STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145935	A. Building B. Wing	03/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Citadel at Saint Joseph Village	659 East Jefferson Street Freeport, IL 61032

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure the dishwasher temperature was at an appropriate temperature to sanitize dishes and silverware and failed to maintain the garbage disposal system. These failures have the potential to affect all residents residing in the facility.The findings include:The Resident Census and Condition Report provided by the facility on 3/4/26 showed 88 residents residing in the building.On 3/3/26 at 9:06AM, The dishwasher was draining large amounts of water onto the dish room floor. The water had small amounts of food and wrappers located in it. The dishwasher was started and showed a wash cycle temperature of 144 degrees Fahrenheit. The front of the machine showed a reference wash cycle temperature of 150 degrees Fahrenheit. There was a strong odor of rotting food within the dish room. Surveyor observed the sink with the garbage disposal was full of orange/brown water with food floating in it.On 3/3/26 at 9:19AM, V5 (Dietary Manager) stated, There is a pipe on the back of the dishwasher that falls off every day at a minimum. If it falls off, the water leaks all over the floor. V5 then put the pipe back in place and the water leaking from the dishwasher greatly decreased. V5 stated he is unsure why the dishwasher was not coming up to the appropriate temperature. V5 stated the garbage disposal is clogged and then proceeded to dig what appeared to be coleslaw, french fries, and unidentifiable food out of the garbage disposal system.On 3/3/26 at 12:50PM, V5 stated, The dishwasher should be coming up to 150 degrees as it is a hot water sanitization. If it does not come up to the desired temperature then dishes will not get sanitized properly. If we don't get that pipe fixed, it could remain a hazard for our staff to have water leaking all over the floor.The facility's undated dishwasher manual showed, Minimum water temperature for hot water sanitization 150 degrees Fahrenheit.

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure 6 residents (R19, R25, R65, R85, R94, R106) were treated with dignity during mealtimes, and failed to provide assistance with facial hair grooming for 1 resident (R31). These failures apply to 7 of 7 residents reviewed for dignity in the sample of 23.The findings include: 1. On 3/4/26 at 11:34AM, R25, R94, and R106 were seated at the lunch table together. R94 received her lunch tray and began eating her food. At 11:48AM, surveyor observed R94 stop eating. R94 stated, I'm trying to wait so we can all eat together but my food is getting cold. At 11:55AM, R25 stated, We always have to wait a long time after (R94) gets served. I think it's ridiculous. We should all be eating at the same time & she shouldn't have to eat slower because we are waiting. At 11:57AM, V5 (Dietary Supervisor) brought R25 and R106's meal tray. R25 stated that wasn't what she ordered and V5 stated her ticket was lost so they brought her the main meal. V5 returned at 12:10PM to serve R25 her correct meal. (26 minutes passed between the time R25 was served and all residents at the table received their meal.) On 3/4/26 at 11:35AM, R19, R73, and R85 were seated at their lunch table. R73 received her meal tray. At 11:45AM, R19 and R85 were served their lunch meal. R85 stated, She (R73) is already halfway done eating and we haven't even been served yet. I don't like that. We should all eat at the same time so we can enjoy eating together. On 3/4/26 at 11:48AM, R32 and R65 were seated at their lunch table. R32 was served her lunch meal. At 12:06PM, dietary staff began picking up plates from empty tables where residents had finished eating and V14 (Cook) stated she was plating the hall trays for residents in their rooms. V14 stated all residents in the dining room had been served. At this time, surveyor notified V5 that R65 did not get a meal tray brought to his table. (18 minutes after R32 was served her meal.) On 3/5/26 at 8:33AM, V5 stated, I did see the dining experience yesterday and it is unacceptable. I saw residents waiting to eat when their tablemates were eating and that is not okay. I didn't realize it was 25 minutes at times for table mates to get their food. That is 100% a concern and that is not ok. I am trying to work with the dietary staff to get them to realize when residents are all sitting at the same table then they should all be served at the same time. It is a concern for the residents dignity if they are all not served at the same time because we do have some residents who feel left out and like we are intentionally not serving them at the same time. That's not the case but that's how they feel. I did not see that (R85) had not been served food until someone notified me right before you did that, he didn't have a plate. We need to be more accountable for our residents and ensure everyone is served in the dining room before we start plating the hall trays to be delivered. The facility's policy titled, Quality of Life-Dignity dated 2018 showed, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.1. Residents shall be treated with dignity and respect at all times. 2. On 3/3/26 at 11:25 AM, R31 was sitting up in bed. R31 had coarse gray and white facial hair above her upper lip, chin and neck. The surveyor asked R31 if the facility had offered to shave her facial hair. R31 replied, No, I wish they would. I know it needs to be shaved. It's embarrassing. R31 said she usually keeps the facial hair shaved at home, but her facial hair hadn't been shaved since admission to the facility (2/11/26). On 3/4/26 at 8:35 AM, R31 was seated in her electric wheelchair, fully dressed. R31 continued to have numerous, coarse gray and white facial hairs to her upper lip, chin, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and neck. R31 said she was going out for an appointment. R31's Face sheet dated 3/5/26 showed R31 was admitted on [DATE] with diagnoses to include, but not limited to multiple sclerosis, diabetes, chronic kidney disease, and hypertension. R31's facility assessment dated [DATE] showed she was cognitively intact and required substantial/maximal assistance with personal hygiene. This assessment defines personal hygiene as the ability to maintain personal hygiene, including combing hair, shaving, applying makeup and washing/drying face and hands. R31's Care Plan initiated 2/11/26 showed R31 required assistance with ADLs (Activities of Daily Living) related to multiple sclerosis. Assist with ADLs was a listed intervention. On 3/4/26 at 1:04 PM, V22 (Certified Nursing Assistant – CNA) said female residents should be offered assistance with shaving on shower days, but we usually don't shave them unless they ask. On 3/4/26 at 3:39 PM, V2 (Director of Nursing – DON) said female residents shouldn't have facial hair unless it is their preference. V2 stated, It's a dignity issue. V2 said the CNAs should offer to shave R31 whenever they notice facial hair and on shower days. The facility's Quality of Life – Dignity Policy reviewed 12/2018 showed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. Residents shall be treated with dignity and respect at all times. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth. Residents shall be groomed as they wish to be groomed (hair styles, nails, facial hair, etc.).

