STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145844	A. Building B. Wing	04/02/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Montclare, The	2833 North Nordica Avenue Chicago, IL 60634

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the low air loss mattresses were used in accordance with facility policy to promote effective pressure redistribution (inappropriate layering of multiple linens) for two residents (R2 and R4); and failed to ensure a resident (R5) with a acquired stage 4 pressure ulcer received wound care as ordered by the physician resulting in the development of a wound infection, requiring IV (intravenous) antibiotic therapy. These failures affected 3 of 3 residents (R2, R4 and R5) reviewed for pressure ulcers in the sample of 61. Findings include: R5 has a diagnosis which includes but not limited to reduced mobility, sepsis, other lack of coordination and non-ischemic myocardial injury. R5's Brief Interview for Mental Status (BIMS) dated 2/10/26 shows that R5 has a score of 7 which indicates that R5 has some cognitive impairments. On 3/30/26 at 10:12 am, Surveyor observed V2 (Director of Nursing, DON) administer R5's IV antibiotic's, identified as Vancomycin. During this interview V2 stated that the IV antibiotics was prescribed for R5's sacral wound infection. On 03/21/25 at 9:06 am, Surveyor observed V8 (Registered Nurse, RN, Wound Care Nurse), V11 (Restorative Aide), and V10 (R5's Physician) perform wound care on R5's acquired stage 4 sacral wound that had 100 % necrotic tissue, foul odor, moderate serous drainage, and visible bone exposed. V10 stated that R5's wound had a foul odor and that R5 was receiving IV antibiotic's for sacral wound infection. V10 was then observed performing bedside sharps debridement to R5's sacral wound removing necrotic tissue. On 4/1/26 at 10:00 am, V8 (Registered Nurse, RN, Wound Care Nurse) stated that she has been the wound care nurse for eight days at the facility. V8 explained that R5's sacral wound was a stage IV pressure ulcer with mild odor and drainage when V8 first observed R5's sacral wound. V8 then stated that R5 currently has wound care orders for sacral wound treatment every shift and IV antibiotics Vancomycin for his sacral wound infection. V8 stated that nurses should treat a residents wound per the physicians orders on the residents physicians orders sheet (POS) and that empty boxes on the resident Treatment Administration Record (TAR) indicates that the nurse did not sign off on the wound care and the treatment was not performed. V8 further explained if a residents treatment is not performed the wound can decline and it may cause an infection. V8 also stated that during the times of R5's missing signatures on his TAR that indicate that R5 did not have treatment rendered, V8 was not employed at the facility. (continued on next page)

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

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 4/1/26 at 10:30 am, V2 (Director of Nursing, DON) stated that pressure ulcers began at a stage 1 with un-blanchable redness. V2 then explained when R5's acquired sacral wound was first observed on 3/6/26, she observed R5's sacral wound as an unstageable pressure ulcer with necrotic tissue. V2 then explained that nurses follow the physicians orders and Treatment Administration Record (TAR) to treat the residents wounds. Surveyor and V2 reviewed R5's current TAR for R5's sacral wound treatment order with no documentation on 3/12/26, 3/14/26, 3/17/26 and 3/21/26. V2 explained that on 3/12/26, 3/14/26, 3/17/26 and 3/21/26 treatment was not rendered for R5's sacral wound and that if treatment is performed the nurse must document performing the treatment by signing the residents TAR. V2 then stated, If a resident does not receive treatment as ordered by the physician there is a potential for the wound to decline and potential for infection in which he (referring to R5) is currently being treated for. V2 then explained R5's sacral wound was first observed as a unstageable pressure ulcer wound on 3/6/26 and was able to be staged as a stage 4 on 3/24/26 with bone exposed. On 4/1/26 at 1:04 pm, V10 (R5's Wound Care Physician) stated that he has treated R5's sacral wound for the last 3 weeks and upon initial treatment of R5's acquired sacral wound, R5's sacral wound presented as a full thickness wound that was beyond the subcutaneous layer with necrotic tissue, moderate serous drainage and no signs of infection that V10 classified as an unstageable wound. V10 then explained that when a pressure ulcer wound initially develops there is non blanchable erythema seen. V10 further explained when a wound is necrotic there is ischemia of the skin over a long period of time, and the capillaries become ischemic the longer the pressure the more ischemic the tissue becomes. V10 then explained that he initially ordered R5's sacral wound with daily wound care with a Santyl dressing. V10 then explained Upon debridement of R5's sacral wound V10 prescribed and order for Dakin's treatment three times a day and ordered IV antibiotics due to concerns for osteomyelitis. V10 also explained that he ordered a x-ray of R5's sacral wound that was negative for osteomyelitis and that V10 then did perform a wound culture with R5's sacral wound because R5's primary care physician reviewed V10's wound care notes and ordered IV antibiotic's to treat R5 for sacral wound infection. V10 stated that if a residents wound care orders are not performed as ordered by the physician the residents wound can worsening, deteriorate, have an increase in bio infectious bacteria and develop a wound infection. On 04/01/26 at 12:00 pm, Surveyor requested R5's initial Wound Assessment Detail report for 3/6/26 when R5's acquired sacral wound was first observed by V2 and V2 stated that there was no documentation for R5's acquired sacral Wound Assessment Detail until 3/9/26. R5's Minimum Data Set (MDS) dated [DATE] shows that is at risk for pressure ulcers and does not currently have unhealed pressure ulcers. R5's Minimum Data Set (MDS) dated [DATE] shows that is at risk for pressure ulcers and has a stage 4 pressure ulcer. The facility's document presented by V3 (Infection Preventionist, IP, Assistant Director of Nursing, ADON, Registered Nurse, RN) shows that R5 is receiving IV (intravenous) Vancomycin 1500 mg (milligrams)/ ml (milliliter) q (every) 12 hours . R5's Physician Order Sheet (POS) active order as of 03/31/26 shows R5 has order for cleanse sacrum wound with NS (Normal Saline) and pack with moist 1/4 strength Dakin's followed by dry 4x4 gauze than (then) a foam border silicone dressing every shift. Every shift for wound care. