STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145857	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of St. Elmo	221 East Cumberland St Elmo, IL 62458

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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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	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 establish and maintain an effective infection prevention and control program to identify infectious disease symptoms as well as track, report, treat and isolate infected residents to prevent urinary tract infections for 4 (R1, R3, R6, R23) of 4 residents reviewed for infection control. This failure has the potential to affect all 33 residents in the facility. This failure resulted in R1 being admitted to the hospital on [DATE] for developing sepsis related to a urinary tract infection (UTI), R3 admitted to the hospital on [DATE] with developing a complicated urinary tract infection, and R23 being admitted to the hospital on [DATE] with an acute metabolic encephalopathy secondary to UTI complicated by bilateral ureter stents and history of UTI caused by a multidrug-resistant organism.The failure resulted in an Immediate Jeopardy which was identified to have begun on 3/29/26 at 10:30 am when R23 returned to the facility after a hospital admission with a diagnosis of a urinary tract infection with an organism of a multidrug-resistant organism and was not placed on contact precautions. V1 (Administrator) was notified of the Immediate Jeopardy on 6/9/26 at 3:19 PM. The immediacy was removed on 6/10/26, but noncompliance remains at a Level 2 because additional time is needed to evaluate the implementation and effectiveness of the in-service training.Findings include:1. R1's admission Record documents an admission date of 02/19/2026 with diagnoses including sepsis due to Escherichia Coli (E. Coli), urinary tract infection, bacteremia, type 2 diabetes mellitus, unspecified dislocation of right hip, depression, hypothyroidism, venous insufficiency, and obstructive sleep apnea. R1's MDS (Minimum Data Set) dated 05/18/2026 documents a BIMS (Brief Interview for Mental Status) score of 15 indicating R1 is cognitively intact. The same MDS documents that R1 is occasionally incontinent of urine and frequently incontinent of bowel. R1's Care Plan documents a focus area of the resident has the diagnosis of sepsis due to E. Coli and is in need of antibiotic medication (initiated 05/14/2026). Corresponding interventions include antibiotic therapy per doctors' orders, encourage fluid intake, monitor, document, and report to medical doctor signs and symptoms of urinary tract infection. There are no Focus areas or interventions related to Enhanced Barrier Precautions documented in R1's Care Plan prior to 06/04/2026. R1's Progress Note dated 05/06/2026 at 12:33 P.M documents R1 was sent to the hospital emergency department for evaluation and treatment for cough and congestion. R1's Progress Note dated 05/06/2026 at 6:13 P.M. documented R1 was admitted to the hospital with a urinary tract infection. R1's After Visit Summary from the local hospital dated 05/14/2026 documented R1 was admitted on [DATE] to the hospital with a primary diagnosis of sepsis secondary to urinary tract infection (UTI) (continued on next page)

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

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	and diagnoses including open wound to the buttock, complicated UTI, pneumonia due to infectious organism, and bacteremia. R1's hospital urine culture with a collection date of 05/06/2026 documented the result as 50,000-100,000 col/ml (coliform/milliliter) Escherichia Coli probable Extended Spectrum Beta Lactamase Producer (ESBL) and > (greater than) 100,000 col/ml Gamma hemolytic strep. On 06/02/2026 at 10:30 A.M. during a tour of the facility, R1's room was observed to not have any signage indicating R1 was on isolation or Enhanced Barrier Precautions. R1's room did not have a Personal Protective Equipment (PPE) station outside of the room. On 06/03/2026 at 1:32 PM, V19 (Certified Nurse Assistant) sanitized hands prior to knocking on R1's door and explained that she is going to provide perineal care. V19 then closed the door for privacy. V19 already had supplies set up on bedside table. V19 placed gloves on her hands and removed R1's sheet and placed a barrier sheet under R1. V19 placed a washcloth in the basin that had water in it. V19 removed the washcloth from the basin, picked up the perineal wash bottle and sprayed it onto the washcloth. V19 took the washcloth in her right hand and spread R1's legs apart with her left hand. V19 then used her left hand to expose R1's perineal area. V19 washed R1's right side of her perineal area with the washcloth. V19 used her left hand to fold the washcloth. V19 used her left hand to expose R1's perineal area, V19 used her right hand with the washcloth to clean the left side of R1's perineal area. V19 then used her left hand, wearing the same gloves, to pull a plastic bag from her pants pocket, opened the plastic bag and placed it on the floor. V19 then placed the washcloth in the bag. V19 grabbed a new washcloth with her right hand, wearing the same gloves, and placed it in the basin with water. V19 removed wash cloth from basin with both hands, still wearing the same gloves, and grabbed the peri spray bottle with her left hand and sprayed the washcloth in her right hand with perineal cleaner. V19 then cleaned R1's middle perineal area, folded washcloth with both hands and cleaned the middle area again. V19 placed wash cloth in plastic bag located on the floor. V19 grabbed a new washcloth with her right hand and placed it in the wash basin with water. V19 removed the washcloth with her right hand and wiped R1's middle perineal area. V19 placed the washcloth in the clear plastic bag. V19 then took a dry washcloth and dried R1's perineal area. V19 then rolled resident and removed barrier. V19 placed sheet on R1 turned resident and placed wedge under R1's left side. V19 removed gloves, picked up basin, gathered trash and left room. V19 took basin to soiled utility room down the hall and disposed of used items. V19 sanitized hands upon exiting soiled utility room. During this observation of perineal care V19 was observed to be wearing the same pair of gloves throughout the care. V19 did not sanitize hands after doffing gloves and exiting the room. V19 only sanitized after exiting the soiled utility room. On 06/03/2026 at 1:43 P.M., V19 stated that she provided the care for R1 just like the facility policy says to. V19 stated the policy does not instruct them to change gloves until the end of care. On 06/04/2026 at 9:47 AM, V2 (Director of Nursing) was observed completing wound care for