STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145970	A. Building B. Wing	06/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Windsor Park	2649 East 75th St Chicago, IL 60649

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to report an incident of a resident burn to the state agency in a timely manner for one (R4) resident that sustained a second degree burn. Findings Include:R4 was admitted to the facility with diagnosis not limited to Essential (Primary) Hypertension, Gastro-Esophageal Reflux Disease, Kyphosis, Cerebral Palsy, Burn of Second Degree of Right Thigh. R4's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. Progress note dated 04/14/26 2:34 PM document in part: Wound Care Note Text: R4 had a recent report of a new skin condition. There has been an additional report of a change in pain level since the event. Progress note dated 04/14/26 3:06 PM document in part: Wound Care Note Text: Wound care assessed resident post spill with a cup of noodles. R4 states that she was going to eat her lunch with other residents on another floor, and she had a spasm. Upon the spasm she spilled the noodles toward her. A burn was obtained to the Right Upper thigh where bunching of her pants was present. Resident was given pain medication; an ice pack and wound care/first aid was performed. Resident was seen by in-house NP (Nurse Practitioner) and orders obtained. Progress note dated 04/14/26 3:16 PM document in part: Visit Type: NP Initial Eval (evaluation). Evaluated today following a thermal injury sustained when she spilled a bowl of hot noodles onto her lap. She reports pain localized to the right thigh. Wound care evaluated the area; dressing remains intact. Image review and examination are consistent with a superficial burn to the right thigh. Review of Systems: Burn to right thigh Skin: Wound dressing intact. Assessment/Plan: Superficial Thermal Burn - Right Thigh Dressing intact and no signs of infection. (Superficial thermal burn is defined as a first-degree burn- the mildest form of traumatic tissue injury caused by heat. It is strictly confined to the outermost layer of the skin, the epidermis). Progress note dated 04/14/26 3:51 PM document in part: Nurses Notes Text: Resident states she was on the elevator going to the second floor and had an involuntary muscle spasm and her cup of noodles spilled out of her hand and fell onto her lap burning her right thigh. Progress note dated 04/14/26 6:54 PM document in part: Nurses Notes Text: writer called to room by residents family, family requesting resident be sent to hospital for burn on her leg. Writer contacted MD (medical doctor), MD states send resident to hospital. Progress note dated 04/14/26 7:10 PM document in part: SBAR Summary for Providers Situation: The Change In Condition/s reported on this Evaluation are/were: Skin wound or ulcer - Skin Status Evaluation: Burn Progress note dated 04/14/26 7:34 PM document in part: Nurses Notes Text: ambulance in facility to transport patient to emergency department per MD orders. Progress note dated 04/15/26 2:01 PM document in part: Nurses Notes Text: Resident returned to facility. Resident c/o (complain of) pain to her right leg. Right thigh burn is wrapped with gauze. Progress note dated 04/15/26 11:02 PM document in part: ER (emergency room) follow-up R4 is seen today for follow-up after ER evaluation last night due to increased right thigh pain related to prior thermal injury from hot noodles. R4 was diagnosed in the ER with a second-degree (partial thickness) burn and a new dressing was applied. Assessment/Plan: Superficial Thermal Burn - Right Thigh. Continue to coordinate with wound care for ongoing assessment. Progress note dated 04/17/26 3:19 PM document in part: Nurses Notes Text: Resident (continued on next page)

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

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	c/o of right leg thigh pain due to recent burn. Gabapentin 100mg administered at 9am. Resident c/o of pain at 12:30pm same site 5/10 pain on number scale. Informed resident she is due for another Gabapentin 100mg, and I can also give 1000mg Tylenol. Resident still c/o pain after a 30-minute f/u (follow-up). Resident stated, the pain did not go away in fact it got worse, and my leg is aching. Wound Assessment Detail Report document in part: Wound: Right thigh front. Assessment date: 04/14/26 01:17 PM. Type Burn. Classification: Thermal Heat. Source: Facility Acquired. Date identified 04/14/26. Clinical stage: Partial Thickness. Tissue Type: Blanchable Erythema -75%, Epithelial - 25%. Exudate: Amount-light. Type-Serosanguineous. Size: 15.0 cm (centimeters) x 17.0 cm x 0.10 cm (L x W x D) length by with by depth. Hospital Record dated 04/15/26 document in part: Chef Complaint/Reason for Consultation: Scald Burn. R4 sustained a 1% TBSA (Total Body Surface Area) burn injury on her right thigh. This injury occurred at a nursing facility from ramen noodles. Patient reports pain and well as numbness /tingling to the area. Notably, the patient expressed concern about going back to her nursing facility as she does not feel she receives adequate care there. Skin: burn along right thigh that appears mixed superficial and deep partial thickness. Wound base appears whitish pink in some areas, with sluggish blanching, top (Thrombotic Thrombocytopenic Purpura). Assessment and Plan: admitted to hospital for advanced wound care, pain control, possible operative intervention. History of Present illness: earlier today, patient was at nursing home and asked the