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to administer medications at ordered times. There were 29 opportunities with 9 errors resulting in a 31% medication error rate. This applies to 4 of 6 (R31, R53, R80, R81) residents reviewed for medication pass.The findings include:1. R31's March 2026 physician's orders showed R31 receives meropenem 1000 milligrams (mg) intravenously every 12 hours for bacterial infection and acetaminophen 650mg at 8AM and 8PM. On 3/3/26 at 03/03/2026 9:30AM, V16 (Licensed Practical Nurse-LPN) administered R31's acetaminophen 650mg (1 hour and 30 minutes past the scheduled administration time).On 3/3/26 at 9:38AM, R31 stated she doesn't think she received her meropenem this morning. V16 stated, I'm an LPN so I can't give it. She's supposed to get it at 6AM. I just can't give it so I have to get time to go get the RN (Registered Nurse) on the other side of the building. V16 then notified the Nurse Practitioner of R31's late medication and informed administration that she needed an RN to administer R31's intravenous meropenem (3 hours and 38 minutes after the scheduled administration time).2. R53's March 2026 physician's orders showed R53 receives memantine 10mg at 8AM and 8PM.On 3/3/26 at 9:41AM, V16 administered R53's memantine 10mg (1 hour and 41 minutes past the scheduled administration time).3. R80's March 2026 physician's orders showed R80 receives ramipril 5mg, rivaroxaban 2.5mg, glipizide 10mg, and gabapentin 300mg at 8AM and 8PM. R80 receives vitamin C 1000mg at 7AM and 4PM.On 3/3/26 at 9:36AM, V16 administered R80's ramipril 5mg, rivaroxaban 2.5mg, vitamin C 500mg, glipizide 10mg, and gabapentin 300mg (2 hours and 36 minutes past the scheduled administration time for R80's vitamin C and 1 hour and 36 minutes past the scheduled administration time for the remainder of R80's medications).On 3/3/26 at 9:52AM, V16 stated, I came in this morning at 6:15AM. I'm not familiar with the residents on this hall as much because I don't work over here often. I feel bad and try to help because there are only 2 aides working this whole unit so I'm trying to help them too. I know my medications were late for a few people, but I don't know what else I could have done to prevent it. 4. R81's March 2026 physician's orders showed R81 receives chlorhexidine mouth rinse at 8AM and 8PM.On 3/5/26 at 8:31AM, V11 (LPN) stated R81's chlorhexidine was unavailable and was unable to find it in her medication cart. V11 stated she reordered the medication on 2/27 so is unsure of why it has not arrived from pharmacy yet.On 3/5/26 at 11:11AM, V2 (Director of Nursing) stated, All medications should be administered within 1 hour before or 1 hour after scheduled time. If the order is at 8AM then they can be given between 7AM-9AM. Anything outside of those times would be considered a medication error for timing. Intravenous antibiotics are especially important to give at the ordered time to ensure a resident receives the full treatment to fight their infection.The facility's policy titled, Administering Medications dated December 2017 showed, Medications shall be administered in a safe and timely manner, and as prescribed.4. Medications must be administered within one hour of their prescribed time, unless otherwise specified.