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R5's Physician Order Sheet (POS) active order as of 03/31/26 shows R5 has order for Vancomycin HCL (hydrochloride) use 1500 mg (milligram) intravenously every 12 hours for wound infection until 04/08/2026 23:59 **Pharmacy to dose medication** R5's Treatment Administration Record (TAR) shows that R5 did not receive treatment to his sacral on 3/12/26, 3/14/26, 3/17/26 and 3/21/26. [According to V2 she initially found R5's wound on 3/6/26. However, no wound assessment was completed until 3/9/26. There are no treatment orders for R5's stage 1 on the TAR or POS.] R5's care plan dated 3/6/26 documents in part: Focus: Alteration in skin integrity – Resident has pressure ulcer to sacrum. Intervention: Treat per MD (Medical Doctor) order. R5's Pressure Ulcer Risk assessment dated [DATE], 2/27/26 and 3/2526 shows that R5 is at risk for pressure ulcers. R5's Wound Assessment Detail dated 3/9/26 shows that R5 has facility acquired pressure ulcer identified by V2 (Director of Nursing, DON) on 3/6/26 with measurements of 8.0cm (centimeter) by 6.0 cm by unknown depth, with necrotic hard, firm, adherent 100% without debridement. R5's Wound Assessment Detail dated 3/12/26 shows that R5 has facility acquired pressure ulcer identified by V2 (Director of Nursing, DON) on 3/6/26 with measurements of 11.0cm (centimeter) by 7.5 cm by unknown depth, with necrotic hard, firm, adherent 50% , necrotic soft 50% with debridement. R5's Wound Assessment Detail dated 3/17/26 shows that R5 has facility acquired pressure ulcer identified by V2 (Director of Nursing, DON) on 3/6/26 with measurements of 10.5cm (centimeter) by 7.5 cm by 2.0 cm with necrotic hard, firm, adherent 100% with debridement. R5's Wound Assessment Detail dated 3/24/26 shows that R5 has facility acquired pressure ulcer identified by V2 (Director of Nursing, DON) on 3/6/26 with measurements of 10.5cm (centimeter) by 8.5 cm by 2.5 cm, with necrotic hard, firm, adherent 100% , with debridement. The facility's document dated March 2026 and titled Wound Prevention and Healing documents in part Intent: To provide wound care treatments/services (using a multidisciplinary approach) based on evidence standards of care under the direction of a physician. The facility document dated March 2026 and titled Wound Prevention Healing documents in part: Intent: To provide wound care treatments/services (using a multidisciplinary approach) based on evidence-based standards of care under the direction of a physician . 10. Wound Care and Treatment: a. Wound care treatments are provided within an individualized plan of care under the direction of a physician. 11. The Multidisciplinary Wound Care Team: 1. The Wound Care team is responsible for identifying problems, coordinating care, and promoting development of the team and the program. The facility document dated March 2026 and titled Treatment/Services to Prevent/Heal pressure Injury documents in part: Intent: It is the policy of the facility to ensure it identifies and provides needed care and services that are resident centered, in accordance with the resident's preference, goal for care and professional standards of practice that will meet each resident's physical, mental, and psychosocial needs. Procedure: b. A resident with a pressure injury receives necessary treatment and services consistent with professional standards of practice, that are aimed to promote healing minimize complications and prevent the development of further pressure injury. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R2's admission record diagnoses include but are not limited to cerebral infarction, heart failure, peripheral vascular disease, metabolic encephalopathy, hemiplegia and hemiparesis. R2's Minimum Data Set (MDS), dated [DATE], documents in part, Section C. Brief Interview for Mental Status (BIMS) Score is blank. Section M. Skin Conditions: Risk of Pressure Ulcer/Injury documents, resident at risk of developing pressure ulcers/injuries. On 3/30/26 at 11:30 am, R2 was in room lying on a low air loss mattress with multiple layers between R2 and the low air loss mattress. The layers observed under R2 consisted of a flat sheet, an incontinent pad and an incontinent brief. On 3/30/26 at 11:40 am, V18 License Practical Nurse (LPN) stated, There are three layers under R2 and should only be one layer for circulation and wound prevention. Having multiple layers will constrict the flow of the air and defeat the purpose of the air loss mattress, which is to prevent skin breakdown. R2's Physician Orders Set dated 4/1/26 documents, in part, Air loss mattress. R2's risk assessment dated [DATE] documents R2's Braden score is16 which indicates at risk. R2's care plan dated 3/17/26 documents in part, Focus: Alteration in skin integrity. Residents have a vascular wound of the right foot with necrotic tissue. Goal: Create an environment for healing. Intervention: Air loss mattress. R4's admission record diagnoses include but are not limited to reduced mobility, tracheostomy, hypertension, encephalopathy, seizures, hemiplegia and hemiparesis. R4's Minimum Data Set (MDS), dated [DATE], documents in part, Section C. Brief Interview for Mental Status (BIMS) Score is blank. Section M. Skin Conditions: Risk of Pressure Ulcer/Injury documents, resident at risk of developing pressure ulcers/injuries. On 3/30/26 at 12:50 pm, R4 was lying on a low air loss mattress with multiple layers between R4 and the low air loss mattress. The layers observed under R4 consisted of a flat sheet, a flat sheet folded multiple times and an incontinent brief. On 3/30/26 at 12:53 pm, V8 Registered Nurse (Wound Care) stated, There are 6 layers under R4 and there should only be one layer, a flat sheet under R4. All those layers defeat the purpose of the air loss mattress. That many layers are not preventing wounds and can develop wounds which defeat the purpose of the air loss mattress. R4's Physician Orders Set dated 3/27/26 documents, in part, Air loss mattress. R4's risk assessment dated [DATE] documents R4's Braden score is 13 which indicates moderate risk. R4 care plan dated 3/20/26 documents, in part, Focus: Actual Impairment to skin integrity skin tears to coccyx due to shearing. Healed as of 3/27/26 but with scar tissue. Intervention: Air loss mattress. On 4/1/26 at 12:07 pm, V2 Director of Nursing (DON) stated, An air loss mattress should only have a (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	flat sheet. The purpose of air loss mattress is for the air to circulate back and forth to help with the distribution to relieve pressure. Multiple layers don't allow the air to breath and will defeat the purpose of having the air loss mattress. Facility's document titled, Skin Management: Specialty Mattress reviewed date 5/25, documents in part, Procedure: 1. As per manufacture guidelines, no more than 1 piece of linen will be placed between the mattress and the resident. Facility's policy/procedure document titled Specialty Mattress dated March 2026, documents, in part, Intent: It is the policy of the facility to ensure it identifies and provides needed interventions including specialty mattresses to aid in the healing of skin impairments. Procedures: As per manufacture guidelines, no more than 1 piece of linen will be placed between the mattress and the resident. The (undated) low air loss mattress Operation Manual documents, in part, Installation Instructions: Step 2. You may place a thin cotton sheet over the quilted mattress top cover. Operation Instructions: Step 5. Patients can directly lie on the mattress or cover with a sheet and tuck loosely to increase the comfort of the patient.

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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 observations, interviews and record reviews, the facility failed to prepare food in a safe sanitizing environment: staff did not wash hands after leaving and returning to food preparation, visibly soiled appliances/serving carts, and sticky floors throughout the kitchen/dining room. This applies to 101 residents (census of 103 residents minus 2 residents with gastronomy tubes) receiving food from the facility's kitchen. Finding Includes:During the puree session on 03/31/2026 starting at 9:32 AM, V16 (Cook) left the food preparation to switch out the blender to a food processor. V16 returned, took the hot dogs from the bin and placed them in the food processor without washing V16's hands. V16 left food preparation again, went to the refrigerator and returned with packaged hot dog buns to puree them. V14 (Dietary Manager/Cook) stated that it is important for kitchen staff to wash their hands upon returning to the food preparation area. On 03/30/2026 at 9:23 AM, the outside of the kitchen's dishwasher was visibly soiled, sticky substances throughout the entire surface. On top of the dishwasher the surface was filled with crumbs and syrupy-like yellowish substances throughout. Dishwasher handles on the inside and outside were also visibly soiled with buildup of yellowish-brown cake-like substances. V14 (Dietary Manager/Cook) agreed that the dishwasher top, surfaces and handles needed cleaning. On 03/31/2026 at 8:51 AM, the 3-level portable gray dining room cart was visibly soiled with what looked like cranberry juice and coffee stains. There were also yellowish-brown substances throughout the surface and corners of the gray cart. On top of the cart were beverages staff served to the residents: coffee, cranberry juice, tea bags, milk, etc. The 3-level portable blue kitchen cart was visibly soiled on the surfaces and in the corners with brown/yellow stains and buildup debris.On 3/31/2026 at 9:03 AM, V14 (Dietary Manager/Cook) agreed that the tray carts were soiled and needed cleaning. On 3/30/2026 at 9:23 AM, the kitchen floor was visibly soiled with buildup of what looked like sticky black substances and dried splatters near the refrigerator and stove aisles. On 3/31/2026 at 8:51 AM, the floors of the second-floor main dining room and dining preparation area were sticky creating suction and significant sounds while walking throughout those areas. The sticky substances were visible blotches and dried up splashes throughout the entire floor.On 3/31/2026 at 9:03 AM, V14 (Dietary Manager/Cook) stated that the floors in the kitchen and dining areas needed to be thoroughly cleaned. On 04/01/2026 at 2:54 PM, V1 (Administrator) stated it is expected the kitchen staff to mop the floor daily and follow up with a floor scrubber for the dining room. V1 added that daily deep cleaning for those areas is important. The facility failed to follow their undated Cleaning Standards policy which documents that non-food contact surfaces must be clean at all times including free of grease deposits, food residue, dust and other soil accumulations/debris. All foods served to residents on a pureed diet must be smooth, moist, cohesive and free of chunks or lumps. The consistency should resemble pudding, mousse, or applesauce with no visible solid pieces.