R1's open wound. During this observation V2 did not wear a gown to provide care. On 06/04/2026 at 10:03 AM, V2 stated R1 should have been on enhanced barrier precautions due to the wound to her coccyx. V2 stated she is not sure why R1 is not on enhanced barrier precautions. On 06/04/2026 at 10:28 A.M., V2 stated she has placed R1 on enhanced barrier precautions at this time. (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	R1's Order Summary Report documents an active order dated 06/05/2026 for ENHANCED BARRIER PRECAUTIONS with diagnoses of wound and history of ESBL (Extended-Spectrum Beta-Lactamase). On 06/09/2026 at 11:56 P.M., V9 (Assistant Director of Nursing/Infection Preventionist) stated she was not aware that R1's urine culture in the hospital resulted in ESBL. V9 stated if she would have been aware of the culture results, R1 would have been placed in isolation upon returning from hospital. The facility's Infection Surveillance Report dated 5/1/26 to 5/31/26 documents that R1 has a UTI with an infection onset date of 5/14/26 and documents an order for Ertapenem Sodium Solution Reconstituted 1 gram. R1's Care Plan with a revision date of 6/4/26 documents an added Focus area of R1 has an abrasion to her right buttock and is in need of wound care (initiated 06/04/2026). Corresponding interventions include ensure thorough skin and peri care with each toileting event and or episode of incontinence care, pressure reducing mattress to bed, wound consult and care per wound nurse practitioner, monitor and record wound healing progress (initiated on 06/04/26). R1's Care Plan also documents a Focus area added of the resident is on enhanced barrier precautions (EBP) related to history of ESBL and wound (initiated 06/04/2026). Corresponding interventions include: educate visitors on necessary precautions needed, follow facility's infection control and enhanced barrier precautions policies / procedures when cleaning / disinfecting room, handling soiled and or contaminated linen, gown and glove use when performing high-contact resident activity, have adequate PPE (Personal Protective Equipment) available, practice good handwashing and use principles of infection control and enhanced barrier precautions. All interventions for this focus area were documented to be initiated on 06/04/2026. 2. R3's admission Record documents and admission date of 05/28/2024 with diagnoses including encephalopathy, urinary tract infection, ESBL, Parkinson's Disease, dysphagia, and acute kidney failure. R3's MDS dated [DATE] documents a BIMS score of 11 indicating R3 is moderately cognitively impaired. The same MDS documents that R3 has an indwelling urinary catheter. R3's Order Summary Report documented an active order dated 04/21/2026 for ENHANCED BARRIER PRECAUTIONS indwelling foley catheter and history of ESBL (Extended-Spectrum Beta-Lactamase) and an active order for foley catheter care every shift and as needed and to change indwelling catheter tubing monthly. R3's Care Plan documents a Focus area of R3 has the diagnosis of urinary tract infection and ESBL and is in need of antibiotic therapy to treat his condition (initiated 05/06/2026). Corresponding interventions include intravenous antibiotic medication, monitor and report back to the nurse any noted UTI symptom complications, and promote daily hydration to include several glasses of water or juice. All interventions were implemented on 05/06/2026 for this focus area. R3's Care Plan also documents a focus area of enhanced barrier precautions related to indwelling catheter and history of ESBL. Corresponding interventions include educate staff/resident/family on enhanced barrier precautions as needed, gown and glove during high contact resident care activities (such as dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting), and maintain enhanced barrier precautions for the duration of their stay or until the indwelling medical device that placed them at higher risk. All interventions listed for this focus area (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	were documented as initiated on 04/24/2024. R3's Progress Note dated 05/03/2026 at 9:19 A.M. documented R3 had decreased level of consciousness, lethargy and altered mental status this morning when the certified nurse assistants went to get R3 up for breakfast. R3's urine is tea colored with a strong odor. R3 sent to hospital for evaluation and treatment. R3's Progress Note dated 05/03/2026 at 12:13 P.M. documented R3 was admitted to the hospital with a diagnosis of complicated urinary tract infection. R3's After Visit Summary from the local hospital dated 05/06/2026 documented that R3 was admitted to the hospital with the diagnoses of complicated urinary tract infection, infection due to ESBL producing E. Coli, and urinary retention. R3's hospital urine culture dated 05/03/2026 documented culture results 50,000 – 100,000 col/ml E Coli probable Extended Spectrum Beta-Lactamase, > 100,000 col/ml Serratia Fonticola, and >100,000 col/ml Proteus Mirabilis. On 06/03/2026 at1:24 PM, an EBP sign and PPE (personal protective equipment) supplies were observed outside of R6's room notifying staff and visitors of completing hand hygiene, including before entering and leaving room, and staff to wear required PPE during high-contact resident care, including providing hygiene, changing briefs or assisting with toileting. V17 (Certified Nurse Assistant) sanitized hands and donned a gown and gloves prior to entering R3's room. V17 explained to R3 that she was going to perform catheter care and removed R3's cover. V17 assisted R3 to lift and place a barrier underneath his bottom. V17 started catheter care without doffing dirty gloves, completing hand hygiene, or donning new gloves. V17 unlatched R3's catheter secure strap. V17 reached into the wash basin on the bedside table that had washcloths in it and pulled a washcloth out. With both hands, V17 wrung the washcloth out. V17 then grabbed the no rinse soap with her left hand and sprayed it on the washcloth that she was holding with her right hand. V17 grabbed R3's penis with her left hand and cleaned it with the washcloth. V17 was observed with dirty gloves, grabbing a clean washcloth from the basin and wrung the washcloth out with both hands. V17 grabbed the no rinse soap with her left hand and sprayed the washcloth. V17 then grabbed R3's penis with her left hand and cleaned around the center and then discarded the washcloth in a trash bag. V17, with dirty gloves, grabbed a washcloth from the basin and wrung it out with both hands. V17, with dirty gloves, then grabbed the no rinse soap with her left hand and sprayed it on the washcloth. V17 cleaned the indwelling catheter tubing and discarded the washcloth. V17 with dirty gloves, grabbed a new washcloth from the