STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145936	A. Building B. Wing	01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Highwood	50 Pleasant Avenue Highwood, IL 60040

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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 - 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 ensure that activities of daily living (ADL) assistance was provided to residents that were dependent on staff assistance for three of 21 residents (R24, R13, R73) reviewed for ADLs in the sample of 21. This failure contributed to R24 obtaining a reddened, excoriated, and painful peri area. The findings include: 1. R24's admission Record shows he was admitted to the facility on [DATE], with diagnoses including hemiplegia, hemiparesis, muscle weakness, cognitive communication deficit, abnormal posture, and heart disease. R24's Minimum Data Set (MDS) dated [DATE], shows R24 has limitations in Range of Motion to both upper and lower extremities. R24 requires substantial/maximal assistance with personal hygiene and is dependent on staff for toileting hygiene. On January 12, 2026, at 11:55 AM, R24 was lying in his bed. There was a large yellow circle noted on the incontinence pad that R24 was laying on. There was a darker yellow circle noted around this yellow circle. At 12:01 PM, V8 Certified Nursing Assistant (CNA) was notified of the yellow circle on R24's incontinence pad. V8 went into R24's room and introduced herself to R24 as R24's CNA. V8 let R24 know she was going to clean him up. V8 undid the sticker tabs on R24's incontinence briefs. R24 had two incontinence briefs on. Both incontinence briefs were completely saturated with urine. There was a strong urine odor coming from the incontinence briefs. V8 said she did not know who put the two incontinence briefs on R24. V8 said this was the first time she went into R24's room, because the hospice CNA was just in R24's room. V8 said, maybe hospice put two incontinence briefs on R24. V8 said hospice was there at about 8:00 AM and performed incontinence care on R24. V8 wiped R24's peri area. R24's peri area was reddened and excoriated on both groin areas. R24 moaned and said ouch multiple times while R24 was wiping the red excoriated areas in R24's peri area. R24's buttocks was also reddened when V8 wiped it. V8 did not apply any skin protectant onto R24's reddened peri area or buttocks. V8 placed a new brief onto R24 and exited R24's room. R24's Care Plan revised on January 1, 2026, shows R24 has an alteration in skin integrity due to moisture associated skin damage. Factors that may inhibit healing: diarrhea, moisture. Apply barrier cream after each incontinent episode and as needed. On January 13, 2026, at 11:35 AM, V2 Director of Nursing (DON) said if a resident is found with two saturated briefs and a saturated incontinence pad, I would say that mean the resident has voided quite a bit. V2 said he would not expect a resident to be that saturated if the resident was checked on every two hours. V2 also said that residents should not have two incontinence briefs on. The facility's Incontinence Care policy reviewed May 2025 shows, Incontinence care if provided to (continued on next page)

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

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F 0677 Level of Harm - Actual harm Residents Affected - Few	keep residents as dry, comfortable and odor free as possible. It also helps in preventing skin breakdown. Apply barrier cream if appropriate. The facility's Activities of Daily Living policy reviewed May 1, 2025, shows, A program of activities of daily living is provided to prevent disability and return or maintain residents at their maximal level of functioning based on their diagnosis. Elimination: Adaptive equipment, assistance and instruction are given as required. 2.On 01/13/2026 at 10:30AM, R13 was sitting up in a reclining wheelchair. R13 was sitting up in a position that places pressure directly on the coccyx in a reclining chair. R13's chair was pushed back into the corner of the room. R13 did not have any engaging activity. R13's left, and right upper arms were contracted against the chest. R13 was wearing left, and right removable volar splints that covered the mid-forearm to the fingertips. At 2:10PM, R13 was sitting up in a position that places pressure directly on the coccyx in a reclining chair. R13 was pushed into the corner of the room. R13 did not respond to verbal stimuli. R13 did not have any engaging activity. At 2:20PM, V14 CNA-Certified Nursing Assistant and V21 CNA used a full body