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F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Keep all essential equipment working safely. Based on observations, interviews and record reviews, the facility failed to prepare food in a kitchen where the stove did not drip oil onto the floor and where the dishwasher did not leak puddles of water into buckets. This applies to 101 residents (census of 103 residents minus 2 residents with gastronomy tubes) receiving food from the facility's kitchen. Finding Includes:On 03/30/2026 at 9:23 AM, there was oil dripping from a pipe connected to the kitchen's grill-top stove. There was cardboard placed under/next to the stove to catch the oil drippings. The cardboard contained a puddle of oil about 4 inches in diameter. Also, there was water dripping and seeping from the Hot Water Temperature Dishwasher and there were two large rectangular black buckets placed underneath to catch the leaks. Bugs were flying over the water buckets. V14 (Dietary Manager/Cook) said V14 did not know why oil was dripping from the stove and why the dishwasher was leaking. V14 said V14 would check it. On 3/31/2026 at 8:51 AM, the stove no longer contained cardboard underneath, but oil was still dripping from the stove leaving a puddle of oil on the floor. And hot water was now aggressively seeping from the middle section of the dishwasher. On 3/31/2026 at 9:03 AM, V14 (Dietary Manager/Cook) said the stove was missing a part that needed to be replaced to prevent the oil from dripping and V14 was still not sure why water was leaking from the dishwasher. On 04/01/2026 at 11:05 AM, there was still oil dripping from the stove. And one of the large black containers under the dishwasher contained water about 8 inches of dark liquid that looked like dirty water.V14 (Dietary Manager/Cook) stated they were still waiting for the repairs to be made to both the stove and dishwasher. On 04/01/2026 at 2:54 PM, V1 (Administrator) stated the kitchen is to report any necessary repairs to the maintenance department. V1 stated a pipe that needed to be added to the stove to prevent the oil from dripping and V1 was not sure why the dishwater was leaking. V1 stated that it is expected for the kitchen equipment to be repaired and in working conditions to prevent fires and keep residents safe. The facility failed to follow their undated Kitchen Appliances/Equipment policy which reports to conduct safety and operations inspections by visually inspect all appliances for damage, test functionality of appliances and proper operation of all controls and remove damaged items from kitchen use.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 proper narcotic control count per facility policy due to the shift verification of controlled substances count form not being signed by one of two nurses (incoming and outgoing nurses) required to count narcotics during shift change and one nurse signing the controlled substances check form on her oncoming and outgoing shift on two floors of four floors reviewed for medication storage and labeling. This failure has the potential to affect 15 residents: 6 residents (R7, R9, R28, R30, R71, and R99) on 3 north cart and 9 residents (R2, R11, R12, R13, R19, R29, R68, R72 and R88) on the 2C cart. Findings include:On 3/31/2026 at 8:41 AM, V25 (Licensed Practical Nurse) verified she had not signed shift verification of controlled substances count form in the red narcotics book that contained 6 residents with controlled substances sheets. V25 stated it is the facility's policy for both nurses to sign the shift verification of controlled substances sheet after the narcotic count has been completed by the oncoming nurse and outgoing nurse. V25 stated the purpose of two nurses signing off on the shift verification of controlled substances count form is to ensure all narcotics are accounted for. On 3/31/2026 at 9:38 AM, V18 (Licensed Practical Nurse) verified she signed her initials on the controlled substances check form at 7:00 am on 3/31/2026 at the start of her shift and at 3:00 PM at the end of her shift on 3/31/2026 at the time she counts with the off going nurse at 7:00 AM and the current time now is 9:38 AM on 3/31/2026. V18 stated she always signed the controlled substances check form for both 7:00 AM oncoming box and 3:00 PM off going nurse times after completing the narcotic count with the offgoing nurse at 7:00 AM. V18 stated That is how we have always done it. V18 stated the purpose of signing the narcotic count is to make sure all narcotics are accounted for. V18 stated she does sometimes pass narcotics on her shift as a prn (when necessary) although she signs the narcotic count sheet at 7:00 AM for the narcotic count slot on the form at 3:00 PM. On 4/01/2026 11:36 am, V2 (Director of Nursing) stated the oncoming nurse counts with the off going nurse and the count should be accurate; the purpose of two nurses signing off on the narcotic count sheets is to verify that the nurse is legally attesting to the medication in the narcotic box and the controlled substance form matches what is in the bingo card; if the narcotic count is incorrect and investigation is started to address the missing medication because the count must be accurate; the narcotic count sheets are signed by 2 nurses at the specific time immediately after the count is completed; and she (V2) has done many in-services on counting narcotics and the nurses knows . Facility's Policy titled Narcotics Storage/Destruction dated 3/20/2026 and last review date 3/27/2026 documents two nurses must count narcotics at the beginning and end of each shift, initialing the narcotic count record. The two nurses should be the incoming and outgoing nurse.Facility's Nurse Supervisor RN/LPN job description undated on page 2 documents: Counts narcotics at the beginning and completion of each shift with the nurse leaving and coming on the shift.