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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. Based on observation, interview, and record review, the facility failed to prepare pureed foods to the desired consistency. This applies to 8 of 8 residents (R2, R35, R46, R48, R53, R87, R90, R91) reviewed for pureed foods in the sample of 23.The findings include: On 3/3/26, the facility provided a list of residents receiving a pureed diet. R2, R35, R46, R48, R53, R87, R90 and R91 were all residents listed as receiving a pureed diet. On 3/3/26 at 11:10AM, V14 (Cook) prepared the pureed fried steak. V14 poured the meat with a small amount of liquid from the bottom of the cooking pan into the blender. V14 blended the meat to a ground consistency and then poured it into a pan. V14 then prepared the pureed corn by pouring the corn into the blender, blended to a ground consistency, and poured it into a separate pan. Upon completion of blending each item, V14 tasted the items and stated they were both a pureed consistency which should be a smooth consistency and not a paste-like consistency.On 3/3/26 at 12:07PM, R35 stated his food was not pureed. He stated the meat wasn't pureed all the way and there were pieces of meat in it. He said he has a swallowing problem and problems with his teeth. Resident had already left the dining room and was sitting in his wheelchair in the hall. He stated he let the staff know that it wasn't pureed. At 12:10PM, R35's lunch plate observed and he left mashed potatoes with gravy, corn with kernel chunks in it, and meat with chunks in it. R35's food was not a creamy texture and only a few bites were taken from his plate. The ticket next to R35's meal ticket showed he is to have pureed consistency with double portions of meat. R35's ticket was circled to show he chose to have fortified pudding, pureed chicken fried steak with country gravy, garlic mashed potatoes, pureed creamed corn, and pureed frosted spice cake. (The Physician Orders for March 2026 for R35 showed regular diet, pureed texture).On 3/3/26 at 12:17PM, surveyor requested a pureed test tray. The meat was thick and not creamy with small chunks of meat in it. The pureed corn had pieces of corn hull in it. At 12:25PM, V1 (Administrator) came into the conference room and stated the test tray appeared to be mechanical soft. V1 confirmed the pureed diet did not appear pureed. On 3/3/26 at 12:58PM, V15 (Registered Dietician) stated, Pureed foods should not have any chunks in them as this creates a choking hazard for our residents with swallowing difficulties. Food should be blended to a smooth consistency and not like a paste for residents to swallow easily.The facility's Guidelines for Pureed Preparation policy (March 2017) showed the pureed diet provides food with semi-liquid to semi-solid consistency (i.e. pudding-like).The recipe for pureed creamed corn printed on 3/4/26 showed, Place portion of prepared corn in food processor and blend until a smooth consistency.The recipe for pureed chicken fried steak printed on 3/4/26 showed, Place prepared portion of chicken fried steak in food processor with hot broth and blend to a smooth consistency.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview and record review, the facility failed to provide HS (bedtime) snacks for 6 of 6 residents (R4, R8, R30, R34, R56, R80) reviewed for HS snacks in the sample of 23.The findings include:On 3/4/26 at 10:07AM, a Resident Council meeting was held with R4, R8, R30, R34, R56, and R80. All residents stated the kitchen does not send snacks every day for them. We don't get offered snacks every day. The only time we get snacks is when we request it but we thought they were supposed to come around and offer it. All residents state they would like to at least be offered a snack because it is a long time to wait from dinner time to breakfast the next day.R4, R8, R30, R34, and R80's most recent facility assessments showed no cognitive impairment. R56's most recent facility assessment showed mild cognitive impairment.The resident council minutes for January 2026 showed, Are you offered a bed time snack? No. Residents were encouraged to go ask for snacks when they stated they do not receive a bed time snack.On 3/5/26 at 11:11AM, V2 (Director of Nursing) stated, Snacks are passed with water pass usually but it can be at different times. We don't have a specific snack pass time, we prefer it to be done after breakfast on day shift and on second shift they do it right when they come in so by 4PM or so. I guess I didn't realize that it had to be after dinner when they passed the snacks, but it makes sense if it's supposed to be an HS snack.On 3/5/26 at 11:29AM, V27 (Certified Nursing Assistant) stated, Second shift snacks are passed with water when I first come in for my shift. I didn't know they had to be offered at bedtime.On 3/5/26 at 12:05PM, V1 (Administrator) stated, I just had an in-service 2 weeks ago telling staff when to pass the snacks. There is no reason why they shouldn't be offering snacks to residents at bedtime. We at least need to offer a snack and document whether or not the resident accepts them.The facility's policy titled, Snacks (Between Meal and Bedtime), Serving dated, September 2010 showed, The purpose of this procedure is to provide the resident with adequate nutrition.