basin and wiped off the no rinse soap. V17 discarded the washcloth and with dirty gloves grabbed a clean towel. V17 dried R3's perineal area and catheter tubing. V17 discarded the towel and without discarding her gloves, sanitizing her hands and donning new gloves, placed tubing back in catheter strap on R3's leg. V17 covered R3 up. V17 removed her gown, removed her gloves and placed new gloves on. V17 stated she put new gloves on to go dump basin in soiled utility room. V17 dumped water from basin in R3's bathroom and took it to soiled utility room. Upon exiting the soiled utility room V17 sanitized her hands. On 06/03/2026 at 1:30 P.M., V17 stated she followed the policy and changed her gloves when the policy told her to. V17 stated she does not have to change her gloves until the end of the procedure. V17 stated the policy did not say that one hand had to be kept clean during the catheter care. 3. R23's admission Record documented an admission date of 11/13/2025 with diagnoses including (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	urinary tract infection, site not specified, other artificial openings of urinary tract status, hematuria, unspecified, resistance to multiple antimicrobial drugs, muscle wasting and atrophy, other lack of coordination, calculus of ureter and anxiety disorder, unspecified. R23's MDS dated [DATE] documented a BIMS Score of 13 indicating R23 is cognitively intact. Section GG documents that R23 is dependent (helper does all the effort) for toileting hygiene and showering/bathing self. Section H, under Appliances documented an indwelling catheter in place, Urinary Continence documented not rated, resident had a catheter and Bowel Continence documented frequently incontinent (2 or more episodes of bowl incontinence, but at least one continent bowel movement). R23's Care Plan documented a focus area of general weakness and unsteadiness. R23 needs staff assistance to meet his toileting needs with an intervention to monitor and report to the nurse any noted symptoms of UTI (Urinary Tract Infections) such as: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns with a start date of 4/2/2026. R23's Progress Note dated 3/23/2026 at 11:55 PM by V18 (LPN) documented R23 admitted to local emergency room related to pneumonia, urinary tract infection, and chronic obstructive pulmonary disease exacerbation. R23's After Visit Summary from the local hospital dated 3/26/2026 to 3/29/2026 documented a reason for admission.urinary tract infection. R23's Urine Culture and Sensitivity result from local hospital dated 3/23/2026 documented culture urine (abnormal) (susceptibility) Specimen: Urine, Voided Collected: 03/23/26 5:05 PM and updated: 03/26/26 at 7:06 AM culture results of 50,000-100,000 COL/ML. Escherichia coli probable extended spectrum bet lactamase producer, susceptibility Escherichia coli. No colonized culture noted. R23's Progress Note dated 4/22/2026 at 7:50 AM by V3 (Registered Nurse/RN) documented sent to local ER (emergency room) via ambulance for confusion. R23 was up all night going through other resident's closets and attempting to crawl into the wrong bed in the wrong room.V16 (physician) and V9 (ADON) notified of transfer. R23's Progress Note dated 4/22/2026 at 12:15 PM by V9 documented resident admitted to local hospital for complicated UTI. R23's After Visit Summary dated 4/23/2026 to 5/21/2026 documented an admission diagnosis of blood in urine of unknown cause. Genitourinary: indwelling catheter in place draining orange colored urine. Under Assessment /Plan documents acute metabolic encephalopathy secondary to UTI complicated by ureter stents and history of UTI caused by ESBL. Under Results documents urine bacteria, unspecified with culture result of >100,000 COL/ML, gram negative rods. No colonized culture noted. R23's Progress Note from out-of-town hospital dated 5/7/2026 at 8:44 AM by V23 (Physician) documented under history and physical: R23 initially presented to the outside hospital emergency department with acute worsening confusion and hallucinations concerning acute metabolic encephalopathy in the setting of suspected complicated urinary tract infection. He had recently been (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	treated at the nursing facility with oral cephalexin (Keflex) for presumed UTI prior to presentation. Given his history of ESBL urinary infections, there was concern for resistant infection, and he was subsequently started on IV meropenem at the outside hospital after urinalysis returned abnormal; urine cultures remain pending at the time of transfer. R23's Physician Orders documented a discontinued order of enhanced barrier precautions with no directions specified for order with a discontinued date of 3/5/2026, contact precautions for MRSA (Methicillin-resistant staphylococcus aureus) with a start date of 5/26/2026 and a discontinued date of 5/29/2026, and contact precautions for ESBL(Escherichia coli probable extended spectrum bet lactamase) in urine with a start date of 5/29/2026 and discontinued on 6/9/2026. On 06/04/2026 at 1:50 PM, V9 (ADON) stated R23 had returned to the facility on 5/21/2026 with an indwelling catheter in place. V9 stated, R23 had been admitted to the hospital for a complicated urinary tract infection with a bacteria organism of extended spectrum beta-lactamase producing Escherichia Coli (ESBL) on 4/22/2026. V9 stated, ESBL can be caused by poor hand hygiene during catheter care. V9 stated, R23 is on an active antibiotic order of Ertapenem Sodium Solution Reconstituted 1 gram intravenously every 24 hours for ESBL producing e-coli UTI until 06/05/2026. On 06/05/2026 at 9:53 AM, V12 (Family) stated R23 had been admitted to the facility almost a year ago. V12 stated, R23 has had multiple urinary tract infections (UTI's) over the last few months. V12 stated, R23 did go to the local hospital around 3/23/2026 for confusion and he was diagnosed with UTI. V12 stated, he did return to the facility a few days later then went back out to the local hospital for confusion on 4/23/2026 and was sent to another hospital up north for further treatment and evaluation. V12 stated, staff does assist R23 with incontinence care. On 06/05/2026 at 10:17 AM, V9 (ADON) stated, R23 had been on an antibiotic for a skin infection that finished up on 3/15/2026. V9 stated, R23 had been sent to the local emergency room on 3/23/2026 related to confusion and admitted with multiple diagnoses including a urinary tract infection. V9 stated, R23 returned to the facility on 3/29/2026 and she did not follow up on R23's UTI with organism of ESBL (Escherichia coli probable extended spectrum beta lactamase producer) and probably should have. V9 stated, R23 did not have any contact precautions in place for ESBL upon reentry to the