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review, the facility failed to ensure medications were properly stored in a locked medication cart. This failure affected all 11 residents on the 1C unit on the first floor. Findings include:On 3/31/2026 at 11:52 AM, V3 (Assistant Director of Nursing) was observed standing by R4's room at the beginning of unit 1C hallway talking to another staff member with her back facing the medication cart stationed against the wall halfway down the hallway on unit 1C. V3 was informed the surveyor would like to conduct a medication observation with her when she was done speaking with the staff member. Surveyors walked to the nurses' station where the medication cart was stationed and observed the medication cart was unlocked. Minutes later, V3 walked to the nurses' station and verified with the surveyors the medication cart on 1C was unlocked. On 3/31/2026 at 11:56 AM, V3 (Assistant Director of Nursing) stated I pushed the lock in before I left the cart. It must have popped out when I walked away. The lock may be broken. V3 stated the medication cart should be always locked so that no residents or any unauthorized individuals can access medications from the cart. V3 stated if the cart is not locked anyone can access medications from the cart and can cause a huge medication error. On 4/1/2026 at 11:43 AM, V2 (Director of Nursing) stated the medication cart should be locked at all times; the lock does not pop back out; we should always lock the cart when staff are not standing next to the medication cart; anyone can walk up and take medications from the cart; and not locking the medication cart is a safety hazard. Facility policy titled Medication Storage date created 5/19 and last reviewal date 12/2025 documents: Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications (such as medication aides) permitted to access medications. Medication rooms, carts, emergency kits/boxes, and medication supplies are locked when not attended by persons with authorized access.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observations, interviews and record reviews, the facility failed to puree food to a safe consistency which has the potential to cause choking among the recipients. This applies to 9 residents (R1, R20, R22, R24, R61, R62, R65, R76 and R80) in the sample of 9 receiving a puree diet. Findings include:On 03/31/2026 at 9:32 AM, V16 (Cook) pureed lunch menu items of hot dogs, hot dog buns and mashed potatoes. When processing the hot dogs, V16 grabbed a handful of hot dogs (approximately 5) and placed them in a blender along with a half cup of liquid. The results were a lumpy, bumpy and gritty texture. To correct this texture, V16 blended the components again. Then, V16 opened and placed both hands in the blender to check for smooth consistency. V16 repeated this kneading three times without success. V16 said this is how V16 determined the correct consistency by feeling the substance. V16 did not taste the purees. V14 (Dietary Manager/Cook) said that it was not acceptable for V16 to place V16's hands in the puree to test for consistency. V16 added the hot dog puree should be mashed potato consistency. Then, V14 attempted to puree the hot dog buns in a different blender which resulted in a gummy, sticky, thick, and stiff texture. V14 said the puree was acceptable and ready for surveyor testing. V16 stated that the hot bun puree consistency was acceptable as well. V14 and V16 stated that all purees should be a smooth consistency to prevent residents from choking. On 04/01/2026 at 2:54 PM, V1 (Administrator) stated it is important that they follow the doctor's order, so the kitchen provides puree consistencies according to their policy. V1 added this is important to prevent residents from choking while providing them with a safe dining experience. The facility failed to follow their Pureed Diet dated 6/23/2025 policy which documents All foods served to residents on a pureed diet must be smooth, moist, cohesive and free of chunks or lumps. The consistency should resemble pudding, mousse, or applesauce with no visible solid pieces.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure that residents who depend on staff's assistance for their ADL (Activities of Daily Living) care received grooming and shaving. This failure affected one resident (R36) out of 61 residents reviewed for ADL care. Findings include:R36's Face Sheet documents R36's diagnosis of adult failure to thrive, multiple sclerosis, dementia, anemia and anxiety disorder. R36's last quarterly Minimum Data Sheet (MDS) documents a Brief Interview for Mental Status (BIMS) score of 14 indicating cognitively intact with little to no impairment. R36's Minimum Data Set, dated [DATE] shows R36 is independent for personal hygiene. On 03/30/2026 at 11:45 AM, R36 was sitting at the end of the hallway in front of the window. When asked about the facial hairs on R36's face, R36 responded that R36 would like the facial hair plucked or shaved. R36 said they usually do not ask if R36 wanted facial hair removed. R36's upper body posture was slouched or angled about 30 degrees in the chair. On 04/01/2026 at 2:54 PM, V1 (Administrator) stated residents should be groomed on a routine basis by the Certified Nursing Assistants. V1 said shaving is offered based on the resident's appearance or as needed. V1 added shaving and grooming is important for the residents' dignity and respect. The facility failed to follow their Supporting Activities of Daily Living (ADL) policy dated 12/2/2025 which documents Appropriate care and services will be provided for residents who are unable to carry out ADLs independently due to cognitive impairment or dementia.