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a resident had a wheelchair that fit and maintained body alignment and positioning needs for 1 of 1 residents (R60) reviewed for accommodation of needs in the sample of 23.The findings include:On 3/4/26 at 9:03 AM, R60 was sitting in her wheelchair in the common area with her left leg twisted inward. The resident's knees were bent, and the back of her knees were about 1 foot away from the seat of the wheelchair. R60 complained of pain to her left leg and did not look comfortable. V13 (Certified Nursing Assistant - CNA) was asked to observe R60 and V13 stated R60 did not look comfortable in the wheelchair.On 3/4/26 at 9:12 AM, V12 (Restorative Nurse) went with the surveyor to observe R60 in her chair. V12 stated R60's positioning in the wheelchair wasn't good and confirmed that the wheelchair did not appear to fit R60 as it should.On 3/4/26 at 9:15 AM, V6 (Director of Physical Therapy) observed R60 in her wheelchair and stated the wheelchair looked too small for R60 and they could get her a larger one.The Face Sheet dated 3/4/26 for R60 showed diagnoses including Alzheimer's disease, unspecified protein calorie malnutrition, depression, dementia, obstructive and reflux uropathy, chronic atrial fibrillation, anxiety, urinary tract infection, chronic pain, mitral valve insufficiency, disorders of the kidney and ureter, cardiomegaly, and hypertension. The MDS dated [DATE] for R60 showed severe impairment of memory and cognition; functional limitation in range of motion to both lower extremities; mobility device - wheelchair; substantial/maximal assistance needed for rolling left and right in bed; dependent for transfers.The facility's Quality of Life - Accommodation of Needs policy (August 2019) showed the resident's individual needs and preferences shall be accommodated to the extent possible, except when the health and safety of the individual or other residents would be endangered. The resident's individual needs and preferences, including the need for adaptive devices and modifications to the physical environment, shall be evaluated upon admission and reviewed on an ongoing basis.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the elasticated tubular support bandages were in place for 1 of 1 residents (R60) reviewed for quality of care in the sample of 23.The findings include:On 3/3/26 at 2:35 PM, R60 was sitting in her wheelchair with her feet on the floor and grip socks on. R60 did not have any elasticated tubular support bandages (leg wraps) on her lower legs. V10 (Certified Nursing Assistant - CNA) was asked to check and see if R60 had any leg wraps in place and she confirmed R60 did not have any and she was not aware of the resident having any.On 3/3/26 at 2:41PM, V7 (Licensed Practical Nurse - LPN) stated the elasticated tubular support bandages should be done as ordered. V7 stated she thought they were put on by the night nurse. V7 looked in her computer and stated the leg wraps can be put on by either the day or night shift nurse. On 3/4/26 at 9:03 AM, R60 was sitting in her wheelchair in the common area and did not have leg wraps in place. On 3/4/26 at 9:24 AM, V11 (LPN) was asked if R60 was supposed to have any wraps to her legs. V11 checked in her computer and stated R60 is supposed to have them. V11 stated the order showed they were to be applied in the morning and removed at bedtime.On 3/4/26 at 12:52 PM, V2 (Director of Nursing - DON) stated R60 has the elasticated tubular support bandages because she gets dependent edema from sitting in the wheelchair. V2 stated the leg wraps were to be applied in the morning. V2 stated she thought the nurse was the one that applies them and the nurse and CNAs monitor compliance to make sure it is being done. V2 stated they should be signed out on the Treatment Administration Record - TAR when they are being done. V2 reviewed R60's March 2026 TAR and stated they were signed out on 3/4/26 at 6:30 AM by V7 that she put them on. V2 stated they were not signed out by V11 today that they were on and that V11 came to talk to her about it after the surveyor asked her about it that morning.The Face Sheet dated 3/4/26 for R60 showed diagnoses including Alzheimer's disease, unspecified protein calorie malnutrition, depression, dementia, obstructive and reflux uropathy, chronic atrial fibrillation, anxiety, urinary tract infection, chronic pain, mitral valve insufficiency, disorders of the kidney and ureter, cardiomegaly, and hypertension. The Physician Orders dated March 2026 for R60 showed Apply elasticated tubular support bandages to both legs in the morning and remove at bedtime every day and night shift. The order was placed on 9/30/25.The Care Plan dated 12/29/25 for R60 did not show the use of elasticated tubular support bandages.The Progress Notes for R60 were reviewed from 1/1/26 - 3/4/26 and did not show any refusal of care.The MDS dated [DATE] for R60 showed severe impairment of memory and cognition; functional limitation in range of motion to both lower extremities; mobility device - wheelchair; substantial/maximal assistance needed for rolling left and right in bed; dependent for transfers.The facility had a policy for Applying Anti-Emboli Stockings (10/2022) that did not show any information specifically for elasticated tubular support bandages. The stockings and bandages were not the same. There was no policy for elasticated tubular support bandages.The facility's Physician Orders policy (February 2019) showed all orders will be processed and carried out by nursing service personnel as soon as the order has been received.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure a resident was positioned safely to prevent a fall for 1 (R4) of 4 residents reviewed for falls in the sample of 23.The findings include:R4s admission record shows she was admitted to the facility on [DATE] with a primary diagnosis of congestive heart failure and a history of falling. The 12/16/25 quarterly resident assessment and care screening documents R4 to be cognitively intact. The same record shows R4 requires partial/moderate assist with rolling right to left. The helper lifts, holds or supports trunk and limb during the movement.R4s 11/30/25 care plan documents her to be a high risk for falls related to functional deficits.The facility's 2/5/26 incident report of a witnessed fall documents R4 fell out of bed during repositioning. She was lowered to the floor gently by the aide. On 3/04/2026 at 12:34 PM, R4 said she had rolled out of her bed about a month ago. The Certified Nursing Assistant (CNA) was repositioning her in bed. She said the CNA rolled her towards the edge of the bed and her feet went over first and her legs shifted. Then she rolled and fell to the floor between the aide and the bed. She said it would have been about a two-foot drop from the bed to the floor. She said at the time, the side rails were not on the bed. She said it was not the first time she had fallen out of bed, there was another incident last year.On 3/4/26 at 12:35 PM, R4 was sitting up in her wheelchair in her room. She had a bariatric bed with bilateral upper rails.On 3/5/26 at 9:01 AM, V24 (CNA) said R4 has always been a 2 assist with rolling her in bed, she recently had bars put on her bed because she rolled out of bed. We use 2 staff for resident safety.On 3/05/2026 at 10:37 AM, V2 (Director of Nursing - DON) said the aide rolled R4 towards herself and when R4s legs were moved over, the momentum of her legs moved her over the edge of the bed shifting her and making her fall off the bed.The facility's 3/2018 policy for falls and fall risk documents a fall is defined as: unintentionally coming to rest on the ground, floor, or other lower level. An episode where a resident lost his/her balance and would have fallen, if not for another person or if her or she had not caught him/herself, is considered a fall. A fall without injury is still a fall.