STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145990	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Symphony Maple Crest	4452 Squaw Prairie Road Belvidere, IL 61008

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 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 a resident was transferred out of bed in a timely manner and failed to provide incontinence care for a resident in a timely manner for 2 of 2 residents (R23, R57) reviewed for activities of daily living in the sample of 35.This failure resulted in R23 crying and voicing feelings of depression.The findings include:1. R23's admission Record, printed on 9/24/20245, showed she had diagnoses including, but not limited to major depressive disorder, mild cognitive impairment, dysphagia, and congestive heart failure. R23's recreational support care plan showed she is at the facility for long-term care and will attend meaningful activities that she chooses. The care plan showed R23 enjoys visiting with family and friends, enjoys reading books, listening to music, and is interested in participating in group activities. R23's care plans showed she has an ADL self-care deficit related to limited mobility, debility, and impaired balance. The care plan showed R23 uses a mechanical lift with 2 staff assist for all transfers. R23's 8/7/2025 facility assessment showed she was cognitively intact and was dependent on staff for transfers. On 9/23/2025 at 9:50 AM, staff informed V5 (Registered Nurse-RN) that R23 was waiting to get up but there was not a sling ready or available so she would have to wait. On 9/23/2025 at 11:17 AM, R23 was in her room lying in bed. R23 said she is dressed and is waiting to be gotten out of bed. R23 said the staff never get her up until close to noon. R23 said yesterday (Monday) and Sunday, they did not get her out of bed all day. R23 said staff told her they did not have a sling to get her up. R23 started to cry and said it is depressing. I want to get up. I don't want to sit in bed like this. I never did this at home. At 11:20 AM, R9 (R23's roommate) said she heard the aides tell R23 they did not have a sling. R9 said R23 is left in bed quite a bit. On 9/23/2025 at 11:36 AM, V6 and V22 (Certified Nursing Assistants-CNAs) entered R23's room with the mechanical sling lift. R23 was still upset when V6 and V22 entered the room. V6 was asked about the facility's supply of slings. V6 said the facility has a lot of slings, it just depends on what you get. When asked to explain, V6 said the 100 wing has more residents that use the mechanical lifts. V6 said we just have to wait sometimes too. Sometimes we have to use the mesh sling that is for showers. On 9/24/2025 10:17 am, R23 in hall sitting in her wheelchair, combing her hair in the doorway to her room. CNA said she just got R23 up. R23 was observed multiple times on 9/24/2025 sitting in the dining room at a table with other females, reading a book. On 9/25/2025 at 9:33 AM, V2 Director of Nursing (DON) said I told staff that a lot of our residents are early birds; they do not want to be left in bed. We have a lot of slings. The slings are taken down when they are soiled and when the residents are laid down for the night. Laundry stays until after 10:00 PM. We are looking at getting more slings, a different style for the residents that are continent (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Actual harm Residents Affected - Few	but not able to stand. On 9/25/2025 at 10:38 AM, V3 (Assistant Director of Nursing-ADON) said R23 came from another facility. She wanted to work on her strength. V3 said R23 is on an active range of motion program to all of her extremities, to strengthen her mobility function. V3 said R23 is dependent on staff for transfers. Her lower extremities are not strong enough for her to stand and transfer currently. On 9/25/2025 at 12:45 PM, V6 (CNA) said on 9/23/2025 R23 was not gotten up until after 11:00 AM (observed by surveyor at 11:36 AM) because we had to wait for a sling. V6 said having to wait for a sling to transfer a resident is not a new thing. We have slings, it is just first come first served. 100 hall CNAs grab the slings first, so we have to wait until more are available. V6 said she worked on Monday; however, she was on the 100 hall and is not sure if R23 was gotten up on Monday. On 9/25/2025 at 12:55 PM, V17 (Nurse Practitioner) said not getting a resident out of bed repeatedly can affect the resident's mental health. V17 said no one has said anything to me about not getting R23 up. On 9/25/2025, R23 was again observed multiple times throughout the day, sitting in the dining room at the same table with other females, reading her book. R9's 6/20/2025 Brief Interview of Mental Status assessment showed she was cognitively intact. (R9 is R23's roommate). The facility's policy and procedure titled Activities of Daily Living, with a review date of August 2025, showed activities of daily living is encouraged to prevent disability and return or maintain residents at their maximal level of functioning based on their diagnosis. C. Feeding: a. Residents are encouraged to eat in the group dining room when possible, for socialization. E. Transfer: a. Privacy is provided to each resident. b. Resident is encouraged, if able, to assist with transfers. c. Adaptive equipment, assistance and instruction are given as required. 2. On 9/23/25 at 12:02 PM, V4 (Dietary Manager) stated to V13 Certified Nursing Assistant (CNA), R57 said she needs to use the bathroom. V13 replied, She doesn't go to the bathroom, she's just a check and change. V13 did not ask R57 if she needed to use the restroom or attend to R57's requests to use the bathroom. On 9/23/2025 at 12:10 PM, R57 was sitting in her wheelchair in the dining room at a table, waiting for her noon meal. R57 smelled like a bowel movement (BM). On 9/23/2025 at 12:19 PM, R57 was sitting in her wheelchair at the dining room table eating her lunch. R57 smelled like BM. On 9/23/25 at 12:43 PM, R57 was sitting in her wheelchair in the dining room at a table. Her wheelchair was pushed back a little and the front of her pants were wet. There were no spilled items on the table or the floor next to R57. There was a strong odor of BM present. On 9/23/2025 at 1:01 PM, R57 was wheeled down hall by V10 CNA and left in the hall. On 09/23/2025 at 1:09 PM, V11 CNA and V10 CNA took R57 into her room and transferred R57 from her wheelchair to her bed using a mechanical lift. The groin area and front of R57's pants were saturated. V11 lifted R57's shirt and there was mushy and loose stool above the waistband of her pants on her abdomen. V11 and V10 pulled down R57's pants and opened her incontinence brief and (continued on next page)