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure physician ordered high protein nutritional supplements were administered, failed to follow facility policies for nutritional assessments, monitor weights, monitor the effectiveness of interventions, and document meal intakes accurately for one of four residents (R23) reviewed for weight loss in a total sample of 61 residents. These deficient practices resulted in R23 sustaining a 7.5 percent significant weight loss from January 2026 through March 2026. Findings include:The Electronic Health Record (EHR) documents, in part, R23's diagnoses include: Hypertensive Heart Disease, Hyperlipidemia, Gastro-Esophageal Reflux Disease and Constipation. The Medication Administration Record (MAR) for February and March 2026 did not show R23 was on any diuretics that would affect her weight. A Weight Summary documents R23's weights as follows: on 1/1/26, weight 99.6 pounds on 2/3/26, weight 92.8 pounds, a five percent significant weight loss in one month; [NAME] 3/3/26, weight 92 pounds, a 7.5 percent significant weight loss in two months. R23 had no re-weights performed after a significant weight change as per facility policy. The Physician Order Sheet (POS) shows that an intervention for a high calorie drink to be increased from twice a day to three times a day was not added until 2/10/26, one week after the five percent weight loss was identified. On 3/3/26, when R23 continued to lose weight, an intervention to increase a high calorie frozen dessert from once a day to two times a day was not ordered until 3/11/26, eight days after the weight loss. R23 is currently on a mechanical soft textured diet for improved nutrition. On 3/30/26 at 12:26 PM, R23 was sitting in bed with a lunch meal of grilled cheese which was cut in half, tomato soup and pasta salad. R23's meal ticket reads: lightly grilled, (cut in quarters) grilled cheese sandwich. R23 did not have a high calorie frozen dessert on her tray as ordered. The meal ticket did not indicate R23 should receive a high calorie frozen dessert. R23 ate less than half of the soup, less than half the grilled cheese sandwich and the pasta salad was untouched. R23 was having difficulty chewing the bread and stated, tomato soup is salty and the grilled cheese is hard. R23 tapped the half sandwich on her plate as she described how hard it was. The sandwich was dark brown in color and hard. The sandwich was not lightly grilled and not cut into fourths as printed on her mechanical soft meal ticket. At 12:44pm, R23 was still chewing the food that was in her mouth originally.R23's Nutrition - Amount Eaten meal intake form dated 3/30/26 documents R23 ate 76-100 percent of her lunch meal even though it was observed that R23 ate less than half of her meal. On 3/31/26 at 12:36 PM, R23 was sitting up in the dining room with a lunch meal of chopped hot dog in a hot dog bun and steak fries. R23 did not have a high calorie frozen dessert on her tray as ordered. The hot dog bun was whole and dry and without any liquid to moisten it. R23 ate less than half the hot dog and none of the fries. R23 stated, It's too hard to swallow the bread. The Meal Intake Form dated 3/31/26 showed that R23 ate 76-100 percent of her lunch meal even though it was observed that she ate less than half of her meal. On 3/31/26 at 1:17 PM, V23 (Director of Rehabilitation/Speech Therapist) indicated that R23 is on a mechanical soft diet due to broken teeth and difficulty chewing meat. When asked about R23's difficulty eating her mechanical textured lunch meals for the last two days, V23 stated, She has never had issues with swallowing. V23 stated the standards for a mechanical soft diet is that meats and foods should be ground up and cut into minced/ground pieces. V23 stated, Grilled cheese should be cut into fourths with soft bread.On 3/31/26 at 12:42 PM, V12 (Traveling Supervisor) was in the 2nd floor dining room passing out High Calorie frozen nutritional desserts. R23 did not receive one. V12 said R23 does not get one. V12 stated that the frozen dessert would be printed on the meal tickets once the Director of Nursing or the nurse receives a physician order and then they notify the dietary department. On 3/31/26 at 12:48 PM, V14 (Director of Dining Services) stated the high calorie frozen dessert supplement is to help residents increase appetite and increase weight for those residents with significant weight loss, due to the higher calories. V14 looked at several meal tickets for R23 and (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	confirmed the high calorie frozen dessert was not printed on R23's meal tickets because no one let V14 know of the change. V14 further confirmed that unless it was printed on the meal ticket, R23 would not receive it. Both V12 and V14 confirmed R23 has not received high calorie frozen desserts from the dietary department recently. R23's medical record shows that V27 (Dietitian) only performed two nutritional assessments for R23 despite the significant weight loss triggers. One assessment was dated 1/31/26 and the other was dated 3/1/26. Neither of these nutritional assessments documented: height, usual body weight and/or ideal body weight as per facility policy. R23's electronic record denotes that R23's weight was performed monthly despite triggering for significant weight changes in two consecutive months. On 4/1/26 at 9:29am, V4 (Restorative Nurse) stated that R23 has only been weighed monthly and that there was no order for weekly weights to be done. On 3/31/26 at 1:37 PM, V27 (Dietitian) stated, Nutritional supplements get ordered for people that have poor oral intake. Primarily added to help those with gaining weight or to stop losing weight. V27 indicated that after R23 had significant weight losses, there were high calorie desserts with lunch and dinner ordered on 3/11/26. High calorie drink was added on 2/3/26. V27 did not know why it took seven and eight days to put interventions into place after significant weight loss triggers. V27 stated, I have not monitored (R23's) meals to see if she is eating and to see how her intake is. The staff do that and input the information into the computer. I did not monitor if (R23) was receiving the nutritional supplements. The inaccurate documentation for meal intakes was discussed. V27 stated that he would like to see dietary intake in the 75-100 percent (%) range. V27 stated, When eating 50% and paired with drop in weight, I'll recommend more interventions. On 4/1/26 at 12:10pm, V27 said additional interventions which could have been added were: weekly weights; asking about food preferences; checking if the mechanically soft diet was texturally right; cueing the resident during meal time, and placing the resident in a high visible area for dining monitor intake more closely. V27 said he did not suggest any of these interventions for R23. V27 said a 7 pound weight loss would be considered a significant weight loss since it was greater than a five percent weight loss. According to V27, R23's usual body weight was below her ideal body weight and weekly weights should