facility on 3/29/2026. V9 stated, she does not typically follow up with infections when they get treated in the hospital, even if symptoms started in the facility. V9 stated, R23 did get transferred to the local hospital on 4/22/2026 related to confusion and was admitted to the hospital for further treatment and evaluation. V9 stated, R23 had been diagnosed with a UTI in the local emergency room with organism of gram-negative rod on 4/23/2026. V9 stated, R23 had an indwelling catheter placed at this time and was then transferred to another hospital up north for further treatment. V9 stated, when R23 returned to the facility on 5/21/2026, the facility put contact precautions in place related to ESBL in the urine and continued intravenous antibiotics until 6/5/2026. V9 stated, R23 did not have orders placed for his catheter, catheter care, and documentation in his care plan until 6/2/2026. V9 stated, she will need to contact V16 (Physician) today to see when R23 should have an indwelling catheter exchanged. V9 stated, there are no orders in place at this time and no discharge instructions from the hospital on 5/21/2026. On 06/05/2026 at 11:30 AM, catheter care on R23 by V13 (Certified Nurse Assistant/CNA) and V2 (Director of Nursing/DON) was observed. V13 was observed with a gown and gloves on prior to entering R23's room and V2 applied personal protective equipment that included a gown and gloves. V13 knocked on R23's door prior to entering. V13 used both gloved hands to move the bedside table over to R23's bed and then went over to the blinds and closed the blinds. V13 returned back to R23's (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	bedside table, removed blanket, and R23's pants while wearing the same gloves. V13 started catheter care without doffing dirty gloves and completing hand hygiene. V13 took rinse free soap bottle from V2 and sprayed spray directly to R23's urinary meatus area. V13 replaced the rinse free bottle on the bedside table, grabbed a clean washcloth, dipped it in the basin of water, wrung out the cloth with both hands and cleaned R23's meatus area by using her left hand to pull the foreskin back and clean area with her right hand, then discarded cloth in a trash bag that is sitting on the clean field next to water basin. V13 observed doffing gloves, completing hand hygiene and donning new gloves. V13 observed taking a new washcloth, dipped it in the water basin, wrung out cloth with both hands, pulled back foreskin and cleaned R23 meatus and catheter tubing. R23's discarded dirty wash cloth in trash bag that is sitting on the clean barrier next to water basin. V13 returned catheter tubing in catheter tube holder grabbed a new washcloth to dry R23's penile area and catheter without doffing dirty gloves, completing hand hygiene and donning new gloves. V13 then asked V2 if she should remove her gown at this time or wait until she had cleaned up the bedside table. V2 directed V13 to change her gloves then clean up bedside table. V2 observed doffing dirty gloves and donning new gloves with no hand hygiene, then cleaned off the bedside table, handing the water basin to V2 to hold. V13 asked V2 if she should take her gown off at this time and V2 gave her directions to remove gown. V13 doffed her dirty gown and gloves with no hand hygiene, donned new gloves and took the water basin from V2 to walk it to the soiled utility room. On 06/05/2026 at 11:36 AM, V2 (DON) stated V13 should have doffed her gloves, completed hand hygiene and donned new gloves prior to starting R23's catheter care and again during cleaning once V13 had contaminated gloves. On 06/05/2026 at 12:25 PM, V14 (Regional Nurse) stated he just got off the phone with V6 (Vice President of Operations) who stated the catheter care policy had been reviewed by the corporate office and it did not meet standards for infection control practices. On 06/05/2026 at 12:30 PM, V15 (Medical Director) stated, with the lack of standard infection control practices, not following up on infections/organisms with the right antibiotic, not following or initiating enhanced barrier precautions or contact precautions, this does have the potential to affect all residents in the facility. V15 stated, the lack of standard infection control practices does have the potential to spread infections to all residents, and it does appear that reeducation is needed. On 06/09/2026 at 10:30 AM, V21 (Regional Nurse) stated the facility follows the Center Disease Control and Prevention (CDC) guidelines on antibiotic stewardship and only recheck urine if a resident had signs and symptoms of a urinary tract infection. V21 stated, it would depend on whether there was a new case of ESBL or not, if they would place a resident on enhanced barrier precautions or transmission-based precautions and it would be the facility's discretion. On 06/09/2026 at 12:01 PM, V15 (Medical Director) stated with the lack of standard infection control practices urinary tract infections can lead to sepsis and hospitalizations for residents. The CDC website, https://www.cdc.gov/sepsis/about/index.html, under What is Sepsis documents Sepsis is the body's extreme response to an infection. It is a life-threatening medical emergency. Sepsis happens when an infection you already have triggers a chain reaction throughout your body. Infections that lead to sepsis most often start in the: Gastrointestinal tract, Lung, Skin, or Urinary Tract. Without fast treatment, sepsis can quickly lead to tissue damage, organ failure, and death. The facility's Infection Control Spreadsheet documented R23 on line 22 with a bacterial infection of (continued on next page)

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	sepsis, unspecified with an infection site of urinary tract with no organism listed with an onset date of 2/23/2026. The facility's Infection Surveillance Report dated March 01, 2026 – March 31, 2026, documented 5 UTI's for the facility with no documentation of R23's infection, signs or symptoms, status of infection, organism or antibiotic. The facility's Infection Control Spreadsheet documented a 6-month period from 12/9/2025 to 6/2/2026 with 27 urinary tract infections and 7 urinary tract infections missing documentation of the organism. 