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F 0677 Level of Harm - Actual harm Residents Affected - Few	the resident's brief was full of mushy and liquid stool. When V10 and V11 turned R57 to remove the sling, it was wet and there was BM on the sling. On 9/24/2025 at 9:54 AM, V2 Director of Nursing (DON) stated, incontinence care should be provided in a timely manner; residents should be toileted frequently. When residents are turned, they are checked and changed. Staff do not have set times when they are to toilet and/or change residents. When someone says they must go to the bathroom, they are toileted. We do not train our staff to have residents wait or not toilet when requested. Even if the resident is confused or can't use a toilet, they should be taken to their room for care, offer a bedpan etc. We don't let the resident sit in the dining room incontinent during their meal. Staff are to change resident when they need to be changed. The Face Sheet dated 9/24/25 for R57 showed diagnoses including dementia, anxiety, protein-calorie malnutrition, chronic kidney disease, asthma, chronic obstructive pulmonary disease, traumatic subdural hemorrhage, hydronephrosis, anemia, depression, hypertension, and type 2 diabetes mellitus. The Care Plan dated 7/9/25 for R57 showed she has an activity of daily living self-care performance deficit related to a subdural hematoma. Toilet use: R57 requires total assist for toileting. The Minimum Data Set (MDS) dated [DATE] for R57 showed severe cognitive impairment; dependent on staff for toileting hygiene; always incontinent of bowel and bladder. The facility's Activities of Daily Living Policy (8/25) showed, A program of assistance and instructions in activity of daily living skills is care planned and implemented. Elimination: a. Privacy is provided to each resident. b. Adaptive equipment, assistance and instruction are given as required.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on interview and record review, the facility failed to properly cool a pork roast after cooking. This has the potential to affect all residents in the building.The findings include:The facility's roster provided to surveyor on 9/23/25 showed 66 residents residing in the building.On 9/23/25 at 10:42AM, V4 (Dietary Manager) sliced the pork roast for the noon meal. V4 stated, We don't normally do cooling logs because we don't normally cook food ahead of time. I did not do a cooling log for this roast but I'm sure we did the correct process. I just took it out of the cooler to slice it and then I'll place it in the oven. If the correct process is not followed and documented, then residents could be at risk for foodborne illness.The facility's recipe for Tender Pork Roast showed, Potentially hazardous foods shall be cooled: a) from 135 degrees F to 70 degrees F within 2 hours. B) From 70 degrees F to 41 degrees F within 4 hours.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain a system for tracking infections, failed to wear personal protective equipment (PPE) into a contact isolation room for 1 resident (R68), failed to wear appropriate PPE for 3 residents (R11,R29,R58) on Enhanced Barrier Precautions, failed to perform hand hygiene and glove changes to prevent cross contamination during incontinence care for 1 resident (R57). These failures have the potential to affect all residents in the building. The findings include:1) The facility roster provided to surveyors on 9/23/25 showed 66 residents residing in the building. On 9/24/25 at 1:56PM, V2 (Director of Nursing/Infection Preventionist) stated, I only have some infection tracking from March 2025 that the previous IP (Infection Preventionist) did. I started in April of this year with my position, but I haven't tracked any infections. I'm going to be creating our infection control tracking but haven't had a chance to start it yet. I think there is a report I can pull from our system to show who is on antibiotics but haven't gotten into that yet. We should be tracking infections so that we can prevent new ones if possible and keep like infections co-horted together if needed. There's just been so much going on I don't even know where to start right now. On 9/24/25 at 2:23PM, V1 (Administrator) stated, We are going to get the infection control program back in order. (V2) is still pretty new so she is trying to get all of the kinks worked out with everything and she just has a lot going on. I know it's important to have the program up to date, but it just hasn't been the priority right now. The facility's policy titled, Infection Prevention and Control Program dated 6/2025 showed, Facility is responsible for protecting and promoting quality of life and health for all their patients and residents by developing and implementing Infection Prevention and Control Programs and systems that provide information and education, effective regulation and oversight, quality services, and surveillance of disease and conditions.4. Surveillance: the facility has a system in place for early detection and management of potentially infectious symptomatic residents, including implementation of precautions as appropriate. 