have been done. V27 stated I will [NAME] up to that. I should have communicated to the dietary department that a change was made in orders and a high protein frozen dessert was added. Especially because there is no way for our systems to communicate electronically. V27 indicated that he is newly certified and a newer dietitian for the facility. On 4/1/26 at 11:05 AM, V2 (DON - Director of Nursing) stated, Dietitian recommendations are relayed to the doctor. Doctor gives the order. Once it's in the system, our (electronic system) does not communicate with the dietary electronic system. So, the dietitian aid should convey those orders or order changes to the dietary department. V2 said she meets with the dietitian and the dietitian aid weekly on Wednesdays to discuss any resident weight loss and any changes in diets. V2 stated that the dietitian aide will let the dietary department know of any changes. It was clarified with V2, three different people gave three different responses for how the facility notifies the dietary department of any changes in dietary orders. On 3/31/26, the dietary department indicated V2 (DON) would let them know. On 3/31/26, V27 (Dietitian) stated he would email the dietary department regarding the change; and now V2 said the Dietary Aide would notify the dietary department. V2 not aware of V27 emailing the dietary staff unless he changed the process. V2 said the facility policy is that any resident with a significant weight loss of five percent, 7.5 percent, or 10 percent should be on weekly weights times four weeks. V2 stated, (R23) should have been weighed weekly to monitor her closely.On 4/1/26 at 12:49pm, V26 (Physician) stated he doesn't focus on the weight, but focus' on nourishment. R23 should be receiving the supplements as ordered to stay nourished and if they weren't, this would be a problem and the resident would continue to lose weight. With significant weight loss, V26 would expect weights to be done every two weeks and for the facility to be monitoring bloodwork. R23's current BMI (Body Mass Index) is documented in the progress notes dated 3/1/26 as 15.9 percent, which is low. R23's medical record denotes that she has not had any blood work performed since 2/16/26. R23's Nutrition Care Plan documents: (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interventions: 1) Monitor/document/report to MD (Medical Doctor) for signs and symptoms of dysphagia, pocketing, choking, coughing, drooling. Holding food in mouth. Several attempts at swallowing, refusing to eat. 2) Provide and serve diet as ordered. 3) Provide and serve supplement as ordered. 4) RD (Registered Dietitian) to evaluate and make diet change recommendations PRN (as needed). A facility policy with a review date of 3/20/26 and titled, Physician Orders documents: Intent: Facility has a process to ensure that all Physician Orders are documented appropriately.A facility policy with a review date of 5/15/25 and titled, Nutrition/Hydration Status Maintenance documents: Intent: it is the policy of the facility to provide Nutrition/Hydration Status Maintenance Services in accordance with State and Federal regulations. Procedure: 1. Nutritional assessments are completed on residents and include body mass index, usual body weight, height, weight, ideal body weight, and diagnosis. A facility policy with a revised date of 12/15/25 and titled, Weight Management documents: Procedure: 3. Monitoring and Review: b. A re-weight will be obtained for any significant or unexpected weight change, including but not limited to: i. 5% change in one month, 7.5% in 3 months and 10% in 6 months. 4. Re-Weight Process: a. Re-weights will be obtained promptly to confirm accuracy. An undated facility policy titled, Characteristics & Procedures for Consistency Modified Foods documents: Policy: Mechanical Soft, Dysphagia and Puree Diets will be prepared to the food characteristics listed below. Ground; Mechanical Soft. Note 1: bite size pieces no larger than 1/2 inch. Note 2: Most entrees of this consistency are served with additional sauce or gravy to ensure adequate moisture is maintained.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. Based on observation, interview, and record review the facility failed to ensure alcohol beverages were monitored according to the physician's order by allowing 1 resident (R69) to store ten cans of beer in his personal refrigerator located in R69's room. This failure affects 1 resident in a total sample of 61 residents.R69's Face Sheet dated 4/1/2026 documents a diagnosis of but not limited to hypertensive heart and chronic kidney disease with heart failure, type 2 diabetes mellitus, gout, retention of urine, and peripheral vascular disease, Minimum Data Set Section C dated 1/2/2026, documents a BIMS (Brief Interview Mental Status) Score of 15 with indicates R69 has an intact cognition, care plan does not have a focus for alcohol consumption.R69's physician order details dated 10/1/2024 was reviewed and does not specify the amount or number of ounces a can of beer R69 can have at dinner time. R69's physician order sheet dated 3/30/2026 documents R69 may not have alcohol.R69's care plan does not document a focus for alcohol use. On 3/30/2026 at 10:47 AM, V6 (Licensed Practical Nurse) verified R69 had 10 cans of beer (five 12-ounce cans of beer and five 8-ounce cans of beer) in his room stored in his (R69's) personal refrigerator. V6 stated she (V6) was not sure if the resident had orders to have beer in his refrigerator. V6 opened R69's electronic health record and verified R69's physician's order documents R69 can have one beer a day after dinner and beer is to be stored at the nursing station. On 3/30/2026 at 2:37 PM, V4 (Restorative Nurse) verified the resident had five 12-ounce cans of beer and five 8 -ounce cans of beer in his refrigerator. V4 stated she is not sure if the resident has an order for alcohol, you must ask the nurse taking care of the resident if there is an order for the resident to have alcohol. On 3/31/2026 at 2:31 PM, surveyor observed alcohol beverages of five 12-ounce cans and five 8-ounce cans of beer in R69's refrigerator.On 4/1/2026 at 11:25 am, V2 (Director of Nursing) stated R69 has an active order to have one