mechanical sling lift to transfer R13 from the reclining wheelchair to the bed. There were dark blue lines visible on the front and rear exterior of R13's incontinent brief. V21 CNA removed R13's incontinent brief. R13 smelled like urine. R13's incontinent brief was saturated with dark yellow urine. V21 CNA lifted R13's right gluteal to expose R13's coccyx. The boney prominence of the coccyx had a 1-centimeter open area with exposed granulation tissue. The surrounding skin was discolored with pallor at the coccyx and mottled redness surrounding. Search of the bed and incontinent brief showed no dressing was present. On 01/13/2026 at 10:30AM, V14 CNA-Certified Nursing Assistant said, R13 gets out of bed after breakfast. I lay R13 down after lunch. R13 is changed every two hours. On 01/13/2026 at 2:20PM, V14 CNA was asked, when was the last time R13 was changed. V14 CNA said, when I got her up at breakfast. (3 hours and 50 minutes) On 01/13/2026 at 2:15 PM, V13 LPN said, the blue lines show the incontinent pad is wet. The open area was reported to me by the night shift. 3. R73's admission Record shows he was admitted to the facility on [DATE], with diagnoses including hemiplegia, repeated falls, aphasia, and chronic kidney disease. R73's MDS dated [DATE], shows R73 requires substantia/maximal assistance with personal hygiene. On January 12, 2026, at 11:08 AM, R73 was observed and interviewed in his room. R73 had a splint to his left hand. R73's right hand had long fingernails on it. There was a large amount of dark substances underneath R73's fingernails. When R73 was asked if he would like his nails to be cleaned and cut, R73 said yes. R73's Care Plan created on January 13, 2026, shows, R73 requires assistance with daily care needs related to hemiplegia, assist resident with ADLs. (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	On January 13, 2026, at 11:35 AM, V2 DON said he would have to double check how often staff clip and clean residents' nails. V2 said residents' hands should be washed before meals. V2 said he would expect residents' nails to be clean. This concern was discussed with the facility on January 13, 2026. On January 14, 2026, at 12:39 PM, R73's nails were cut and cleaned. The facility's Nail Care policy reviewed May 1, 2025, shows, To provided care and maintain hygiene for the resident's nails. Remove dirt from underneath fingernails. Nail care is offered and performed on the resident's shower day and as needed.

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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 was provided with a bed suited for his height for one of 21 residents (R24) reviewed for accommodation of needs in the sample of 21.The findings include: R24's admission Record shows he was admitted to the facility on [DATE] with diagnoses including hemiplegia and hemiparesis, muscle weakness, cognitive communication deficit, aphasia, and dysphagia. R24's weights and vitals summary shows he is 73 inches long. On January 12, 2026 at 11:55 AM, R24 was observed laying in his bed. The head of his bed was elevated slightly. R24's knees were bent and his left foot was off of the wooden foot end of the bed. R24 said he had a stroke, had back pain and said he could not move his right arm. When R24 was asked if he was comfortable in bed he said he was six feet 2 inches tall and a longer bed would be more comfortable. R24 placed his foot against the wooden foot of the bed to demonstrate if he placed his feet on his bed, his knees were bent upward. The was a small amount of mattress above R24's head. On January 13, 2026 at 11:25 AM, V2 Director of Nursing (DON) said he was not sure if a longer bed was available for R24. This concern was discussed with the facility on January 13, 2026. On January 14, 2026 at 10:50 AM, V1 Administrator said facility staff did not know that R24 wanted a longer bed. When V1 was asked if any staff noticed that R24's feet were hanging off the foot of the bed, V1 said she did not know. On January 14, 2026 at 12:35 PM, R24 was lying in a new bed. There was a four-inch-wide extender added to the foot of R24's bed. R24's legs were straight and his feet were not touching the foot of the bed. R24 said his new bed was Much more comfortable. Thank you so much.The facility's Accommodation of Needs policy reviewed October 15, 2025 shows, The facility will treat every resident with respect and dignity. It will evaluate and make reasonable accommodations for each individual's needs and preferences except when the health and safety of the individual or other residents would be at risk of endangerment.

