STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145816	A. Building B. Wing	05/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Lake Zurich	900 South Rand Road Lake Zurich, IL 60047

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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 observation, interview, and record review the facility failed to ensure dishes were air-dried prior to stacking. This has the potential to effect all residents receiving food from the kitchen. The findings include: Centers for Medicare and Medicaid Services form 671 dated 5/4/26 shows there are 143 residents residing in the facility. Facility Diet Type Report dated 5/4/26 shows only one resident has an order of NPO (nothing by mouth) and does not receive food from the kitchen. On 5/4/26 at 10:55 AM, V11 (Dietary Aide) was on the clean, outfeed side of the dish machine. V11 was removing trays from the dish racks immediately out of the dish machine without allowing it to air dry. V11 would place the trays on an adjacent cart in a manner that allowed them to air dry. When V11 ran out of room, V11 began stacking the trays top to bottom, on top of the row of previously placed trays, while still wet and did not allow them to air dry. V11 also stacked insulated plate tops with the tops facing down, stacking additional insulated plate tops directly on top of the last on the bottom rack of the cart. At 11:07 AM, V10 (Food Service Director) told V11 that the plate tops needed to be stacked differently and V11 inverted the plate tops, draining all the water that accumulated in them. On 5/4/26 at 11:04 AM, V10 said when dishes come out of the dish machine, they should be allowed to air dry before stacking. Facility provided Cleaning and Sanitation Food Safety policy dated 11/11/24 states, . 5.2.4. Air-Drying. After sanitizing using either a manual or mechanical process, air-dry all equipment and utensils. Provide ample space to facilitate self-draining of equipment and utensils so that they can air-dry properly.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure residents were treated in a dignified manner for 4 of 30 residents (R152, R12, R14, and R113) reviewed for dignity in the sample of 30.The findings include: 1. On May 4, 2026, during the lunch meal, V13 and V16 Certified Nursing Assistants (CNA) were feeding residents at one of the tables. V13 and V16 were talking to each other in spanish in front of english-speaking residents. Staff were also observed speaking across the dining room to each other in spanish. The dining room was full of residents eating their lunch meals including R12, R14, and R113. 2. On May 5, 2026, at 12:45 PM, V19 Registered Nurse (RN) was standing next to R152 feeding him the lunch meal. There was an empty chair next to V19. On May 6, 2026, at 9:34 AM, V13 CNA said staff should be sitting when they are feeding the residents so that they are eye level with the residents. V13 said if a resident is spanish speaking, then staff can speak to them in spanish. V13 said english should be spoken in the dining room because this is the residents' home and the residents may think that staff are talking about them if staff don't speak in english. At 9:45 AM, V2 Director of Nursing said that staff should be sitting down to feed residents and staff should be speaking english so that everyone is able to understand them. V2 said this is done to provide dignity to the residents. The facility's Privacy and Dignity Policy revised July 3, 2025, shows, It is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to ensure pressure relieving interventions were in place and failed to ensure ordered treatments were in place for five of eight residents (R113, R75, R9, F26, and R31) reviewed for pressure injuries in the sample of 30. The findings include:1. R113's admission Record shows she was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, bipolar disorder, anxiety disorder, dementia, and major depressive disorder. R113's Pressure Injury Risk assessment dated [DATE], shows she is high risk for developing pressure injuries. R113's Skin and Wound note dated April 11, 2026, shows R113 was seen by the wound care nurse practitioner for new wound evaluation. R113 had a deep tissue pressure injury to her left heel that measured 6.5 centimeters (cm) X 5 cm and a deep tissue pressure injury to her right heel that measured 4.5 cm X 4 cm. R113's Order Summary Report dated May 5, 2026, shows orders for Wound Care left and right heel: Cleanse with wound cleanser, pat dry then apply betadine, cover with a foam dressing every-day shift. R113's Care Plan does not show that R113 has any behaviors of refusing treatment or removing wound care dressings. On May 5, 2026, from 9:45 AM-10:30 AM, R113 was sitting in a high back wheeled recliner in the facility dining room. R113's feet and heels were on the footrest of the high back wheeled recliner. R113 had one shoe on her left foot and the shoe for R113's right foot was off, but laying on its side right next to R113's right foot. R113 was crying