nursing home staff to help make hot Ramen soup for her. When she received the noodles, she used power chair to go up in the elevator to a different floor. While in the elevator, she had a muscle spasm and spilled the hot liquid onto her right thigh. Endorses are associated with pain. Skin: Comments: Partial superficial and thick thickness burn on right thigh and with associated blistering. Wound base exposed, with blanching. Long-Term Care Facility -Serious Injury Incident and Communicable Disease Report: document in part: Report Type: Initial. Date of Incident: 04/21/26. Report date: 04/21/26. Incident Category: Burn. Incident Description: Assessment/Test date: 04/21/26 Time: 12:35 PM. Detailed Incident Summary: R4 knocked her food into her lap. R4 was immediately cleaned and returned to her room for further thorough evaluation. R4 noted to have an open area to R (Right) upper thigh. R4 complained of pain 5/10 to site. Pain medication was given as indicated with relief noted. MD notified promptly, and treatment orders were received and implemented. Family was immediately notified regarding incident and new orders received from MD. Investigation initiated. Long-Term Care Facility and IID -Serious Injury Incident and Communicable Disease Report: document in part: Report Type: Final. Date of Incident: 04/21/26. Report date: 04/26/26. Incident Category: Burn. Upon further investigation by the interdisciplinary team (IDT), it is determined that R4 had warmed up her food and while returning to her room, she experienced leg spasms that caused her to spill the food onto her lap resulting in an open area to right upper thigh. R1 immediately received assistance from staff. Per CNA (Certified Nurse Assistant) I warmed up her food and I offered to bring the food back to her room: however, R4 declined. Per R4 I warm up my food all the time. This is the first time this happened. Despite current proactive interventions implemented, R4 remains at risk due to co-founding underlying factors identified such as weakness, decreased mobility and endurance, gait/balance problems, requires reinforcement of safety awareness, need for assistance with personal care and muscle spasms. On 06/09/26 at 11:32 AM Per telephone interview V6 (R4' Family Member) stated on 04/14/26 R4 was given hot noodles by a staff member. R4 got on the elevator, jerked or had a spasm. V2 (Director of Nursing) was on the elevator. They told R4 that everything was fine, they could take care of it, and they bandaged the leg. I told V18 (Licensed Practical Nurse) that R4 needs to be sent to the hospital. R4 said I had a cup of ramen noodles, and I was going to the second floor to hang out. V8 (Certified Nurse Assistant/CNA) warmed up my noodles and she was not aware I had muscle spasms. On 06/09/26 at 12:46 PM V8 (CNA) stated R4 came up, approached me and asked me to warm up some noodles. The aide put the noodles in the microwave, and I took the noodles to R4's room then placed them on the table on R4's wheelchair. R4 was in her room, in the wheelchair that has a table on top of it. R4 then asked for a fork, I went to get her a fork and when I went back to her (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	room R4 was not in her room. The incident happened in the elevator. I was made aware of the incident later that day when I heard the noodles wasted on R4. I was not aware that R4 had muscle spasms. The burn was on R4's right thigh. On 06/09/26 at 12:37 PM V13 (Registered Nurse) stated I R4 had an incident with a burn on her leg. It was reported to me that R4 had a cup of noodles that spilled onto her leg. V8 (CNA) gave R4 the noodles. R4 provided her own noodles and asked V8 to warm them up for her. R4 was on the elevator going upstairs to see a resident, had a muscle spasm and the noodles spilled on her leg. I was not aware R4 had muscle spasms. When it happened, I did an assessment, followed up with wound care, spoke to the Nurse practitioner and documented. V2 (Director of Nursing) was on the elevator with R4. R4 was not sent out to the hospital that day but eventually yes. On 06/10/26 at 12:19 PM V32 (Wound Care/Licensed Practical Nurse) stated On 04/14/26 I received a phone call from V2 (Director of Nursing/DON) at approximately 1 pm. I met V2 at the room with R4. R4 spilled the noodles, and I removed her pants. The burn was on R4's right thigh and there was a lot of bunching of the legging type pants, clingy to the skin. It was still warm when I lifted the fabric and pulled it down. I asked what happened and R4 said she spilled a cup of noodles on her. R4 was in a motorized wheelchair with a stationary table tray and knocked the noodles in her lap when she had a spasm. It happened on the elevator and V2 (DON) brushed off the noodles. V2 used the towel to remove some of the broth. I used saline and gauze to clean, I measured and put on proper dressing. R4's thigh was blistered with a big blister that ruptured. Initially the large blister was intact, I went to my cart and when I returned the blister had ruptured. I took xeroform, a dry dressing and wrapped it with gauze. I changed R4's pants and she remained in the wheelchair. I conferred with the V38 (Nurse Practitioner), and the wound doctor came in on Friday 04/17/26. Most of the areas that were blistered were very small lines. The Nurse Practitioner said it was ok and R4's pain was not terrible 3/10 rating which was addressed with Tylenol. The burn wound was identified on 04/14/26 that same day. I will have to go get the order and hospital records and I will come back. At 