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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. Based on observation, interview and record review the facility failed to ensure no new recommendations were made after a resident's orthopedic follow up appointment. This applies to 1 of 21 residents (R34) reviewed for quality of care in the sample of 21. The findings include:R34's face sheet lists her diagnoses to include: fracture of left hand and fracture of superior rim of left pubis (pelvic fracture). On 1/13/26 at 10:08 AM, during the morning medication pass, V10 Registered Nurse (RN) was passing R34's medications. R34's husband was also in the room. She observed R34 did not have a cast on her left arm anymore. R34 and her husband both agreed that she had an orthopedic follow up appointment the day before where the cast was removed. V10 RN asked, if they gave her a sling or splint for her arm. R34's husband stated, they gave her a brace and told her to wear it whenever she wanted. V10 RN said ok, she also observed that R34's left wrist was still slightly swollen. R34 had nothing on her left wrist and was not wearing the brace. R34's after visit summary dated 12/8/25 shows, You were admitted after a fall and found to have a fracture of the distal radius and ulna of the left wrist. Also noted was superior and inferior pubic ramus fracture in the left pelvis. No surgery was recommended. You are advised to use a left wrist splint and use a platform walker to avoid bearing weight through the left wrist. R34's electronic medical record (EMR) shows, she had a follow up appointment for her left wrist on 1/12/26. The after-visit summary does not show any information about a brace for R34 to wear. The summary only shows, an occupational therapy referral. On 1/13/26 at 3:05 PM, V3 Assistant Director of Nursing (ADON) stated, he wasn't aware of any brace sent with R34 after her follow up appointment and he would look into it. At the end of the day on 1/13/26, R34's EMR did not show, any nurses notes in regards to her orthopedic follow up appointment. R34's progress notes with a late entry of 1/12/26 4:00 PM entered on 1/13/26 at 3:00 PM by V3 ADON shows, Spoke to NOD (nurse on duty) about what happen at the ortho appointment. NOD stated that they removed the splint and gave a referral to occupational therapy at local hospital. Copy of instruction/referral sent to our in-home PT/OT (physical therapy/occupational therapy) services. R34's progress notes dated 1/13/26 shows, Spoke to the resident and the husband, confirmed that the office gave a brace but no proper instruction from them. Contacted doctors office, spoke with operator that will sed a message to the nurse for call back regarding the instruction for the brace. At 1430 (2:30 PM), received a call back from the office. Spoke to nurse, stating that they gave a brace to the husband. The brace is like for a transitional support as needed for resident's left wrist. She can when she is active [SIC- statement is correct]. Requested for a written instruction from the office. At 1530 (3:30 PM), received an instruction that resident was evaluated in the ortho clinic. Resident will wear the Velcro brace for the next 2 weeks. The husband and resident instructed. Verbalized understanding. R34's faxed progress note received at 3:29 PM dated 1/13/26 shows, To whom it may concern, R34 is a patient under the care of orthopedic doctor. She was evaluated in the office yesterday. A Velcro wrist brace was provided. The patient can wear this for transitional support for the next 2 weeks. Okay to remove the brace throughout the day for gentle hygiene/when inactive.On1/14/26 at 11:38 AM, V2 Director of Nursing stated, they got the brace clarified by the doctor.On 1/14/26 at 11:42 AM, V9 Regional therapy manager stated, R34 should be wearing her brace all the time except during showers/hygiene. He also questioned, her weight bearing status and was requesting more information. He was concerned because the patient was originally no weight bearing to the left wrist and he wanted to clarify if she is allowed to bear weight now or not. That information was still not clear. R34's current order summary report shows, may wear Velcro brace at left wrist for transitional support every day and evening shift for wrist support for 2 weeks may remove throughout the day for gentle hygiene/when inactive. The order was entered on 1/14/26 (2 days after follow up appointment).

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure R13 and R12 received the minimum necessary treatments and services to promote healing and to prevent infection and to prevent new ulcers from developing for 2 of 4 resident reviewed for pressure ulcers in the sample of 21.The findings include:1.On 01/13/2026 at 10:30AM, R13 was sitting up in a position that placed pressure directly on the coccyx in a reclining chair. R13's left, and right heels were not off loaded and the boney area of the left and right heel was resting directly on the leg rest. At 2:10PM, R13 was sitting up in a position that placed pressure directly on the coccyx in a reclining chair. R13 did not have a pressure reducing pad in the seat of the chair. R13's left, and right heel were not off loaded. R13's left, and