2) R68's electronic face sheet printed on 9/25/25 showed R68 has diagnoses including but not limited to osteoarthritis, hypertension, cerebral infarction, depression, and atherosclerotic heart disease. R68's physician's orders dated 9/19/25 showed, Maintain enhanced barrier precautions to prevent infections related to history of ESBL (extended-spectrum beta-lactamase). R68's local hospital records dated 9/17/25 showed, (R68) presented from (facility) for bloody stools. Facility reported observing stringy bloody diarrhea which started yesterday.ADDENDUM - C diff returned back positive - oral vancomycin ordered> R68's physician's orders dated 9/21/25 showed, Fidaxomicin 200mg BID for 10 days for C-DIFF (Clostridium Difficile). On 9/23/25 at 9:51AM, V6 (Certified Nursing Assistant) entered R68's room with no PPE on. Surveyor entered room and observed V6 providing R68 with repositioning assistance with no PPE on. R68's door had a sign on it that stated, Contact Precautions: All staff must apply gown and gloves prior to entering room . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/23/25 at 10:08AM, V6 stated, (R68) is on isolation for CDIFF. As long as his stool is contained you don't need to wear PPE as long as you don't touch surfaces or anything. On 9/24/25 at 1:56PM, V2 stated, Contact precautions are required for anyone infected with C. Diff. It is a highly contagious organism and any staff entering that resident's room should be wearing a gown and gloves at all times. I'm not sure why (V6) thought she didn't need PPE on because C. Diff is transmittable by touching infected surfaces. It has never been our guidance to staff that they don't need PPE on when entering (R68's) room. The facility's policy titled, Transmission Based/Contact Precautions dated 8/2025 showed, Contact Precautions: Wear a gown and gloves for all interactions with the patient or potentially contaminated areas in the patient's or resident's environment. Donning personal protective equipment (PPE) upon room entry and discarding before exiting the patient room.use contact precautions for the following: residents with C. difficile infection. 3. R58's admission Record (Face Sheet) showed diagnoses to include chronic venous ulcer of the left leg, stage 4 pressure ulcer of the buttock, and diabetes. On 9/23/25 at 10:31 AM, R58 was in his room. The door to his room had no signage indicating he was in any type of infection control isolation. There was no isolation bin outside or near R58's room. R58's cotton gauze dressing to his left leg extended from just below his knee to his foot. The dressing had a 4-inch circle of bloody drainage visible on the exterior of the dressing. On 9/23/2025 at 11:18 AM, V7 Licensed Practical Nurse (LPN) changed R58's soiled left leg dressing; V7 did not wear an isolation gown during this process. On 9/24/2025 at 11:12 AM, V2 Director of Nursing (DON) stated the floor nurses are trained on which residents require EBP (Enhanced Barrier Precautions), and the floor nurses should be posting EBP signage for those residents. V2 stated R58 should be in EBP. V2 stated V7 should have worn a gown during R58's dressing change on 9/23/25. V2 stated she was not aware the facility's policy stated PPE (Personal Protective Equipment) bins should be placed outside EBP rooms. V2 stated the purpose of EBP and PPE during wound care is to prevent wound infection and also to prevent taking organisms out of the isolation room. R58's Care Plan Focus area (created 10/28/24) showed he required EBP related to wounds. The facility's Enhanced Barrier Precaution policy (reviewed 2/2025) showed EBP is .an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of [organisms]. The policy showed EBP is required for residents with wounds and PPE is required during wound care. The policy showed, Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE.Make PPE, including gowns and gloves, available immediately outside the resident room. 4. On 9/23/25 at 1:57 PM the door of R29's room had an enhanced barrier precaution sign on it. V12 Registered Nurse (RN) put gloves on and went into R29's room to provide wound care to the resident's pressure injury. V12 did not put on a gown, removed R29's soiled dressing, cleaned the pressure injury, applied a new treatment, and dressing to the wound. R29 had an indwelling urinary catheter. V12 stated R29 should be on enhanced barrier precautions. V12 stated she should wear a gown and gloves when providing care and she forgot to put the gown on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 9/24/25 at 9:54 AM, V2 Director of Nursing (DON) stated enhanced barrier precautions are for anyone that is colonized with a multidrug resistant organism (MDRO), has an indwelling device like a catheter, feeding tube, lines, and wounds that are not draining. If the resident has draining wounds they are on contact precautions. V2 stated anytime a resident has a device and/or is colonized an EBP sign is posted on their door. Staff should wear gowns and gloves with any close contact care for someone on EBP. They should wear gowns when emptying foley catheter, doing g-tube site care, wound care, peri care etc. The Face Sheet dated 9/24/25 for R29 showed diagnoses including anxiety disorder, hypertension, depression, mild protein calorie malnutrition, postherpetic polyneuropathy, chronic obstructive pulmonary disease, neuromuscular dysfunction, edema, and multiple sclerosis. The Wound Care Progress Note dated 9/19/25 for R29 showed she has a stage 4 pressure wound to her sacrum that is full thickness. The dressing treatment plan showed, Primary dressing - alginate calcium with silver once daily and as needed: if saturated, soiled, or dislodged. Secondary dressing - gauze island with border, apply once daily and as needed: if saturated, soiled, or dislodged. Peri wound treatment - skin prep apply once daily and as needed: if saturated, soiled, or dislodged. The facility's Enhanced Barrier Precaution policy (2/25) showed, enhanced barrier precautions apply to all residents with any of the following: wounds, and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy) regardless of MDRO status. When a resident is placed in enhanced barrier precautions, gown and gloves will be used during high-contact resident care activities. (Dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs, assisting with toileting, device care or use, central line, urinary catheter, feeding tube, tracheostomy, wound care: any skin opening requiring a dressing). Make PPE (personal protective equipment) including gowns and gloves, available