01:00 PM V2 (DON) returned to the conference room with the documentation that the surveyor requested from V32 and stated V32 had left the facility. On 06/10/26 at 02:28 PM V2 (DON) stated R4's burn happened on 04/14/26. I was getting on the elevator, R4 came out of her room with another resident. R4 and another resident entered the elevator. R4 had a game system and noodles on the wheelchair tray table, moved the game and she yelled. I had turned to put in the elevator code. The noodles on table spilled in R4's lap. We got off the elevator on the second floor, I asked the nurses to get towels and wiped R4 off. We got back on the elevator, went to the first floor and V32 (Wound Nurse/Licensed Practical Nurse) was outside the elevator. V32 took R4 to her room, got her undress and assessed the wound. I did not go into the room with them. I went to look for a [NAME] about what I need to do. I did not see R4's thigh until the next day. V32 did tell me R4 had a blister and a little area that had a skin tear. The template has to notify the doctor, wound care nurse, wound assessment notes and route cause analysis. I am assuming after V32 spoke to the doctor if they did not give an order, that is why R4 was not sent out to the hospital. I would have sent R4 out to the hospital based on the picture and measurements. That is something that would be reported to the state. I knew the day that I brought it to V25 (Former Administrator) and the consultant's attention, but the directive was to hold off on reporting the incident. It was reported 04/21/26. Surveyor asked V2 should the incident have been reported on 04/14/26 when the incident happened. V2 responded, Absolutely. Burn Injury Checklist Evaluation: Burn Injury Investigation Checklist: undated, Date found and reported? Wound MD (Medical Doctor) notified, based on RCA (Root Cause Analysis) were appropriate interventions in place for prevention? Once you have completed the event's checklist and assessment, use the QAPI (Quality Assurance and Performance Improvement) Plan/Action plan to help address identified opportunities. Policy: Titled Documentation-Electronic Health Record revised 11/12/18 document in part: Entries made in the electronic health record shall be: Accurate. Identification of the author of a medical record entry by that author, and confirmation, that the contents are what the author intended and that the entry made is complete, accurate and final. Policy Titled Abuse Prevention and Reporting-Illinois (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	revised 01/22/19 document in part: All alleged violations are reported immediately not later than 24 hours if the event that caused the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including State Survey Agency where the state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview and record review, the facility failed to ensure a resident dependent on incontinent care was provided incontinent care in a timely manner for one (R9) of four residents reviewed for quality of care/treatment.Findings Include:R9's diagnoses include but not limited to History of Falling, Chronic Diastolic (Congestive) Heart Failure, Malignant Neoplasm of Prostate, Atrial Fibrillation, Hypertensive Heart Disease with Heart Failure, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Absolute Glaucoma, Right Eye, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Type 2 Diabetes Mellitus with Diabetic Neuropathy, , Peripheral Vascular Disease, Gastro-Esophageal Reflux Disease, Diseases of Anus and Rectum, Pressure Ulcer of Sacral Region, Stage 3, Pressure Ulcer of left Buttock, Stage 2. R9's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response.R9's Care Plan document in part: Focus: R9 presents with a functional deficit in Bed Mobility related to: generalized weakness and musculoskeletal impairment. Focus: is at risk for alteration in skin integrity related to, Braden Scale Score of 15, Prostate Cancer, Diabetes, Immobility, Incontinence of Bowel, Fragile Skin, PVD (Peripheral Vascular Disease), Incontinence of Urine and Poor Skin Turgor. Interventions: Provide incontinence care as needed. Turn and reposition at least every 2 hours while in bed and as needed. Focus: New Onset Bowel Incontinence. Focus: New Onset Urinary Incontinence. Focus: R9 has alteration in skin integrity. Interventions: Keep skin clean and dry. Focus: R9 has an ADL Self Care Performance Deficit related to Impaired balance, Limited Mobility, and Musculoskeletal impairment. Focus: R9 has bowel/bladder incontinence related to Activity Intolerance, Dementia, Impaired Mobility, Physical limitations, and Poor toileting habits. Interventions: Incontinent: Check every 2-3 hours and as required for incontinence. Wash, rinse and dry perineum. Change clothing PRN after incontinence episodes. Focus: R9 is at risk for falls d/t (due/to) confusion and gait/balance problems. Focus: R9 Has Gastrostomy Tube.MDS Section GG - Functional Abilities dated 04/01/26 document in part: Toileting Hygiene, Dependent (Helper does all of the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. Roll left and right, Substantial/maximal assistance - Helper does more than half the effort.On 06/10/26 at 09:58 AM R9's call light was observed to be illuminated outside of his door. R9 began calling out, help. R11 came near R9's door and told R9 that he was just coming to check on him. In the meantime, R9's call light was illuminated outside of the door. R11 was observed at R9's door sitting in a wheelchair. R9 asked R11 was his call light on. R11 