right heel was resting directly on the leg rest. On 01/13/2026 at 2:28PM, V7 Wound Nurse pointed to two undated dressing to the left heel and two undated dressing to the right heel and said, R13 was admitted with the Stage 4 Pressure Ulcer and an Unstageable Pressure Ulcer to the left heel as well as the two Unstageable Pressure Ulcers to the Right heel. R13 should wear the pressure reducing heel boots when in the chair and when in the bed. On 01/13/2026 at 2:30PM, V13 LPN-Licensed Practical Nurse said, R13's pressure reduction boots are in the closet. On 01/14/2026 at 6:52PM, V22 Wound Doctor said, pressure ulcers should be off loaded. R13 has pressure ulcers to the left and right heels. Pressure reduction heel protectors are a standard order to ensure offloading of pressure to the wounds. R13's Physician's Orders on 01/13/2026 shows, initiated 12/21/25 may offload heels with heel boot protector or pillow as tolerated while in bed every shift for protection. R13's Care Plan on 01/13/2026 shows, initiated 12/11/2025, Off Load Heels. R13's Minimum Data Set, dated [DATE] shows, R13 has severe cognitive impaired. R13 is Dependent, the helper does ALL the effort. Resident does none of the effort to complete the activity of putting on and take off socks, shoes, or other footwear. On 01/13/2026 at 3:00PM, R13's Wound Notes dated 01/07/2026 shows, Stage 4 Pressure Ulcer, and an Unstageable Pressure Ulcer to the left heel as well as the two Unstageable Pressure Ulcers to the Right heel. The facility's Skin Management policy dated 05/2025 shows, no guidance for off-loading pressure ulcers. 2. R12's admission Record shows she was admitted to the facility on [DATE] with diagnoses including major depressive disorder, dysphagia, pain in right hip, anxiety disorder, and history of urinary tract infections. R12's Scale for predicting pressure injury risk dated January 9, 2026 shows she is at risk for developing pressure injuries. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R12's Order Summary Report dated January 13, 2026 shows Treatment: Left big toe-cleanse with normal saline, pat dry and apply skin prep and cover with a dry dressing every day shift for wound care and Treatment: Sacrum-cleanse with normal saline, pat dry, apply medi honey, apply xeroform, cover with dry dressing every day shift. These orders were entered on January 8, 2026. On January 12, 2026 at 1:53 PM, V5 and V6 Certified Nursing Assistants (CNA) provided incontinence care to R12. R12 was turned onto her right side. There was a large wound to R12's sacral area. The middle of R12's wound was a dark color close to black. The area surrounding the dark area was red. R12 complained of pain when this area was wiped. There was no dressing in place to this wound. V5 said she did not know when the dressing came off of R12's wound. At 10:36 AM, V7 Licensed Practical Nurse/Wound Care Nurse came into R12's room to clean R12's wound and to place a dressing on it. R12 was tensing up and moaning while V7 was cleaning her sacral wound. R12 was asked if she had pain to her sacrum and she nodded her head yes. V7 said that R12 also had an unstageable wound to her left great toe. R12's heels were directly on the bed. V7 removed R12's left sock and there was a pencil eraser sized darkened area on the tip of R12's left great toe. There was no dressing in place. V7 said staff are offloading R12's heels with pillows. R12's Wound Assessment Details Report dated January 9, 2026 shows R12 has a stage 3 pressure injury to her sacrum that measures 10 cm X 10 cm and an unstageable pressure injury to her left big toe that measures 0.8 cm X 0.9 cm. On January 13, 2026 at 11:35 AM, V2 Director of Nursing (DON) said the purpose of treatments in place to pressure injuries are to add protection. V2 said he expects treatments to be in place to pressure injuries, and if they are not, then the wound could get worse. The facility's Skin Management: Monitoring of Wounds and Documentation policy reviewed May 2025 shows, It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility.

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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 address an increase in resident's pain after a urinary catheter change. The facility also failed to ensure a urinary drainage bag was kept below the level of the bladder. This applies to 2 of 6 residents (R55 & R25) reviewed for urinary catheters in the sample of 21. The findings include:1. On 1/12/26 at 10:30 AM, R55 was sitting up in his wheelchair. He stated, he was having a lot of pain in is groin area. The nurse changed his urinary catheter a few days ago and he has been in pain since. He described the pain as feeling like his groin area was on fire and felt no one paid any attention to it. He did state, the facility had given him something for it however it didn't really help the pain, it was still there. R55 had a urinary catheter that was attached to his wheelchair. He stated, he had the urinary catheter because he could not urinate on his own. On 1/13/26 at 1:46 PM, R55 was lying in bed. He stated, he was still in pain in his groin area. They hadn't done anything different and were just giving him the medication. He stated, the medication helps a little. He