immediately outside the resident room. 5. On 9/23/2025 at 1:09 PM, V11 Certified Nursing Assistant (CNA) and V10 CNA were at R57's bedside to provide incontinence care. V10 and V11 had gloves on. V11 lifted R57's shirt and she had a bowel movement. The BM was up over the top of her pants to her abdomen. V11 unfasted R57's incontinence brief and it was full of mushy BM. V11 used disposable wipes to clean the BM of the front of the resident. V11 removed her gloves, left the room to get washcloths and incontinence pad for the bed. V11 came back with the linen, applied gloves, and washed R57's groin. V11 cleaned R57's residents' buttocks and anus. V11 discarded the soiled washcloth. The mechanical lift sling under the resident had BM on it. V11 rolled up the linen and sling and tucked it under R57. V11 grabbed a clean incontinence pad and brief and placed that under the resident. R57 was then turned on her other side. V11 put her hands on R57 to keep her on her side. V10 cleaned R57's buttocks. V11 grabbed a clean dry towel to pat dry R57's groin area. V11 grabbed a clean washcloth and put it on the handle of the wheelchair. V11 asked V10 to wet the washcloth for her. V10 did not do it. V11 finished putting the incontinence brief on the resident and fastened it closed. V11 grabbed the washcloth from the handle of the chair, wet it and put some soap on it. V11 washed the BM off R57's abdomen and removed her soiled top. V11 put clean pants on R57. V11 straightened R57's pillow under her head and pillow and pulled her sheets and blanket up. V11 tied bags of garbage and linen closed. V11 stated she changes her gloves after she throws this away. V10 stated she changes her gloves after she wipes a person and before she gets a clean/new incontinence brief. V10 stated she changes her gloves when going from dirty to clean. V10 stated it is for infection control. V11 stated it's important for cross contamination. On 9/24/25 at 9:54 AM, V2 Director of Nursing (DON) stated staff should perform hand hygiene, they (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	should wash their hands and put on gloves before the start of care. Gloves should be changed anytime they are soiled. Gloves are changed when going from dirty to clean. This is done because we don't want to contaminate the clean area. This is done to prevent cross contamination and transmission of bacteria especially during peri care. The Face Sheet dated 9/24/25 for R57 showed diagnoses including dementia, anxiety, protein-calorie malnutrition, chronic kidney disease, asthma, chronic obstructive pulmonary disease, traumatic subdural hemorrhage, hydronephrosis, anemia, depression, hypertension, and type 2 diabetes mellitus. The Care Plan dated 7/9/25 for R57 she has an activity of daily living self-care performance deficit related to a subdural hematoma. Toilet use: R57 requires total assist for toileting. The Minimum Data Set (MDS) dated [DATE] for R57 showed severe cognitive impairment; dependent on staff for toileting hygiene; always incontinent of bowel and bladder. The facility's Hand Washing Policy (4/21) showed, Goal: To prevent the spread of infection. Procedure: hand washing will occur b) When obviously soiled. h) After handling used dressings, used sputum containers, urine, bedpans, catheters, or soiled linen, or assisting the guest in the bathroom. The facility's Perineal Care policy (1/2025) showed, wash hands thoroughly and explain procedure to residents. Put on disposable gloves. Using clean washcloth/peri wipe, rinse thoroughly from front to back, pat dry. Remove your gloves, wash your hands (your gloves are dirty try not to touch anything). Reposition guest and make comfortable. 6. R11's Order Summary Report, printed on 9/24/2025, showed an order for an indwelling catheter related to a diagnosis of neurogenic bladder (a condition in which a person lacks bladder control due to brain, spinal cord or nerve problems). The Order Summary Report showed an order to maintain enhanced barrier precautions to prevent infections related to indwelling catheter. R11's care plans, provided by the facility on 9/24/2025, showed she was on Enhanced Barrier Precautions (EBP) related to an indwelling catheter and history of MRSA (methicillin-resistant Staphylococcus aureus). The care plan showed staff should wear gowns and gloves when having high-contact resident care activities. On 9/24/2025 at 1:14 PM, V6 (Certified Nursing Assistant-CNA) went with R11 to her room to empty her urinary drainage bag. Signage on R11's door showed Enhanced Barrier Precautions (EBP). The signed showed staff should wear a gown and gloves when providing direct patient care. Catheter care was one of the care tasks listed on the signage as needing a gown and gloves for. V6 only had gloves on. While emptying bag. At 1:17 PM, V6 was asked if emptying the catheter required a gown. V6 said no. V6 said a gown is needed if the resident has an active infection. On 9/24/2025 at 1:23 PM, V3 (Assistant Director of Nursing-ADON) said a gown and gloves are needed when emptying a catheter bag, to prevent infection. V3 said even if the resident does not have an active infection. On 9/25/2025 at 9:27 AM, V2 (Director of Nursing-DON) said when a resident is on EBP precautions, staff should be wearing a gown and gloves when providing direct care. The sign shows any resident with an indwelling device. That includes urinary catheters. For infection control. The facility's policy and procedure titled Enhanced Barrier Precautions, with a revision date of (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	September 2025, showed Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. aureus and Multidrug Resistant Organisms (MDRO).EBP may be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices, regardless of MDRO status, Infection or colonization with a CDC-targeted or other epidemiologically important MDRO. Examples of indwelling medical devices included central lines, urinary catheter, feeding tube, and tracheostomies. The policy showed examples of high-contact resident care activities included dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care.