responded, yes the light is on. At 10:13 AM V13 (Registered Nurse) entered R9's room and said your call light is on. R9 said I'm wet. V13 responded, your aide is starting to do her rounds right now. R9's room and call light was turned off by V13 at 10:14 AM and V13 exited R9's room. At 10:18 AM this surveyor entered R9's room and said I see that you had your call light on. R9 stated the nurse came in. I am wet and need to be changed. I know they are making their rounds, and I need to be changed and repositioned. I have been wet since 07:30 AM. The nurse gave me my medications. R9 was observed lying in bed on a low air-loss mattress with a gastric tube in place. At 10:37 AM V40 (Certified Nursing Assistant/CNA) entered R9's room and said I came to get your mechanical lift pad. At 10:51 AM R9 called out six times, help, somebody help me please and turned the call light back on. R9 then called out three times, I cannot find my call light. At 10:53 AM V41 (CNA) entered R9's room and said you got your light on. V41 turned R9's call light off and said let me go get my cart. At 10:56 AM R9 said out loud, out of sight, out of mind. At 11:11 AM R9 called out four times, help me.On 06/10/26 at 11:13 AM This surveyor entered R9's room with V41 (CNA). Enhanced Barrier Precaution signage was posted on the wall to the right side of R9's door. V41 stated He thought I forgot about him. I get sidetracked when the lights go off. R9 said I am more wet. I urinated a couple of times. V41 stated I checked R9 this morning when I came about 07:30 AM. I make rounds 3 times a day, in the morning, noon and before I go home. At 11:16 AM V41 exited R9's room to get assistance. R9 stated I (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	feel like I am being misused, and I don't like being wet. They will change me; I will urinate again and that starts the waiting process all over again. When people say that they are going to do something for you and leave the room you get out of sight and out of mind. They forget about you and start doing something else. At 11:23 AM V41 reentered R9's room with V42 (CNA) and began performing peri care with no gown in use. V41 removed R9's incontinence brief that was saturated with urine. R9's under pad, gown and top sheet were changed. At 11:25 AM V3 (Assistant Director of Nursing) knocked on R9's door, looked into the room then closed the door.On 06/10/26 at 01:00 PM V13 (Registered Nurse) stated I am R9's nurse. I did not hear R9 calling out for help. I saw R9's call light was on, I stopped and asked what he needed. R9 was wet, the aide started her rounds and would be to his room soon. I did not tell the aide R9 was wet. If I am being completely honest, I assist with (incontinent care) changes but have not initiated a change. The nurses can change residents. I do not know how long R9 was wet after I left the room, and I did not ask R9 how long he was wet. The residents are repositioned every 2-4 hours. I get overwhelmed with the task I have. I was trying to catch up with the doctor and I was not attentive to R9's needs. There was a failure to attend to R9's needs to be changed at that moment.On 06/10/26 at 02:08 PM V2 (Director of Nursing) stated My expectation is that the call light is answered promptly and to meet the residents' immediate needs as possible. Everyone is responsible for answering the call light. A nurse can change a resident if they complain about being wet. At 02:28 PM V2 (Director of Nursing) stated my expectation is staff are making rounds every 2 hours. The residents are checked and changed, not a check and I will be back. V2 was informed that V41 said that she makes rounds in the morning, at noon and before she leaves. V2 stated that would not be every 2 hours. If a resident is not changed and repositioned every 2 hours there is a risk for skin break down and not being changed there is a potential for a urinary tract infection.Job Description undated document in part: Registered Nurse (RN) Summary: The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. To ensure that the highest degree of quality care is maintained at all times. Fill out and complete accident/incident reports and submit to Director as required.Job Description undated document in part: Licensed Practical Nurse (LPN) Summary: The LPN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. To ensure that the highest degree of quality care is maintained at all times. Fill out and complete accident/incident reports and submit to Director as required.Job Description undated document in part: Certified Nurse Assistant (CNA) Summary: The Certified Nurse Assistant (CNA) is responsible for providing resident care and support in all activities of daily living and ensure the health, welfare and safety of all residents. Provide for resident comfort by utilizing resources and material, answering call lights and requests.Policy:Titled Call Light revised 02/02/18 document in part: Purpose: To respond to residents' request and needs in a timely courteous manner. 4. Requests shall be responded to in a courteous and professional manner. 5. Respond to request. If item is not available, or request questionable, get assistance from charge nurse. Return to resident with prompt reply.Titled Incontinence Care revised 04/20/21 document in part: Purpose: T prevent excoriation and skin breakdown, discomfort and maintain dignity. Incontinent residents will be checked periodically in accordance with the assessed incontinent episodes or approximately every two hours and provide perineal and genital care after each episode.