asked if he could have something for the pain at that time. On 1/13/26 at 1:48 PM, V10 Registered Nurse (RN) stated, R55 has had pain in his groin area and they have been giving him tramadol (pain medication) for it. He has a urology appointment on Friday (3 days later). She received in report he was complaining of pain and nothing else had been done about it. On 1/13/26 at 1:59 PM, V11 Dietitian stated, she saw R55 that day and he was in a lot of pain. He refused to eat his lunch because his groin was hurting. On 1/13/26 at 3:05 PM, V2 Director of Nursing (DON) and V3 Assistant Director of Nursing (ADON) stated, R55 had pain and was seeing the urology on Friday. They were not sure if anyone had contacted the doctor about his pain, they would find out. On 1/14/26 at 11:10 AM, V2 DON stated, no one had contacted the doctor. They were treating him with the tramadol and going to send him to the urologist on Friday. they contacted V12 Nurse Practitioner (NP) after being asked if the doctor was notified about R55's pain on 1/13/26. He stated, V12 NP ordered another medication that helps with urinary burning, a urine analysis and renal ultrasound. R55 would also continue to go to his appointment with the urologist on Friday. On 1/14/26 at 12:38 PM, R55 was sitting up in his room eating lunch. He stated, he was still in pain. The pain felt like razor blades and burning all the way to his scrotum. R55's Minimum Data Set, dated [DATE] shows, he is cognitively intact. R55's electronic medical record (EMR) did not show, any complaints of pain by R55 even though staff were aware he was in pain and they were giving him pain medication for it. The same EMR shows, R55's urinary catheter was changed on 1/7/26. R55 stated, he had pain since the urinary catheter was changed (5 days prior). R55's care plan date initiated 4/23/25 shows, Focus: R55 requires use of an indwelling catheter (urinary catheter) r/t (related too) (neurogenic bladder) is at risk for of infection [sic- statement is (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	correct]. Interventions: Monitor for s/s (signs/symptoms) UTI (urinary tract infection): flank pain, strong odor, increased temp, decreased output, hematuria; Notify MD (medical doctor) of abnormal findings. The facility's indwelling catheter care policy dated 1/2023 does not address what to do if a resident is having pain with or because of their urinary catheter. The facility did not provide any other polices for urinary catheters. The facility's change in resident condition policy dated 1/2023 shows, General: It is the policy of the facility, except in a medical emergency, to alert the resident, resident's physician and resident's responsible party of a change in condition. Policy: 1. Nursing will notify the resident's physician or nurse practitioner when: . e. it is deemed necessary or appropriate in the best interest of the resident. The facility's pain management policy dated 1/20233 shows, General: To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. Guideline: The pain management program is base don a facility-wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does. Pain Management is defined as the proves of alleviating the resident's pain to a level that is acceptable to the resident and is based on his or her clinical condition and established treatment goals. Pain management is a multidisciplinary care process that includes the following: Observing for the potential for pain, Effectively recognizing the presence of pain, Identifying the characteristics of pain, Addressing the underlying causes of the resident's pain. Policy: 5. Licensed Nursing may notify the Health Care Provider of any new development of pain, change in pain, change in condition that could potentially cause pain, for pharmacological interventions based on the individual's pain factors. 2. On 01/12/2026 at 12:51PM, R25 was lying on the right side. R25 had a urinary catheter that was coming out the back left leg of the incontinent brief. R25's urinary catheter was not secured. The collection tube was suspended off the bed by the indwelling urinary catheter until it touched the corner of the bed. The tube continued down the side of the bed and looped up into the collection bed. The indwelling urinary catheter was held taut by the weight of the collection tubing. was lifted off the On 01/12/2026 at 12:54 PM, V8 CNA-Certified Nursing Assistant with the assistance of another staff member rolled R25 to his back and pulled up in bed. The indwelling urinary catheter stretched as R25 was moved to the head of the bed. V8 CNA then covered R25 with a blanket with the catheter tubing under R25's left leg. V8 CNA was notified of the position of the indwelling urinary catheter. V8 CNA uncovered R25 and lifted the urinary collection bag over the top of the bladder. Urine in the collection tube ran back into the indwelling urinary catheter. On 01/12/2026 at 12:54PM, V8 CNA said, R25 should no be lying on the urinary catheter tubing. R25 does not like to get out of bed. The securing device came loose. The securing device is applied by the nurse. The facility's Indwelling Catheter Care policy revised 05/2025 shows, secure and anchor the catheter by utilizing a leg strap or other device.