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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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. Based on observation, interview, and record review, the facility failed to offer activities. This applies to 6 of 6 residents (R10,R15,R28,R44,R48,R66) reviewed for activities in the sample of 35.The findings include: On 9/23/2025 at 10:46 AM, R66 stated There are no activities on the weekend. R66 stated she enjoys some of the activities the facility provides, and she would enjoy activities on the weekend. R66 said she would like weekend activities because they give us something to do. It helps us to pass the time.On 9/25/2025 at 9:06 AM, V18 Activities stated R66 does enjoy attending some of the activities the facility provides.R66's 7/18/25 Minimum Data Set (MDS) showed she was cognitively intact.R66's 1/16/25 Activity Assessment showed, [R66] is a LTC (Long-term care) resident. She has expressed the desire to remain in her room for most of her day. Activities of [R66] choice include, watching her favorite tv shows, visiting with family, reading, doing word searches, arts and crafts, and food related activities. She sometimes comes to bingo, music programs, and the dine in club. Activity staff will continue to encourage [R66] to participate in activities and provide her with monthly activity calendars. The assessment showed it was very important for R66 to do her favorite activities and to do things with groups of people.On 9/24/25 at 10:00AM, R28, R44, and R48 were present during the Resident Council Meeting. All residents stated there is only one activity staff member and she is off every other Monday, Friday, and weekend. Residents stated when the activity aide is not at the facility, no activities get done. Residents verbalized frustration with the weekends as they are just given a movie to watch and have to find something to do. All residents agreed that they are bored on the weekends, and the weekends seem very long until they have to wait until Monday when the activity aide comes back. On 9/24/25 at 2:33PM, V1 (Administrator) stated, I am the activity director right now because we don't have anyone else. We only have 1 activity aide and I am trying to hire another one for the days our aide is off. We do have movies on the weekends and either a physical church service or a video of a church service but that's all we have right now. Residents can always find something to do if they get bored. I don't currently have an activity calendar that is posted for the residents but we have a handwritten one that we go off of. We try to announce the activities as they come up but it doesn't always work that way. Observations of resident rooms on all hallways showed no activity calendar posted in common areas, resident rooms, or activity area. The facility's policy titled, Life Enrichment dated 8/25 showed, Guests will be offered Life Enrichment that enhance their sense of well-being and promote their physical, cognitive, spiritual, social and emotional health.

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	145990	A. Building B. Wing	09/25/2025

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure dignity was maintained for 2 of 2 residents (R50, R47) reviewed for dignity in the sample of 35.The findings include:R50's admission Record, printed on 9/24/2025, showed she had diagnoses including, but not limited to, anxiety disorder, depression, memory deficit following cerebrovascular disease (stroke), protein-calorie malnutrition, chronic kidney disease stage 3, and Parkinson's disease. R50's facility assessment dated [DATE], showed she had severe cognitive impairment, range of motion impairment one-sided upper and lower extremities, and required substantial/maximal assist from staff for transfers. R50's care plans showed she was on hospice care due to a terminal condition. The care plan showed the goal was that R50 would receive emotional, physical, and spiritual support during the terminal phase of illness. Interventions in place were to approach in a calm manner and ensure a quiet environment for resident while offering activities of interest.R47's admission Record, printed on 9/25/2025, showed she had diagnoses including, but not limited to, dementia, depression, anxiety disorder, heart failure, protein-calorie malnutrition, and encounter for palliative care. R47's care plans, provided by the facility on 9/25/2025 showed she is receiving hospice services. R47's care plan showed R47 will be enabled to live to the limit of potential in physical, mental, emotional, and spiritual health and will be kept as comfortable and as pain free as possible.On 9/23/2025, between 9:30 AM-10:00 AM, R5 was heard yelling two times. V5 (Registered Nurse-RN) identified the resident that was yelling as R5. V5 said it is a behavior and she does it frequently. At 10:23 AM, R5 was heard yelling out again. At 10:25 AM, R5 was lying in her room, in the middle bed of a three-bed room. R50 and R47 were the residents that occupied the other beds. R50 was in a low bed with mattresses on both sides of the bed. V23 (R50's Daughter/POA) was sitting next to R50 holding her hand. This surveyor asked V23 if she could speak to her in private for a moment, V23 agreed. V23 said R50 was placed on hospice care a little over a week ago. V23 said R50 communicates very little and she (V23) struggles with R5 being in the same room as R50 because R5 swears and yells out frequently. V23 said R5 tells her (V23) to get out when she is in the room. She (R5) has said she is going to kill me and call the FBI. V23 said it is not peaceful. V23 said R50 was placed on hospice care for comfortable, peaceful, end-of-life care. V23 said she does not think it is peaceful with R5 yelling. At 10:43 AM, R5 was yelling again. V19 (Certified Nursing Assistant-CNA) said R5 yells out a lot. It is a behavior. At 3:00 PM, R5 yelled out Hello, where is she. Can you help just for a minute? R50 was lying in bed with her eyes closed. This surveyor knocked and asked R5 if she needed something. R5 was still yelling when she said Yes, I want that curtain pulled back. I can't see anyone and how am I supposed to call the nurse or anyone for help. When asked if she put the call light on, if staff would come see what she wanted. R5 said what call light. This surveyor pointed out the