at 11:38 AM, V6 stated, he has the dish machine sanitizer working now.On 09/29/25 at 11:38 AM, V6 rechecked the sanitizer in the dish machine, the sanitizer read approximately 75 ppm (parts per million) chlorine. V6 stated, it should read between 50 and 100 ppm chlorine. V6 stated, he has never documented anything for the dish machine on the dish machine log because the numbers did not make sense to him, so he just left it alone. On 09/29/25 at 11:33 AM, V1 (Administrator) stated, she is not for sure when the dish machine was checked last, and she did not know the sanitizer was not reading properly. After reviewing the facility document titled, Dish Machine Log dated September 25, V1 stated she was not sure what the sanitizer should read. V1 stated, she does not know why there has not been any documentation on the log since the 24th of September and before the 24th it appears whoever filled it in was just following suit of the numbers before theirs. V1 stated, they have not changed sanitizer in the kitchen.The facility document titled, Dish Machine Log dated September 25 documents under the PPM column 200 for breakfast, lunch, and dinner for date 1 - 23, for date 24 the PPM under the breakfast heading, 200 is documented. The facility Resident Matrix dated 10/15/25 documents 74 residents reside at the facility.The undated facility policy titled, Dish Machine Operation documents: The dining services maintain the operation of the dish washing machine according to established procedure and manufacturer guidelines posted or contained in this guideline to ensure effective cleaning and sanitizing of all tableware and equipment used in the preparation and service of food. Procedure: 1 all dishwashing machines should be operated according to manufacturer recommendations. Tableware, utensils, and posts and pans should be cleaned and sanitized in either a high - temperature dishwashing machine that uses hot water, or a chemical sanitizing machine that uses a chemical sanitizing solution. 2 check the dishwashing machine each morning before first set of dishes are to be washed. This is usually before the breakfast meal and again in the PM or generally before the supper meal. If the dishwashing machine has not been used for several hours, it is generally recommended to allow the dishwashing machine to cycle for one or two cycles to allow dishwashing machine to come up to proper function. If a chemical sanitizer is used, check the concentration using the correct test tape for type of sanitizer in use.

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	145813	A. Building B. Wing	11/17/2025

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (continued on next page)

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide a functional call system in a bathroom for 1 of 1 resident (R29) reviewed for functional call lights in the sample of 46. Findings include:R29's admission Record dated 10/20/25 documents an admission date of 3/16/22. R29's face sheet documents diagnoses including but not limited to unsteadiness on feet, repeated falls, other abnormalities of gait and mobility, and generalized muscle weakness.R29's most recent care plan dated 10/20/25 documents a focus area that states R29 is at risk for falls due to deconditioning, decreased safety awareness and impulsivity dated revised 9/10/24. Interventions for this focus area include but are not limited to adjust bathroom call light length to ensure resident can use effectively dated 4/22/25; be sure the resident's call light is within reach and encourage the resident to use it for assistance dated revised 3/16/22; and educate R29 about calling for assistance, slowing down and waiting for staff to be ready to assist when transferring and what to did if a fall occurs dated 12/27/23. Another focus area in the same care plan states R29 has an activities of daily living self-care performance deficit dated 3/23/22. Interventions for this focus area include but aren't limited to R29 requires assist of one staff for toileting dated 3/23/22 and R29 requires 1 staff assist for transfers dated 3/23/22.R29's most recent Minimum Data Set (MDS) dated [DATE] documents R29 has a brief interview for mental status score of 8 indicating R29 moderately cognitively intact. The same MDS documents R29 is completely dependent for toileting hygiene and partial to moderate assist for toilet transfer. Same MDS for R29 documents he is occasionally incontinent of both bowel and bladder. On 10/20/25 at 12:00 P.M., V32 (Licensed Practical Nurse /LPN) stated R29's call light in the bathroom is not currently working. V32 stated the call light in R29's bathroom had been out approximately two weeks, and V3 (Environmental Operations Director) had known about it for that length of time. V32 stated he had put a work order in for it at that time. V32 stated he was told by V3 that V3 was unable to repair the call light and needed to get an electrician to repair the call light.On 10/20/25 at approximately 12:05 P.M., V32 demonstrated the call light didn't work in the bathroom for R29's room. There was no light above the door and no sound at the nurse's desk. On 10/21/25 at 11:58 A.M., V43 (Technician for outside call light company) stated he was able to repair the call light in R29's bathroom today on 100 hall so it would at least send an audible notification to the nurses' station. V43 stated he was not able to get the light above the door to come on. V43 stated there is no longer replacement parts for the facility's call system. V43 stated the facility's call system is old and no longer up to date. V43 stated the company he was employed by had given the facility a quote to replace the entire call system because that would be the only way to repair the call light in R29's bathroom and any other call lights that go down after this incident. V43 stated the first time he was made aware of a call light not working at the facility was yesterday, 10/20/25.On 10/21/25 at 2:41 P.M., V3 stated he was made aware of R29's call light in the bathroom not working the first time about two weeks ago. V3 stated he is not sure where the original work order for the call light is, or if there even was one and someone simply told him about it. V3 stated he tried to repair the call light himself but was not successful. V3 stated he then notified area director of maintenance about one week later. V3 stated the reason he didn't notify area director of maintenance sooner was because he was trying to repair it himself first. V3 stated he didn't want to call someone in case it was a simple repair. V3 stated he notified V1, (Administrator) the same time as he notified area director of maintenance. On 10/22/25 at 8:53 A.M., V3 stated he believes he should have attempted to repair the call light in the bathroom of R29's room sooner, and if was unable to repair it, he should have notified administration sooner of the problem. V3 stated the facility is currently waiting on a quote from a company to replace the entire system.On 10/20/25 at 12:25 P.M., V2 (Director of Nurses) stated there is a call light in R29's bathroom that needs to be repaired. V2 stated she wasn't aware of the call light in R29's bathroom not working until this morning. On 10/20/25 at 3:28 P.M., V2, DON stated the facility has no policy on call light system.On 10/21/25 at 1:48 P.M., V2, DON stated the facility has placed a literal bell in R29's bathroom until the facility is able to make the repairs or replace the call light system. On 10/20/25 at 1:01 P.M., V1 stated she was not aware of R29's call light in his bathroom wasn't working until this morning. V1 stated the facility is putting a literal bell to place in the bathroom of R29's bathroom to use until they can get his call light fixed. V1 stated she was going to call the company who they have contracted for their call light system to see when they can come look at it. V1 stated the facility has no call light policy. On 10/30/25 at 9:19 A.M., V83 (Regional Director Maintenance) stated he was made aware of the call light