4. R6's admission Record documented an admission date of 12/30/2025 with diagnoses including obstructive and reflux uropathy, unspecified, retention of urine, unspecified, muscle wasting and atrophy, other lack of coordination, and unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. R6's MDS dated [DATE] documented a BIMS Score of 09 indicating R6 is moderately cognitively impaired. Section GG documents R6 requires substantial/ maximal assistance with toileting hygiene and showering/bathing self. Section H, under Appliances documented an indwelling catheter in place, Urinary Continence documented as not rated, resident had a catheter and Bowel Continence documented frequently incontinent (2 or more episodes of bowl incontinence, but at least one continent bowel movement). R6's Care Plan had a focus of required enhance barrier precautions (EBP) related to an indwelling catheter with interventions in place of follow facility's infection control and enhanced barrier precautions policies/procedures when cleaning/disinfecting room, handling soiled and/or contaminated linen, disinfecting equipment, gown and gloves are to be used when performing high-contact resident contact activity, practice good handwashing, use principles of infection control and enhanced barrier precautions with a start date of 2/16/2026. On 06/03/2026 at 11:13AM, an EBP sign and PPE (personal protective equipment) supplies was observed outside of R6's room notifying staff and visitors of completing hand hygiene, including before entering and leaving room, and staff to wear required PPE during high-contact resident care, including providing hygiene, changing briefs or assisting with toileting. V17 (Certified Nurse Assistant/CNA) and V2 (Director of Nursing) were observed entering R6's room with no hand hygiene or PPE applied. V17 (CNA) was observed donning gloves with no hand hygiene prior to starting R6's catheter care. V17 moved the bedside table with both gloved hands closer to R6's bedside. V17 turned to R6, pulled his blankets down then removed R6's pants and pulled down his incontinent brief. V17 assisted R6 to lift and placed a barrier underneath his bottom. V17 started catheter care without doffing dirty gloves, completing hand hygiene, donning new gloves or donning of a protective gown. V17 was observed with dirty gloves, placing a clean washcloth in the water basin, wrung the washcloth out with both hands then pulled back R6's foreskin with her left hand and wiped R6's meatus area and catheter tube with right hand. V17 then discarded the washcloth in a trash bag. V17, with dirty gloves, grabbed a new washcloth, dipped it in the water basin, wrung out the washcloth with both hands, picked up the non-rinse soap bottle, sprayed the soap on the washcloth, used her left hand to retract foreskin and used right hand to clean R6's meatus area and catheter tube without doffing dirty gloves, completing hand hygiene, donning new gloves and continuing to not wear a protective gown. V17, with dirty gloves, grabbed a new washcloth from the bedside table to dry R6's meatus area and catheter tube without doffing dirty gloves, completing hand hygiene, and donning (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven of St. Elmo	221 East Cumberland St Elmo, IL 62458

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F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Many	new gloves. V17 observed doffing gloves and donning new gloves without hand hygiene prior to removing barrier under R6, then assisted to pull up his incontinence brief and pants. On 06/03/2026 at 11:25 AM, V17 (CNA) stated EBP is used to help not spread infections or contamination. V17 (CNA) stated, she should have worn PPE during catheter care and completed hand hygiene, however the facility policy directs staff that she does not have to change gloves until after care is completed. V17 stated, R6's does have a lot of UTI's. On 06/03/2026 at 11:52 AM, V2 (Director of Nursing/DON) stated V17 should have been using PPE during catheter care. On 06/03/2026 at 12:19 PM, V1 (Administrator) stated his expectations are for all staff to follow EBP and infection control practices per policy. On 6/3/2026 at 2:25 PM, V9 (Assistant Director of Nursing/ADON) stated she is the infections preventionist and does track all infections, organisms and antibiotics for the facility. V9 stated, she enters the information into the infection surveillance report. On 06/04/2026 at10:56 AM, V6 (VP/Vice President of Operations) stated she sent the facility's catheter care policy and procedure to the corporate office for review of infection control standards of practice. V6 stated, she had been discussing with V14 (Regional Nurse) and V1 (Administrator) that 19 urinary tract infections are a lot in a 6-month timeframe. R6's Progress Note dated 1/29/2026 at 1:06 PM by V7 (LPN) documented R6 had been admitted to the local hospital with acute kidney injury and urinary tract infection. R6's Urine Culture results dated 1/29/2026 documented a culture result of >100,000 COL/ML Proteus Mirabilis and 50,000 – 100,000 COL/ML of Morganella Morganii. R6's Progress Note dated 3/25/2026 at 9:19 AM by V7 (LPN) documented R6's on an antibiotic for UTI without SE (side effects) noted. Indwelling catheter patent, draining yellow urine and voices no complaints of pain or discomfort. R6's Progress Note dated 4/2

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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 interview, observation, and record review, the facility failed to complete skin and wound assessments for a resident at risk for skin breakdown, failed to notify the physician of a new wound, and failed to identify worsening of a wound for 1 (R1) of 1 residents reviewed for pressure ulcers in the sample of 25. This failure resulted in R1 developing a stage 2 pressure ulcer that worsened to the right buttock and developed a new stage 2 pressure ulcer to the left buttock.The Findings Include:R1's admission Record documents R1 was admitted to the facility on [DATE] with diagnoses including sepsis due to Escherichia Coli, urinary tract infection, bacteremia, type 2 diabetes mellitus, unspecified dislocation of right hip, depression, hypothyroidism, venous insufficiency, and obstructive sleep apnea.R1's MDS (Minimum Data Set) dated 05/18/2026 documented R1's BIMS (Brief Interview for Mental Status) score of 15 indicating R1 is cognitively intact. The same MDS documents that R1 is occasionally incontinent of urine and frequently incontinent of bowel. The MDS section for Skin Conditions documents that R1 is at risk for the development of pressure ulcers/injuries and that R1 does not have a pressure ulcers/injuries. Under Other Ulcers, Wounds and Skin Problems documents that R1 has Moisture Associated Skin Damage. Under Skin and Ulcer/Injury Treatment, the following are checked: Pressure reducing device for bed and application of nonsurgical dressings.R1's Care Plan documents an added Focus area of due to R1's history of pressure ulcers, reduced mobility and incontinence, R1 is at an increased risk of skin pressure breakdown (initiated 03/05/2026). Corresponding include ensure through skin and peri care with each toileting event and or episode of incontinence care, ensure turning and repositioning to meet R1's needs, Nursing skin assessment