out, moaning, and saying her right foot was hurting. At 10:30 AM, R113 told V14 (Memory Care Director) that she had to use the bathroom. V15 (Certified Nursing Assistant-CNA) and V18 (Hospice CNA) brought R113 to her room to use the bathroom. V18 placed R113's right shoe back onto her foot. While V18 was putting R113's shoe back onto her right foot, R113 screamed in pain. V15 asked R113 if she wanted pain medication, and R113 said yes. V15 went out into the hall and got R113's nurse. V29 (Licensed Practical Nurse-LPN) came and administered morphine to R113. R113 said the pain was bad when V29 asked how bad her pain was rated. R113 was transferred back into bed by V15 and V18. V18 removed R113's shoes and R113 cried again in pain when her shoes were removed. V15 removed R113's socks so that R113's heels could be observed. There were [NAME] areas noted to R113's bilateral heels that were larger than a half dollar size. These dark areas were mainly to the back of R113's heels where the back of the shoes would be pressing against these areas if R113 had shoes on. There were no dressings in place to R113's bilateral heels. R113 cried again in pain when V15 placed her heel boots onto her heels still with no dressings in place. R113 did not refused the heel protectors, nor did she try and remove them. At 1:11 PM, R113 was observed sitting in her wheelchair in the dining room. R113 had foam dressings to her heels that were observable over her socks. R113 did not have any shoes on her feet. R113 was not complaining, crying, or moaning of any pain to her heels. R113 was not making any movements or attempts to remove the dressings to her heels. R113 said her lunch meal was very good. R113's Progress Note dated May 5, 2026, at 11:59 AM, entered by V29 (LPN) shows that R113 was removing her dressings and her heel protectors. R113's legs were elevated on a pillow, and the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	dressings and heel protectors were reapplied. On May 6, 2026, at 9:34 AM, V13 (Restorative CNA) said R113 should not wear shoes if she has pressure injuries on her heels because shoes would irritate the heels. V13 was not aware that R113 had pressure injuries to her heels. At 9:45 AM, V2 (Director of Nursing) said if shoes are causing R113 pain, then she should not have shoes on. V2 said that R113 self-propels herself at times if she is up in the wheelchair. V2 said that R113 could still self-propel herself if she had nonskid socks on. On May 6, 2026, at 11:41 AM, V9 (Wound Care Nurse) said R113's pressure injuries to her bilateral heels were first identified on April 7, 2026, as deep tissue injuries that measured left heel 6.5 cm X 5 cm and right heel 5.5 cm X 4 cm. V9 said interventions that are in place for R113 include adding extra protein to her diet, turning and repositioning, offloading her heels, and an air mattress. V9 said that R113 should have a dressing in place to her heels at all times. V9 said that R113 used to propel herself in the wheelchair. V9 said that if R113 does not have dressings in place to her heels, then she should not have shoes on. If the shoes are what caused the pressure injury itself, then she should not have shoes on at all. V9 said that R113 should not have shoes on if she is in a high back wheeled recliner because she cannot self-propel herself in that type of chair. 2. On 5/4/26 at 9:25 AM, R75 was sitting up in her wheelchair. R75 had gripper socks on and dressings were visible above the sock around R75's ankles. R75's heels were resting directly against the platform on the footrests of the wheelchair. R75's bed had a low air loss mattress on which was set to 250 pounds. At 9:35 AM, V21 (CNA) came into the room and took R75's gripper socks off. R75's heels wrapped in gauze dressing with part of heel on bottom exposed. R75's gauze dressing on the left heel had some dried brownish blood On 5/4/26 at 12:17 PM, V9 (Wound Care Nurse) performed dressing changes for R75. V9 removed R75's left heel gauze dressing (which had dried brownish blood on it) and revealed a tan foam dressing stuck to the wound. V9 had to loosen the foam dressing with wound cleanser to remove it. V9 then cleansed the wound and applied a blue foam dressing and then wrapped the heel in gauze dressing. V9 repeated the same procedure to R75's right heel. V9 then lifted R75's pant leg to change the dressing to R75's pressure injury on her left knee. R75 had a band aid on her left knee with red skin surrounding the band aid. V9 removed the band aid, cleansed the wound, applied Medi honey to the wound and then covered the knee wound with an adherent foam dressing (covered the entire wound plus the surrounding reddened area). R75 said the foam dressing got ripped off over the weekend and they just put the band aid on. On 5/5/26 at 9:08 AM, R75 was in her wheelchair with her heels flat against the footrest platform. R75's low air loss mattress was set at 300 pounds. R75 said last night when they put her to bed the mattress was not plugged in and she felt like a hot dog