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F 0689 Level of Harm - 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 interview and record review the facility failed to safely warm up food in the microwave for one resident (R4) out of four residents reviewed for accidents and supervision. This failure resulted in the resident sustaining a second degree burn measuring 15.0 cm (Centimeter) x 17.0 cm x 0.10 cm after hot noodles were spilled in her lap. Findings include: R4 was admitted to the facility with diagnosis not limited to Essential (Primary) Hypertension, Gastro-Esophageal Reflux Disease, Kyphosis, Cerebral Palsy, Burn of Second Degree of Right Thigh. R4's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. Progress note dated 04/14/26 2:34 PM document in part: Wound Care Note Text: R4 had a recent report of a new skin condition. There has been an additional report of a change in pain level since the event. Progress note dated 04/14/26 3:06 PM document in part: Wound Care Note Text: Wound care assessed resident post spill with a cup of noodles. R4 states that she was going to eat her lunch with other residents on another floor, and she had a spasm. Upon the spasm she spilled the noodles toward her. A burn was obtained to the Right Upper thigh where bunching of her pants was present. Resident was given pain medication; an ice pack and wound care/first aid was performed. Resident was seen by in-house NP (Nurse Practitioner) and orders obtained. Progress note dated 04/14/26 3:16 PM document in part: Visit Type: NP Initial Eval (evaluation). Evaluated today following a thermal injury sustained when she spilled a bowl of hot noodles onto her lap. She reports pain localized to the right thigh. Wound care evaluated the area; dressing remains intact. Image review and examination are consistent with a superficial burn to the right thigh. Review of Systems: Burn to right thigh Skin: Wound dressing intact. Assessment/Plan: Superficial Thermal Burn - Right Thigh Dressing intact and no signs of infection. (Superficial thermal burn is defined as a first-degree burn- the mildest form of traumatic tissue injury caused by heat. It is strictly confined to the outermost layer of the skin, the epidermis). Progress note dated 04/14/26 3:51 PM document in part: Nurses Notes Text: Resident states she was on the elevator going to the second floor and had an involuntary muscle spasm and her cup of noodles spilled out of her hand and fell onto her lap burning her right thigh. Progress note dated 04/14/26 6:54 PM document in part: Nurses Notes Text: writer called to room by resident's family, family requesting resident be sent to hospital for burn on her leg. Writer contacted MD (medical doctor), MD states send resident to hospital. Progress note dated 04/14/26 7:10 PM document in part: SBAR Summary for Providers Situation: The Change In Condition/s reported on this Evaluation are/were: Skin wound or ulcer - Skin Status Evaluation: Burn. Progress note dated 04/14/26 5:34 PM document in part: Nurses Notes Text: ambulance in facility to transport patient to emergency department per MD orders. Progress note dated 04/15/26 2:01 PM document in part: Nurses Notes Text: Resident returned to facility. Resident c/o (complain of) pain to her right leg. Right thigh burn is wrapped with gauze. Progress note dated 04/15/26 11:02 PM document in part: ER (emergency room) follow-up R4 is seen today for follow-up after ER evaluation last night due to increased right thigh pain related to prior thermal injury from hot noodles. R4 was diagnosed in the ER with a second-degree (partial thickness) burn and a new dressing was applied. Assessment/Plan: Superficial Thermal Burn - Right Thigh. Continue to coordinate with wound care for ongoing assessment. Progress note dated 04/17/26 3:19 PM document in part: Nurses Notes Text: Resident c/o of right leg thigh pain due to recent burn. Gabapentin 100mg administered at 9am. Resident c/o of pain at 12:30pm same site 5/10 pain on number scale. Informed resident she is due for another Gabapentin 100mg, and I can also give 1000mg Tylenol. Resident still c/o pain after a 30-minute f/u (follow-up). Resident stated, the pain did not go away in fact it got worse, and my leg is aching. Wound Assessment Detail Report document in part: Wound: Right thigh front. Assessment date: 04/14/26 01:17 PM. Type Burn. Classification: Thermal Heat. Source: Facility Acquired. Date identified 04/14/26. Clinical stage: Partial Thickness. Tissue (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Type: Blanchable Erythema -75%, Epithelial - 25%. Exudate: Amount-light. Type-Serosanguineous. Size: 15.0 cm (centimeters) x 17.0 cm x 0.10 cm (L x W x D) length by with by depth. Hospital Record dated 04/15/26 document in part: Chef Complaint/Reason For Consultation: Scald Burn. R4 sustained a 1% TBSA (Total Body Surface Area) burn injury on her right thigh. This injury occurred at a nursing facility from ramen noodles. Patient reports pain and well as numbness/tingling to the area. Notably, the patient expressed concern about going back to her nursing facility as she does not feel she receives adequate care there. Skin: burn along right thigh that appears mixed superficial and deep partial thickness. Wound base appears whitish pink in some areas, with sluggish blanching, ttp (Thrombotic Thrombocytopenic Purpura). Assessment and Plan: admitted to hospital for advanced wound care, pain control, possible operative intervention. History of Present illness: earlier today, patient was at nursing home and asked the nursing home staff to help make hot Ramen soup for her. When she received the noodles, she used power chair to go up in the elevator to a different floor. While in the elevator, she had a muscle spasm and spilled the hot liquid onto her right thigh. Endorses associated pain. Skin: Comments: Partial superficial and thick thickness burn on right thigh and with associated blistering. Wound base exposed, with blanching. On 06/09/26 at 11:32 AM Per telephone interview V6 (R4' Family Member) stated on 04/14/26 R4 was given hot noodles by a staff member. R4 got on the elevator, jerked or had a spasm. V2 (Director of Nursing) was on the elevator. They told R4 that everything was fine, they could take care of it, and they bandaged the leg. I told V18 (Licensed Practical Nurse) that R4 needs to be sent to the hospital. R4 said I had a cup of ramen noodles, and I was going to the second floor to hang out. V8 (Certified Nurse Assistant/CNA) warmed up my noodles and she was not aware I had muscle spasms. On 06/09/26 at 12:46 PM V8 (CNA) stated R4 came up, approached me and asked me to warm up some noodles. The aide put the noodles in the microwave, and I took the noodles to R4's room then placed them on the table on R4's wheelchair. R4 was in her room, in the wheelchair that has a table on top of it. R4 then asked for a fork, I