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure an indwelling catheter drainage bag was maintained below the level of the bladder for 1 of 3 residents (R31) reviewed for indwelling catheters in the sample of 23. The findings include:On 3/4/26 at 8:35 AM, V19 and V20 (Certified Nursing Assistants - CNAs) had the total lift in R31's room. They said they just got R31 up and were getting her ready for her dentist appointment. V20 left the room briefly and re-entered. R31 was seated in her electric wheelchair. V19 lifted R31's catheter drainage bag in the air to place it in the privacy bag. R31's catheter drainage bag was at the level of R31's shoulders (above the level of her bladder) and yellow urine was flowing back toward R31 in the tubing.On 3/4/26 at 12:34 PM, V21, V22, and V23 (CNAs) entered R31's room to transfer her to bed with the total lift. V22 and V23 applied R31's total lift sling to the mechanical lift. V22 said someone will need to hold R31's catheter. V22 removed the catheter drainage bag from R31's electric wheelchair and handed it to V23. R31 was still seated in her electric wheelchair. V23 held R31's catheter drainage bag near R31's shoulder level (above the level of her bladder) while waiting for V21 and yellow urine was backflowing in the catheter tubing.On 3/4/26 at 2:20 PM, V18 (Registered Nurse - RN) was preparing for R31's wound care. V18 removed R31's urinary catheter bag from the side of the bed, lifted it approximately 1-2 feet above R31 and handed it to V27 (CNA). Yellow urine back flowed toward R31 in the tubing. R31's Face sheet dated 3/5/26 showed R31 had diagnoses to include, but not limited to multiple sclerosis, diabetes, chronic kidney disease, hypertension, neuromuscular dysfunction of the bladder, and urinary tract infection. R31's facility assessment dated [DATE] showed she was cognitively intact and had an indwelling urinary catheter.R31's Care Plan initiated 2/11/26 showed R31 required the use of an indwelling catheter related to neurogenic bladder. The care plan included an intervention to keep the drainage bag lower than the level of the bladder.On 3/4/26 at 1:04 PM, V22 (CNA) said the catheter bag is supposed to be kept below the resident's waist to decrease the risk of an infection.On 3/4/26 at 3:39 PM, V2 (Director of Nursing - DON) said the catheter drainage bag should be kept below the level of the bladder to prevent backflow that could cause R31 to get a urinary tract infection.The facility's Urinary Catheter Care Policy reviewed 9/2019 showed the purpose of this procedure is to prevent catheter-associated urinary tract infections. This policy showed the urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the bladder.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review the facility failed to label open tube feeding, ensure a feeding tube dressing was intact, and check placement of a feeding tube prior to using the tube for 1 of 1 residents (R3) reviewed for enteral feeding in the sample of 23. The findings include:On 3/3/26 at 10:07 AM, there was an open bottle of tube feeding sitting on R3's dresser. There was 300 milliliters (ml) left in the bottle. The tube feeding was not labeled when it was opened.On 3/3/26 at 1:19 PM, R3 was laying in bed with his abdomen exposed. R3's feeding tube was slightly pulled out and there wasn't a dressing on his abdomen around the feeding tube. The dressing was twisted with bloody drainage and was hanging down on his tubing. V7 (Licensed Practical Nurse - LPN) was leaving his room and stated she was just cleaning up his room. At 1:24 PM, V7 was asked if she was returning to R3's room and she stated she had already given R3 his bolus of tube feeding at 11:00 AM and his medications had been given so she was done in his room. V7 stated his dressing around his feeding tube is changed by the night nurse but can be done as needed. V7 was asked to observe R3's dressing. V7 went into his room and stated she could change his dressing.On 3/4/26 at 10:30 AM, V11 (LPN) went into R3's room to give him his tube feeding. V11 had a gown and gloves on. V11 flushed R3's feeding tube with water, gave a bolus of 325 ml of tube feeding, and flushed the feeding tube. V11 never checked placement prior to giving the bolus of tube feeding. V11 stated there weren't any orders for her to check placement of his feeding tube. V11 stated she does it sometimes and when she does there is a residual of 25 ml to 50 ml of tube feeding. V11 stated she said R3 recently switched to bolus feedings, and she doesn't think that he is tolerating it. V11 stated there aren't any parameters for his tube feeding to show if he is tolerating it or not. V11 stated she never received any education related to the facility's policy on tube feeding.On 3/4/26 at 12:52 PM, V2 (Director of Nursing - DON) stated the facility does have feeding tube policies. V2 stated they do residual checks for placement prior to tube feeding administration. V2 stated checking the potential of hydrogen - pH is not part of their policy. V2 stated the facility's policies are on the computers and there are copy binders on the unit. V2 stated staff should follow physician orders. V2 stated tube feeding should be labeled when it is opened, and it is good for 24 hours.The Physician Orders dated March 2026 for R3 showed apply split gauze to tube site. Enteral feed - tube feeding Bolus 325 ml five times a day. Monitor for tolerance. Must document in nursing note. Place binder on