call light next to her and R5 said Why don't you push it and see what the hell happens. This surveyor put a glove on and pushed the call light. The call light lit up in the hallway. R5 said Yeah, don't leave any fingerprints. This surveyor informed R5 that it was for her protection surveyor did not touch her call light. R5 said Yeah right. Pull the curtain back. (she was saying all this very loud). This surveyor informed R5 I would get someone to help her. She said, Oh another one of them huh? As surveyor went out to get someone to assist R5, she started yelling again. At 3:06 PM, R9 was propelling herself down the hall. R9 stopped in front of this surveyor as she was walking out of R50's, R47's and R5's room. R9 asked if this surveyor was having fun with their screamer. R9 said, If I didn't know a lot of words, I could learn some from her. R5 yelled out Can someone help. I want that curtain pulled back. At 3:07 PM, V20 (Registered Nurse-RN/Charge Nurse) was informed of R5's yelling and agitation regarding the curtain being pulled. V20 said We left it like that because (R50) is dying, and her family was here. V20 went into the room and pulled the curtain back.On 9/24/2025 at 10:10 am, R50 was observed in a different room, down the hall. V23 (R50's (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	daughter/Power of Attorney) was sitting next to R50, holding her hand. V23 thanked this surveyor for helping to get R50 moved to another room. V23 stated, (R5) was getting out of control with her yelling. V23 said one of the nurses working the previous night said she spoke to someone in management and told them they need to get R50 out of that room because R5's yelling is too much.On 9/24/2025 at 10:13 AM, R5 was sitting in her geriatric chair in the hall. R5 was yelling out. When R5 saw this surveyor, she said very loud Did you go to New York to get the pills. This surveyor was in the process of clarifying that was what she asked. R5 yelled Get over here. Quit dragging your feet. Did you go to New York to get the medicine? This surveyor informed R5 she does not work at the facility. R5 started yelling again, telling this surveyor her pants were dragging to pull up her pants. R47, (R5's other roommate) was in the hall near R5 while she was yelling. R47 was also on hospice care. R47's head was back, and her eyes were closed. At 1:08 PM, R5 was in her room screaming and swearing. Telling staff to get in there. R5 hit the side of the chair and yelled, Somebody get in here now. This surveyor went to the doorway and asked if she needed help. R5 yelled, I need out of this chair and into bed now. This surveyor informed R5 that she would get someone to help her. R5 said of course you are. As soon as this surveyor walked out of the room, R5 started yelling again. V5 (RN) was in the hall, just outside of the room, assisting another resident. R5 started calling V5 names. One of the CNAs went in to help R5.On 9/24/2025 at 1:26 PM, V21 (Hospice RN) said the goal of hospice care is to provide comfort and symptom management for the resident until their end-of-life transition. A calming, comfortable environment. V21 said a roommate yelling and swearing is not conducive to a calm environment.On 9/25/2025 at 8:43 AM, V2 (Director of Nursing-DON) said R50 was moved to that room to be close to the nurses' station due to falls. At 9:19 AM, V2 (DON) said R50 was already in that room. We put R5 in the room later. R5 was in another room. V2 said it is not fair to (R47 and R50) to have R5 in with them. In hindsight, I was looking at it from a fall risk. We moved R5 in there because she is also a fall risk. V2 said R47 has been on hospice a very long time. V2 said, Now, thinking about it and knowing that R50 was imminent, I would have moved R5. V2 said R5 is always like that.On 9/25/2025 at 10:28 AM, V3 (Assistant Director of Nursing-ADON) said R5 does have behaviors. We have staff reapproach; a different staff may work better. V3 said R5 has medications for her delusional disorders and depression, however, half of the time R5 refuses the medications.On 9/25/2025 at 1:39 PM, V20 (RN-Charge Nurse) said on 9/23/2025, sometime on second shift, she tried notifying V1 (Administrator) and V2 (DON), then got in touch with V3 (ADON). V20 said R5 was being extra vocal. I let them know we need to move her to another room because it was not the proper environment for hospice residents. V20 said R5 has behaviors. This is not something new. Everyone can hear R5.The facility's Dignity policy, with a reviewed date of August 2025, showed each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. 1. Residents shall be treated with dignity and respect at all times. 2. Treated with dignity means the resident will be assisted in maintaining and enhancing his or her self-esteem and self-worth.

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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 wound care was provided in a manner to prevent cross contamination and failed to apply tubular compression stockings for a resident with swelling. This applies to 2 of 2 residents (R58, R61) reviewed for quality of care in the sample of 35.The findings include: 1. R58's admission Record (Face Sheet) showed diagnoses to include chronic venous ulcer of the left leg, stage 4 pressure ulcer of the buttock, and diabetes. On 9/23/25 at 10:31 AM, R58 was in his room. R58's cotton gauze dressing to his left leg extended from just below his knee to his foot. The dressing had a 4-inch circle of bloody drainage visible on the exterior of the dressing. On 9/23/2025 at 11:18 AM, V7 Licensed Practical Nurse (LPN) began preparations to change R58's left leg dressing. V7 used scissors to cut and remove part of R58's soiled dressing. V7 then set the scissors down on her clean tray of dressing supplies; V7 did not sanitize her scissors. After V7 removed R58's dressing, she changed her gloves; however, she did not sanitize or wash her hands prior to donning the new gloves. V7 then cleansed R58's wound, changed her gloves, but V7 did not sanitize or wash her hands. V7 then used her scissors to cut R58's oil emulsion dressing and calcium alginate dressing. V7 then applied the oil emulsion dressings and calcium alginate dressings to R58's open and draining left leg wounds. On 9/24/2025 at 11:12 AM, V2 Director of Nursing (DON) stated scissors should be disinfected after cutting potentially soiled dressings and prior to cutting clean dressing materials. V2 stated the purpose of disinfecting scissors is to prevent cross-contamination and to prevent wound infection. V2 stated, during wound care, nursing staff should be sanitizing with alcohol-based hand sanitizer or washing hands prior to donning new gloves. V2 stated the purpose of hand hygiene prior to donning gloves, is to prevent cross-contamination and to prevent possible wound infection. The facility's PPE (Personal Protective Equipment) Gloves policy (Approved 7/2017) showed, Gloves must be worn when handling blood, body fluids, secretions, excretions, mucous membranes and/or non-intact skin.8. Wash your hands after removing gloves. The facility's Skin Management (Wound Policy; Revised 9/2024) showed, Goals: Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, assessed, and provided appropriate treatment to promote healing. 