went to get her a fork and when I went back to her room R4 was not in her room. The incident happened in the elevator. I was made aware of the incident later that day when I heard the noodles wasted on R4. I was not aware that R4 had muscle spasms. The burn was on R4's right thigh. On 06/09/26 at 12:37 PM V13 (Registered Nurse) stated I R4 had an incident with a burn on her leg. It was reported to me that R4 had a cup of noodles that spilled onto her leg. V8 (CNA) gave R4 the noodles. R4 provided her own noodles and asked V8 to warm them up for her. R4 was on the elevator going upstairs to see a resident, had a muscle spasm and the noodles spilled on her leg. I was not aware R4 had muscle spasms. When it happened, I did an assessment, followed up with wound care, spoke to the Nurse practitioner and documented. V2 (Director of Nursing) was on the elevator with R4. R4 was not sent out to the hospital that day but eventually yes. On 06/09/26 at 03:32 PM V18 (Licensed Practical Nurse) stated The incident when R4 got burned happened on 7am - 3 pm shift. I work 3 pm - 11 pm and they told me what happened. R4's family member wanted her to go to the hospital. I called V6 (R4's Family Member) and they wanted R4 sent to the hospital. On 06/10/26 at 12:19 PM V32 (Wound Care/Licensed Practical Nurse) stated On 04/14/26 I received a phone call from V2 (Director of Nursing) at approximately 1 pm. I met V2 at the room with R4. R4 spilled the noodles, and I removed her pants. The burn was on R4's right thigh and there was a lot of bunching of the legging type pants, clingy to the skin. It was still warm when I lifted the fabric and pulled it down. I asked what happened and R4 said she spilled a cup of noodles on her. R4 was in a motorized wheelchair with a stationary table tray and knocked the noodles in her lap when she had a spasm. It happened on the elevator and V2 (Director of Nursing) brushed off the noodles. V2 used the towel to remove some of the broth. I used saline and gauze to clean, I measured and put on proper dressing. R4's thigh was blistered with a big blister that ruptured. Initially the large blister was intact, I went to my cart and when I returned the blister had ruptured. I took xeroform, a dry dressing and wrapped it with gauze. I changed R4's pants and she remained in the wheelchair. I conferred with the V38 (Nurse Practitioner), and the wound doctor came in on Friday 04/17/26. Most of the areas that were (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	blistered were very small lines. The Nurse Practitioner said it was ok and R4's pain was not terrible 3/10 rating which was addressed with Tylenol. The burn wound was identified on 04/14/26 that same day. I will have to go get the order and hospital records and I will come back. At 01:00 PM V2 (Director of Nursing) returned to the conference room with the documentation that the surveyor requested from V32 and stated V32 had left the facility. On 06/10/26 at 01:12 PM V38 (Nurse Practitioner) stated I am aware of R4's burn. R4 was in her room and the nurse mentioned she spilled a cup of noodles. R4 was on the elevator when she hit the bump, that is when the noodles wasted. When I saw R4 they had already changed her. I reviewed the image, and I ordered medicine for pain. I would not know how to classify a burn. I did not see the wound because it was covered by the wound care team. The wound care nurse said they could manage R4's burn and I went on what the wound care nurse said. V32 (Wound Nurse/Licensed Practical Nurse) did not report to me that a blister had ruptured. If we are not to do wound management knowing what I know now I would have sent R4 out to the hospital. I don't know what wound care did. My specialty is not burns or wounds. On 06/10/26 at 03:12 PM V39 (Alternate Physician) stated I was made aware of R4's burn and I saw R4 the next day after R4 was sent to the hospital. Based on the tissue description the nurse gave me, the burn went through more than one layer of skin and a blister formed as well, I would have sent R4 to the hospital. On 06/10/26 at 02:28 PM V2 (Director of Nursing) stated R4's burn happened on 04/14/26. I was getting on the elevator, R4 came out of her room with another resident. R4 and another resident entered the elevator. R4 had a game system and noodles on the wheelchair tray table, moved the game and she yelled. I had turned to put in the elevator code. The noodles on table spilled in R4's lap. We got off the elevator on the second floor, I asked the nurses to get towels and wiped R4 off. We got back on the elevator, went to the first floor and V32 (Wound Nurse/Licensed Practical Nurse) was outside the elevator. V32 took R4 to her room, got her undress and assessed the wound. I did not go into the room with them. I went to look for a [NAME] about what I need to do. I did not see R4's thigh until the next day. V32 did tell me R4 had a blister and a little area that had a skin tear. The template has to notify the doctor, wound care nurse, wound assessment notes and route cause analysis. I am assuming after V32 spoke to the doctor if they did not give an order, that is why R4 was not sent out to the hospital. I would have sent R4 out to the hospital based on the picture and measurements. That is something that would be reported to the state. I knew the day that I brought it to V25 (Former Administrator) and the consultant's attention, but the directive was to hold off on reporting the incident. It was reported 04/21/26. Surveyor asked V2 should the incident have been reported on 04/14/26 when the incident happened. V2 responded, Absolutely. R4 was sent to the hospital on [DATE] after sustaining a second degree burn to the right thigh after the family requested R4 be sent out. Burn Injury Checklist Evaluation: Burn Injury Investigation Checklist: undated, Date found and reported? Wound MD (Medical Doctor) notified, based on RCA (Root Cause Analysis) were appropriate interventions in place for prevention? Once you have completed the event's checklist and assessment, use the QAPI (Quality Assurance and Performance Improvement) Plan/Action plan to help address identified opportunities. Policy: Titled Wound Management dated 03/02/24 document in part: The facility will treat wounds according to physician's orders and current standards of clinical practice. IV. Optimizing Medical Conditions and General Systemic Function B. Medical conditions will be assessed and addressed to improve the resident's risk and/or ability to heal. Titled Etiology of the Wound dated 03/02/24 document in part: The facility will provide an aggressive skin care program following current standards of clinical practice. Management will be based upon the etiology of the wound. VI. Other wounds such as those caused by trauma or incontinence are managed using appropriate clinical practice guidelines and current standards of clinical practice.