in a bun because the mattress was folded up around her and she was resting on the bed frame. R75 said her tailbone was sore from sitting on the hard bed underneath. On 5/6/26 at 9:25 AM, V9 said low air loss beds should be plugged in and on to be working correctly. The staff should check the power cord and that the cords underneath have not got disconnected to make sure the bed is on. V9 said if the air mattress is not on it could cause a pressure injury from resting directly on bed frame. V9 said R75 should have blue foam dressing on her heels which is antimicrobial and a foam dressing on her knee not a band aid per the doctors' orders. R75's heels should be aligned on wheelchair platform cushion, so they are not directly resting flat against it to prevent direct pressure on the heels. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R75's Physician orders for May 2026 shows Offload heels dated 3/30/26, Left heel and right heel-pressure-stage 3- cleanse with wound cleanser, pat dry the apply blue foam, secure with gauze wrap, Left knee-pressure-stage 3- cleanse with wound cleanser, pat dry then paint with Medi honey, cover with bordered foam dressing. R75's Weights and Vitals Exceptions dated 5/5/26 shows R75 most recent weight on 5/5/26 was 152.7 pounds. 3. On 5/4/26 at 10:17 AM, R9 was in bed watching TV. R9 was wearing socks only and her heels were resting directly on the air mattress. R9's green padded heel protection boots were in her wheelchair, and a pair of purple waffle heel protectors were on top of R9's closet. R9 said they don't put the boots on all the time. On 5/4/26 at 12:05 PM, R9 was still in bed with her heels on the air mattress without heel protector boots. On 5/5/26 at 8:53 AM, R9 was sitting up in bed eating breakfast. R9's mattress appeared lumpy and deflated. R9's heels (without heel protector boots) were in a deflated section of the mattress resting on the bed frame. R9 said it felt like she was sitting in a hard spot on the bed. R9's air mattress controller was not on. At 8:57 AM, V20 (CNA) came into the room and turned on the power button on the air controller and the bed began visibly inflating. V20 said the mattress was not turned on, but it should be. R9's Physician Orders (POS) dated 3/30/26 shows an order check air mattress if functioning properly every shift and as needed. R9's Wound Note dated 4/30/26 shows The patient has a pressure injury. Recommend ongoing pressure reduction and turning/repositioning precautions per protocol, including pressure reduction to the heels and all bony prominences. The patient continues on an alternating air/low air loss mattress for pressure redistribution. Ensure settings are maintained at an appropriate level based on the patient's needs and body habitus. R9's Care Plan dated 4/15/25 shows off loading of bilateral heels when in bed every shift and as needed. On 5/6/26 at 9:25 AM, V9 said air mattresses should be plugged in and on to be working correctly. V9 said if the air mattress is not on, it could cause a pressure injury from resting directly on bed frame. V9 said R9 is at high risk for pressure injuries due to immobility. R9 should have her heels offloaded with heel boots when in bed. 4. On 5/4/26 at 9:47 AM, R26 was sitting up in bed eating breakfast. R26's air mattress was set at 320 pounds. R26 said she was in pain due to her scoliosis, and the bed is very hard, it hurts her back. On 5/5/26 at 9:01 AM, R26 was sitting up in her bed eating breakfast. R26's air mattress was still set at 320 pounds. R26 said the bed was so hard, it caused her back and hip to hurt. R26's Physician Orders (POS) for May 2026 shows R26 has diagnoses of chronic pain syndrome, scoliosis, unspecified osteoarthritis, other idiopathic scoliosis, presence of right artificial hip joint, and disorder of bone density and structure. This same POS dated 3/30/26 shows orders low air loss (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	mattress and check air mattress if functioning properly as needed. R26's Weights and Vitals Exceptions dated 5/5/2026 shows 5/4/26 weight: 89.8 pounds. R26's Care Plan dated 4/22/26 shows R26 had potential for pressure ulcer development related to Skin Braden Score of 13 (high risk). The facility's Skin Care Regimen and Treatment Formulary Policy dated 7/3/25 shows It is the policy of this facility to ensure prompt identification, documentation, and to obtain appropriate treatment for resident with skin breakdown. Treatment Protocol for Deep Tissue Injury: Foam dressing, Relieve pressure. 5. On 5/4/26 at 9:47 AM, R31 was in bed lying on an air mattress. R31 said his bed was uncomfortable and hard. The air mattress pump weight setting was set at 350 pounds. R31's Weight and Vitals report for 4/29/26 showed R31's weight was 248.6 pounds. R31's Wound Note dated 4/28/26 showed R31 was on an air mattress and to ensure the settings are maintained at an appropriate level based on the resident's body habitus. On 5/6/26 at 9:12 AM, V9 (Wound Care Nurse) said air mattress pumps should be set to the resident's weight. If the air mattress is set above the resident's weight the air mattress would provide too much air pressure causing the mattress to be firmer.