abdomen so the patient cannot accidentally pull-on tube. Place binder when tube is not being used. Clean external tube site with mild soap daily. Flush tube before and after every use whether it is medication, nutrition etc.The Care Plan for R3 dated 1/29/26 showed the resident has difficulty swallowing related to medical diagnosis of dysphagia and is nothing by mouth with dependency on tube feeding. Let staff check residuals per nursing policy. Monitor tube feeding tolerance. Provide tube feeding as ordered. Tube feeding: Resident is at risk for complications related to tube feeding. Check feeding tube residual as ordered. Check tube placement by auscultating air injection every shift. Keep head of bed raised 30 degrees. Tube feeding as ordered. R3's The Face Sheet dated 3/4/26 showed diagnoses including hypoxic ischemic encephalopathy, asthma, critical illness myopathy, type 2 diabetes mellitus, obstructive sleep apnea, dysphagia, cognitive communication deficit, aphasia, spastic hemiplegia, gastroesophageal reflux disease, iron deficiency anemia, benign prostatic hyperplasia, down syndrome, hyperlipidemia, hypothyroidism, major depressive disorder, anxiety disorder, hypertension, gastrostomy, and bipolar disorder.The facility's Checking Gastric Residual Volume - GRV policy (March 2023) showed the purpose of this procedure to assess tolerance of enteral feeding and minimize the potential for aspiration. Measure GRV with at least a 60 ml syringe. Once target rate and amount of feeding have been reached and are being tolerated, check GRV every 6-8 hours.The facility's Confirming Placement of Feeding Tube policy (March 2023) showed the purpose is to ensure placement of the feeding tube to prevent aspiration during feedings. Observe for changes in residual (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	volume. A. A sharp increase in residual volume may indicate that a small bowel tube has moved into the stomach; b. Little to no residual volume may suggest that the tube has migrated from the stomach to the esophagus. Post- pyloric/intestinal contents can be bile stained, light to dark yellow or greenish-brown. The person performing this procedure should record the following information in the resident's medical record the date and time the procedure was performed. The name and title of the individual(s) who performed the procedure. All assessment data obtained during the procedure. If the resident refused the procedure, the reason(s) why and intervention taken. The signature and title of the person recording the data.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review the facility failed to follow professional standards when starting an intravenous (IV) antibiotic for 1 of 1 resident (R38) in the sample of 23. The findings include:On 3/3/26 at 9:35 AM, V18 (Registered Nurse - RN) prepared to administer IV antibiotics to R38's PICC (peripherally inserted central catheter) line. V18 flushed R38's PICC line with 10 milliliters (ml) of Normal Saline (NS), clamped the PICC line and left the syringe attached to R38. V18 checked the IV antibiotic and stated, This is ampicillin 500 milligrams (mg) and we will run the 100 ml over 60 minutes. V18 opened the IV tubing and spiked the antibiotic. V18 primed the IV tubing with the antibiotic, clamped the white C-clamp and roller clamp. V18 removed the flush syringe from R39's PICC line, cleansed the site with an alcohol swab and attached the IV tubing. V18 opened the clamp on the PICC line site and the roller clamp on the IV tubing. The white C-clamp was still closed on the IV tubing. V18 said the next step was to put the tubing in the pump and set the rate. V18 attempted to place the tubing into the pump and said the white clamp had to go in a specific way. V18 was unable to get the tubing in on the first try. The white C-clamp opened during this failed attempt. The IV antibiotic began to flow freely into R38's PICC line. A steady stream of fluid passed through the drip chamber. V18 did not notice the freely flowing antibiotic and continued to attempt to place the tubing in the IV pump. The surveyor intervened and asked V18 if the antibiotic should be flowing freely. V18 replied, Oh, no. It shouldn't be going that fast. V18 closed the roller clamp on the IV tubing, and the flow of the antibiotic stopped. R38 received approximately 20-30 ml of the 100 ml antibiotic (ampicillin 500 milligrams (mg) in 100 ml of fluid) medication in less than a minute. V18 said the antibiotic should not have been administered so quickly. V18 stated, It stopped as soon as I closed the roller clamp. V18 said she should have had the roller clamp closed when she was placing the IV tubing in the IV pump. V18 said pharmacy enters the appropriate rate for infusion on the label of the medication. V18 said R38's antibiotic label showed that the entire 100 ml should be administered over one hour. R38's Face Sheet dated 3/5/26 showed diagnoses to include, but not limited to chronic kidney disease, urinary tract infection, bladder cancer, dysphagia, disorders of the muscles, lack of coordination, and cognitive communication deficit. R38's Physician Order Sheet dated 3/5/26 showed an order for Ampicillin Sodium 500 mg IV four times a day for an infection in the urine for 10 days. R38's IV antibiotic label dated 3/3/26 showed Ampicillin 500 mg in 100 ml of NS. Infuse 100 ml IV piggyback over 60 minutes every 6 hours for 10 days. R38's Care Plan initiated 2/28/26 showed R38 had a urinary tract infection. One of the interventions was to administer medications as ordered. On 3/4/26 at 3:45 PM, V2 (Director of Nursing - DON) said R38's antibiotic should not have been free flowing while V18 (RN) tried to place the IV tubing. V2 said the nurse should prime the IV tubing and place the IV tubing into the IV pump before the IV tubing is attached to the PICC site. V2 said that prevents the risk of accidentally infusing medication too quickly while trying to place the IV tubing in the IV pump. V2 said some of the nurses have trouble loading the IV tubing into the IV pumps because the white C-clamp must go in a specific direction. V2 said that's why it's so important to make sure the roller clamp is closed to prevent the antibiotic from free flowing. V2 said