weekly, CNA's (Certified Nursing Assistant) to monitor and report on skin condition during routine care, pressure reducing mattress to bed, and wound consult and treatment per doctors orders should one occur.R1's Progress Note dated 05/06/2026 documented V16 (Physician) was at the facility and saw R1. R1 was sent to the local hospital for evaluation and treatment related to chest congestion and cough.R1's Progress Note dated 05/06/2026 documented that R1 was admitted to the hospital with diagnosis of a urinary tract infection.A photograph in R1's local hospital records shows an open area to R1's right buttock. The photograph is labeled Wound 5/6/26 Coccyx. This indicates that R1 had an open area to the right buttock upon admission to the local hospital.R1's Progress Notes from the local hospital authored by V22 (Nurse Practitioner) documented on 05/07/2026 that R1 had a Stage 2 pressure ulcer to the left buttock.R1's After Visit Summary from the local hospital, documents a hospital stay dated 05/06/2026-05/14/2026, documented an order for coccyx wound care: remove soiled dressings, cleanse with wound cleanser, pat dry, apply Thera honey to wound bed and cover with foam border dressing daily.R1's electronic health record does not have an assessment upon R1's readmission to the facility on 5/14/26 or any documentation that R1 has a wound to the coccyx or buttocks area.On 06/02/2026 at 10:30 A.M. during a tour of the facility, R1's room was observed to not have any signage indicating R1 was on isolation. R1's room did not have a Personal Protective Equipment (PPE) station outside of the room.R1's Braden Scale For Predicting Pressure Sore Risk dated 05/14/2026 documents a Braden Score of 15 and a Category of At Risk. The Braden Assessment further documents the following: Sensory Perception: Slightly limited. Moisture: Very moist. Activity: Chairfast. Resident ability to walk severely limited or nonexistent. Cannot bear own weight and /or must be assisted into chair or wheelchair. Mobility: Slightly limited makes frequent though slight changes in body or extremity position independently. Nutrition: Adequate. Friction and shear: Potential problem.R1's Order Summary Report documents a treatment order dated 05/16/2026 documenting: Treatment -coccyx wound care-cleanse with wound cleanser, pat dry, apply thera honey to wound bed, cover with foam dressing every shift.R1's May 2026 TAR (Treatment Administration Record) documented R1 did not receive any wound care until 05/16/2026.R1's Electronic Medical Record did not have any skin assessments to review.On 06/04/2026 at 3:03 P.M., V3 (Registered (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Nurse) stated when she completed R1's treatment on 5/16/2026, the area to the right buttock has a small spot to it and slough. V3 stated the area was roughly the size of a pencil eraser. V3 stated when she completed the treatment on 5/25/2026 and 5/26/2026, she noticed the wound was bigger and looked worse. V3 stated she did not notify anyone because she assumed that R1 was being followed by the wound care company. V3 stated she was not aware that it was not being measured or the wound company wasn't following the resident. V3 stated she would have notified someone if she would have known that the wound company was not following the resident at this time.R1's Progress note dated 06/04/2026 documented R1 was seen by V10 (Physician Assistant).R1's Wound Assessment Plan dated 06/04/2026 authored by V10 (Physician Assistant) documented Wound type: abrasion, Wound location Right buttock wound onset date: 06/04/2026, depth of tissue involvement partial thickness, wound measurement: 1.8 cm (Centimeters) long, by 0.9 cm wide by 0.2 cm deep, exudate minimal serosanguineous. Comments: present upon readmission from hospitalization.R1's Order Summary Report contains a treatment order dated 06/04/2026 documenting: Treatment - wound care for right buttock - clean with wound wash, apply Medi honey to wound bed, cover with dry dressing change daily and as needed.On 06/04/2026 at 8:30 A.M., V1 (Administrator) presented the wound log to this surveyor. The wound report period is documented dates of 05/01/2026 - 05/31/2026 and 06/01/2026 - 06/03/2026. R1 is not listed on the wound log for having a wound.On 06/04/2026 at 9:47 AM, V2 (Director of Nursing) was observed completing wound care for R1. V2 was not observed donning appropriate PPE including gown during wound treatment. There was a small amount of drainage observed to old dressing. R1's wound right buttock was red and there was granulation tissue observed. R1's left buttock was red and had the appearance of shearing. After the dressing change was completed to the right buttock, V2 applied barrier cream to R1's left buttock.On 06/04/2026 at 10:03 AM, V2 stated R1 should have been on enhanced barrier precautions, for her wound to her coccyx. V2 stated she is not sure why R1 is not on enhanced barrier precautions.On 06/04/2026 at 10:28 A.M., V2 stated she has placed R1 on enhanced barrier precautions.On 06/04/2026 at 12:38 P.M., V9 (Assistant Director of Nursing) stated that the resident was readmitted from the hospital with the area to the right buttock. V9 stated the hospital called the area to the wound a skin tear. V9 stated she was on vacation for a week and when she returned from vacation the wound had deteriorated. V9 stated that is why the wound group saw her today. V9 stated they were not measuring it and the nursing staff were monitoring it. V9 stated the facility was using the treatment that the hospital discharged R1 back on. V9 stated when V10 (Physician Assistant) saw R1 today she did not change the order. On 06/04/2026 at 1:31 P.M., V11 (Licensed Practical Nurse / MDS) stated the MDS completed on 05/18/2026 documented that R1 only had moisture associated skin damage. V11 stated he did not assess R1's skin condition. V11 stated the day he did the MDS, he asked the nurse who was caring for R1, the condition of her skin. V11 stated he does not remember which nurse it was that he asked about R1's skin.On 06/04/2026 at 1:48 P.M. V10 (Physician Assistant) stated she was made aware today that she needed to see R1. V10 stated she was told R1 was readmitted from the hospital with the wound. V10 stated she was not aware that R1 was readmitted on [DATE] or that she had a previous stage 3 pressure ulcer to that area that had healed. V10 stated she was told by the facility that R1's hospital discharge documented the area as a skin tear / abrasion and that is why she coded it as an abrasion today. V10 stated if she knew R1's history she would have coded the wound as a Stage 2 pressure ulcer. V10 stated the treatment would stay the same even if she would have coded it as pressure ulcer.On 06/04/2026 at 1:53 P.M. V9 (Assistant