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. Based on observation, interview and record review the facility failed to ensure a resident and their personal property were respected. This applies to 1 of 30 residents (R76) reviewed for resident rights in the sample of 30. The findings include: R76's face sheet shows she has diagnoses including type 2 diabetes, chronic kidney disease, hypertension, atrial fibrillation, CHF, and acquired absence of right leg below the knee. On 5/5/26 at 9:02 AM, loud yelling was heard in the hallway coming from R76's room. Get out, Get out repeatedly. V23 (Licensed Practical Nurse) was outside of R76's room. He said the housekeeper and V25 (Regional Relations Director) are in her room trying to throw items away from R76's fridge. Food items can only be in the fridge for 72 hours and should be discarded. V25 remained in the room during the escalation. V3 (Guest Relations) entered R76's room. R76 was heard from the hallway agitated. V25 came out of R76's room upset and asked to speak to V23. V23 said V25 reported R76 was physically aggressive with her and needed to be sent out for psych evaluation. On 5/5/26 at 10:18 AM, V3 (Guest Services) said we have to ensure the food items in the fridge are not expired. During morning rounds V25 was in R76's room explaining expired food items need to be thrown away. R76 had a plate of onions and tomatoes wrapped without a date with drippings that needed to be thrown out. V23 was trying to show R76 there were drippings on the tomato and onions, and it needed to be thrown away. R76 was very upset and yelling at staff to get out of her room. When he entered R76's room he saw R76 strike V25 in the back like a shove, enough to cause V25 to stumble. When a resident is upset, normally we try to de-escalate and re-approach the resident. The situation escalated after the staff did not leave the room and continued to remove items from her fridge. At the end of the day, this is the resident's home. He said the situation could have been handled in a different way. We removed R76's fridge to clean it and will be returning the fridge to her tomorrow. R76 has a history of getting irate and has behaviors. Staff should de-escalate and re-approach the resident if they are having behaviors. On 5/5/26 at 12:10 PM, R76 was in her room sitting in her wheelchair. She said the staff don't care what they do to you. R76 said she was sleeping in her bed when V25 came in her room and woke her up. I was sleeping she (V25) flips on the light and says I'm doing an inspection and opened my fridge. R76 said V25 said she has to check for dates and expired food in my fridge. I asked her not to go in there and she did it anyway. R76 said I've had the fridge in my room for over two years and they never have inspected my fridge before. R76 said V25 opened my fridge door without asking, she told me this is what I'm doing. R76 said I got myself in my wheelchair went over to her fridge and told V25 I could clean the fridge myself. We were arguing back and forth, I told her to get out and she would not leave my room. R76 said she pushed V25 on her lower back to get her away from my personal property. V25 told me she was going to tell my nurse and get me hospitalized . R76 said if they want us to respect them, they should respect us. V25 was making a huge deal and exaggerating about the items in my fridge. R76 said there was condensation coming from the top of my fridge. R76 said I had some lunch meat, cream cheese, shredded cheese, pudding, pickles and water bottles. R76 said the lunch meat was bad and I threw it out. V25 was not listening, it was bad enough I was woken up, whatever V25 wanted, I could have done myself. You're invading my things; it was terrible and very unprofessional. V3 removed my fridge so they could clean it and they would return it tomorrow. On 5/5/26 at 1:20 PM, V23 (LPN) said R76 is doing better than this morning. R76 prefers certain staff, who she likes. R76 has verbal behaviors, but usually not physical. When she has behaviors, we walk away and re-approach her when she is calm. V23 said after V25 left the room he went in the room with V3 to remove the fridge for cleaning. We talked to her in a calm manner, and she was fine. R76 was cooperative with him and V3. On 5/6/26 at 8:48 AM, V25 (Regional Relations Director) said on 5/5/26, she was doing rounds, she knocked on R76's door and explained she would be checking the fridge for spoiled food. V25 said she opened R76's fridge and told her looks like you have a spoiled food. V25 said there was a plate with spoiled tomato and onions (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with liquid over the wrapping. R76 became verbally aggressive towards me, she left the room and brought housekeeping staff to clean R76's fridge. V25 said she returned back to R76's room and continued removing the spoiled