STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145863	A. Building B. Wing	06/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Marion	1301 East Deyoung Marion, IL 62959

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to answer call lights for residents needing assistance in a timely manner to promote dignity for 3 residents (R36, R43, R55) of 24 residents reviewed for dignity in the sample of 52. Findings including: 1. R43's admission record documented R43 was readmitted to this facility on 5/28/2024, with diagnoses of type 2 Diabetes Mellitus with neuropathy and foot ulcer, need for assistance with personal care, and muscle weakness, among others. R43's MDS (Minimum Data Set), dated 4/8/2025, documented R43 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, which indicates R43 is cognitively intact. This same MDS documented R43 is dependent on staff for toileting and personal hygiene, and needs moderate assistance with transferring. On 06/03/25 at 08:43 AM, R43 said, Call lights take forever to get answered. On 6/1/25, which was Sunday, I waited over an hour for call lights to be answered. On 6/5/25 at 9:15 AM, R43 said yesterday (6/4/2025) after lunch, she was placed on the toilet in her room. When ready, R43 activated the bathroom call light and waited 30 minutes for the staff to respond. R43 said when staff did respond, she had told her they were busy with other things, and she waited another 15 minutes before staff assisted her off the toilet. R43 said, The facility needs more staff so we don't have to wait so long for help. 2. R55's admission record documented R55 was readmitted to this facility on 11/15/2024, with diagnoses of chronic obstructive pulmonary disease, heart failure, and muscle weakness, among others. R55's MDS. dated 4/6/2025. documented R55 with a BIMS score of 15 out of 15. which indicates R55 is cognitively intact. This same MDS documented R55 is dependent on staff for toileting, personal hygiene, bed mobility. and transferring. On 06/02/25 at 01:23 PM, R55 said, Weekends are the worst at getting your call light answered. Last weekend, I waited over an hour for my call light to be answered several times. R55 said the facility needed more staff to answer call light more quickly. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R36's admission Record documented R36 was admitted to this facility on 4/5/2024, with diagnoses of spinal stenosis, fusion of the spine, and type 2 diabetes mellitus with polyneuropathy, and foot ulcer, among others. R36's MDS, dated [DATE], documented R36 had a BIMS score of 14 out of 15, which indicates R36 is cognitively intact. This same MDS documented R36 is dependent on staff for toileting, dressing, bed mobility, and transferring. On 6/5/2025 at 8:19 AM, R36 was observed with his call light activated, and at 8:45am, the call light was answered. During the observation period, 6 staff members were noted to walk past R36's activated call light. At 8:50 AM, R36 said he put on his call because he wanted to get out of bed for the day, but staff told him he would have to wait, but staff would return to help him out of bed. R36 said he needs staff assistance to get out of bed, and wished the facility would hire more help. On 6/9/2025 at 1:30 PM, V47 (Registered Nurse) stated, Call lights are not answered timely when we only have one CNA (Certified Nursing Assistant) on the one hundred and two hundred hallways. When we are stretched thin on staff and there is only one CNA per hall, and every hall has 30 residents, we cannot get the call lights answered in a timely manner. On 6/4/25 at 12:18 PM, V16 (CNA) said he has worked with just one CNA on a hall ,and wasn't easily able to meet the needs of the residents timely. V16 said call light go unanswered for long periods of time, but they do the best they can to get them answered. On 6/10/2025 at 8:30 AM, V2 (Director of Nursing) said the facility did not have a call light policy. V2 said he expected call lights to be answered timely to meet the needs of the residents. V2 said he would consider 10 to 15 minutes to be timely call light response time. V2 said 30-minute call light wait times would not be very timely answered.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to formulate or offer to formulate an Advanced Directive for 2 of 24 residents (R57, R300) reviewed for Advanced Directives in a sample of 52. Findings included: 1. R57's admission Record documented R57 was admitted on [DATE], with diagnoses of metabolic encephalopathy, dementia, and pressure ulcer of the sacral region, among others. This same Admissions Record under the section titled Advanced directives has a blank space. R57's MDS (Minimum Data Set), dated [DATE], documented R57 with a BIMS (Brief Interview for Mental Status) score of 0 out of 15, which indicates R57 has severe cognitive impairment. R57's care plan does not include a focused area of care for R57's choice for Advanced Directives. On [DATE] at 9:00 AM, V25 (Registered Nurse) said she was the nurse responsible for R57's care that day. V25 said R57 had lived at this facility for about 5 weeks, and is dependent on staff for all activities of daily living. After V25 reviewed R57's EHR (electronic health record), V25 said she could not find an Advanced Directive, POLST (physician's ordered Life Sustaining Treatment) form, or code status for R57. V25 said she could not find any Advanced Directive information on R57's care plan. V25 said Advanced Directives are supposed to be completed upon admission by the nursing staff or Social Services. V25 said R57's Advanced Directives must have been missed. V25 said without an Advanced Directive, she would not know what type of care to provide for R57 in an emergency. On [DATE] at 9:15 AM, V24 (Social Service Assistant) reviewed R57's EHR, and could not locate an Advanced Directive, POLST form, or code status for R57. V24 said Advanced Directives are supposed to be completed upon admission. V24 looked through a large filing cabinet, but could not locate any paperwork for R57's Advanced Directives. On [DATE] at 9:20 AM, V2 (Director of Nursing/DON) was asked for R57's Advanced Directives. V2 reviewed R57's EHR, and could not locate an Advanced Directive, POLST form or code status for R57. V2 could not find any Advanced Directive information on R57's care plan. V2 was asked in an emergency, how would staff quickly identify R57's code status? V2 replied and said they could not, due to R57's Advanced Directive, POLST form, and code status information not being entered into R57's EHR. V2 said Advanced Directives are to be completed at the time of a resident's admission, and would be included in the resident's care plan. On [DATE] at 10:00 AM, V26 (Social Service Director) brought surveyors a completed POLST form for R57 that was signed by V27 (Wound Care Doctor), who had just entered the facility. The signature on the POLST form was noted to be [DATE]. On [DATE] at 10:10 AM, V27 said he was asked to sign R57's POLST this morning ([DATE]), and he did not sign the POLST on [DATE], as documented on R57's POLST. V27 said he did not know how an incorrect date became written on R57's POLST form. V27 said he does not usually sign the residents POLST forms, but he can still do it. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:15 AM, V26 said she did not know how an incorrect signature date was written on R57's POLST form for V27's signature, but they had asked V27 to sign the POLST that morning. V26 was observed correcting the signature date for V27 from [DATE] to [DATE]. V26 said it was unusual for V27, who was the facility's wound care doctor, to sign resident's POLST forms. 2. R300's face sheet documents an admission date of [DATE]. R300's diagnoses found in R300's electronic health record (EHR) includes, but are not limited to, nondisplaced intertrochanteric fracture of the right femur, type II diabetes, chronic obstructive pulmonary disease, anemia, and hypothyroidism. R300's Minimum Data Set (MDS), dated [DATE], section C, records a Brief Interview for Mental Status score (BIMS) of 13, indicating R300 is mostly cognitively intact. R300's care plan documents the following focus areas: R300 has elected full code status. On [DATE], upon review of R300's EHR, there was no copy of Advanced Directives orders or a Physician's Order for Life Sustaining Treatment (POLST) form. On [DATE] at 3:16 PM, received a POLST signed and dated for [DATE], by R300 and R300's doctor. R300's active physician orders documents an order for full code/attempt resuscitation/CPR (cardiopulmonary resuscitation), with a start date of [DATE]. On [DATE] at 11:07 AM, V25 (Social Service Director) stated the POLST is usually completed by nursing staff on admission. A facility policy titled Advanced Directives (revised [DATE]) documented the following: Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so. Prior to or upon admission of a resident, the Social Services Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives. Information about whether or not the resident has executed an advance directive shall be displayed prominently in the medical record. If the resident indicates that he or she has not established advance directives, the facility staff will offer assistance in establishing advance directives. Nursing staff will document in the medical record the offer to assist and the resident's decision to accept or decline assistance. The Attending Physician will provide information to the resident and legal representative regarding the resident's health status, treatment options and expected outcomes during the development of the initial comprehensive assessment and care plan.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure allegations of peer-to-peer abuse were reported to the Administrator timely for 1 of 1 (R37) resident reviewed for abuse in the sample of 52. Findings Include: R37's admission Record, with a print date of 6/9/25, documents R37 was admitted to the facility on [DATE], with diagnoses that include metabolic encephalopathy, schizoaffective disorder, vascular dementia, and altered mental status. R37's MDS (Minimum Data Set), dated 3/23/25, documents a BIMS (Brief Interview for Mental Status) score of 07, which indicates R37 has a severe cognitive deficit. R37's current Care Plan documents a Focus initiated 5/21/2019 of, (R37) has impaired cognitive function/impaired thought processes r/t (related to) metabolic encephalopathy and vascular dementia. She is at increased risk for communication difficulties d/t (due to) altered mental status, but she is usually able to make herself understood and usually able to understand others. R44's admission Record, with a print date of 6/9/25, documents R44 was admitted to the facility on [DATE], with diagnoses that include diabetes, unspecified dementia, unspecified psychosis, anxiety disorder, and cognitive communication deficit. R44's MDS, dated [DATE], documents a BIMS score of 03, indicating R44 has a severe cognitive deficit. R44's current Care Plan documents a Focus Area initiated on 5/20/2024 of, (R44) displays adverse behaviors. She may be verbally aggressive with other residents and staff. She may become physically aggressive with other residents and staff. At times, she may be noncompliant with the use of recommended assistive devices (walker). This Focus Area includes interventions of, redirect with activity of choice, remind her that touching others without consent can be harmful and it is against the law. R64's admission Record, with a print date of 6/10/25, documents R64 was admitted to the facility on [DATE], with diagnoses that include diabetes, anxiety disorder, anemia, major depressive disorder, and osteoarthritis. R64's MDS (Minimum Data Set), dated 3/19/25, documents a BIMS (Brief Interview for Mental Status) score of 07. This indicates R64 has a severe cognitive deficit. R64's BIMS assessment, dated 6/10/25, documents a current BIMS score of 15, indicating R64 is cognitively intact. On 6/2/25 at 9:56 AM, R64 stated R44, whose room is across the hall, came into her room a couple of days ago (specific date unknown), and was hitting her roommate, R37. R54 stated they yelled for assistance from staff and when they arrived, they told them not to yell at R37. On 06/02/25 at 10:05 AM, R37 stated R44 previously resided in her room and was moved across the hall. R37 stated R44 comes in her room and hits her, and tells her to get out of her bed. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R37 and R44's progress notes were reviewed with no documentation related to a peer-to-peer aggression. The facility abuse/neglect allegations were reviewed with no documentation of an investigation related to a peer-to-peer abuse involving R37 and/or R44. On 6/3/25 at 2:29 PM, V12 (Certified Nursing Assistant/CNA) stated, (R44) is physically combative and has behaviors all the time. On 6/3/25 at 2:32 PM, V14 (CNA) stated, if provoked, R44 will become physically aggressive. V14 stated she does wander into other residents rooms, and they have told all the residents if she comes into their room to put their call light on and/or yell for them, because she will become aggressive if provoked. V14 stated he wasn't aware of R44 hitting any peers lately. V14 stated the other day (date unknown), R44 went into R37's room and was bothering her and was agitated. V14 stated R37 called, and they had to go in and get R44 out of her room. On 06/04/25 at 10:00 AM, V15 (Licensed Practical Nurse/LPN) stated she was working (on an unknown date) and heard R64 yelling really loud for help. V15 stated when she got to the room, R44 was sitting on the foot of R37's bed. V15 stated R64 said R44 had hit R37. V15 stated she asked R37, and R37 said she hadn't been hit. On 6/3/25 at 2:46 PM, V1 (Administrator) stated the last resident to resident investigation involving a peer-to-peer aggression was on 8/17/24. The facility Initial Incident and/or Abuse Notification report documents, Administrator notified by Surveyor on 6/3/20205 (sic) at 2:50 PM that (R37) made an allegation (sic) that (R44) came into contact with her. Nurse has done a body assessment no injuries noted. Full investigation started. POA (power of attorney) and MD (physician) notified Review of the handwritten statements in the abuse investigation documents, (R64) yelled to have some help getting (R44) out of their room. I left room (number of another room) to their room. She said (R44) hit (R37) in the face. I asked (R37) if she was hit, she said no. Nurse came in at the same time to ask if incident occurred. (R37) also told (V15) she was not hit and just wanted (R44) removed from their room and off of her bed. This was signed by V14 (Certified Nursing Assistant/CNA). The investigation documents a second handwritten statement that documents, I heard (R64) yelling help then get out of here. (R44) sitting on end of (R37's) bed. (R64) said she hit her. I asked (R37) did she hit you or just sit in your bed. (R37) said I just wanted her off my bed. This statement was signed by V15 (LPN). On 06/09/25 at 1:49 PM, V1 stated she would expect facility staff to report an allegation of peer-to-peer abuse, even if it was reported by a different resident. The facility Abuse Prevention Training Program, dated 2022, documents under B. Internal Reporting. Employees are required to report any allegation of potential abuse, neglect, exploitation, mistreatment or misappropriation of resident property they observed, hear about, or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a copy of the bed hold policy to residents or their representatives for a resident who had been hospitalized for 2 of 2 residents (R28, R88) reviewed for hospitalizations in the sample of 52. Findings include: Facility's bed hold policy notification, dated 1/2021, documents, This Bed Hold Policy will be given to you at the time of admission and a copy will be given to you each time you are transferred from the facility. 1. R28's face sheet documents an admit date of 11/18/24. Related diagnoses obtained from electronic health record (EHR) includes but are not limited to chronic obstructive pulmonary disease, unspecified dementia, need for assistance with personal care, and diverticulosis of large intestine. R28's current physician orders documented in the EHR include lorazepam oral tablet 0.5 MG - give 0.5 mg by mouth every 2 hours as needed for restlessness, diphenhydramine hcl capsule 25 MG - give 1 capsule by mouth every 6 hours as needed for allergic reaction, Morphine Sulfate (Concentrate) Solution 20 MG/ML - give 0.25 ml by mouth every 4 hours as needed for pain. R28's Minimum Data Set (MDS), dated [DATE], documents in Section C, a Brief Interview for Mental Status (BIMS) score of 10, indicating R28 can communicate, but cognitively confused. Section GG lists some of R28's toileting hygiene as partial to moderate assistance, dressing upper and lower body as partial to moderate assistance, and partial to moderate assistance in rolling left and right in bed, transferring, and lying to sitting. R28's EHR documents in a nurse's progress note R28 was sent to the hospital on [DATE]. In that note, there is no documentation that a copy of the bed hold policy was provided to R28 himself, or to his representative upon him being hospitalized . There is no other progress note documenting later a copy of the bed hold policy was provided to R28 or his representative for that hospitalization. R28 was hospitalized from [DATE]-[DATE]. On 06/05/25 at 9:20 AM, V1, Administrator, stated the bed hold policy doesn't have to be signed, but the resident or resident representative must be provided a copy of the bed hold policy on transfer to hospital. 2. R88's face sheet documents an admit date of 11/18/24. Related diagnoses from the EHR includes but are not limited to metabolic encephalopathy, chronic obstructive pulmonary disease, diverticulosis of large intestine, and hemiplegia and hemiparesis following unspecified cerebrovascular disease. R88's EHR documents the following physician orders including catheter care every shift, elevate head of bed as tolerated to relieve shortness of breath, lorazepam concentrate 2 milligrams (mg) per milliliter (ml) - give 0. 5 ml by mouth every four hours as needed for anxiety, shortness of breath, morphine sulfate concentrate solution 20 mg per milliliter - give 0.25 ml by mouth every four hours as needed for pain. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R88's MDS, dated [DATE], documents in section C, R88 has a BIMS of 00 indicating R88 is unable to participate in the brief interview for mental status. Section GG documents R88 is dependent for all his functional abilities indicating that helper does all the effort. Resident does none of the effort. R88's EHR documents in a nurse's progress note, dated 1/23/25, that R28 was transferred to the local hospital. There is no documentation in this progress note or any other documenting R28 or R28's representative was given a copy of the bed hold policy.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a current PASSR (Preadmission Screening and Resident Review Evaluation) 2 screening was in place for 1 of 5 (R36) residents reviewed for PASSR's in the sample of 52. Findings Include: R36's admission Record, with a print date of 6/4/25, documents R36 was admitted to the facility on [DATE], with diagnoses that include schizoaffective disorder, agoraphobia with panic disorder, insomnia, major depressive disorder, and anxiety disorder. R36's MDS (Minimum Data Set), dated 3/24/25, documents a BIMS (Brief Interview for Mental Status) score of 14, which indicates R36 is cognitively intact. R36's current Care Plan documents a Focus area of (R36) has dxs (diagnoses) of anxiety, depression, schizophrenia, and agoraphobia with panic disorder Has history of s/s (signs/symptoms of schizophrenia (increased paranoia, agitation, hallucinations, disorganized speech) although these have been controlled with medications. Date Initiated: 04/08/2024. Interventions for this Focus area include, .Let (R36) express himself .Redirect to an activity of choice Offer conversation, drink, or snack .Try to encourage calm environment R36's Notice of PASSR (Preadmission Screening and Resident Review Evaluation), dated 11/29/24, documents under determination, Short Term Approval without Specialized Services. This same evaluation documents it as a short-term approval with the end date documented as, March 29, 2025. R36's medical record did not document an PASSR screening after 3/29/25. On 6/4/25 at 4:45 PM, V40 (Business Office Manager) stated she submitted a new PASSR two screening request for R36 yesterday. V40 stated it had just been missed. V40 stated the Social Services Director normally requests them, but she is very new and hadn't done it yet, so she was helping.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to assist resident with dietary needs for 3 residents of 17 (R10, R22, and R61) residents reviewed for dining in a sample of 52. Finding include: 1. R22's admission record documents an admission date of 02/17/22, with diagnoses including: hemiplegia and hemiparesis following cerebral infarction, arthropathic psoriasis, dementia, anemia, major depressive disorder, anxiety disorder, Alzheimer's disease, chronic pain syndrome, muscle weakness, chronic kidney disease, and restlessness and agitation. R22's Minimum Data set (MDS), dated [DATE], documents a Brief interview of mental status (BIMS) of 06, indicating severe cognitive impairment and eating assistance required as setup or clean up assistance needed indicating helper sets up or cleans up, resident completes activity, helper assists only prior to or following the activity. R22's care plan documents a focus area of: R22 has potential for nutritional problems related to anemia, vitamin deficiency, diagnosis HLD (hyperlipidemia). She is on a regular mechanical soft diet with thin liquids. She is able to feed herself but does require staff set-up assistance related to impaired range of motion in bilateral hands secondary to RA (Rheumatoid arthritis). R22's order summary report documents an order for a regular diet with a mechanical soft texture, with directions for fortified pudding at lunch and supper, with an ordered date of 01/16/25, a start date of 01/16/25, and an end date of indefinite. On 06/03/25 at 8:19 AM, R22 had her food in front of her, the lid was still on her hot cereal, and the jelly packets were on her plate unopened. R22 was attempting to remove the lid from her hot cereal and was unable to remove the lid, and quit trying after approximately after a minute, and then was observed attempting to open her jelly packet with no success. After approximately a minute, she set the jelly packet down and looked around. At 8:21 AM, R22 was asking for help. On 06/03/25 at 8:24 AM, V13 (Certified Nurse Aide), one staff member of the nine staff members standing in line waiting for a tray from the kitchen, was asked if she could assist R22 with her breakfast. V13 assisted R22. On 06/05/25 at 12:35 PM, V36 (Dietary) stated R22 would need assistance with the lids on her items and opening any condiments, due to the contractures in both of her hands are really bad. V36 stated staff should be removing the lids from the containers and opening her condiments when they bring her food to her. 2. R10's admission record documents an admission date of 01/16/19, with diagnoses including: chronic obstructive pulmonary disease, type 2 diabetes mellitus, atherosclerotic heart disease, atrial fibrillation, vitamin D deficiency, muscle weakness, schizoaffective disorder, bipolar type, major depressive disorder, anxiety disorder, dysphagia, and cognitive communication deficit. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Marion	1301 East Deyoung Marion, IL 62959

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R10's Minimum Data Set, dated [DATE], documents a Brief Interview for Mental Status (BIMS) of 08, indicating moderate cognitive impairment and eating assistance needed as setup or clean up assistance needed indicating helper sets up or cleans up resident, helper assists only prior to or following the activity. R10's active order sheet documents an order dated 05/01/25, with no end date listed, and an order status of active documents of low concentrated sweets (LCS) diet, mechanical soft texture, thin liquids consistency, ice cream at lunch and supper, PB&J (peanut butter and jelly) at lunch and supper, health shake at breakfast and supper, super cereal at breakfast, cut meat into bite sized pieces, staff reports resident has difficulty chewing regular texture (diet). On 06/02/25 at 12:45 PM, R10 had her lunch tray in front of her; the food was still on the tray and the lids were still on her dessert and her ice cream. At 12:46 PM, R10 was struggling to remove the items from the tray onto the table. R10 attempted to remove the lid from her dessert, and could not get it off, so set it down, with the lid still on it and attempted to remove the paperboard lid off of her individually packaged ice cream, and could not accomplish removing the lids off of either item. At 12:51 PM, R10 gave up and asked for assistance to remove the lids. On 06/08/25 at 12:38 PM, V38 (Dietary) stated, If a resident is assessed for tray set up, their food should be taken off the tray, lids taken off glasses and bowls, their silverware unwrapped, any cartons opened, lids on ice creams removed, any condiments opened and put on the food if needed, generally their food set up and ready for them to eat. 3. R61's admission record documents an admission date 01/19/23, with diagnoses including: unspecified fracture of right wrist and hand, unspecified fracture of sacrum, fracture of other parts of pelvis, age related osteoporosis, dementia, unspecified severe protein calorie malnutrition, muscle weakness, tinea unguium, leiomyoma of uterus, vitamin D deficiency, major depressive disorder, peripheral vascular disease, chronic kidney disease, fibroadenosis of unspecified breast, dysphagia, cognitive communication deficit, and need for assistance with personal care. R61's Minimum Data Set, dated [DATE], documents a Brief Interview of Mental Status (BIMS) of 08, indicating moderately cognitively impaired. R61's eating assistance is documented as supervision or touching assistance indicating helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity, Assistance may be provided throughout the activity or intermittently. R61's order summary report documents an order for a regular diet, regular texture, thin liquids consistency, ice cream at lunch, health shakes three times a day, super cereal at breakfast for diet order with an order date of 11/01/23, an order status of 'active' and no end date listed. On 06/03/25 at 12:36 PM, R61's food was sitting in front of her, with her spoon stuck up right into the orange chicken. There were no bites taken from any items. R61 was sitting in front of her food, with her head leaned forward. On 06/03/25 at 12:50 PM, three staff members walked through the dining room, approximately four feet from R61, and did not stop to encourage or assist R61. R61 was still sitting in front of her food with her head leaned forward with no bites taken from her food and no attempts to take any bites of her food. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/03/25 at 12:54 PM, V1 (Administrator) walked into the dining room saw R61 sitting there, and walked over to her, said her name, and asked if she would like some of her lunch. R61 opened her eyes and lifted her head and started eating the food that V1 was assisting her to eat. R61 ate several bites of her food while being assisted. On 06/03/25 at 12:54 PM, V1 stated someone should have stopped and assisted R61. The facility policy, dated 2020, titled, Assistance with Meals, documents: residents shall receive assistance with meals in a manner that meets the individual needs of each resident.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Deficiencies at this level require more than one Deficient Practice Statements A. Based on interview and record review, the facility failed to prevent the development of unstageable ulcers, identify and assess newly developed ulcers, consistently implement interventions to promote healing of the ulcers, and implement physician orders to treat ulcers for 1 (R149) of 7 residents reviewed for ulcers in the sample of 52. This failure resulted in R149 developing unstageable ulcers to bilateral heels and subsequently being admitted to the hospital with diagnoses of sepsis, gangrene, and necrosis of the bone, tendon, and surrounding tissue. R149 underwent surgery to debride the ulcers on bilateral heels. Post surgery, R149 was placed on hospice and died on 6/9/25. The Immediate Jeopardy was identified to have begun on 4/17/25, when V27 (Wound Specialist) identified a monthly care goal to decrease odor in the right heel ulcer and indicated infected tissue was removed through debridement, without obtaining a culture of the wound and/or treating the underlying infection. This failure resulted in R149 being admitted to the local hospital with sepsis, gangrene, and required surgery to debride bilateral heels. R149 was placed on hospice after the surgery due to the extent of the injury to his bilateral heels and the severity of the infection. R149 expired at the hospital on 6/9/25, with cause of death listed as cardiorespiratory failure due to septic shock. V1 (Administrator), V2 (Regional Director of Clinical Services/Acting Director of Nurses), and V52 (Operations Consultant) were notified of the Immediate Jeopardy on 6/10/25 at 2:38 PM. The surveyors confirmed by observations, interview, and record review, the Immediate Jeopardy was removed on 6/11/2025, but noncompliance remains at Level Two due to additional time needed to evaluate the implementation and effectiveness of in-service training. Findings Include: R149's admission Record, with a print date of 6/5/25, documents R149 was admitted to the facility on [DATE], with diagnoses that included Parkinson's disease, adult failure to thrive, diabetes, hypertension, peripheral vascular disease, and osteoarthritis. R149's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status score of 09, which indicates a moderate cognitive deficit. This same MDS documented R149 was at risk for skin breakdown, no unhealed pressure ulcers, and two venous/arterial wounds. Under Skin and Ulcer/Injury Treatments, this MDS documents the following interventions, pressure reducing device for chair and bed, nutrition or hydration intervention, non-surgical dressings, ointments/medications, and dressings to feet. Turning and repositioning and pressure ulcer/injury care are not marked as interventions to implement. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R149's current Care Plan documents, (R149) has potential for pressure ulcer development r/t (related to) Hx (history) of ulcers, impaired mobility, impaired circulation 03/06/2025 Site #22 arterial wound of R (right) heel 03/20/2025 Site #24 Arterial wound to L (left) heel. 03/20/2025 Site #25 End stage skin failure to R (right) buttocks (resolved 04/24/2025). 04/03/2025 Site #26 End Stage skin failure L (left) buttocks (resolved 04/24/2025) Date Initiated: 02/27/2024. This Focus area includes the following interventions, .03/06/2025 Tx (treatment) as ordered Site #22 arterial wound of R heel. EBP (enhanced barrier precautions) per facility policy. Date Initiated: 3/17/2025. 03/20/2025 Tx as ordered to Site #24 arterial wound to L heel. EBP per facility policy Administer medications as ordered. Monitor/document for side effects and effectiveness. Date Initiated: 02/27/2024. Administer treatments as ordered and monitor for effectiveness. Date Initiated: 02/27/2024. Assess/record/monitor wound healing weekly. Measure length, width, and depth where possible. Assess and document status of wound perimeter, wound bed, and healing progress. Report improvements and declines to MD (physician). Date Initiated: 02/27/2024. Follow facility policies/protocols for the prevention/treatment of skin breakdown. Date Initiated: 02/27/2024. Inform the resident/family/caregivers of any new area of skin breakdown. Date Initiated: 02/27/2024. Low air loss mattress as ordered. Date Initiated: 03/14/2024. Monitor/document/report to MD PRN (as needed) changes in skin status: appearance, color, wound healing, s/sx (signs/symptoms) of infection, wound size (length x width x depth), stage. Date Initiated: 02/27/2024. Nutritional supplements as per MD orders. Date Initiated: 02/27/2024. Obtain and monitor lab/diagnostic work as ordered. Report results to MD and follow up as indicated. Date Initiated: 02/27/2024. Skin checks as scheduled. Date Initiated: 02/27/2024. (name of wound specialty) wound specialist to evaluate and treat as indicated. Date Initiated: 02/27/2024. This care plan does not document interventions to float heels and/or wear heal protection. R149's Braden Scale, dated 1/8/25, documents a score of 15, indicating R149 has a low risk of skin breakdown. R149's facility Progress Notes document the following: 5/14/25 1:50 PM, .Resident seems lethargic, able to wake up to voice but falls back asleep quickly. Temp. (temperature) 100.9, HR (heart rate) 116, BP (blood pressure) 96/60, O2 sat (saturation) 97% RA (room air). Blood sugar 355. V35 (Physician) office notified, waiting on call back from (V35) nurse for any new orders. 5/14/25 2:15 PM, .(V35) office called back and gave verbal order per (V35) to send resident to ER (emergency room). EMS (emergency medical services) transported resident to (name of local hospital). POA (Power of Attorney) notified. 5/15/25 5:08 AM, .admitted to (name of local hospital) ICU (intensive care unit) r/t (related to) sepsis. PT (patient) is currently receiving IV (intravenous) ABX (antibiotics) and fluids. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R149's local hospital record documents on 5/14/25 under Chief Complaint: Patient presents with Altered Mental Status, Wound Check. 88 yo (year old) wm (white male) is brought to ER (emergency room) for eval (evaluation) of ams (altered mental status). As per nh (nursing home) staff, patient is confused, patient has fever, patient has low bp (blood pressure). Nh staff is concerning of sepsis. Patient has bil (bilateral) heel necrotic ulcers. Patient has no chest pain. No abd (abdominal) pain Pt (patient) arrives for AMS (altered mental status) EMS (Emergency Medical Services) reports we were called for AMS (altered mental status) that was worsening throughout the day. He has sores on both feet that are becoming necrotic. They are concerned he is becoming septic. His BP (blood pressure) was 95/40 .Pungent scent noted. Under Physical Exam, R149's hospital records document temperature of 100.2 degrees Fahrenheit, R149 is ill appearing, bed bound, with bilateral heel ulcers with necrosis. The CT (Computerized tomography) results dated 5/14/25 of the left foot documents under impression, Cellulitis. Deep soft tissue ulceration along the posterior plantar aspect at the calcaneal tuberosity with gas extending to the bone at that level. Erosive change/osteomyelitis involving the posterolateral portion of the calcaneal tuberosity at that level through the attachment the Achilles tendon with appearance concerning for underlying tendinosis/partial-thickness tear of the tendon and possible tendon infection The CT results dated 5/14/25 of the right lower extremity/foot documents the following under Impression, Cellulitis. Progressive, deep soft tissue ulceration overlying the calcaneal tuberosity with exposure the bone and underlying acute osteomyelitis. There is gas and ill-defined fluid throughout the underlying soft tissues at that level as well as gas within abscess cavity extending along the distal plantar fascia with possible infection with gas-forming organisms. Full thickness tear and osseous avulsion fracture involving the Achilles tendon with partial thickness tearing and abscess cavity extending more proximally along the tendon. Under Clinical Impression, R149's hospital record documents, Sepsis, due to unspecified organism .altered mental status .osteomyelitis of foot, unspecified laterality, unspecified . The hospital history and physical dated 5/14/25 documents, heel wounds. In ED (emergency department), patient met criteria for sepsis as patient was noted to have fever, tachycardia, tachypnea, elevated lactic acid, leukocytosis. Patient was started on broad spectrum IV (intravenous) antibiotics after imaging studies showing questionable osteomyelitis. ER provided consulted on-call podiatrist . R149's hospital record documents a physical exam, dated 5/14/25, under skin, the assessment documents, . Multiple healing abrasion/skin tears over extremities. Examination of right heel- on plantar aspect of right heel, large necrotic ulcer with foul-smelling ulcer base/eschar, 5.4 cm (centimeters), ankle swelling with erythema. Examination of left heel - on plantar out of left heel, large necrotic ulcer 3 x 2 cm with purulent base. V33 (Podiatrist/Surgeon) hospital consult note for R149, dated 5/14/25, documents under Assessment, (R149) is an 88 yo male with gangrene of heels, bilateral .Dakins wet to dry gauze applied bilateral. Plan for OR (operating room) debridement tomorrow and wound vac (vacuum) application. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R149's Operation Note signed by V33 documents, Preoperative diagnoses: 1. Gangrene of bilateral heel with necrosis of bone. 2. Decubital ulceration, Stage IV, bilateral heel. Postoperative Diagnoses: 1. Gangrene of bilateral heel with necrosis of bone. 2. Decubital ulceration, Stage IV, bilateral heel. Under Description of Procedure the note documents, .Attention was first directed towards the posterior right heel. There was significant foul odor and necrosis of skin, soft tissue, and exposed necrotic bone within the wound cavity of the right heel. There was exposed necrotic bone within the wound cavity of the right heel. There was exposed necrotic Achilles tendon with purulent fluctuance at the Achilles tendon course .The bone at the plantar posterior margin of the calcaneus as necrotic in appearance .Attention was then directed towards the posterior left heel at full-thickness necrotic ulceration .Nonviable bone at the posterior dorsal lateral margin of the calcaneus was excised . The patient was then transported back to the ICU (Intensive Care Unit) on a ventilator with vital signs stable. Heel offloading boots were applied after repositioning the patient in the supine position. R149's hospital Progress Note, dated 5/18/25, documents under Plan for Today, Per discussion with intensivist and ICU RN (Registered Nurse): Plan to extubate later today. Continue management in ICU, as already discussed earlier today with intensivist (name) Prognosis is dismal and this has apparently been relayed to the family; patient remains full coder per his previously stated wishes at this point, per discussion with intensivist R149's hospital Progress Note, dated 6/1/25, documents, patient was made comfort care yesterday after family decided. Pending hospice evaluation tomorrow as per case management R149's three separate Initial skin Alteration Records, dated 1/8/25, document three separate shear wounds to buttocks, with treatments documented as provide relief on chair and bed, turning and repositioning, and dressing care with treatments documented as apply silver sulfadiazine (SSD), collagen, calcium alginate, and apply dry dressing. There is no documentation of any wounds/ulcers to R149's heels documented on this assessment indicating R149 returned to the facility on 1/8/25, with no ulcers/wounds identified on his bilateral heels. R149's skin Monitoring: Comprehensive CNA (Certified Nursing Assistant) Shower Review, dated 3/3/25, documents, Perform a visual assessment of the resident's skin when giving a shower. Report any abnormal looking skin (as described below) to the charge nurse immediately Use this form to show the exact location and description of the abnormality. Using the body chart below, describe and graph all abnormalities by number. This form documents a circle around the feet on body chart with no documentation of what was observed. This surveyor attempted to contact the CNA (Certified Nursing Assistant) who did this assessment, but she no longer works at the facility and didn't answer the phone and/or return this surveyors call. There is no documentation in R149's assessments and/or progress notes related to the abnormal areas indicated by a circle on the body chart on this assessment. R149's facility progress notes document on 3/6/25 at 12:18 AM, .this nurse was in the hallway standing at med (medication) cart during evening med pass when res (resident) daughter approached her stating that she saw blood coming through res white socks. At assessment, nurse observed a 6 cm (centimeter) x 5.8 cm wound to right heel. See skin assessment for details. Wound treated per wound doctor (V27/Wound Specialist) standing order. V27 and V3 ADON (Assistant Director of Nurses) notified to assess on wound rounds. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R149's Weekly Skin Record, dated 3/6/25, documents, 3/6/25 - Right heel .full thickness tissue loss wound; 6 cm length x 5.8 cm width x 0.3 cm deep; no slough present. The assessment documents no tunneling, no undermining of the wound, no odor, irregular wound edges, and no pain verbalized. Under comments the assessment documents, Wound cleansed c (with) ns (normal saline); applied ssd/cp (collagen powder) mix et (and) covered c ca (calcium alginate) et dry dressing per standing order. (V27/Wound Specialist) and V3 (Assistant Director of Nurses/ADON) notified of the need to assess during wound rounds. R149's Wound Evaluation and Management Summary (V27/Wound Specialist) note document the following: 3/6/25- .Chief Complaint: Patient has wounds on his upper scalp; right heel, anterior penis, right scalp . Examination of right lower extremities. Foot warm, moderate edema, wound present .Focused Wound Exam (Site 22) Arterial Wound of the Right Heel Full Thickness. Etiology .Arterial, Duration: > (greater than) 5 days, Objective .Healing/Maintain healing, Wound size (L (length) x W (width) x D (depth): 6.4 x 7.2 x 0.1 cm, Surface Area .46.08 cm² (squared), exudate Moderate Serous, Slough 30%, Granulation tissue 70% . Dressing Treatment Plan Primary Dressings: Alginate Calcium apply once daily for 30 days; Betadine apply once daily for 30 days. Secondary Dressing: ABD (abdominal pad) apply once daily for 30 days; Gauze roll (kerlix) 4.5 apply once daily for 30 days. Under Site 22: Surgical Excisional Debridement Procedure, the assessment documents, Indication for Procedure: Remove necrotic tissue and establish the margins of viable tissue Procedure Note: the wound was cleansed with normal saline, and anesthesia was achieved using topical benzocaine. Then with clean surgical technique, curette was used to excise 13.82 cm² of devitalized tissue including slough, biofilm and non-viable subcutaneous level tissues were removed at a depth of 0.3 cm and healthy bleeding tissue was observed . 3/13/25- .Chief Complaint: Patient has wounds on his upper scalp; anterior penis; right heel; right scalp . Under Arterial wound of the Right Heel Full Thickness the assessment documents, Objective Healing/Maintain Healing, Wound Size . 6.4 x 7 x 0.1 cm, Surface Area 44.80 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue (eschar) 70%, Slough 30%, Wound Progress Improved evidenced by decreased surface area Dressing Treatment Plan Primary Dressing: Alginate calcium apply once daily for 23 days; Betadine apply once daily for 23 days Under Site 22: Sharp Selective Debridement Procedure: Procedure Note: The wound was cleansed with normal saline and anesthesia, though not required, was achieved using topical benzocaine. Then with clean surgical technique, curette was used to selectively remove biofilm, remove devitalized epidermis and/or dermis, remove devitalized tissue at margins of a wound over the wound surface area of 44.8 cm². (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3/20/25 - Chief Complaint: Patient has wounds on his upper scalp; anterior penis; right heel; right buttock; left heel; right scalp. Under Focused Wound Exam (Site 22) the assessment documents, Arterial Wound of the Right Heel Full Thickness .Objective .Healing/Maintain Healing, Wound size .6.2 x 7 x 0.1 cm, Surface Area 43.40 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue (eschar) 70%, Slough 30%, Wound Progress Improved evidenced by decreased surface area Dressing Treatment Plan Primary Dressing: Alginate calcium apply once daily for 16 days; Betadine apply once daily for 16 days . Under Site 22: Sharp Selective Debridement Procedure the assessment documents, .Procedure Note curette was used to selectively remove biofilm, remove dried exudates or debris over the wound surface area of 43.4 cm² Goal primary to control infection risk in a chronic wound. Treating only the margins of an otherwise stable heel eschar. Under Focused Wound Exam (Site 24) the assessment documents, Arterial Wound of the Left Heel Full Thickness. Etiology: Arterial, Duration: > 3 days, Objective: Healing/Maintain Healing, Wound Size . 3.2 x 3 x 0.3 cm, Surface Area 9.60 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue (eschar) 100%. Dressing Treatment Plan: Primary Dressing: Alginate Calcium apply once daily for 30 days; Betadine apply once daily for 30 days. Secondary Dressings: Gauze roll (kerlix) 4.5 apply once daily for 30 days. Reason For No Sharp Debridement: Non-infected heel necrosis. There is no documentation in R149's facility medical record when the ulcer to R149's left heel was first identified, an assessment of the left heel, or treatment of the area, prior to V27's assessment on 3/20/25. R149's Order Summary Report Active Orders as of 04/01/2025 includes the following orders, Left heel-cleanse with n/s (normal saline) or wound cleanser/pat dry/apply betadine/ca (calcium alginate) and wrap with kerlix daily and PRN (as needed) and Right heel- cleanse with n/s or wound cleanser and apply Betadine/ca and wrap with kerlix every day shift for wound, both orders have a start date of 3/20/25. R149's Order Summary Report does not document an order to treat the ulcer on the right heel from when it was identified on 3/6/25 until 3/20/25. R149's TAR (Treatment Administration Record), dated 3/1/25 to 3/31/25, includes the following orders, Left heel cleanse with n/s or wound cleanser/pat dry; apply betadine/ca and wrap with kerlix daily and PRN every day shift for wound and Right heel- cleanse with n/s or wound cleanser and apply Betadine/CA and wrap with kerlix every day shift for wound. Both physician orders have a start date of 3/21/25. This TAR does not document a physician order to treat the right heel ulcer from 3/6/25 until 3/20/25. On 6/7/25 at 10:55 AM, V2 (Regional Director of Clinical Services/Acting Director of Nurse) stated they were unable to find treatment orders from 3/6 to 3/21/25 for the ulcer located on R149's right heel, but he looked at the wound specialist notes, and the area was improving. V2 stated V3 (Assistant Director of Nurses/ADON) did rounds with V27 (Wound Specialist), and they saw R149 weekly. V2 stated V3 (ADON) remembered there being dressings on R149's right heel when she did rounds with V27 each week, but there was no order in the system for a treatment to the right heel. R149's Wound Evaluation and Management Summary (V27/Wound Specialist) notes document the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	3/27/25 - .Chief Complaint: Patient has wounds on his upper scalp; right heel; right buttock; left heel; right scalp; anterior penis. Under Focused Wound Exam (Site 22) the assessment documents, Arterial Wound of the Right Heel Full Thickness .Objective: Healing/Maintain Healing, Wound Size .: 6.2 x 6.4 x 0.1 cm, Surface Area .39.68 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue (eschar) 70%, Slough 30%, Wound Progress Improved evidenced by decreased surface area . Dressing Treatment Plan: Primary Dressing: Alginate Calcium apply once daily for 9 days; Betadine apply once daily for 9 days . Under Site 22: Surgical Excision Debridement Procedure the assessment documents .curette was used to surgically excise 3.97 cm² of devitalized tissue and necrotic subcutaneous level tissue along with slough and biofilm were removed at a depth of 0.2 cm and healthy bleeding tissue was observed. This same assessment documents under Focused Wound Exam (Site24), Arterial Wound of the Left Heel Full Thickness Objective . Healing/Maintain Healing, Wound Size .: 3 x 3 x 0.3 cm, Surface Area .9.00 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue 100%, Wound Progress Improved evidenced by decreased surface area Dressing Treatment Plan, Primary Dressing: Alginate Calcium apply once daily for 23 days; Betadine apply once daily for 23 days . Reason for No Sharp Debridement: Non-infected heel necrosis. 4/3/25 - .Chief Complaint: Patient has wounds on his upper scalp; right heel; left heel; left buttock; anterior penis. Under Focused Wound Exam (Site 22) the assessment documents, Arterial Wound of the Right Heel Full Thickness .Objective Healing/Maintain Healing, Wound Size .: 6 x 6.4 x 0.1 cm, Surface Area 38.40 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue (eschar) 70%, Slough 30%, Wound Progress Improved evidenced by decreased surface area Dressing Treatment Plan, Primary Dressing: Alginate Calcium apply once daily for 30 days; Betadine apply once daily for 30 days . Under Site 22: Surgical Excision Debridement Procedure, the assessment documents, Procedure curette was used to surgically excise 2.30 cm² of devitalized tissue and necrotic subcutaneous level tissues along with slough and biofilm were removed at a depth of 0.2 cm and healthy bleeding tissue was observed. Under Focused Wound Exam (Site 24) this same assessment documents, Arterial Wound of the Left Heel Full Thickness .Objective Healing/Maintain Healing, Wound Size .: 3 x 3 x 0.3 cm, Surface Area 9.00 cm², Exudate None, Thick adherent black necrotic tissue (eschar) 100%, Wound Progress At Goal Dressing Treatment Plan Primary Dressing: Alginate Calcium apply once daily for 16 days; Betadine apply once daily for 16 days Reason for No Sharp Debridement: Non-infected heel necrosis. Under Site 24: Sharp Selective Debridement Procedure the assessment documents, .Procedure .curette was used to selectively remove devitalized tissue at margins of a wound, remove dried exudates or debris over the wound surface area of 9 cm² . (continued on next page)

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Integrity Hc of Marion	1301 East Deyoung Marion, IL 62959

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4/10/25 - .Chief Complaint: Patient has wounds on his right heel, upper scalp, right scalp, left heel, anterior penis, right buttock. Under Exam, this assessment documents Foot Warm, Moderate Edema, Wound present for bilateral lower extremities. Under Focused Wound Exam (Site 22) the assessment documents, Arterial Wound of the Right Heel Full Thickness, Etiology .Arterial, Duration: > 40 days, Objective Healing/Maintain Healing, Wound Size .: 5.6 x 5.3 x 0.8 cm, Surface Area 29.68 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue (eschar) 70%, Slough 30%, Wound Progress Improved evidenced by decreased surface area Dressing Treatment Plan, Primary Dressing: Alginate calcium apply once daily for 23 days; Betadine apply once daily for 23 days . Under Site 22: Surgical Excisional Debridement Procedure, the assessment documents under Procedure Note, .curette was used to surgically excise 1.19 cm², of devitalized tissue and necrotic periosteum and bone along with slough and biofilm were removed at a depth of 0.9 cm and healthy bleeding tissue was observed This same assessment documents under Focused Wound Exam (Site 24), Arterial Wound of the Left Heel Full Thickness Objective Healing/Maintain Healing, Wound Size 2.8 x 3 x 0.3 cm, Surface area 8.40 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue (eschar) 100%, Wound Progress .Improved evidenced by decreased surface area .Dressing Treatment Plan, Primary Dressing: Alginate Calcium apply once daily for 9 days; Betadine apply once daily for 9 days Reason No Sharp Debridement: Non-infected heel necrosis. 4/17/25 - Chief Complaint: Patient has wound on his right heel; upper scalp; left heel; right scalp; left buttock; anterior penis. Under Focused Wound Exam (Site 22) the assessment documents, Arterial Wound of the Right Heel Full Thickness Objective .Healing/Maintain Healing, Healing Potential Good, Estimated Time to Heal 2-4 months, Care goal(s) this month . Decrease Ulcer Area, Maintain Skin Integrity, Decrease Odor Wound Size .5 x 5.3 x 0.8 cm, Surface Area 26.50 cm², Exudate Moderate Serous, Thick adherent black necrosis tissue (eschar) 70%, Slough 30%, Wound Progress Improved evidenced by decreased surface area .Infection Assessment .No sign (s) of infection Dressing Treatment Plan, Primary Dressing: Alginate calcium apply once daily for 14 days; Sodium hypochlorite solution (dakins) apply once daily and as needed: if saturated, soiled, or dislodged. For 30 days . Under Site 22: Surgical Excisional Debridement Procedure, the assessment documents under Indication for Procedure, Remove Infected Tissue, Remove thick Adherent Eschar and Devitalized Tissue. Under Procedure Note this assessment documents, .curette was used to surgically excise 5.30 cm² of devitalized tissue and necrotic periosteum and bone along with slough and biofilm and removed at a depth of 1 cm and healthy bleeding tissue was observed . This same assessment documents under Focused Wound Exam (Site 24), Arterial Wound of the Left Heel Full Thickness . Objective: Healing/Maintain Healing, Healing Potential . Good, Estimated Time to Heal 2-4 months, Care goal(s) this month Decrease Ulcer Area .Wound size .2.2 x 3 x 0.3 cm, Surface Area 6.60 cm², Exudate Moderate Serous, Thick adherent black necrotic tissue (eschar) .100%, Wound Progress . Improved evidenced by decreased surface area Infection Assessment No sign (s) of infection) Dressing Treatment Plan, Primary Dressing: Alginate calcium apply once daily for 30 days; Sodium hypochlorite solution (dakins) apply once daily and as needed: If saturated, soiled, or dislodged. For 30 days . Under Site 24: Surgical Excisional Debridement Procedure the assessment documents under Indication for Procedure, Remove Necrotic Tissue and Establish the Margins of Viable Tissue. Under Procedure Note the assessment documents, curette was used to surgically excise 3.30 cm² of devitalized tissue and necrotic subcutaneous level tissues were removed at a depth of 0.4 cm and healthy bleeding tissue was observed There is no documentation in R149's facility records of V27 (Wound Specialist) ordering a wound culture of the right heel ulcer to determine the cause of the odor documented under the care goals of the month, and no documentation of V27 ordering an antibiotic to treat the infected tissue referenced under the surgical debridement section of V27's progress note. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	There are no facility skin assessments or progress notes documented with assessments of the ulcers to R149's heels and/or assessments of his condition until 4/22/25, when R149's Weekly Skin Record documents, Right heel- measured 6 cm x 5.8 cm x 0.3 cm. Under Additional Narrative Description of Wound the assessment documents Full thickness tissue loss wound .no slough present. The assessment describes the wound bed as greenish/yellow, red/beefy with no odor, and purulent (brownish/yellow) drainage. The healing process is documented as no change. R149's facility Progress Notes document the following: 4/24/2025 12:26 PM, .res (resident) noted more lethargic than usual today, not responding verbally as he normally does but will make eye contact. When fed res is letting food fall out of and not swallowing. Vitals 98. 9 t (temperature), 18 r (respirations) 96 p (pulse), 99% O2 (oxygen) on RA (room air), 62/46 b/p (blood pressure), lung sounds clear, bowel sounds present. Res presenting with non-productive cough. MD (physician) notified. MD gave orders for CBC (complete blood count) w/diff (with differential), CMP (comprehensive metabolic panel), TSH (thyroid stimulating hormone), Free T4, Ammonia, Lactic Acid and 2 view chest (sic) xray. Orders put into pcc (point click care), biotech and lab. 4/25/25 5:25 PM, .Sent chest x-ray and labs to (V35/Physician) New ant (antibiotic) Clindamycin 300 mg (milligrams) po (by mouth) TID (three times daily) for 10 days ordered. R149's Order Summary Report active orders as of 05/01/2025 includes the following orders, 4/29/25 Daily skin check every night, 4/12/25 heel protectors on while in bed. Every day and night shift. 4/25/25 Clindamycin 300 mg three times daily for ten days. There are no antibiotic orders documented for treatment to the ulcers on bilateral heels on R149's Order Summary Report from 4/25/25 until his hospitalization on 5/14/25. R149's Weekly Skin Records do not document assessments of the ulcers to bilateral heels on 4/28, 5/5, 5/9, and 5/13/25. The assessments document no new areas noted and/or no changes to current wounds. R149's Wound Evaluation and Management Summary (V27/Wound Specialist) notes document the following: (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	4/24/25- .Chief Complaint: Patient has wounds on his right heel, left heel; right scalp; anterior penis; right buttocks; left buttocks. Under Focused Wound Exam (Site 22) the assessment documents, Arterial Wound of the Right Heel Full Thickness Objective .Healing/Maintain healing Healing Potential .Good. Care goal(s) this month. Decrease Ulcer Area, Maintain Skin Integrity, Decrease Odor .Wound Size 5 x 5.3 x 0.8 cm .Surface Area .26.50 cm² .Exudate Moderate Serous .Thick adherent black necrotic tissue (eschar) .70%. Slough 30% .Wound Progress .At Goal Infection Assessment .No signs of infection .Dressing Treatment Plan .Alginate Calcium apply once daily for 9 days; Sodium hypochlorite solution (dakins) apply once daily and as needed Under Site 22 Surgical Excisional Debridement Procedure the evaluation documents the indication for the procedure as Remove Infected Tissue, Remove Thick Adherent Eschar and Devitalized Tissue, Remove Necrotic Tissue and Establish the Margins of Viable Tissue. Under Procedure Note the Evaluation documents, curette used to surgically excise 15.90 cm² of devitalized tissue and necrotic periosteum and bone along with slough and biofilm were removed at a depth of 1 cm and healthy bleeding tissue was observed This same assessment documents under Focused Wound Exam (Site 24) Arterial Wound of the Left Heel Full Thickness .Objective .Healing/Maintain Healing Healing Potential .Good Care goal(s) this month .Decrease Ulcer Area Wound Size 2 x 3 x 0.3 cm Surface Area .6.00 cm² Exudate . Moderate Serous .Thick adherent black necrotic ti[TRUNCATED]

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to manage pain for 1 of 2 residents (R81) reviewed for pain in a sample of 52. This failure resulted is R81 experiencing decreased mobility and participation in daily activities related to uncontrolled severe pain. Findings include: R81's admission Record documents an admission date of 05/14/24, with diagnoses including: polyneuropathy, injury of left ankle, bilateral primary osteoarthritis of knee, osteoarthritis, myalgia, depressive episodes, anxiety disorder, bipolar disorder, chronic pain, lumbago with sciatica on right side, and lumbago with sciatica on left side, age related osteoporosis, and anxiety disorder. R81's Minimum Data Set (MDS), dated [DATE], documents a Brief interview of mental status (BIMS) of 15, indicating cognitively intact with diagnosis including: polyneuropathy, unspecified injury of left ankle, myalgia, other chronic pain, lumbago with sciatica on right side, and lumbago with sciatica on left side. Section GG documents R81's sit to stand, chair/bed to chair transfer and toilet transfer as supervision or touching assistance- helper provides verbal cues or touching/steadying assistance as resident completes activity. R81's Care Plan documents a Focus Area of: R81 has potential for pain related to arthritis, neuropathy, and lumbago with an initiated date of 06/04/24 with intervention documented of: administer analgesia as per orders, monitor/document for probable cause of each pain episode, remove/limit causes where possible, monitor/record pain characteristics every shift and as needed: quality (example: sharp, burning);severity (1 to 10 scale); anatomical location; onset; duration (example: continuous, intermittent); aggravating factors; relieving factors; monitor/record/report to nurse any signs or symptoms of non-verbal pain: changes in breathing (noisy, deep/shallow, labored, fast/slow); vocalizations (grunting, moans, yelling out, silence); eyes (wide open/narrow slits/shut, glazed, tearing, no focus); face (sad, crying, worried, scared, clenched teeth, grimacing) body (tense, rigid, rocking, curled up, thrashing); monitor/record/report to nurse loss of appetite, refusal to eat and weight loss; monitor/record/report to nurse resident complaints of pain or requests for treatment; notify physician if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain; observe and report changes in usual routine, sleep patterns, decrease in functional abilities, decrease range of motion, withdrawal or resistance to care with interventions dates of 06/04/2024. R81's Order Summary Report documents her most current order for a Lidoderm external patch 5% on 08/29/24, with an end date of 08/29/24. R81's order summary report documents an order for acetaminophen oral tablet, give 1000 milligrams by mouth every 8 hours as needed for pain with an order date of 02/27/25, and an order status of active. R81's order summary report documents an order for gabapentin oral tablet 400 milligrams, give one tablet by mouth three times a day for pain with an order date of 05/28/25, and an order status of active. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	R81's order summary report documents an order for ibuprofen oral tablet 200 milligrams, give 2 tablets by mouth every 8 hours as needed for pain give 1 ibuprofen tab with 1 325 milligrams Tylenol, with an order date of 02/27/25, and an order status of active. R81's Pain Questionnaire, dated 02/17/25, documents: mental status with alert marked, ability to verbally communicate has able to communicate marked, routine medications ordered for pain with ordered and somewhat effective (moderate relief) marked, frequency of pain with intermittent/occasionally less than daily marked, conditions/diagnosis associated with potential for pain with one condition/diagnosis marked, intensity of pain with moderate pain marked, pain scale used with numeric observations of pain (non-verbal pain indicators) with no observations of pain marked. R81's Medication Administration Record (MAR), dated May 2025, documents an order for: monitor and document pain level every shift with a start date of 05/17/25, with zero documented for days 1-24 for day and night, day 25 has a 3 documented for night, day 26 has a 0 documented for day and night, day 27 documents a 2 at night, and days 28 - 31 documents a 0 for day and night. R81's MAR, dated May 2025, documents Acetaminophen 1000 milligrams given on 05/21, 05/22, 05/25, and 05/27 for the month of May. R81's Nurse's Note dated 05/28/25 at 8:17 PM, documents, Medical Doctor (MD) in the building and spoke with resident about concerns with her gabapentin making her feel unsteady since it had been increased from 300 mg (milligrams) three times a day to 600mg three times a day. MD gave new order to start gabapentin 400 mg three times a day. R81's Nurse's Note, dated 05/27/25 at 3:37 PM, documents: (Nurse Practitioner) assessed resident, resident voiced severe pain to hips to the point of not able to walk. Resident voiced she went to (hospital) after a fall and had an x-ray and CT scan with no findings. (NP) ordered to send referral to brain and spine for further evaluation. R81's order summary report documents an order for referral to brain and spine related to increase pain to back, hips, and leg with an order date of 05/28/25, and an order status of active. R81's MAR, dated June 2025, documents an order for: monitor and document pain level every shift with a start date of 05/17/25 with zero documented for days 1-8 for day and night. R81's MAR, dated June 2025, does not document any acetaminophen 1000 milligrams given 06/01 - 06/05. On 06/02/25 at 4:20 PM, R81 was observed sitting in her wheelchair, leaning to her side so her left hip area was not touching much of the chair. R81 was leaning more of her weight on her right elbow. R81 stated her hip and leg hurt, and she has a walker, but she cannot use it because of the pain, so she has to use this wheelchair. R81 stated she has been telling them it hurts. On 06/03/25 at 12:15 PM, R81 stated she has pain daily, and she has never told the nurses she did not have pain. R81 said she has never said it was a zero or a three when they have asked. She stated she would be happy if it was only a three. R81 said she believes she is supposed to have a scan of some kind to hopefully find out what is going on because she would like to use her walker and get around more. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 06/04/25 at 8:10 AM, R81 was observed lying in bed, with dark circles under her eyes and moving very slowly. R81 repositioned her leg with her hands and then started rubbing her hip. When she did this, she had a slight grimace on her face. R81 stated she has not got up yet, because the gabapentin makes her so tired and does not help much with the pain. R81 said she hopes to get up later and do something, her hip area is just really hurting, and she is in bed a little more than she would like. R81 stated the nurse has been asking if she has pain and she tells them yes, daily, and never says it is a zero or even a three. R81 stated there are days that she tells the nurses the pain is above ten on a one to ten scale. She stated even after the pain medication, which is just acetaminophen, ibuprofen, and gabapentin, she still has pain. The gabapentin does not seem to help the pain that much, it just makes her tired, but she takes the ibuprofen and the acetaminophen. R81 stated her pain is more than just moderate. R81 said she would like to have a little more tolerable pain so she could go to more activities and get up more, but she does not have the energy with the pain. On 06/16/25 at 11:27 AM, V35 (Physician) stated he was notified by the facility about her pain on 02/26/25 about her pain, but he believes that was after she had a fall. He has seen her in the facility and knows she has chronic pain and sometimes it is worse with the weather. He was unaware the pain assessments were not completed as more than a casual conversation; he would have expected the questions to be asked and assessed. He would expect the staff to be documenting her pain consistently on the MAR (Medication Administration Record). V35 stated, The upcoming scan is to gauge the progression of her diagnoses and to assist with gauging her pain. On 06/05/25 at 12:00 PM, V28 (Care Plan Coordinator/Minimum Data Set Coordinator) stated she does the pain assessments for the residents including R81's assessment. V28 stated if she was busy, she may have done the pain assessment by using the resident's chart. V28 stated she does not think R81 stated she has pain daily, but this was just a passing conversation with her, not an in-depth conversation. V28 stated when she does the pain assessments, it is not a sit-down process; she does not take the paper (the assessment) in with her and sit and ask her the questions; she has five of these a day. On 06/05/25 11:54 AM, V25 (Registered Nurse) stated she has asked R81 if she has had pain, and R81 has expressed she does have pain, and it bothers her. V25 stated she has been complaining of pain for the last couple months. V25 stated the doctor will not give R81 anything stronger for pain. On 06/05/25 at 1:10 PM, V20 (Registered Nurse) stated, (R81) has chronic pain. There is nothing they can do about her pain; she gets gabapentin and acetaminophen. (R81) had lidocaine patches in the past. What do you expect us to do? When V20 was asked if he knew what R81's diagnoses were, V20 stated No. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	The facility policy, dated 2022, titled, Pain Management documents: to facilitate resident independence, promote resident comfort and preserve resident dignity. The facility will achieve these goals through: promptly and accurately assessing and managing pain to the greatest extent possible, encouraging residents to self-report pain, increasing comfort and reducing to depression and anxiety in residents, optimizing the residents' ability to perform activities of daily living, monitoring treatment efficacy and side effects. A standard format for assessing, monitoring and documenting pain in both cognitively intact and cognitively impaired residents will be utilized. As part of a comprehensive approach to pain assessment and management, pain will be considered the fifth vital sign at the facility, along with temperature, pulse respiration, and blood pressure. For the purposes of this policy, pain is defined as whatever the experiencing person says it is, existing whenever the experiencing person says it does.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review. the facility failed to ensure adequate staffing to meet the needs of the residents timely. This has the potential to affect all 96 residents who currently reside at the facility. Findings Include: The facility Resident Matrix dated 6/2/25 documents 96 residents currently reside at the facility. 1. R43's admission Record documented R43 was readmitted to this facility on 5/28/2024. with diagnoses of type 2 Diabetes Mellitus with neuropathy and foot ulcer, need for assistance with personal care and muscle weakness among others. R43's MDS (Minimum Data Set), dated 4/8/2025, documented R43 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15, which indicates R43 is cognitively intact. This same MDS documented R43 is dependent on staff for toileting and personal hygiene and needs moderate assistance with transferring. On 06/03/25 at 08:43 AM, R43 said, Call lights take forever to get answered. On 6/1/25, which was Sunday, I waited over an hour for call lights to be answered. On 6/5/25 at 9:15 AM, R43 said yesterday (6/4/2025) after lunch she was placed on the toilet in her room. When ready, R43 activated the bathroom call light and waited 30 minutes for the staff to respond. R43 said when staff did respond, she was told they were busy with other things, and she waited another 15 minutes before staff assisted her off the toilet. R43 said, The facility needs more staff, so we don't have to wait so long for help. 2. R55's admission Record documented R55 was readmitted to this facility on 11/15/2024, with diagnoses of Chronic Obstructive Pulmonary Disease, heart failure and muscle weakness among others. R55's MDS, dated [DATE], documented R55 with a BIMS score of 15 out of 15, which indicates R55 is cognitively intact. This same MDS documented R55 is dependent on staff for toileting, personal hygiene, bed mobility and transferring. On 06/02/25 at 01:23 PM, R55 said, Weekends are the worst at getting your call light answered. Last weekend, I waited over an hour for my call light to be answered several times. R55 said the facility needed more staff to answer call lights more quickly. 3. R36's admission Record documented R36 was admitted to this facility on 4/5/2024, with diagnoses of spinal stenosis, fusion of the spine and type 2 diabetes mellitus with polyneuropathy and foot ulcer among others. R36's MDS, dated [DATE], documented R36 had a BIMS score of 14 out of 15, which indicates R36 is cognitively intact. This same MDS documented R36 is dependent on staff for toileting, dressing, bed mobility and transferring. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/5/2025 at 8:19 AM, R36 was observed with his call light activated, and at 8:45 AM, the call light was answered. During the observation period, 6 staff members were noted to walk past R36's room with the activated call light. At 8:50 AM, R36 said he put on his call light because he wanted to get out of bed for the day, but staff told him he would have to wait, but staff would return to help him out of bed. R36 said he needs staff assistance to get out of bed and wished the facility would hire more help. On 6/9/2025 at 1:30 PM, V47 (Registered Nurse) said, Call lights are not answered timely when there is only one CNA (Certified Nursing Assistant) on the one hundred and two hundred hallways. When we are stretched thin on staff and there is only one CNA per hall and every hall has 30 residents, we cannot get the call lights answered in a timely manner. On 6/4/25 at 12:18 PM, V16 (CNA) said he has worked with just one CNA on a hall, and wasn't easily able to meet the needs of the residents timely. V16 said call lights go unanswered for long periods of time, but they do the best they can to get them answered. On 6/10/2025 at 8:30 AM, V2 (Director of Nursing) said the facility did not have a call light policy. V2 said he expected call lights to be answered timely to meet the needs of the residents. V2 said he would consider 10 to 15 minutes to be timely call light response time. V2 said 30 minute call light wait times would not be very timely answered. 4. R51's admission Record, with a print date of 06/10/2025, documents R51 was admitted to the facility on [DATE] with diagnoses that include chronic obstructive pulmonary edema, ventricular tachycardia, anemia, hypertension, spinal stenosis, and difficulty in walking. R51's MDS, dated [DATE], documents R51 has a BIMS score of 15, indicating R51 is cognitively intact. On 06/02/25 at 01:05 PM, R51 stated there wasn't enough staff on the weekends. R51 stated they have one nurse on each hall and he has to take his medications as needed, and he can't get them when there is only one nurse and she is doing treatments on the other hall. R51 stated they only have one CNA on his hall at times, and that isn't enough. On 6/4/25 at 12:18 PM, V16 (CNA) stated he had worked with just one CNA on a hall, and wasn't as easily able to meet the needs of the residents timely. V16 stated there was one nurse covering the 100 and 200 halls at times. V16 stated when they only had one CNA on a hall, he would pull the nurse to assist with two person transfers and answer the call lights as best as he could, but it would take longer to answer them at times. On 6/5/25 at 2:27 PM, V32 (CNA) stated staffing depends on the day. V32 stated it isn't bad on day shift (6-2), but can be spotty on weekends. V32 stated he had worked with just one CNA on each hall and it wasn't fun. V32 stated he did it on Easter. When asked if they could provide timely care with one CNA on each hall, V32 stated, probably not as well as we should. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Integrity Hc of Marion	1301 East Deyoung Marion, IL 62959

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/06/25 at 11:33 PM, V41 (CNA) stated staffing is pretty good through the week, but not on the weekends. V41 stated they have one CNA on each hall on the weekends. When asked if they could meet the needs of the residents timely with one CNA on each hall, V41 stated Not really, no. V41 stated sometimes they get stuck in a room providing care and can't answer the call lights timely, especially if the nurse is in the middle of passing medications. V41 stated it can be hard to get showers done, and if supper is running late and they are trying to get supper done, lay everyone down, and do showers, it just isn't feasible. V41 stated they work with just one CNA on a unit 3-4 days per week. On 06/06/25 at 11:49 PM, V42 (Registered Nurse/RN) stated staffing wasn't the greatest. V42 stated during the week, it wasn't too bad. V42 stated on Friday, Saturdays, and Sundays, there is typically one CNA per hall, and every other weekend only one nurse for the 100 and 200 halls. V42 stated they were not able to meet the needs of the residents timely especially from 6-10 PM. V42 stated they have families visiting and asking questions, supper trays have to be passed, and showers done. V42 stated they manage to get it all done, but not in the best time they could if they were properly staffed. V42 stated (R38) is a very independent resident, and if they are short staffed and he notices, he will pass the supper trays. On 06/07/25 at 12:07 AM, V43 (Licensed Practical Nurse/LPN) stated she had worked as the only nurse on two halls. V43 stated she wouldn't say they were able to meet the needs of the residents timely all the time. On 06/07/25 at 12:16 AM, V30 (LPN) stated she had worked with just one CNA. V30 stated she worked on the 200 hall on the night of 6/7/25, and there are 23 residents on that hall. V30 stated she had one CNA on that hall from 6 PM to 10 PM. On 06/07/25 at 12:26 AM, V44 (CNA) stated staffing was terrible. V44 stated she works as the only CNA on the weekends on the 100 hall. When asked if she was able to meet the needs of the residents timely, V44 stated, for the most part. On 06/07/25 at 12:36 AM, V45 (CNA) stated they have enough staff during the week, but not on Friday, Saturdays, and Sundays. When asked if there were any specific needs they weren't able to meet timely, V45 stated getting them up in the morning. When asked if they could answer the call lights timely V45 stated, It depends on how much they are calling. On 06/09/25 at 1:54 PM, V1 (Administrator) stated she thinks they have enough staff. V1 stated if they are short, the lead CNA is supposed to come in. This surveyor reviewed the nursing schedules with V1, and she stated her expectations are four nurses on each shift and 10-12 CNA's on day shift (6 AM-6PM), and 8-10 CNA's on night shift (6 PM-6 AM). The facility nursing schedules, dated May and June 2025, were reviewed and documents on 5/31/25 (Saturday) there were four nurses working from 6 AM to 6 PM, and three nurses working from 6 PM to 6 AM. The schedules document on 5/15/25 (Thursday) there were four nurses working from 6 AM to 6 PM and three nurses working from 6 PM to 6 AM. The facility CNA schedules, dated May and June 2025, were reviewed and document on 5/31/25 (Saturday) there were five CNA's working from 10 PM to 6 AM, on 6/1/25 (Sunday) there were seven CNA's working from 2 PM to 6 PM and from 10 PM to 6 AM, and on 6/7/25 (Saturday) the schedules document there were five CNA's working from 6 AM to 10 AM, 4 PM to 6 PM and 10 PM to 6 AM. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The Facility Assessment Tool, dated 5/28/2025, documents under Staffing Plan: 3.2 The Integrity Healthcare of [NAME] staff plan is centered on the resident population and needs of the residents for care and support to ensure sufficient staffing to meet those needs at any given time. The director of nursing schedules sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medications were stored using current standards of practice for 1 of 1 resident (R68) reviewed for medication storage in the sample of 52. Findings Include: R68's admission Record, with a print date of 6/4/25, documents R68 was admitted to the facility on [DATE], with diagnoses that include alcohol dependence with withdrawal, chronic obstructive pulmonary edema, hypertension, anxiety disorder, and major depressive disorder. R68's Minimum Data Set, dated [DATE], documents a Brief Interview for Mental Status score of 15, which indicates R68 is cognitively intact. R68's current Care Plan documents a Focus area of, (R68) uses psychotropic medications r/t (related to) depression and anxiety. Date Initiated: 04/06/2023. This Focus area includes interventions of, Give anti-anxiety medications ordered by physician . There is no Focus area and/or intervention documented related to R68 self-administering medications. On 06/02/25 at 9:11 AM, R68 was sitting on his bed, picked up a small medication cup from his bedside table, with a small blue pill and a small blue and white capsule in it, and showed it to this surveyor. R68 stated his medications were being adjusted by the psychiatrist to attempt to reach the right dose of medication. R68 stated a nurse came into his room to give him his medications about a week ago. R68 stated she had one of the pills that were in the medication cup. R68 stated the medication she attempted to give him had been discontinued. R68 stated he always checks his medications for accuracy before taking them. R68 stated he told the nurse it was discontinued, and she didn't take it back, so he kept it in the cup on his bedside table. R68 stated the same thing happened with the other pill in the medication cup, but it happened a month or more ago. On 6/2/25 at 12:00 PM, V2 (Director of Nurses/DON) was asked to go to R68's room, and V2 was shown the medications in the cup. V2 asked R68 which nurse had left the medication, and R68 told him it was V15 (Licensed Practical Nurse/LPN). On 06/04/25 at 10:00 AM, when asked about the medications left at R68's bedside, V15 (LPN) stated it was a medication error. V15 stated she thought she read the physician orders correctly prior to administering R68's medications, but she gave him a medication that had been discontinued the day before. V15 was not able to recall what the medication was and thought it happened 5/28/25. V15 stated she handed him his medications and R68 went to his room. V15 stated R68 came back out with four medications and the fifth pill wasn't there. V15 stated she asked R68 if he took it. V15 stated R68 went through the other four medications with her and took them, but didn't give her the fifth (unknown) medication back. V15 stated she didn't know anything about the other pill, but thought it was from January. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 9:02 AM, V2 (DON) stated one of R68's pills were discontinued approximately 5 months ago, and the other one was discontinued recently. V2 stated he had taken care of R68 in the past 5 months, and he had never shown him those pills. V2 stated one was Zoloft, and he believed the other one was Cymbalta. V2 stated he educated staff on not leaving medications in resident rooms. V2 stated he thought they left the medications in R68's room for him to take, and R68 does not have an order to self-administer medications. The facility Administering Medications policy, dated January 2024, documents, Policy Statement- Medications shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation. 1. Only persons licensed or permitted by this state to prepare, administer, and document the administration of medication may do so .3. Medications must be administered in accordance with the orders, including any required time frame 24. Residents may self-administer their own medications only if the Attending Physician, in conjunction with the Interdisciplinary Care Planning Team, has determined that they have the decision-making capacity to do so safely