she's not sure what could happen if R38 received 20-30 ml of Ampicillin in less than a minute. V2 said there's a reason the antibiotics are labeled to run at a specific rate. V2 said the nurses are expected to follow the prescribed rate of administration. On 3/5/26 at 9:36 AM, V26 (Pharmacist) said ampicillin IV is used to treat infectious processes. V26 said the IV room pharmacist calculates the infusion rate and then labels the medication appropriately. V26 said she expected the nurses to administer at the appropriate rate. V26 said R38's ampicillin should be administered through an IV pump and shouldn't have been flowing freely. The surveyor asked what potential side effects could R38 experience from receiving 20-30 ml in less than a minute. V26 said the error would not have been clinically significant. The facility's Continuous Infusion of Medications and Solutions dated July 2017 showed the IV tubing should not be attached to the resident's IV site until the IV tubing inserted into the IV pump and set at the (continued on next page)

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	prescribed rate. The policy showed the roller clamp should be closed while loading the IV tubing into the pump and should not be opened until the nurse is prepared to start the infusion.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to have respiratory masks covered and stored in a manner to prevent any cross contamination for 3 of 3 residents (R3, R29, and R107) reviewed for respiratory care in the sample of 23.The findings include:1. On 3/3/26 at 10:07 AM R3 had a CPAP (Continuous Positive Airway Pressure) machine with a face mask sitting face down uncovered on the bedside table. The mask was dirty with white substances on the inside of the mask and some tan flakes. R3's nebulizer mask was uncovered on the bedside table, and the inside of the mask was dirty.On 3/3/26 at 2:25 PM, V3 (Assistant Director of Nursing - ADON/Infection Control Preventionist) stated respiratory masks are kept in little black bags next to the machines. This is done for sanitary reasons/infection control.R3's Face Sheet dated 3/4/26 showed diagnoses including hypoxic ischemic encephalopathy, asthma, critical illness myopathy, type 2 diabetes mellitus, obstructive sleep apnea, dysphagia, cognitive communication deficit, aphasia, spastic hemiplegia, gastroesophageal reflux disease, iron deficiency anemia, benign prostatic hyperplasia, down syndrome, hyperlipidemia, hypothyroidism, major depressive disorder, anxiety disorder, hypertension, gastrostomy, and bipolar disorder.The Physician Orders dated March 2026 for R3 showed change nebulizer mask/tubing every week and as needed. Bilevel positive airway pressure/continuous positive airway pressure - BiPap/CPAP on at bedtime and off in the morning. Cleanse mask w/ 0.25% Acetic Acid every morning am after removal.The Care Plan dated 1/29/26 for R3 showed, Respiratory: has potential for difficulty in breathing related to asthma and obstructive sleep apnea. Administer medications/treatments as ordered. Head of bed elevated to prevent Shortness of Breath. Monitor vital signs and lung sounds. Observe for changes in breathing pattern. There wasn't any plan in place for BiPap/CPAP.The facilities CPAP/BiPAP Support policy (March 2023) showed, General Guidelines for Cleaning. Masks, nasal pillows and tubing: clean daily by placing in warm, soapy water and soaking/agitating for 5 minutes. Mild dish detergent is recommended. Rinse with warm water and allow to air dry between uses.The facility's Administering Medications through a Small Volume Nebulizer (October 2024) showed rinse and disinfect the nebulizer equipment according to facility protocol or. When equipment is completely dry, store in a plastic bag with the resident's name and date on it.2. On 3/3/26 at 10:33 AM, R107 was lying on his side asleep in bed with oxygen on via a nasal cannula. There was a urinal on R107's bedside table with his nebulizer mask laying uncovered next to the urinal.On 3/3/26 at 2:25 PM, V3 (Assistant Director of Nursing - ADON/Infection Control Preventionist) stated respiratory masks are kept in little black bags next to the machines. This is done for sanitary reasons/infection control. V3 stated the masks should not be sitting next to any urinals and there shouldn't be any urinals sitting out. V3 stated this is for infection control. The Face Sheet dated 3/4/26 for R107 showed diagnoses including anoxic brain damage, chronic obstructive pulmonary disease, unspecified severe protein calorie malnutrition, atherosclerotic heart disease, heart failure, hypertensive heart disease with heart failure, hyperlipidemia, dysphagia, and hypertension.The Physician Orders for R107 for March 2026 showed, change nebulizer mask/tubing every week and as needed every night shift every Friday. Ipratropium-Albuterol Solution 0.5-2.5 (3) milligrams (MG)/3 milliliters (ML), 3 ml inhale orally every 4 hours as needed for shortness of breath or wheezing via nebulizer. The Care Plan dated 2/20/26 for R107 showed, Respiratory: R107 has potential for difficulty in breathing related to chronic obstructive pulmonary disease - COPD. Administer medications/treatments as ordered. R107 is on respiratory therapy for improvement in pulmonary function related to COPD. Administer nebulizer treatment as ordered. 3. On 3/3/26 at 10:36 AM, R29 was sitting up on his bed watching television. There was a urinal with urine in it on R29's bedside table. R29's nebulizer machine and uncovered nebulizer mask was on the bedside table next to his urinal.On 3/3/26 at 2:25 PM, V3 (Assistant Director of Nursing - ADON/Infection Control Preventionist) stated respiratory masks are kept in little black bags next to the machines. This is done for sanitary reasons/infection control. V3 stated the masks should not be (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	sitting next to any urinals and there shouldn't be any urinals sitting out. V3 stated this is for infection control. The Face Sheet dated 3/4/26 for R29 showed diagnoses including chronic obstructive pulmonary disease, pneumonia, atrial fibrillation, heart failure, acute on chronic respiratory failure with hypoxia, disorders of muscle, hyperlipidemia, and hypertension. The Physician Orders for March 2026 for R29 showed, change nebulizer mask/tubing every week and as needed every night shift every Friday. Ipratropium-Albuterol 0.5-2.5 (3) MG/3ML Solution use 1 vial in nebulizer twice daily. The Care Plan dated 2/27/26 for R29 showed, Respiratory: resident has potential for difficulty in breathing. Administer medications/treatments as ordered. Assess respiratory status: rate, depth, pattern, skin color. Head of bed elevated to prevent Shortness of Breath. R29 is on respiratory therapy for improvement in pulmonary function related to chronic obstructive pulmonary disease and chronic respiratory failure. Administer nebulizer treatment as ordered. Administer oxygen therapy as ordered.