items from her fridge when R76 came in her wheelchair and punched me in the back enough to startle me. V25 said she was trying to talk to R76, but she was mainly yelling at me to GET OUT, GET OUT. My primary focus was the safety of the food. I know if she ate the food she would become ill. I could have left R76's room sooner. I did not want her to eat any of those items. R76 has a temper, has behavior and hoards food. I wanted to make sure she was safe, and that's why she remained in the room for the safety of the resident. On 5/6/26 at 12:50 PM, V28 (Ombudsman) said she received a call from R76 yesterday. R76 was upset about how the situation was handled. R76 reported to her V25 came into her room, turned on the lights and stated she was doing an inspection, then went through her things without her consent. R76's current care plan shows R76 has behaviors of anger and depression interventions include educating staff on manipulative behaviors, staff involved in her care should discuss the behavior, refer to consulting psychiatrist or clinical social worker. R76's EHR (electronic health records) shows there was no documentation regarding the incident on 5/5/26. The Residents admission Packet, section Resident Rights and Obligations revised 2025 states. A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident, the facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination or reprisal from the facility.The resident has the right to treated with respect and dignity.the right to retain and use personal possessions, including furnishings.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide incontinence care to residents that require staff assistance with toileting. This applies to 2 of 30 residents (R17 and R14) reviewed for activities of daily living in the sample of 30. The findings include: 1. R17's face sheet shows she had diagnoses of type 2 diabetes, hypertension, COPD, asthma, osteoporosis and chronic kidney disease. On 5/4/26 at 11:08 AM, V22 (Registered Nurse) said R17 has redness to her buttock from being saturated. On 5/4/26 at 1:00 PM, R17 was lying in her bed. She said she is soiled and needs to be changed. She was last changed by the overnight staff. She said she has a sore on her bottom and V9 (Wound Nurse) has been putting cream on her bottom. On 5/4/26 at 1:20 PM, V9 (Wound Nurse) said R17 has a history of pressure injury to her bottom. R17 has redness to her bottom, she gets medicated cream to her bottom. R17 is incontinent of bowel and bladder and should be changed frequently. V9 entered R17's room, he asked R17 do you need to be changed? V9 stated, It's all wet here we are going to need to change all of this. V26 (Wound Care CNA) entered the room to assist. V9 and V26 removed R17's soiled incontinent brief, urine soaked through the pad and the sheet, a strong smell of urine was present. R17's buttocks had redness to her inner cheeks. R17's current care plan shows she is alert and oriented, incontinent of bowel and bladder. Interventions include remind, offer and assist with toileting, staff to provide prompt peri care every shift and as needed. The facility's Incontinence and Perineal Care Policy revised 6/2025 states, It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident to prevent infection and skin irritation and to observe the resident's skin condition. Do round at least every two hours to check for incontinence during shift. 2. R14's Face Sheet shows she was admitted to the facility on [DATE], with diagnoses including Alzheimer's Disease, dementia, major depressive disorder, and scoliosis. R14's Minimum Data Set (MDS) dated [DATE], shows R14 is not cognitively intact, does not reject cares, is dependent on staff for toileting hygiene and personal hygiene, and is always incontinent of bowel and bladder. R14's Care Plan initiated July 20, 2021, shows, Keep skin clean and dry. On May 5, 2026, R14 was observed in the dining room at the same spot, at various times from 9:22 AM-1:20 PM. V17 Certified Nursing Assistant (CNA) brought R14 to her room at 1:24 PM. V17 said R14 was already up in her chair when she got to the facility for her shift at 7:00 AM. V17 said that R14 has not gotten out of her chair since then. V17 and V15 CNA transferred R14 out of her high back wheeled recliner into her bed using at mechanical lift. There was a urine odor and R14's incontinence brief was wet with urine and soiled with stool. V15 said that incontinence care should be done at least every two hours. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 6, 2026, at 9:45 AM, V2 Director of Nursing (DON) said incontinence care should be provided as often as the residents need it, but at least every two hours. The facility's Incontinence and Perineal Care policy revised June 30, 2025, shows, It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. Do rounds at least every two hours to check for incontinence during shift.