Director of Nursing) stated she was on vacation from 05/22/2026 - 05/26/2026. V9 stated when she returned from vacation and completed R1's treatment to her coccyx she observed it to be bigger in size than before she was on vacation. V9 stated she notified the wound company today to see R1. V9 stated she did not notify the primary care physician of the wound deterioration. V9 stated she should have notified the physician. V9 stated she would consider the wound a pressure ulcer and a stage 2 by physical assessment. V9 stated the wound was not measured prior to today. V9 stated wound (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	assessments are supposed to be completed weekly. V9 stated she realized yesterday that R1 has not had a skin assessment since April.On 06/04/2026 at 2:20 P.M. V1 stated that while V9 was on vacation no staff reported to her that R1's wound was deteriorating. R1's progress note dated 06/09/2026 documented V10 was notified of area to left buttock that had opened. New order received to clean with wound wash, apply Medi honey and cover with a dry dressing.On 06/11/2026 at 12:15 P.M. V9 stated R1's wound was on the right buttock upon readmission from the hospital. On 06/11/2026 at 15:11 P.M. V7 (Registered Nurse) stated she helped readmit R1. V7 stated she helped complete the assessments but does not remember the specifics about the resident.R1's Wound Assessment Plan authored by V10 dated 06/11/2026 documented wound location : left buttock, wound type: pressure injury, pressure injury stage upon completion of visit: 2, wound measurement 0.9 cm long by 0.4 cm wide by 0.2 cm deep.On 06/12/2026 at 10:51 A.M. attempted to call V26 (Agency Nurse). Voicemail left for a return call.On 06/12/2026 at 12:04 P.M. V10 stated when she assessed R1 on 06/04/2026, she does not recall there being a skin concern on the left buttock. V10 stated the facility notified her on 06/09/2026 of a new open area to the left buttock. V10 stated she gave verbal orders that day for a dressing. V10 stated she saw the wound on 06/11/2026 and did not change the orders.R1's Order Summary Report documents an active order dated 06/05/2026 for ENHANCED BARRIER PRECAUTIONS diagnosis wound and history of ESBL (Extended-Spectrum Beta-Lactamase).R1's Care Plan documents an added Focus area of R1 has an abrasion to her right buttock and is in need of wound care (initiated 06/04/26). Corresponding interventions include ensure thorough skin and peri care with each toileting event or episode of incontinence care, pressure reducing mattress to bed, therapeutic diet per doctor's order, and wound consult and care per wound nurse practitioner, monitor and record wound healing process. All interventions for this focus area were documented to be initiated on 06/04/26.The facility policy titled Pressure Ulcer and Wound Prevention/Management Program with an updated date of 09/30/2025 documented under the section titled Purpose: To identify residents who are at risk for pressure ulcers and skin breakdown, to prevent pressure ulcers and skin breakdown, to provide a guideline for the appropriate nursing management of skin breakdown when it occurs.2. Residents will have a head-to-toe skin assessment upon admission, readmission, at the time of transfer/discharge, and prior to/return from leave of absence by a licensed nurse. 4. Skin assessments will be completed weekly or as ordered for residents who are mild and moderate, high and severe risk for breakdown. 8. Braden Pressure Risk Scale will be completed upon admission/readmission and weekly for four weeks. Mild Risk - a resident who scores 15-18 on the Braden Risk Assessment is considered to be at mild Risk for development of pressure ulcers, unless determined to be at higher risk by clinical assessment by the nurse, physician or dietitian.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation and record review the facility failed to follow standards of practice for antibiotic use for 2 (R7, R23) of 2 residents reviewed for antibiotic stewardship in the sample of 25. This has the potential to affect all 33 residents living in the facility. Findings included:1. R7's admission Record documented an admission date of 8/6/2024 with diagnosis including type 2 diabetes mellitus with hyperglycemia, retention of urine, overactive bladder, benign prostatic hyperplasia with lower urinary tract symptoms and dysphagia.R7's MDS (minimum data set) dated 5/15/2026 documented a BIMS (Brief Interview for Mental Status) Score of 04 indicating R7 is severely cognitively impaired. Section GG documents R7 is Dependent for assistance with toileting hygiene and showering/bathing self. Section H under Urinary Continence is documented with frequently incontinent.R7's Care Plan documented a focus area of general weakness, unsteadiness and endurance and is in need of staff assistance to meet his toileting needs with an intervention including to ensure through skin and peri care with each toileting event and or episode of incontinence care with monitor and report to the nurse any noted symptoms of UTI such as: flank pain, changes in color or clarity of urine with a start date of 10/20/2024.On 6/3/2026 at 2:25 PM, V9 (Assistant Director of Nursing/ADON) stated she is the Infection Preventionist and does track all infections, organisms and antibiotics for the facility. V9 stated, she enters the information into the infection surveillance report. V9 stated, she does review all information when she enters the information. V9 stated, she does not have R7's microbiology report dated 4/3/2026 with culture and sensitivity. V9 stated, she would need to call the local hospital to have them send over his results. The facility's Infection Control Spreadsheet documented R7 on line 35 with a urinary tract infection with no organism listed, current medication for treatment of ciprofloxacin 500 milligram tablet and an onset date of 4/3/2026.R7's Progress Note dated 4/3/2026 at 4:30 PM by V7 (LPN) documented R7 returned from local emergency room with an indwelling catheter placed. R7's to start ciprofloxacin tomorrow.R7's Medication Administration Report dated April 2026 documented with a start date of 4/4/2026, ciprofloxacin tablet 500 milligrams (Ciprofloxacin HCl) Give 1 tablet by mouth two times a day for UTI until 04/13/2026.On 06/05/2026 at 10:58 AM, V9 brought R7's microbiology report dated 4/3/2026 that she just received from the hospital. R7's microbiology results dated 4/3/2026 documenting a final report of Methicillin-Resistant Staphylococcus Aureus with a susceptibility result of ciprofloxacin being resistant to the organism. 