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to dispose of a residents (R90) expired insulin pen, failed to store narcotics in a manner to prevent medication diversion for a resident (R80). These failures apply to 2 of 2 medication carts reviewed for medication storage.The findings include:On [DATE] at 1:34PM, surveyor reviewed medication cart belonging to V17's (Licensed Practical Nurse-LPN) assignment. R90's insulin aspart pen had an open date of 12/15 and an expiration date of 1/15. V17 stated, We try to keep an eye on the insulin pens to check expiration dates. (R90) hardly ever uses his sliding scale insulin so that's probably why we didn't notice it but it should have been discarded if it's been open for more than 28 days. V17 disposed of R90's insulin aspart pen and obtained a brand new one out of the medication room and stated, I don't know why we didn't replace it if there's a new one here that we should be using. R90's February and March medication administration records were reviewed and showed R90 utilized the insulin aspart pen multiple days while it would have been expired.On [DATE] at 1:39PM, Surveyor completed a narcotic count with V16 (LPN) on her assigned medication cart. R80 had a card of Norco 5/325mg with one of the tabs taped into the card. V16 stated, If someone pops out a medication and then they don't use it we usually just tape it back in so we don't waste it. I can only assume that is a Norco pill, I guess I would have to verify with someone to see if that's what it actually is.On [DATE] at 11:11AM, V2 (Director of Nursing) stated, Insulin pens are discarded after 28 days of opening due to expiration of medication. I think the potency decreases with time opened. Narcotics should be wasted in a drug buster with 2nd nurse witness, should not be taped back into card because it causes the potential for diversion or the medication could get loose or mixed up with other medications.The facility's policy titled, Storage of Medications dated [DATE] showed, The facility shall store all drugs and biologicals in a safe, secure, and orderly manner.4. The facility shall not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs shall be returned to the dispensing pharmacy or destroyed.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility staff failed to follow enhanced barrier precautions - EBP when providing care for a resident with a feeding tube for 1 of 3 residents (R3) reviewed for enhanced barrier precautions in the sample of 23.The findings include:On 3/3/26 at 1:24 PM, R3 was laying in bed with his dressing around his feeding tube twisted with bloody drainage. The dressing was down on the tubing and not secure to his abdomen. At 1:28 PM, V7 (Licensed Practical Nurse - LPN) and V9 (Certified Nursing Assistant - CNA) went into R3's room with gloves on but no gowns on. They repositioned R3 in the bed. V7 removed the old dressing from around R3's feeding tube, did site care, and placed a new dressing. V7 and V9 repositioned R3 in bed. V9 stated R3 was incontinent of bowel movement and said she needed to go and get help. When V9 returned to the room she had V8 (CNA) with her. V7, V8, and V9 were asked about EBP. V7 stated she did not know if R3 was on EBP. V8 stated that a gown, gloves, and face mask is to be worn with care of the feeding tube and close contact care of the resident. V9 stated V8 told her that she needed to wear a gown when they provide care. On 3/3/26 at 2:25 PM, V3 (Assistant Director of Nursing - ADON) stated staff know if someone is on EBP because there is signage on the door. The sign tells the staff what they should wear and when they should wear it. If it is a double occupancy room there is an orange sticker on the name plate of the resident that is on them. Staff also know what they should wear and when to wear it because we have covered it during in-services. V3 read what the sign states and said it would be for close contact care, residents with devices including feeding tubes, dressing changes etc. R3's Face Sheet dated 3/4/26 showed diagnoses including hypoxic ischemic encephalopathy, asthma, critical illness myopathy, type 2 diabetes mellitus, obstructive sleep apnea, dysphagia, cognitive communication deficit, aphasia, spastic hemiplegia, gastroesophageal reflux disease, iron deficiency anemia, benign prostatic hyperplasia, down syndrome, hyperlipidemia, hypothyroidism, major depressive disorder, anxiety disorder, hypertension, gastrostomy, and bipolar disorder. The Physician Orders dated March 2026 for R3 showed an order for Enhanced Barrier Precautions (EBP). The Care Plan dated 1/29/26 for R3 showed resident requires enhanced barrier precautions related to feeding tube. Staff will wear gloves and gowns for device care or use of central lines, urinary catheters, feeding tubes, tracheostomy, colostomy/ileostomy or any wound care. Gown and glove one use only and for only one resident. The facility's Enhanced barrier Precaution - EBP policy (March 2023) showed EBP is indicated during high-contact resident care activities that provide for transfer of multidrug resistant organisms - MDROs with any of the following: Indwelling medical devices, regardless of MDRO colonization status (central lines, urinary catheters, feeding tubes, hemodialysis catheters, tracheostomies, and ventilators). High contact resident care activities include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use EBP requires the use of gown and gloves when performing high contact care resident care activities.