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a resident's skin was cleansed after an incontinent episode for one of four residents (R74) reviewed for incontinence in the sample of 30. The findings include:R74's admission Record shows she was admitted to the facility on [DATE] with diagnoses including insomnia, chronic kidney disease, Alzheimer's disease, dementia, and mood disorder. R74's Care Plan initiated on June 6, 2023 shows, Keep skin clean and dry. R74's Minimum Data Set (MDS) dated [DATE] shows she is not cognitively intact. R74 has not exhibited behavior of rejecting care. R74 requires substantial/maximal assistance with toileting hygiene and personal hygiene. R74 is frequently incontinent of urine and always incontinent of bowel.On May 4, 2026 at 11:06 AM, R74 was walking the halls throughout the memory care unit. R74's pants were wet past her knees towards the inside of her legs. V15 Certified Nursing Assistant (CNA) and V13 CNA brought R74 to her room to change her pants. V15 removed R74's soiled brief and soiled pants. V15 wiped R74's buttocks area, but did not wipe from the front of R74 nor did she cleanse R74's legs from the soiled pants. V15 then placed new pants, new brief, and R74's shoes on. On May 6, 2026 at 9:34 AM, V13 CNA said the front and back areas on residents should be cleaned when they are incontinent. At 9:45 AM, V2 Director of Nursing said residents front and back areas should be cleaned. V2 said residents' legs should be cleaned if they get soiled. This is all done to make sure the residents are fully clean and to prevent infection. The facility's Incontinence and Perineal Care policy revised June 30, 2025, shows, It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. Maintain clean technique.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. Based on observation, interview, and record review, the facility failed to implement person-centered dietary interventions to support independent eating, maintain dignity, and promote adequate nutritional intake for one resident (R112) with a diagnosis of dementia and a preference to eat meals using their hands in the sample of 30.The findings include:R112's Face Sheet printed on 3/6/26 showed R112 was admitted to the facility with diagnoses that included chronic obstructive pulmonary disease, Alzheimer's disease, dementia, and moderate protein calorie malnutrition.R112's Care Plan printed on 5/6/26 showed R112 has an alteration in neurological status related to dementia with an intervention to accommodate eating issues in order to maximize independence and nutritional intake as well as an alteration in nutritional status related to dementia with an intervention to consider finger foods.On 5/4/26 at 12:45 PM, during the lunch meal, R112's meal was lemonade, broth soup, turkey stuffing casserole, green beans, and spaghetti noodles. R112 was observed attempting to consume non-finger foods with his hands, resulting in food being spread on the resident's hands, clothing, table surface and floor. No finger foods or clothing protector was offered nor was R112 encouraged or cued to use utensils.On 5/5/26 at 8:59 AM, during the breakfast meal, R112's meal was scrambled eggs, a slice of toast, fortified cream of wheat, orange juice, and a nutrition juice. R112 was observed eating with his fingers. R112 did not attempt to use utensils, resulting in food being on R112's hands, clothing, on the floor and in R112's drinks. V19 (Registered Nurse) and V27 (Certified Nursing Assistant-CNA) interacted with R112 during the meal but did not offer a clothing protector or finger foods, nor encourage the use of utensils.On 5/5/26 at 12:36 PM, during the lunch meal, R112's meal was coffee, milk, juice, baked ziti in meat sauce, and steamed broccoli. R112 was observed attempting to consume non-finger foods with his hands, resulting in food being on the resident's hands (which became reddish orange in color), on the resident's clothing, the table surface and on the floor. No finger foods or clothing protector were offered. V14 (Memory Care Manager) asked R112 if he wanted to use his hands over a fork and R112 stated yes. V14 did not encourage the use of utensils nor offered R112 finger foods. When a CNA attempted to feed R112 baked ziti with a fork, R112 took a bite, but when the CNA attempted again, R112 said no. R112 finished the meal by using his fingers.On 5/5/26 at 1:02 PM, V14 (Memory Care Manager) stated that R112 feeds himself, prefers to eat with his fingers and typically refuses a clothing protector. V14 stated that she was not aware that R112's care plan has an intervention of finger foods. V14 stated that she will speak with the dietician to assess R12's dietary needs.On 5/6/26 at 9:55 AM, V2 (Director of Nursing) stated that the facility honors a resident's preference to feed themself independently, with encouragement and prompting, in attempt to not take away their remaining ability. V2 stated that finger foods (e.g., snack foods, chicken nuggets) can be an intervention for those that self-feed. V2 stated that a clothing protector is offered to provide more dignity than if clothes were dirty, however the resident has a right to refuse.The