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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 0697 Level of Harm - Minimal harm or potential for 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 observation, interview, and record review, the facility failed to manage residents' pain for two of 21 residents reviewed for pain management in the sample of 21.The findings include: 1 R24's admission Record shows he was admitted to the facility on [DATE] with diagnoses including hemiplegia, hemiparesis, muscle weakness, abnormalities of gait, cognitive communication deficit, dysphagia, and abnormal posture. R24's Care plan created on December 18, 2025 shows, Pain/Resident will participate in development of a personal pain management program. Resident will receive education related to pain management including non-pharmacological approaches related to medications and recording pain rating. R24's Care Plan initiated January 5, 2026 shows, Pain management as needed. R24's Order Summary Report dated January 13, 2026 shows, an order for acetaminophen 325 mg give two tablets by mouth every four hours as needed for mild pain. On January 12, 2026 at 11:55 AM, R24 was interviewed while he was laying in his bed. R24 said he had back pain and was not able to move his right arm. At 12:01 PM, V8 Certified Nursing Assistant (CNA) provided incontinence care to R24. V8 lifted R24's Right arm up to change his shirt, and R24 hollered and moaned and said his right arm hurt. V8 apologized to R24. V8 removed R24's t shirt. V8 then removed R24's soiled incontinence brief. R24's peri area was very reddened. V8 wiped R24's peri area with a towel and R24 moaned and moved side to side complaining that his peri area hurt while V8 was wiping him. R24's Medication Administration Record shows he did not receive any medication for pain on January 12, 2026. R24 did receive medication for pain on January 13, 2026 for pain rated at a 7/10 scale. 2. R12's admission Record shows that R12 was admitted to the facility on [DATE] with diagnoses including fracture of right pubis, malignant neoplasm of bladder, major depressive disorder, pain in right hip, anxiety disorder, and osteoarthritis. R12's Order Summary Report dated January 13, 2026 shows an order for acetaminophen 325 mg give two tablets by mouth every six hours as needed for pain and hydromorphone (narcotic) 1mg/1ml give 0.5ml by mouth every eight hours as needed for pain. On January 12, 2026 at 10:17 AM, V5 and V6 Certified Nursing Assistants (CNAs) were providing peri care to R12. When V5 removed R12's incontinence brief, there was a moderate amount of blood in her brief. V5 said they were not sure where the blood was coming from but believed it to be coming from R12's rectum. When R12 was asked if she had any pain, R12 used her hands to pat her abdomen. There were two urinary drainage bags noted coming from her back area (directly in her kidneys). R12 has a history of bladder cancer. V7 Licensed Practical Nurse/Wound Care Nurse provided wound care to R12's sacral area. There was a large, uncovered wound noted to R12's sacrum. When V7 was cleaning R12's sacral wound, R12 was tensing up and moaning. V6 was holding R12's hand and told R12 V7 was almost done. When V7 was finished and R12 was laid back on her back, R12 was asked if her sacrum area hurt and R12 nodded her head yes. V6 lifted R12's right lower extremity up so that R12's heel was visible and R12 said Ow. R12's Medication Administration Record dated January 1, 2026-January 31, 2026 shows R12 was given acetaminophen on January 9, 2026 for pain rated a 9/10 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	There were two urinary drainage bags noted coming from her back area (directly in her kidneys). R12 has a history of bladder cancer. V7 Licensed Practical Nurse/Wound Care Nurse provided wound care to R12's sacral area. There was a large, uncovered wound noted to R12's sacrum. When V7 was cleaning R12's sacral wound, R12 was tensing up and moaning. V6 was holding R12's hand and told R12 V7 was almost done. When V7 was finished and R12 was laid back on her back, R12 was asked if her sacrum area hurt and R12 nodded her head yes. V6 lifted R12's right lower extremity up so that R12's heel was visible and R12 said Ow. R12's Medication Administration Record dated January 1, 2026-January 31, 2026 shows R12 was given acetaminophen on January 9, 2026 for pain rated a 9/10 and given hydromorphone on January 11, 2026 for pain rated a 8/10. R12 was not given any pain medication on January 12, 2026. The facility's Pain Management policy reviewed May 2025 shows, To facilitate and provide guidance on pain observations and management. To facilitate resident independence, promote resident comfort and preserve resident dignity. They will be accomplished through an effective pain management program, providing our residents the means to receive necessary comfort, exercise greater independence, and enhance dignity and life involvement. The pain management program is based on a facility wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exists whenever he or she says it does. Pain management is a multidisciplinary care process that includes the following: effectively recognizing the presence of pain, addressing the underlying causes of the residents' pain, and monitoring the effectiveness of interventions; and monitoring approaches as necessary.