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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 wore the proper PPE (Personal Protective Equipment) while providing care for one (R9) resident on Enhanced Barrier Precautions. Findings Include:R9's diagnoses include but not limited to History of Falling, Chronic Diastolic (Congestive) Heart Failure, Malignant Neoplasm of Prostate, Atrial Fibrillation, Hypertensive Heart Disease with Heart Failure, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Absolute Glaucoma, Right Eye, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Type 2 Diabetes Mellitus with Diabetic Neuropathy, , Peripheral Vascular Disease, Gastro-Esophageal Reflux Disease, Diseases of Anus and Rectum, Pressure Ulcer of Sacral Region, Stage 3, Pressure Ulcer of left Buttock, Stage 2. R9's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response.Care Plan document in part: Focus: R9 Has Gastrostomy Tube.Physician order document in part: Enhanced Barrier Precautions. G-tube wounds every shift -Start Date-04/01/26.On 06/10/26 at 11:13 AM V41 (Certified Nursing Assistant/CNA) and this surveyor entered R9's room. Enhanced Barrier Precaution signage was posted on the wall to the right side of R9's door. R9 said I am more wet. I urinated a couple of times. At 11:16 Am V41 exited the room to get assistance. At 11:23 AM V41 reentered R9's room with V42 (CNA) and began performing peri care with no gown in use. V41 removed R9's incontinence brief that was saturated with urine. R9's under pad, gown and top sheet were changed. At 11:25 AM V3 (Assistant Director of Nursing) knocked on R9's door, looked into the room then closed the door.06/10/26 at 11:31 AM V42 (CNA) exited R9's room. This surveyor asked V42 to read the signage next to R9's door. V42 stated I should have put on a gown for barrier precautions. There is a potential the other residents can catch something.On 06/10/26 at 11:33 AM V41 (CNA) exited R9's room. This surveyor asked V42 to read the signage next to R9's door. V41 stated I should have put on a gown because R9 has a feeding tube. There is a potential I can bring something to them, myself and the other residents. R9 is a heavy wetter.On 06/10/26 at 02:08 PM While sitting in the conference room this surveyor asked V2 (Director of Nursing) to look outside the door at the wall next to R9's room. V2 stated the signage has enhanced barrier precautions. A gown and gloves should be worn for any high contact resident care. If the gown and gloves are not worn there is a potential for the spread of infection to the residents themselves and other residents in different rooms.Enhance Barrier Precaution Signage document in part: Providers and staff must also: Wear gloves and a gown for the following High-Contact resident care activities, Changing Linens, Providing Hygiene, changing briefs or assisting with toileting. Policy: Titled Enhanced Barrier Precautions (EBP) reviewed 03/20/26 document in part: Purpose: To minimize the risk of acquiring, transmitting, or complications resulting from multi-drug-resistant organism (MDRO) colonization among residents in this setting. Population Affected: Residents with existing or colonized MDRO's where other transmission-based precautions are not warranted. Residents at increased risk of MDRO acquisition (Residents with wounds or indwelling medical devices). Equipment Needed: Gowns, Gloves. Guidelines: Residents Will require the use of personal protective equipment (PPE) for high-risk activities such as: Toileting, Linen Changes. Any situation where expected contact of blood, body fluids, skin breakdown or mucous membranes will be encountered. PPE required: Gowns, Gloves. Persons expected to encounter these circumstances are to don PPE (gowns and gloves) in accordance with the activity that will be encountered when caring for the resident.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview, and record review the facility failed to maintain a safe, functional, sanitary, comfortable environment. The facility failed to maintain and repair water leaks in the kitchen timely. The facility also failed to maintain an adequate supply of dining ware resulted in residents being served meals using disposable Styrofoam items. These deficient practices have the potential to affect all 189 residents receiving food prepared in the facility's kitchen. Findings Include:1.) On 6/9/26 at 9:50AM, V7 (Dietary Manager) and surveyor toured the kitchen. Observed an active ceiling leak over the handwashing sink. There were no mold or discolored areas observed in the kitchen. Observed discolored area on the ceiling tile in the dishwashing area in the kitchen. On 6/9/10 at 9:58AM, V7 (Dietary Manager) stated, The discolored ceiling tile in the dishwashing area was from a leak over a month ago. The first-floor shower room was leaking down. The former administrator, housekeeping director and maintenance staff were made