2. On 9/23/25 at 11:16 AM, R61 was sitting in a padded wheelchair in the dining room with family visiting her. R61's feet were elevated on the footrest. R61 did not have the tubular compression stockings on her bilateral lower extremities. On 9/23/25 at 1:52 PM, R61 was on her back in bed. V11 Certified Nursing Assistant (CNA) was asked to check R61's legs with the surveyor. V11 pulled the sheet back that were covering R61's legs and R61's pants were down around her ankles. R61's legs were bare; she did not have any tubular compression stocking in place. On 9/23/2025 at 1:54 PM, V12 Registered Nurse (RN) stated R61's tubular compression stockings are put on early in the morning by the night nurse. The nurse should have documented if there was a (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	problem. V12 stated she did not hear anything in report regarding R61's tubular compression stockings. On 9/24/25 at 9:54 V2 Director of Nursing (DON) stated, every physician order should be followed. If an order is not followed, it should be documented why the order was not followed. The nurse should reach out to the physician and get orders. Staff are expected to let the nurse practitioner know if a resident refuses something that is ordered and they should document if a new order or no new orders were received. V2 stated the tubular compression stocking order for R61 should be followed. On 9/25/25 at 11:33 AM, V1 Administrator stated the facility did not have a policy for following physician orders. A review of R61's Progress Notes dated 9/16/25 to 9/23/25 did not show any documentation of refusal and/or problems with tubular compression stockings. The September 2025 Medication Administration Record for R61 showed to apply the tubular compression stockings in the morning and to remove at bedtime. R61's MAR showed on 9/23/25 at 7:00 AM the nurse signed off that the tubular compression stockings were applied. The Care Plan dated 9/22/25 for R61 showed she is at risk for impaired skin integrity related to fragile skin, bilateral lower extremity edema with need for knee high socks/tubular compression stockings. R61's care plan did not have any other information regarding the use, application, and removal of the stockings. The Face Sheet dated 9/24/25 for R61 showed diagnoses including chronic kidney disease, dementia, peripheral vascular disease, hypothyroidism, hypertension, generalized edema, and heart failure.

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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 a resident's pressure injury dressing was intact for 1 of 1 resident (R29) reviewed for pressure in the sample of 35. The findings include:On 9/23/25 at 1:57 PM, V12 Registered Nurse (RN) went into R29's room to change the dressing on the pressure injury to the resident's sacral area. V12 pulled R29's covers back and turned her on her side. R29's open sacral wound was not covered, and the dressing was barely attached at the bottom of the dressing. R29's dressing was soiled with drainage and an odor present. On 9/24/25 at 9:54 AM, V2 Director of Nursing (DON) stated staff should be monitoring the wound dressing to make sure it is intact. The Certified Nursing Assistant (CNA) should let the nurse know anytime a dressing becomes loose or is off so it can be reapplied. The CNA should let the nurse know if the dressing is soiled and needs to be changed. It is important for the dressing to remain in place to help with healing. The treatment is in place for a reason. Open wounds can get infected, so the dressing helps prevent infection and promote healing.The Face Sheet dated 9/24/25 for R29 showed diagnoses including anxiety disorder, hypertension, depression, mild protein calorie malnutrition, postherpetic polyneuropathy, chronic obstructive pulmonary disease, neuromuscular dysfunction, edema, and multiple sclerosis.The Wound Care Progress Note dated 9/19/25 for R29 showed she has a stage 4 pressure wound to her sacrum that is full thickness. The dressing treatment plan showed, Primary dressing - alginate calcium with silver once daily and as needed: if saturated, soiled, or dislodged. Secondary dressing - gauze island with border, apply once daily and as needed: if saturated, soiled, or dislodged. Peri wound treatment - skin prep apply once daily and as needed: if saturated, soiled, or dislodged. The Care plan dated 7/28/25 for R29 showed she is at risk for impaired skin integrity: multiple sclerosis, chronic obstructive pulmonary disease, and mild protein-calorie malnutrition, history of sacral pressure ulcer, bowel incontinence. Check skin daily The care plan did not show the resident currently has a stage 4 pressure ulcer and treatments.The Minimum Data Set (MDS) dated [DATE] for R29 showed she is dependent for toileting; needs substantial/maximal assistance for bed mobility, transfers, and dressing.The facility's Skin Management policy (9/24) showed, residents with wounds and/or pressure injury and those at risk for skin compromise are identified, assessed, and provided appropriate treatment to promote healing. Ongoing monitoring and evaluation are provided to ensure optimal resident outcomes. The clinician will document preventative measures on the care plan. The licensed nurse will monitor, evaluate, and document changes regarding skin condition (to include dressing, surrounding skin, complications, and pain) in the medical record.