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide a meal for 1 of 17 residents (R12) reviewed for dining in a sample of 52. Findings include: R12's admission record documents an admission date of 04/23/25, with diagnoses including: metabolic encephalopathy, vascular dementia, sequelae of unspecified cerebrovascular disease, chronic obstructive pulmonary disease, anemia, hypo-osmolality and hyponatremia, major depressive disorder, anxiety disorder, polyneuropathy, visual disturbance, sensorineural hearing loss, osteoarthritis, scoliosis, dysphagia, and muscle weakness. R12's order summary report documents an order, dated 04/23/25 with no end date listed, and an order status of active, of regular diet, mechanical soft texture, and thin liquids consistency. R12's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 09, indicating R12 has moderate impaired cognition. On 06/03/25 at 8:17 AM, R12 was sitting in her wheelchair in her doorway yelling that she is hungry. When R12 was asked if she was ready for breakfast R12 stated, Yes! She is hungry, they forgot her last night, but they are not going to forget her this morning. She is hungry. On 06/03/25 at 8:39 AM, R12 was served her breakfast tray. On 06/04/25 at 12:31 PM, R12 had a lunch tray on her bedside table that was half eaten. The tray contained pureed food. The diet card on the tray was for R83. R12 was laying down in her bed; when R12 was asked about the food, R12 stated she was not done. On 06/04/25 at 12:38 PM, V11 (Certified Nurse Aide) brought R12's lunch tray to her. V11 told R12 she had her lunch, and R12 stated I already ate, but I am not done. V11 asked do you want me to leave your lunch? On 06/04/25 at 12:40 PM, R83 still did not have any lunch. At this time, this surveyor pointed out to V11 that R83's dietary card on the tray in R12's room, and that R83 still did not have any lunch. V11 then proceeded to get R83 a lunch tray. R12's food intake record does not document any food intake for dinner on 06/02/25. On 06/05/25 at 3:45 PM, V1 (Administrator) stated, When delivering trays, they should check the diet ticket on the tray with the resident in the room to make sure the correct resident gets the correct tray of food. If they are unsure if it is the resident they can ask the resident, check the door or ask another staff. They should do this also to make sure all residents receive their meal. (continued on next page)

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F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document, dated 03/20/25, titled, Resident council compliment/concern form documents: previous concerns not fixed: dinner and weekend tickets are not being read properly, residents are getting things they do not like. Portions are still inconsistent particularly at dinner. One dinner meal there was not enough food to finish service. The facility document, dated 04/17/25, titled, Resident council compliment/concern form documents: dinner and weekend tickets being read wrong, residents getting things they don't like on their tray.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interview, observation, and record review, the facility failed to provide food portions as directed by the dietary spreadsheet approved by the registered dietician for 4 (R17, R53, R61, and R63) of 17 residents reviewed for dining in a sample of 52. Findings include: 1.R17's admission Record documents an admission date of 02/02/22, with diagnoses including: type 2 diabetes mellitus with diabetic neuropathy, hemiplegia and hemiparesis following cerebral infarction, vitamin D deficiency, dementia, major depressive disorder, muscle weakness, and peripheral vascular disease. R17's Physician Order Sheet documents an order of no added salt diet with regular texture and thin liquid consistency with directions stating whole milk three times a day for nutrition, with an ordered date of 01/30/23, and a start date of 01/30/23 and an end date of indefinite. 2. R53's admission Record documents and admission date of 12/22/23, with diagnoses including: chronic kidney disease, dementia, adult failure to thrive, anemia, Alzheimer's disease, and weakness. R53's Physician Order Sheet documents an order dated 12/22/23 of Regular diet, regular texture, thin liquids and utilized built up utensils with an end date of indefinite and a status of active. 3. R63's admission Record documents an admission date of 04/03/23, with diagnoses including: respiratory failure, chronic kidney disease, paroxysmal atrial fibrillation, type 2 diabetes mellitus, anxiety disorder, and nonrheumatic aortic stenosis. R63's Order Summary Report documents an order, dated 03/20/24 with no end date listed, and an order status of active of regular diet with regular texture and thin liquids consistency. 4. R61's admission Record documents an admission date 01/19/23, with diagnoses including: unspecified fracture of right wrist and hand, unspecified fracture of sacrum, fracture of other parts of pelvis, age related osteoporosis, dementia, unspecified severe protein calorie malnutrition, muscle weakness, tinea unguium, leiomyoma of uterus, vitamin D deficiency, major depressive disorder, peripheral vascular disease, chronic kidney disease, fibroadenosis of unspecified breast, dysphagia, cognitive communication deficit and need for assistance with personal care. R61's Order Summary Report documents an order for a regular diet, regular texture, thin liquids consistency, ice cream at lunch, health shakes three times a day, super cereal at breakfast for diet order, with an order date of 11/01/23, an order status of 'active', and no end date listed. The facility document titled, Diet Spreadsheet dated day 23 Monday documents: regular: honey glazed ham 3 oz (ounces) and cauliflower 4 oz spdl (spoodle). On 06/02/25 at 12:10 PM, V21 (Dietary Manager) weighed a slice of the ham, it weighed just under 2.75 ounces. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/02/25 at 12:10 PM, V21 (Dietary Manager) served a slice of ham weighing just under 2.75 ounces to residents including R17, R53, and R61. The ham served was similar sized sliced pieces. On 06/02/25 at 1:41 PM, R63 received her lunch tray containing the honey glazed ham and cauliflower. On 06/02/25 at 12:10 PM, V21 stated, The amount of ham that should be served is 3 ounces; it (the ham) is just under. On 06/05/25 at 12:35 PM, V36 (Dietary) stated, If the ham was weighed at just under 2.75 ounces, more ham should have been added to make the appropriate amount listed on the dietary spreadsheet. The facility has a slicer that slices to all the pieces to the same size, and it can be set to slice at the appropriate size needed. The facility document, dated 03/20/25, titled, Resident Council compliment/concern form documents: previous concerns not fixed: dinner and weekend tickets are not being read properly, residents are getting things they do not like. Portions are still inconsistent particularly at dinner. One dinner meal there was not enough food to finish service. The facility document, dated 04/17/25, titled, Resident Council compliment/concern form documents: dinner and weekend tickets being read wrong, residents getting things they don't like on their tray.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on interview, observation, and record review, the facility failed to serve food at a preferred palatable temperature for 4 of 17 residents (R17, R53, R61, R63) reviewed dining in a sample of 52. Findings include: On 06/02/25 at 8:30 AM, a digital metal stemmed thermometer used for taking temperatures for this survey was checked for accuracy using the ice-point method and was accurate within +/- 2 degrees Fahrenheit. The facility document titled, Diet Spreadsheet, dated day 23 Monday, documents: regular: honey glazed ham 3 oz (ounces). On 06/02/25 at 12:05 PM, V21 (Dietary Manager) took the temperature of the sliced ham in three different locations of the ham before serving the ham. The temperature of the ham was 90 degrees Fahrenheit in all three locations of the ham when the ham was temped. On 06/02/25 starting at 12:07 PM, V21 served the ham without any attempts at raising the temperature of the ham. 1. R17's admission record documents an admission date of 02/02/22. R17's physician order sheet documents an order of no added salt diet with regular texture and thin liquid consistency. On 06/02/25 at 12:40 PM, R17 who was alert to person, place and time received her lunch tray and stated, The ham's not hot, it is barely warm. 2. R53's admission record documents and admission date of 12/22/23. R53's physician order sheet documents an order, dated 12/22/23, of Regular diet, regular texture, thin liquids and utilized built up utensils with an end date of indefinite and a status of active. On 06/02/25 at 12:43 PM, R53 received her lunch tray containing the honey glazed ham. On 06/02/25 at 12:43 PM, R53 who was alert to person, place and time received her lunch tray and stated, The ham is kind of warm, but not hot. 3. R63's admission record documents an admission date of 04/03/23. R63's order summary report documents an order, dated 03/20/24 with no end date listed, and an order status of active of regular diet with regular texture and thin liquids consistency. On 06/02/25 at 1:41 PM, R63 received her lunch tray containing the honey glazed ham and cauliflower. On 06/02/25 at 1:35 PM, R63 who was alert to person, place, and time, received her lunch tray and stated the ham is not even warm, but she is eating it because that is the only thing she is going to eat. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R61's admission record documents an admission date 01/19/23. R61's order summary report documents an order for a regular diet, regular texture, thin liquids consistency. On 06/02/25 at 1:15 PM, R61 who was alert to person, place and time stated, It's not hot. (indicating the ham). On 06/02/25 at 1:30 PM, this surveyor obtained a tray that was refused by a resident to record a temperature of the ham. The ham was temped using a metal stemmed thermometer and was noted to be a temperature of 83 degrees Fahrenheit. The facility policy, dated 2020, titled, Assistance with Meals documents: All residents 1. Hot foods shall be held at a temperature of 136 degrees or above until served. Cold foods shall be held at 40 degrees or below until served. Nursing and dietary services will establish procedures such that delivery of food to serving areas accommodates this requirement.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to provide food in a texture according to physician orders for 4 (R10, R22, R28, and R56) of 17 residents reviewed for dining in a sample of 52. Findings include: 1. R22's admission Record documents an admission date of 02/17/22, with diagnoses including: hemiplegia and hemiparesis following cerebral infarction, arthropathic psoriasis, dementia, anemia, major depressive disorder, anxiety disorder, Alzheimer's disease, chronic pain syndrome, muscle weakness, chronic kidney disease, and restlessness and agitation. R22's Minimum Data Set (MDS), dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 06, indicating severe cognitive impairment and eating assistance required as setup or clean up assistance needed indicating helper sets up or cleans up, resident completes activity, helper assists only prior to or following the activity. R22's Order Summary Report documents an order for a regular diet with a mechanical soft texture, with directions for fortified pudding at lunch and supper, with an order date of 01/16/25, a start date of 01/16/25, and an end date of indefinite. On 06/02/25 at 12:26 PM, R22 received pieces of cauliflower that were over 1.5 inches long, with florets over 0.75 inches wide on her plate. R22's Care Plan documents a focus area of: R22 has potential for nutritional problems related to anemia, vitamin deficiency, diagnosis HLD (hyperlipidemia). She is on a regular mechanical soft diet with thin liquids. She is able to feed herself, but does require staff set-up assistance related to impaired range of motion in bilateral hands secondary to RA (Rheumatoid Arthritis). Receives fortified pudding at lunch and dinner. She is allergic to pork. 2. R56's admission Record documents an admission date of 11/03/23, with diagnoses including: Parkinson's disease, fracture of unspecified part of neck of right femur, irritable bowel syndrome, low back pain, muscle weakness, major depressive disorder, anxiety disorder, and weakness. R56's Order Summary Report documents an order dated 01/21/25, with no end date listed, and an order status of active, of regular diet, mechanical soft texture, thin liquids consistency, health shake with meals, and utilize weighted utensils. On 06/02/25 at 12:56 PM, R56 received pieces of cauliflower that were over 1.5 inches long, with florets over 0.75 inches wide. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R56's Care Plan documents a focus area of: R56 has the potential for nutritional complications relating to dietary restrictions secondary to mechanically altered diet order and edentulous status. She is on a regular mechanical soft diet with thin liquids. She receives health shakes with all meals and 60 milliliters medpass 2. 0 two times a day. She utilizes weighted silverware with a date initiated of 11/21/23 with an intervention of: provide and serve diet as ordered. Monitor intake and record every meal with a date initiated of 11/21/23. 3. R10's admission Record documents an admission date of 01/16/19, with diagnoses including: chronic obstructive pulmonary disease, type 2 diabetes mellitus, atherosclerotic heart disease, atrial fibrillation, vitamin D deficiency, muscle weakness, schizoaffective disorder, bipolar type, major depressive disorder, anxiety disorder, dysphagia, and cognitive communication deficit. R10's Minimum Data Set, dated [DATE], documents a Brief Interview for Mental Status (BIMS) score of 08, indicating moderate cognitive impairment and eating assistance needed as setup or clean up assistance needed indicating helper sets up or cleans up resident, helper assists only prior to or following the activity. R10's active order sheet documents an order dated 05/01/25, with no end date listed and an order status of active, documents of low concentrated sweets (LCS) diet, mechanical soft texture, thin liquids consistency, ice cream at lunch and supper, PB&J (peanut butter and jelly) at lunch and supper, health shake at breakfast and supper, super cereal at breakfast, cut meat into bite sized pieces, staff reports resident has difficulty chewing regular texture (diet). R10's Care Plan documents a focus area of R10 has potential for nutritional complications relating to dietary limitation due to diagnoses of: GERD (Gastroesophageal Reflux Disease), anemia, and HLD. She is on a LCS mechanical soft diet with thin liquids. R10 receives PB&J sandwiches at lunch and supper, ice cream at lunch and supper, health shakes at breakfast and supper, super cereal at breakfast and offer snacks between meals with a date initiated of 04/05/21 with an intervention dated 04/13/21 of modify diet consistency to mechanical soft with thin liquids at this time. On 06/02/25 at 12:46 PM, R10 received pieces of cauliflower that were over 1.5 inches long, with florets over 0.75 inches wide. On 06/02/25 at 12:46 PM, R10 did not receive the PB&J sandwich with her lunch. 4. R28's admission Record documents an admission date of 11/18/24 with diagnoses including: chronic obstructive pulmonary disease, dementia, need for assistance with personal care, and diverticulosis of large intestine. R28's Order Summary Report documents an order for: no added salt diet with mechanical soft texture, thin liquids consistency, double portions at breakfast with an order date of 12/17/24, an order status of active and no end date listed. R28's Care Plan documents a focus area of: R28 has potential for nutritional complications relating to obesity. He is on a no added salt/low concentrated sweets mechanical soft diet with thin liquids, with double portions at breakfast. His teeth are in poor condition, with a date initiated of 08/24/2020, with an intervention listed of: provide and serve diet as ordered with a date initiated of 08/24/2020. (continued on next page)

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/02/25 at 12:39 PM, R56 received pieces of cauliflower that were over 1.5 inches long, with florets over 0.75 inches wide. The facility document titled, Diet Spreadsheet, dated day 23 Monday, documents: dental soft (mech (mechanical) soft) chopped soft cooked cauliflower. The facility policy, dated 2022, titled, Therapeutic Diets documents: 6. The food services manager will establish and use a tray identification system to ensure that each resident receives his or her diet as ordered. The facility document, dated 03/20/25, titled, Resident Council compliment/concern form documents: previous concerns not fixed: dinner and weekend tickets are not being read properly, residents are getting things they do not like. Portions are still inconsistent particularly at dinner. One dinner meal there was not enough food to finish service. The facility document, dated 04/17/25, titled, Resident council compliment/concern form: dinner and weekend tickets being read wrong, residents getting things they don't like on their tray.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, interview, and record review, the facility failed to follow the resident's dietary preferences for 3 of 17 (R17, R54 and R63) residents reviewed for dining in a sample 52. Findings include: 1. R17's admission record documents an admission date of 02/02/22, with diagnoses including: type 2 diabetes mellitus with diabetic neuropathy, hemiplegia and hemiparesis following cerebral infarction, vitamin D deficiency, dementia, major depressive disorder, muscle weakness, and peripheral vascular disease. R17's physician order sheet documents an order of no added salt diet with regular texture and thin liquid consistency with directions stating whole milk three times a day for nutrition, with an ordered date of 01/30/23 and a start date of 01/30/23, and an end date of indefinite. R17's diet card documents: notes: no apple juice at all. On 06/03/25 at 8:48 AM, R17 received her breakfast tray; the tray had apple juice and coffee on it. On 06/03/25 at 8:48 AM, R17 stated she does not like apple juice, and if she lets it sit there long enough, maybe it will turn into something else. 2. R63's admission record documents an admission date of 04/03/23, with diagnoses including: respiratory failure, chronic kidney disease, paroxysmal atrial fibrillation, type 2 diabetes mellitus, anxiety disorder, and nonrheumatic aortic stenosis. R63's order summary report documents an order dated 03/20/24, with no end date listed, and an order status of active of regular diet, with regular texture and thin liquids consistency. The facility document titled, Diet Spreadsheet, dated day 23 Monday, documents: regular: honey glazed ham 3 oz (ounces) and cauliflower 4 oz spdl (spoodle). On 06/02/25 at 1:41 PM, R63 received her lunch tray containing the honey glazed ham and cauliflower. On 06/02/25 at 1:41 PM, R63's dietary card lists allergies: cauliflower. On 06/02/25 at 1:41 PM, R63 who was alert to person, place, and time, stated she is not eating the cauliflower; she does not like it. She keeps telling them that, but it doesn't matter how many times you tell them, they do not listen. R63 stated the ham is not hot, it is barely warm, but that is not unusual. R63 stated she will eat the ham anyway, but that is all she is eating, the rest is awful. On 06/02/25 at 1:45 PM, V18 (Licensed Practical Nurse) stated he does not see in R63's electronic medical record where it states R63 is allergic to cauliflower; it is probably a dislike of hers. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. R54's admission record documents and admission date of 07/26/22, with diagnoses including: dementia, vitamin D deficiency, bipolar disorder, schizoaffective disorder, major depressive disorder, anxiety disorder, and muscle weakness. On 06/02/25 at 12:45 PM, R54's dietary card documents notes: no ice in the drinks. On 06/02/25 at 12:45 PM, R54's had ice in her drinks. The facility document, dated 03/20/25, titled, Resident council documents: compliment/concern form: documents: previous concerns not fixed: dinner and weekend tickets are not being read properly, residents are getting things they do not like. The facility document, dated 04/17/25, titled, Resident council documents: compliment/concern form: dinner and weekend tickets being read wrong, residents getting things they don't like on their tray. The facility policy, dated 2020, titled, Resident food Preferences documents: 1. Upon the resident's admission (or within seventy-two (72) hours after his/her admission) the dietary department or nursing staff will identify a resident's food preferences.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on interview, observation, and record review, the facility failed to provide adaptive equipment for 2 (R53 and R56) of 17 residents reviewed for dining in a sample of 52. Findings include: 1. R53's admission record documents and admission date of 12/22/23, with diagnoses including: chronic kidney disease, dementia, adult failure to thrive, anemia, Alzheimer's disease, and weakness. R53's physician order sheet documents an order, dated 12/22/23, of Regular diet, regular texture, thin liquids and utilized built up utensils, with an end date of indefinite, and a status of active. R53's care plan documents a focus area of: R53 has potential for nutritional complications relating to poor appetite and diagnosis of failure to thrive. She is on a regular texture general diet with thin liquids. R53 utilizes built up utensils with a date of 11/12/2024. On 06/02/25 at 1:01 PM, R53 received her lunch tray, and did not receive built up utensils; she received regular utensils. On 06/03/25 at 8:41 AM, R53 received her breakfast tray. R53's breakfast tray did not contain built up utensils; she received regular utensils. On 06/03/25 at 8:41 AM, R53 who was alert and oriented, stated she does not always get the bigger silverware. 2. R56's admission record documents an admission date of 11/03/23, with diagnoses including: Parkinson's disease, fracture of unspecified part of neck of right femur, irritable bowel syndrome, low back pain, muscle weakness, major depressive disorder, anxiety disorder and weakness. R56's order summary report documents an order, dated 01/21/25, with no end date listed ,and an order status of active, of regular diet, mechanical soft texture, thin liquids consistency, health shake with meals and utilize weighted utensils. On 06/02/25 at 12:56 PM, R56 received her lunch tray, and she did not receive any weighted utensils; she had regular utensils. On 06/03/25 at 8:37 AM, R56 received her lunch tray, and she did not receive any weighted utensils; she had regular utensils. On 06/03/25 at 8:37 AM, R56, who was alert and oriented, stated she does not always get the bigger silverware, but she doesn't not know if they help much with her shaking, but her sister wants her to use them. On 06/05/25 at 12:38 PM, V36 (Dietary) stated if the residents have an order for any adaptive equipment, the kitchen staff need to be reading the tickets and making sure they receive the adaptive equipment. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility document, dated 04/17/25, titled, Resident council documents: compliment/concern form: dinner and weekend tickets being read wrong, residents getting things they don't like on their tray. The facility policy, dated 2020, titled Assistance with Meals documents: residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Residents who may benefit from assistive devices 1. adaptive devices (special eating equipment and utensils) will be provided for residents who need or request them. These may include devices such as silverware with enlarged/padded handles, plate guards, and/or specialized cups.

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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 interview, observation, and record review, the facility failed to store, handle, and sanitize food and food contact surfaces to prevent contamination. This failure has the potential to affect all 96 residents residing in the facility. Findings include: On 06/02/25 at 9:39 AM, there was a large accumulation of ice on the floor of the freezer. The accumulation of ice was over 1.5 feet by over 1 foot and over 9 inches tall. There was also ice on two boxes of food. One box had individual ice creams in it, and the ice had caused some of the ice creams to fall out of the box onto the floor. On 06/02/25 at 9:39 AM, V21 (Dietary Manager) stated they have a leak, and when there is a storm more water comes in, and they have been short staffed, and V21 has been working as a cook also, and has not had time to clean it up. On 06/02/25 at 12:00 PM, V23 (Dietary Aide) transferred glasses with gloves on, by the rim area where residents would drink from, after touching the milk carton, her shirt, the drink cart, health shakes, the ice scoop, and her face. On 06/02/25 at 12:15 PM, V38 (Dietary Aide) wiped off the counter with the cloth from the sanitizer bucket, and then started preparing sandwiches for lunch substitutions. V38 tested the sanitizer bucket, and the sanitizer level was less then 25 parts per million chlorine. When V38 was asked if she knew what the sanitizer level should be, V38 stated she did not know. The facility document dated 06/02/25 titled, Midnight Census Report documents 96 residents residing at the facility.