aware. The leak was leaking for about two weeks. The leak was repaired about two weeks ago. The ceiling leak over the handwashing sink started yesterday [6/8/26]. I made the administrator, director of nursing and maintenance aware yesterday. On 6/9/26 at 10:12AM, V10 (Dietary Aide) stated, There was a water ceiling leak in the dishwashing area a few weeks ago. The leak was recently fixed. The ceiling started leaking over the handwashing sink a day or two ago. On 6/9/26 at 10:50AM, V5 (Maintenance Assistant) stated, The maintenance director has been off work now for a month. I do not speak good English. Yes, the kitchen had a leak in May. The leak was fixed about a week ago. It took a while to find out where the leak was coming from. There is a new ceiling leak that should get fixed today. Yes, the ceiling tiles fell down from roof leak in R6's past room. The roof was repaired a couple days after the leak. On 6/10/26 at 2:44PM, V31 (Maintenance Supervisor) stated, There was ceiling leak in the kitchen in the dishwashing area about a month ago. The leak was repaired about two weeks ago. It took some time to figure out where the leak was coming from. At first, we thought the leak was coming from the first-floor shower room drainage, but that was not the source. Eventually a company came out and had to fill in concrete a space between the floors to stop the leak in the kitchen. We have a maintenance log for the nursing floor at the nursing station, but we do not have work orders for the basement, kitchen or laundry. I do not have any work slips regarding the leak in the kitchen. On 6/10/26 at 3:05 PM, V21 (Interim Maintenance Director) stated, I work at another sister facility. The Maintenance Director here is out on medical leave. The other sister facilities all take turns and come here to assist with repairs. I do not know anything about the kitchen leak over by the dish area. Today, I repaired the ceiling leak over the hand washing sink. The leak was from a toilet on the first-floor. The toilet was repaired and leak in kitchen stopped. I think the leak started a few days ago. When I got here today, I was made aware and completed the repair. I did not ask when the leak started. 2.) On 6/9/26 at 9:50AM, V7 (Dietary Manager) and surveyor toured the kitchen. Observed the return dishes from breakfast. There were some hardware plates, bowls, silver ware and Styrofoam plates, bowl and plastic forks, and spoons. On 6/9/10 at 9:58AM, V7 stated, We are short on dishes. I think some of the residents are hoarding the dishes. I made the former administrator aware a couple of months ago of the shortage. I use the hardware then I start using the Styrofoam dish ware. V25 (Former Administrator) ordered some dishes in May and June, but somehow the dishes are still missing and not enough for each meal tray. During meal try line I will think approximately half the residents received their food on the regular dining ware and the other half receive Styrofoam dish ware. Facility census on 6/9/26 was 197 residents. Eight are NPO. Total that eats from kitchen is 189. The dish washing machine is functioning properly. Facility order history:6/4/26: 9-inch plates 24 count per case. Two cases ordered. 9inch three compartment plates 12 count.5/5/26: [NAME] Ceramic ware 9inches 48 counts.3/27/26: 8 1/4 inch rim stoneware plate 36 count. On 6/10/26 at 3:30PM, V25 (Former Administrator) stated, I was told, the kitchen was only missing a few dishes, so (continued on next page)

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	I ordered a few dishes. The facility census is typically around 170 to 190. I was not made aware I needed to order more dishes. On 6/10/26 at 3:40 PM V1 (Administrator) stated, I been working here for five days. I was not aware of the shortage of the dining ware, I will order. The only times residents should eat on paper/Styrofoam plates, and bowl is if the dishwasher is down or infection control reasons. While some residents eat on dining plate and other eat on paper/Styrofoam, it's the resident rights to all eat on the hardware dishes. Water leaks in the kitchen should be repaired timely. If not it could potentially cause fall incidents, and cross contamination of food. R1, R2, R3, R6, and R10 all said they would like to eat on dining wear because styrofoam plates and bowls start to melt if you warm up the food in the microwave. Policies in part:Mechanical Ware WashingIf the dish machine is not working properly, may require disposable dishes to be used for the meal until it can be repaired. Kitchen Operation Policies, Sanitation and Food SafetyTo ensure the dietary department is maintained according to state and federal regulations as well as a clean, sanitary, and safe environment. Maintenance Job Description:Be prepared to handle emergencies as they come.Repair facility, resident property. In the event of inability to repair coordinate with outside vendors to make repair.