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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. Based on observation, interview, and record review the facility failed to ensure a catheter tubing secure device was in place and did not clean the drainage spout on the catheter after emptying the drainage bag for 2 of 2 residents (R29 & R11) reviewed for catheters in the sample of 35. The findings include: 1. On 9/23/25 at 1:57 PM, V12 Registered Nurse (RN) was at R29's bedside to change the dressing to the resident's pressure ulcer on her sacrum. R29 had an indwelling urinary catheter with a lot of sediment in the tube and amber urine in drainage bag. The catheter tubing was hanging and pulling to the side; no secure device was in place. V12 stated they use a secure device on catheter tubing, and no one let her know that R29 did not have one in place. V12 stated the secure devices are used to prevent the catheter from getting pulled out. On 9/24/25 at 9:54 AM V2 Director of Nursing (DON) stated the facility has leg straps that are used for anyone with a foley. The straps should be in place. V2 stated the straps help stop the pulling and tugging of the tubing. The strap secures the tubing in place, helps to prevent breakdown in that area, and the catheter from coming out. The Face Sheet dated 9/24/25 for R29 showed diagnoses including anxiety disorder, hypertension, depression, mild protein calorie malnutrition, postherpetic polyneuropathy, chronic obstructive pulmonary disease, neuromuscular dysfunction, edema, and multiple sclerosis. The Physician Orders dated September 2025 for R29 showed Indwelling urinary catheter: 16 or 18 French; No more than 10cc in balloon. May change catheter if displaced, clogged or no urine output to assure catheter patency related to neurogenic bladder. The Care Plan dated 7/28/25 for R29 showed she has an indwelling urinary catheter related to neuromuscular dysfunction of the bladder. Monitor placement of tubing. R29 will adjust placement of tubing at times and not realize it is on the floor. The care plan did not show the use of a device to anchor the resident's catheter tubing. The facility's Indwelling Catheter Care and Maintenance policy (3/2025) did not show any information regarding the use of a device to secure the catheter tubing. 2. R11's admission Record, printed on 9/24/2025, showed she had diagnoses including, but not limited to neuromuscular dysfunction of bladder, paraplegia, autonomic neuropathy, and anxiety disorder. R11's Order Summary Report, printed on 9/24/2025, showed an order for an indwelling catheter related to a diagnosis of neurogenic bladder (a condition in which a person lacks bladder control due to brain, spinal cord or nerve problems). The Order Summary Report showed an order to maintain enhanced barrier precautions to prevent infections related to indwelling catheter. R11's care plans showed she was on Enhanced Barrier Precautions related to an indwelling catheter and history of MRSA (methicillin-resistant Staphylococcus aureus). The care plan showed staff should wear gowns and gloves when having high-contact resident care activities. R11's care plans showed she has an indwelling catheter and a colostomy and is dependent on staff for toileting/peri-cares. R11's 8/20/2025 facility assessment showed she is cognitively intact. On 9/24/2025 at 1:14 PM, V6 (Certified Nursing Assistant-CNA) went with R11 to her room to empty her urinary drainage bag. While emptying the urinary drainage bag, the end of the catheter tubing touched the container she was emptying it into twice. 300 milliliters of orangish-colored urine was (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	emptied into the container. V6 did not clean the end of the tubing and reattached the tubing to the catheter bag. On 9/25/25 at 9:27 AM, V2 (Director of Nursing-DON) said if the catheter tubing touched the container, it should have been cleaned with alcohol swabs. The expectation is that the end of tubing would not touch the container. V2 said after the urinary drainage bag is emptied, the tubing should be wiped with an alcohol pad, even if it does not touch the container, to prevent infection and to keep it clean. V2 said the containers are just rinsed out, not disinfected. The facility's policy titled Indwelling Catheter care and Maintenance, with a reviewed date of March 2025, showed CARE OF INDWELLING CATHETERS: 1. Indwelling catheters should be cleansed at least daily; with focus on the site where the catheter enters the body, and the tubing, (see Peri-Care Policy). 2. Keep the drainage bag below the level of resident's bladder. 3. Keep the drainage bag off the floor 4. Keep the catheter tubing free of kinking to prevent blocking the flow of urine in the tubing. 5. Provide resident dignity by placing the drainage bag in a dignity bag when in public areas 6. Empty the drainage bag every shift and as needed. The policy does not address cleaning the end of the tubing (spicket) after emptying or avoiding contact of end of tubing (spicket) with the container.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to administer medications at ordered times. There were 25 opportunities with 3 errors resulting in a 12% medication error rate.The findings include: R47's electronic face sheet printed on 9/24/25 showed R47 has diagnoses including but not limited to psychotic disorder with delusions, dementia without behaviors, anxiety disorder, and adjustment disorder.R47's medication administration record for September 2025 showed R47 receives Hydroxyzine 50mg at 8AM and 4PM, Seroquel 25mg at 8AM, 12PM, and 8PM, and Lorazepam 2mg at 8AM, 12PM, and 4PM.On 9/23/25 at 9:50AM, V5 (Licensed Practical Nurse) administered R47's Hydroxyzine 50mg, Seroquel 50mg, and Lorazepam 2mg. (1 hour and 50 minutes past the scheduled administration time).On 9/23/25 at 10:25AM, V5 stated there is no reason why she is administering medications late other than she is a newer nurse still trying to learn the process. During the medication observation, 2 other nurses were observed completed with their medication pass and available to assist V5. V5 stated she did not ask for any assistance with completing her medication pass because she needs to learn a routine to keep herself on track. When asked how many residents still needed to receive their medications, V5 stated, a lot.On 9/24/25 at 1:56PM, V2 (Director of Nursing) stated, All medications should be given 1 hour before or 1 hour after their scheduled administration times. There are 3 nurses working on day shift so if a nurse needs help all she needs to do is ask. Timing of medications is one of the 5 rights of medication administration so if it is given at the wrong time then it is an error.The facility's policy titled, Medication Administration-General Guidelines dated November 2021 showed, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so.4. Five rights- right resident, right drug, right dose, right route, and right time are applied for each medication being administered.12) Medications are administered within 60 minutes of scheduled time, except before, with or after meal orders.