can of beer (dinner). V2 is not aware of how many beers R69 has in his refrigerator. V2 is not aware of R69's order documenting beer one time a day and beer should be at the nursing station. V2 is not aware R69 does not have alcohol care planned, verified the order dated 10/1/2024 documents one beer one time a day and beer is kept at the nurses station and the order was discontinued on 3/28/2026 because R69 needed reevaluated for alcohol privileges. V2 doesn't know how he is being monitored but R69 has not had any behaviors and as is alert and oriented. V2 said if R69 is noted with slurred speech or lethargy his alcohol privileges will be revoked for intoxication. Facility's policy titles Physician Orders dated 7/1/2020 with a last review date of 3/20/2026 documents the facility has a process to ensure that all Physician Orders are documented appropriately and physician orders will be entered, updated as needed and revised as necessary.Facility's policy titled Resident Alcohol Use in Long-Term Care (LTC): Clinical Guidance documents Alcohol use (e.g.) is not prohibited in long-term care and may align with resident rights and preferences.#3. Ordering alcoholOrders must be clear and specific (type, amount, frequency, timing).Example: Beer, 12 oz, one daily with dinner.DocumentationInclude alcohol use in the care plan.Document risk assessment, medication review, and monitoring approach.Ensure the MAR reflects complete order details.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. Based on observations, interviews, and record review the facility failed to monitor resident's personal refrigerator temperature logs; and failed to ensure that resident's personal refrigerators had a thermometer. These failures affected three residents (R19, R56, and R84) out of 61 residents in the total sample.Findings include: R56's diagnoses include but are not limited to asthma, hydrocephalus, heart disease, hyperlipidemia, dementia, polyneuropathy, and anemia. On 3/30/26 at 10:50 am, R56's personal refrigerator was noted with a temperature log taped to the side of R56's refrigerator. The last date the temperature log was checked was on 3/29/26. R56's refrigerator did not have a thermometer inside the refrigerator. On 3/30/26 at 11:00 am, V20 Housekeeper stated, Housekeeping is responsible for checking the resident's personal refrigerators. I (V20) did not check R56's refrigerator because it doesn't have a thermometer. I need to call maintenance to get a thermometer. The refrigerators temperatures are checked every day to make sure the food doesn't spoil. Every refrigerator should have an inside thermometer. On 3/31/26 at 12:45 pm, R56's personal refrigerator temperature log was not checked. The last date R56's personal refrigerator was checked was 3/29/26. On 4/1/26 at 1:25 pm, V7 Housekeeping Supervisor stated that the housekeeping department checks the resident's personal refrigerators, and they should be checked every day. The refrigerators are checked daily to make sure the temperature doesn't drop below 36 degrees or get above 40 degrees. A thermometer should be inside the refrigerator. If the temperature goes above 40 degrees, the food can spoil, and the residents can get sick. On 4/2/26 at 8:45 am, V1 Administrator stated, The resident's personal refrigerators should be checked daily, and a thermometer should always be in the refrigerator. The facility's practice is to check the personal refrigerators daily. The policy says to check the refrigerators weekly. We go beyond the policy for good practice. I don't know why our policy says weekly and our refrigerator temperature log says daily, so we should be checking the resident's personal refrigerators daily. The facility's document undated and titled, Food Refrigerator Temperature Log documents, in part, Adjust refrigerator temperatures as necessary to maintain temp between 35-40 degrees Fahrenheit. Night Shift Please Record Temps Daily. Write needed adjustments in comments. Facility's policy titled, Food Brought in the Facility by Family or Vistors reviewed 3/2/26, documents, in part, Intent: It is the right of the residents of this facility to have food brought in by family or other visitors. The food will be handled in a way to ensure the safety of the residents. Facility's job description undated and titled, Housekeeping Aide documents, in part, Job summary: Performs a variety of general housekeeping/cleaning duties in various areas to maintain the center in a sanitary, safe, attractive and orderly condition. General Requirements: a. Works in a safety-conscious manner, which ensures that safe work practices are used in order not to pose a risk to self or others in the workplace. Reports any safety violations or hazards to supervisor b. Complies with company policies and procedures and local, state, and federal regulations. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R19's Face Sheet documents R19's diagnosis of anemia, coronary artery disease, heart failure, hypertension, and hyperlipidemia. R19's last quarterly Minimum Data Sheet (MDS) documents a Brief Interview for Mental Status (BIMS) score of 15 indicating cognitively intact with little to no impairment. R84's Face Sheet documents R84's diagnosis of anemia, atrial fibrillation, coronary artery disease, heart failure, orthostatic hypotension, and diabetes. R84's last quarterly Minimum Data Sheet (MDS) documents a Brief Interview for Mental Status (BIMS) score of 6 indicating cognitively impairment. On 03/30/2026 at 11:40 AM, R19 did not have a thermometer in R19's refrigerator nor did R19 have daily temperature logs on R19's refrigerator. On 03/30/2026 at 11:44 AM, there was no thermometer in R84's refrigerator. R84 stated that R84 did not have thermometer in R84's refrigerator. On 04/01/2026 at 2:54 PM, V1 (Administrator) stated residents with personal refrigerators should have thermometers and daily log sheets. V1 said temperatures should remain in safe temperature range to ensure food does not spoil so residents do not get sick. The facility failed to follow their Food Storage policy dated 12/30/2025 which documents Personal refrigerators must be checked at least weekly for safety. Staff must check resident refrigerator temperatures weekly.