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to ensure medications ordered by a physician were available. This applies to 1 of 21 residents (R85) reviewed for pharmacy services in the sample of 21. The findings include:On 1/13/26 at 9:51 AM, V10 Registered Nurse (RN) was passing R85's morning medications. R85 had an order for dextromethorphan (cough suppressant) pills. V10 RN could not find the medication in the medication cart. She looked at the order and it showed, the medication was ordered from the pharmacy on 1/7/26. She stated, she would notify the doctor and find out what was going on after medication pass. On 1/14/26 at 11:31 AM, V2 Director of Nursing (DON) stated, the medication is an over the counter (OTC) medication so pharmacy does not send those medications. The facility provides them. The floor nurse that entered the order should have received a message from pharmacy saying they would not deliver the medication. They should have reported that to V2 DON or someone so they could get the medication.R85's January Medication Administration Record shows, dextromethorphan HBr oral tablet, 15 mg (milligrams), give 1 tablet by mouth at bedtime for TBI (traumatic brain injury) related mood instability for 3 days. The MAR shows, the medication was signed out and given by the nurses. The same MAR also shows, another order for dextromethorphan HBr oral tablet, 15 mg, give 1 tablet by mouth two times a day for TBI related mood instability with a start date of 1/10/26. The medication is signed out for the first dose on 1/10/26 at 9:00 AM but the rest of them are signed out as not available. The facility's ordering medications from the pharmacy policy does not address what to do if ordering a OTC medication from the pharmacy. The facility did not provide any other pharmacy policy.

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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. Based on observation, interview and record review the facility failed to ensure a resident's pain patches were stored in a locked compartment and administered by a licensed nurse. This applies to 1 of 21 residents (R28) reviewed for medication storage in the sample of 21. The findings include:On 1/12/26 at 10:07 AM, R28 was lying in bed. There were medication patches lying on her bedside table. She stated, the patches were pain in her knees. She will put them on her knees when she was ready. During the conversation, she placed both patches below each knee. She stated, she always puts them on herself and will remove them later in the day. On 1/13/26 at 1:48 PM, V10 Registered Nurse (RN) stated, R28 puts her own patches on. The nurses give them to her and she does it herself. R28's January medication administration record (MAR) shows two separate orders, Lidocaine external patch 5% (lidocaine), apply to left knee topically in the morning for pain management. Lidocaine external patch 5% (lidocaine), apply to right knee topically for pain management. Both medications are signed out by the nurses as given. The facility provided a self- administration of medication assessment for R28 dated 6/27/24 that were for a different medication and not the lidocaine patches. They did not provide any other self-administration assessments. R28's electronic medical record did not show any other self -administration assessments or physician orders for the lidocaine patches and self administration. The facility's medication storage in the facility policy dated 1/2023 shows, General: Medications and biologicals are stored safely, securely, and properly following the manufacture or supplier recommendations. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedure: .17. Residents who have been trained in self-administration will have access only to their individual drug supply.The facility's self-administration of medications and treatments policy dated 1/2023 shows, General: Self administration of medications and treatments are done to prepare a resident for discharge and to help the resident maintain their independence. The decision for self-administration is done by the interdisciplinary team. Guideline: 1. Self-administration of medications and treatments is determine by an order after determining the resident is able to self-administer.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview and record review the facility failed to follow the menu serving size for the noon meal. This failure resulted in two residents not receiving the planned noon meal. This applies to 2 of 21 residents (R84 and R5) reviewed for dietary services in the sample of 21. The findings include: On 1/12/26 at 12:08 PM, during the noon meal service in the dining room. The noon meal being served was turkey casserole and chopped carrots. Two large steam pans of the turkey casserole dish were at the steam table with a white scoop. V17 (Cook) was plating the noon meal while staff were verbally requesting the type of meal (regular, puree or mechanical). Several staff were in line waiting for a plate, V1 (Administrator) went behind the steam table and began plating . V1 scooped heaping scoop sizes (a mound over the flat of the scoop) of the turkey casserole on the plates. V4 (Dietary Manager) was at the steam table preparing substitute meal requests. The last room cart was being plated by V17. V17 was scrapping the metal tray to fill the