2.R23's admission Record documented an admission date of 11/13/2025 with diagnoses including urinary tract infection, site not specified, other artificial openings of urinary tract status, hematuria, unspecified, resistance to multiple antimicrobial drugs, muscle wasting and atrophy, other lack of coordination, calculus of ureter and anxiety disorder, unspecified.R23's MDS dated [DATE] documented a BIMS Score of 13 indicating R23 is cognitively intact. Section GG documents that R23 is dependent (helper does all the effort) for toileting hygiene and showering/bathing self. Section H, under Appliances documented an indwelling catheter in place, Urinary Continence documented not rated, resident had a catheter and Bowel Continence documented frequently incontinent (2 or more episodes of bowl incontinence, but at least one continent bowel movement).R23's Care Plan documented a focus area of general weakness and unsteadiness. R23 needs staff assistance to meet his toileting needs with an intervention to monitor and report to the nurse any noted symptoms of UTI (Urinary Tract Infections) such as: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patterns with a start date of 4/2/2026.R23's Urine Culture and Sensitivity result from local hospital dated 3/23/2026 documented culture urine (abnormal) (susceptibility) Specimen: Urine, Voided Collected: 03/23/26 5:05 PM and updated: 03/26/26 at 7:06 AM culture results of 50,000-100,000 COL/ML. Escherichia coli probable extended spectrum bet lactamase producer, susceptibility Escherichia coli. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	No colonized culture noted.The facility's Infection Surveillance Report dated March 01, 2026 - March 31, 2026, documented 5 UTI's for the facility with no documentation of R23's infection, signs or symptoms, status of infection, organism or antibiotic from his urine culture results dated 3/23/2026.On 06/05/2026 at 10:17 AM V9 (ADON) stated, R23 had been on an antibiotic for a skin infection that finished up on 3/15/2026. V9 stated, R23 had been sent to the local emergency room on 3/23/2026 related to confusion and admitted with multiple diagnoses including a urinary tract infection. V9 stated, R23 returned to the facility on 3/29/2026 and she did not follow up on R23's UTI with organism of ESBL (Escherichia coli probable extended spectrum beta lactamase producer) and probably should have. V9 stated, she does not typically follow up with infections when they get treated in the hospital, even if symptoms started in the facility.The facility's Infection Control Spreadsheet documented R23 on line 22 with a bacterial infection of sepsis, unspecified with an infection site of urinary tract, an order for antibiotic of ceftriaxone Sodium Solution Reconstituted 2 GM Use 2 gram intravenously every 24 hours for infection for 6 Days in sodium chloride 0.9% solution 50ml (milliliters) with a -Start Date-02/24/2026 and no organism listed with an onset date of 2/23/2026 to verify if R23 had been on the appropriate antibiotic.R23's Medication Administration Record dated February 1st-28th, 2026 documented ceftriaxone sodium solution reconstituted 2 GM (grams) use 2 grams intravenously every 24 hours for infection for 6 Days in sodium chloride 0.9% soln (solution) 50ml -and administered on 2/24/26 through 2/28/2026.R23's Medication Administration Record dated March 1st- 31st, 2026 documented ceftriaxone sodium solution reconstituted 2 GM (grams) use 2 grams intravenously every 24 hours for infection for 6 Days in sodium chloride 0.9% soln 50ml -and administered on 3/1/2026.As of 6/12/26, no documentation was received on the urine culture or sensitivity collected on 2/23/2026 from facility during survey. The facility's Infection Control Spreadsheet documented a 6-month period from 12/9/2025 to 6/2/2026 with 27 urinary tract infections with antibiotics listed and 7 urinary tract infections missing documentation of organism to verify if residents had been on appropriate antibiotic.The facility's Long Term Care Application for Medicare/Medicaid form dated 6/3/2026 documented 33 residents residing in the facility. The facility's Antibiotic Stewardship Program Guideline (reviewed4/29/2025) documented under Purpose: the purpose of antimicrobial stewardship is to promote the appropriate use of antimicrobials by selecting the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration and route of administration to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance. The purpose of the antimicrobial stewardship program is to improve antimicrobial stewardship practices and to monitor outcomes and antimicrobial use. Documented under Objective: .potential benefits include the following reduce the rates of facility-acquired infections and reduce risk of clostridium difficile infections, disruption of normal flora, and the emergence of multidrug-resistant organisms. Under Guidelines documents Tracking: the facility will monitor antibiotic use and outcomes from antibiotic use.

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. Based on observation, interview and record review, the facility failed to provide at least 80 square feet per resident in multiple occupancy resident bedrooms for 4 (R9, R10, R19 and R24) of 4 residents reviewed for room size in a sample of 25.On 6/5/26 at 10:00 AM, V1 (Administrator) stated the dementia unit rooms 23, 24, 25, 26, 27, 28, 29, 30, 31 and main hall rooms (not on the dementia unit) 17, 18, 19, 20, 21, 22 were all waivered rooms and don't meet the proper room size requirements. On 6/5/26 at 10:15 AM, R19 and R24's double occupancy room was observed with V1, who stated the room was less than 80 square feet per resident bed. V1 used the measuring tape to measure the length and width of R19 and R24's room and stated it was 11 by 14 feet, indicating that the room was 177 square (sq.) feet (ft.), or 77 sq. ft. per bed. The measurements did not include the closet. At that time, R19 was in her room and stated she had no issues with the room size. The room contained two beds, two nightstands, a recliner, 2 chest of drawers, a wheelchair, 2 walkers and 2 over the bed tables. At this time, R19 and R24 were roommates and were present in the room with no concerns. On 6/5/26 at 10:25 AM, R9 and R10's double occupancy room was observed with V1, who stated the room was less than 80 sq ft per resident bed. V1 measured the room and it measured the same size of 11 by 14 feet for a total of 177 sq ft., or 77 sq. ft. per bed. The measurements did not include the closet. The room contained two beds, a chest, two over the bed tables and two nightstands. R10 was present in the room and voiced no concerns regarding the room size. An undated facility room roster provided by V1 (Administrator) on 06/2/26 documented R9, R10, R19, and R24 reside in the waivered rooms measured by V1.Resident Council meeting minutes for the last 6 months documented no complaints or concerns related to the size of the rooms.