facility's Residents' Rights for People in Long-term Care Facilities' pamphlet (undated) showed that residents have the right to participate in their own care and the facility must make reasonable arrangements to meet the residents' needs and choices.The facility's Privacy and Dignity Policy revised July 3, 2025, shows, It is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure residents consumed their medications when medications were administered for 2 of 6 residents (R164 and R33) reviewed for pharmacy services in the sample of 30.The findings include:1. On 05/04/2026 at 10:47 AM, R164 was in her room in bed. A clear plastic medication cup was sitting on the table in R164's room. There were four pills in the cup. No staff were present in R164's room. R164 said she was not sure if the pills were hers.On 05/04/2026 at 10:49 AM, V7 (Registered Nurse- RN) said R164 did not self-administer medications.R164's Care Plan (undated) did not indicate R164 could self-administer medications. 2. On 05/04/2026 at 10:25 AM, R33 was in her room. On the bedside table was a clear plastic medication cup that contained two white ovel pills. No staff were present in R33's room. R33 stated she would take the pills later. On 05/04/2026 at 10:44 AM, V6 (RN) said R33 did not self-administer medications.R33's Care Plan (undated) did not indicate R33 could self-administer medications.On 05/05/2026 at 12:23 PM, V8 (RN) said nurses should not leave medications unattended when administering medications. V8 added that when nurses administer medications they should stay with the resident to make sure they consume the medication.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer medications as ordered (at ordered times and ordered routes). There were 30 opportunities with 6 errors resulting in a 20 % error rate. This applies to 3 of 4 residents (R102, R107, R162) observed in the medication pass.The findings include: 1.On 5/4/26 at 10:45 AM, V22 (Registered Nurse) was observed during morning medication pass. V22 prepared R107's medications including acetaminophen 325 mg (milligrams) two tablets, Colace 100 mg one tablet, spironolactone 25 mg one tablet, apixaban 2.5 mg one tablet and carbidopa-levodopa 25-100 mg one tablet. Six pills were in the medication cup. V22 entered R107's room and gave her the medication cup. R107 stated, I'm missing one, there's only six pills. I usually have 7 pills in the morning. V22 replied, No you have all your medications. V22 went back to her medication cart and did not check R107's EMAR (electronic medication administration record) to verify if R107's medications and signed off the medications. R107's Medication Administration Record (MAR) dated May 2026 shows orders for morning medication pass include: Colace 100 mg, spironolactone 25 mg, apixaban 2.5 mg, acetaminophen 325 mg two tablets, carbidopa-levodopa 25-100 mg and furosemide 20 mg. (A total of 7 pills, V22 did not administer R107's furosemide and signed off the EMAR it was administered). 2. On 5/4/26 at 10:52 AM, V22 prepared R107's morning medications including multivitamin tablet, bumetanide 2 mg give two tablets twice a day, doxycycline hyclate 100 mg one capsule three times a day and did not administer Ipratropium-albuterol inhalation solution. At 11:01 AM, V22 said she was not going to administer R107's nebulizer treatment because he is lying flat and he needs to be sitting up. She said she would come back to administer his nebulizer after the staff transfer him. V22 said morning med pass if from 7:30 AM to 9:30 AM, she is late passing medications because she has a lot of patients. There are two nurses for this unit, one on each side. V22 said she has 9 more residents to give morning medications too. On 5/4/2026 at 1:43 PM, R107 was sitting in his wheelchair in his room. He said he did not get his nebulizer treatment yet. On 5/5/26 at 8:50 AM, R107 was in his room lying in bed. He said he received his nebulizer treatment only twice yesterday. R107's MAR dated May 2026 shows orders including multivitamin one tablet give in the evening daily, doxycycline 100 mg give one tablet twice a day scheduled at 9:00 AM, Bumex 2 mg give two tablets twice a day AM pass, and Ipratropium-Albuterol Inhalation solution 0.5-2.5, one application inhale orally three times a for15 minutes at 9:00 AM. (R107's MAR shows V22 signed of the albuterol was administered, however R107 did not receive the medication). The facility's Medication Pass revised 7/25 states, It is the policy of the facility to adhere to all Federal and State Regulations with medication pass procedures. 3. R162's Order Summary Report dated May 5, 2026, shows R162 was admitted to the facility on [DATE], with diagnoses including vitamin B12 deficiency anemia. An order was entered on April 27, 2026, for cyanocobalamin (vitamin B12) injection solution 1000mcg (micrograms)/ml (milliliter) inject one ml intramuscularly every day shift every Monday for supplement. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 4, 2026, at 9:56 AM, V12 (Registered Nurse) administered vitamin B12 oral tablet to R162 instead of the ordered injection. On May 6, 2026, at 10:30 AM, V2 (Director of Nurses) said R162's doctor is aware that the nurse administered an oral tablet of vitamin B12. V2 said the nurse got nervous and missed the verification of the medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure staff changed gloves and performed hand hygiene to prevent cross contamination, and failed to ensure staff wore the required personal protective equipment for enhanced barrier precautions for three of 30 residents (R74, R17, and R64) reviewed for infection control in the sample of 30. The findings include: 1.R74's admission Record shows she was admitted to the facility on [DATE], with diagnoses including insomnia, chronic kidney disease, Alzheimer's disease, dementia, and mood disorder. R74's Minimum Data Set (MDS) dated [DATE], shows she is not cognitively intact. R74 has not exhibited behavior of rejecting care. R74 requires substantial/maximal assistance with toileting hygiene and personal hygiene. R74 is frequently incontinent of urine and always incontinent of bowel. On May 4, 2026, at 11:06 AM, R74 was walking the halls throughout the memory care unit. R74's pants were wet past her knees towards the inside of her legs. V15 (Certified Nursing Assistant-CNA) and V13 (CNA) brought R74 to her room to change her pants. V15 removed R74's soiled brief and soiled pants. V15 the wiped R74's buttocks area but did not wipe from the front of R74 nor did she cleanse R74's legs from the soiled pants. V15 then placed new pants, new brief, and R74's shoes on. V15 did not change her gloves nor did she perform hand hygiene. On May 6, 2026, at 9:34 AM, V13 (CNA) said gloves should be changed when going from dirty items to clean. At 9:45 AM, V2 (Director of Nursing) said residents front and back areas should be cleaned. V2 said gloves should be changed and hand hygiene should be performed every time staff touch contaminated items to prevent spread of organisms, The facility's Incontinence and Perineal Care policy revised June 30, 2025, shows, It is the policy of the facility to provide perineal care to ensure cleanliness and comfort to the resident, to prevent infection and skin irritation, and to observe the resident's skin condition. Maintain clean technique. Wash the perineal area and gently dry after the procedure. Remove gloves and dispose. Wash hands. Put on a new set of clean gloves to put on clean briefs/incontinent pads, to make resident comfortable, groom, and change clothing. 2. On 5/4/26 at 1:20 PM, V9 (Wound Nurse) provided peri-care to R17 and with the same contaminated gloves applied barrier cream to her buttocks. V9 continued to touch several surfaces before removing his gloves. On 5/5/26 at 1:11 PM, V20 (CNA) said gloves should be changed after providing incontinence and new gloves should be used when applying barrier cream. The facility's Hand Hygiene Policy revised 6/25 states, Hand hygiene is important in controlling infections. Hand Hygiene consists of either hand washing or the use of alcohol gel. The facility will comply with the CDC Guidelines in regards to hand hygiene .before and after assisting a resident with toileting. before moving from work on soiled body site to a clean body site on the same resident . 3. R64's Face Sheet printed on 3/6/26 showed R64 was admitted to the facility with diagnoses hemiplegia, hemiparesis following cerebral infarction, dysphagia and has a feeding tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R64's Care Plan printed on 5/6/26 showed R64 requires enhanced barrier precaution related to having a feeding tube. On 5/4/26 at 1:00 PM, an Enhanced Barrier Precaution (EBP) sign on R64's door documents staff must wear gloves and gown for high-contact resident care activities that include device care or use of feeding tube. At this time, V12 (Registered Nurse Supervisor) entered the room and donned only gloves then administered enteral feeding. On 5/4/26 at 1:14 PM, V12 stated confirmation that R64 was on EBP and V12 should have worn standard precautions, gown and gloves, when administering R64's enteral feeding. V12 stated V12 was nervous and did not put on a gown, which is required. On 5/6/26 at 9:55AM, V2 (Director of Nursing) stated that EBP are initiated for residents who meet the criteria, that includes residents with feeding tubes. V2 stated that the facility's process is that EBP signage is posted on or near the resident's room door to alert staff of precautions. V2 stated that the PPE (personal protective equipment) for EBP is gown and gloves and must be used during tube feeding administration. V2 stated the purpose of EBP is to prevent infection. The facility's Enhanced Barrier Precaution (reviewed/revised 9/16/25) policy documents that enhanced barrier precautions is an infection control intervention designed to reduce transmission of organisms that employs targeted gown and gloves use during high contact resident care activities that includes device care use of feeding tubes.