scoop and ran out of the turkey casserole. Staff told V17 they needed two more plates. V17 plated two plates with a hot dog and carrots, and placed in the cart. At 12:26 PM, V17 said she was short two servings, she said the turkey casserole was being served with the white scoop (6 ounces) because the meal had a starch and protein. She is not sure how they ran out of food; she was using the correct serving ladle. On 01/12/26 at 12:52 PM, V4 said during the noon meal they ran out of turkey casserole and two residents were served a hot dog. On 01/13/26 at 11:13 AM, V4 said on 1/12/26, R5 and R84 did not receive the regular meal. She said literally this is the only time it's happened running out of food. She said the right scoop was used, but the scoop sizes were to big. She said the scoop size should be flat and confirmed the scoop sizes were larger. On 1/13/26 at 1:49 PM, R84 was in his room and explained the facility ran out of the noon meal yesterday. R84 states, is that why, I was given a hot dog. Yesterday they handed me a tray and he thought that was the normal meal being served. Someone came in my room yesterday a female with long black hair someone higher up and told me they accidently gave me the hot dog. R84 told the staff he would have preferred the regular meal and she told me no, I wanted the hot dog.' He said he ate the hot dog because he thought that was the regular meal being served. I had to eat something. R84 said at optimal they should have given me a choice to choose an alternative and informed me of running out of meal. On 1/13/26 at 1:05 PM, V1 said she talked to R84. R84 said he was okay with the hotdog. V1 confirmed R84 was not informed of running out of turkey casserole and was not given a choice to choose an item from the alternative menu. The facility's Diet Spreadsheet Menu shows turkey casserole portion size is 6 oz (ounces), soft chopped carrots 4 oz and bread pudding.

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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 provide R35 with food that accommodated R35's preferences for 1 of 21 residents (R35) reviewed for accommodations of food and drink preferences.The findings include:On 01/12/2026 at 1:02 PM, R37 was lying in bed. The head of the bed was at a 20-degree angle. R37's food tray was on the over bed table. There was an uneaten turkey casserole, uneaten carrots, one 120 milliliters cup of fluid. There was no health shake and no soup. On 01/12/2026 at 1:02PM, R37 stated, every day, every day they send the wrong thing. The facility never serves the food on the menu. I asked for soup, they did not send the soup. I cannot eat this food. On 01/12/2026 at 1:10PM, V19 RN said, dietary will usually send the health shakes up on the cart with the milk. V19 RN checked four dietary carts on the different hallways of the facility. V19 said, the kitchen did not send any health shake to the floor. On 01/12/2026 at 1:20PM, V20 Dietary Manager, looked at R37's dietary sheet and said, oh.well we don't have soup, the health shakes are on the carts with the milk. R37 dietary sheet dated 01/12/2026 shows, Supplements: HEALTH SHAKE-1each, Food Adds: SOUP-1 serving, NO CASSEROLES

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review the facility failed to ensure staff were wearing PPE (personal protective equipment) in a residents room that is on contact isolation to prevent possible cross contamination. This applies to 1 of 21 residents (R91) reviewed for infection control in the sample of 21. The findings include:On 1/12/26 at 12:51 PM, V17 housekeeping and V19 Certified Nursing Assistant (CNA) were in R91's room. R91's room had a sign on his door that said, Contact isolation. V17 housekeeping was cleaning R91's room. She was only wearing gloves. V19 CNA was helping R91 and taking his dirty laundry out of his room. His laundry was in a yellow cinch bag and not an isolation bag. She carried the laundry out of the room, to the soiled utility room. She did not have any PPE on (gloves or gown). On 1/13/26 at 1:05 PM, V18 ICP (infection control preventionist) Nurse stated, if a resident is on contact isolation staff should wear gloves and a gown when they enter the room. R91 was the only resident on contact isolation in the facility. R91's current order summary report shows, Strict contact isolation precaution d/t (due too) c.diff (Clostridioides difficile (contagious bowel infection)). All needs to be rendered in the room to prevent cross contamination. The facility provided on 1/13/26 an isolation list that shows, R91 is on contact isolation for c-diff with a start date of 1/10/26 and a potential stop date of 1/20/26. The facility's transmission-based precautions policy dated 1/1/25 shows, General: Transmission Based Precautions are a second tier of basic infection control and are to be used in addition to standard precautions for patients who may be infected or colonized with certain infectious agents for which additional precautions are needed to prevent infection transmission. Responsible party: All staff. Policy: Set up: Contact, Sign: sign on door, Hand hygiene: required, Gloves: required upon entry to room, must be removed before exiting, follow by hand hygiene, Gown: required, Mask: Only during high COVID-19 hospital admission levels or outbreak facility, N95 Mask: Required for residents in quarantine/COVID-19 positive.