STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146017	A. Building B. Wing	02/24/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Haven of Champaign	1315 Curt Drive, Suite B Champaign, IL 61821

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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 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 record and maintain documentation for food temperatures taken prior to meal service and temperatures of refrigerator and freezers used to store facility food. This failure has the potential to affect all 50 residents residing in the facility. Findings Include: The Service of Food policy, last revised in June 2023, documents foods will be held between 135- and 140-degrees Fahrenheit or higher for service. Food temperatures should be taken on the food service line by the culinary team prior to serving each meal and recorded in a temperature logbook. On 2/22/26 at 1:15 PM V8 [NAME] confirmed he did not document food service line temperatures on the log sheets for that day's noon meal. V8 also confirmed there were other meals on the log with no temperatures documented. The Weekly Food Temperature Sheet dated February 2026 was missing documentation for meal temperatures for nine meals total from 2/1/26 through 2/22/26. The Record of Refrigeration Temperatures log dated February 2026 was missing refrigerator and freezer temperatures for three days (2/19, 2/20, 2/21) and only ever recorded temperatures once per day. The Food Storage policy, last revised in June 2023, documents the facility will monitor refrigerator and freezer temperatures twice daily and they will be recorded on temperature monitor log sheets. On 2/23/26 at 2:50 PM V7 Dietary Manager stated staff should be monitoring refrigerator and freezer temperatures twice daily and recording them on the temperature monitor log sheets. V7 also confirmed staff should be taking temperatures on the food service line prior to serving each meal and recording them on the log sheet. The Long-Term Care Facility Application for Medicare and Medicaid dated 2/22/26 documents a facility census of 50 residents.

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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide food to six residents (R31, R20, R19, R7, R28, R10) that was attractive palatable, and in a form, they could easily consume of 37 residents reviewed for dining in a sample of 37 residents.Findings include: The facility's Service of Food policy, revised June 2023, states: PolicyIt is the policy of Extended Care LLC to distribute and serve food in a safe, accurate, timely, and acceptable manner. PurposeThe purpose of this policy is to create an exceptional culinary experience for residents that reflects the philosophy and vision of the organization and is delivered in the most efficient and safe manner. Process Hot foods will be held at 135–140 degrees F or higher, and cold foods will be held at 40 degrees F or below for service. Properly cooked roasts may be held at 130 degrees F or above. Maintain cold food at 41 degrees F or below. Frozen food must remain frozen. Food temperatures will be taken on the line by culinary team members prior to serving each meal and recorded in a temperature logbook. Temperatures will be taken using a sanitized food probe. Hot and cold production orders will be provided daily to prep and line culinarians, communicating the type and modification of foods in the amounts specified. Appropriate hot and cold foods will be prepared fresh in the main kitchen as required and transported to the satellite kitchen. Hot foods will leave the kitchen above 140 degrees F and cold foods below 41 degrees F. Culinary staff will be responsible for delivering food carts to the appropriate areas. Residents will be served meals by a Culinary Host in the main dining room. All meals will be served in a timely manner. Dietary aides are responsible for clearing and cleaning tables in the dining room. 1.R31's Minimum Data Set (MDS) dated [DATE] documents R31 is cognitively intact. On 2/22/26 at 12:15 p.m., R31 was observed sitting at the lunch table with her lunch in front of her. The meal included a slice of roast pork, mashed potatoes, Brussels sprouts, a cookie, and beverages. When asked how lunch was, R31 stated, The pork is really tough. R31 attempted to cut the pork with a butter knife but was unable to. The pork appeared dry. The Brussels sprouts appeared pale and mushy. 2. R20's MDS dated [DATE] documents R20 is mildly cognitively impaired. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 2/26/25 at 12:20 p.m., R20 was seated in the common area with his lunch in front of him. R20 was served roast pork, mashed potatoes, Brussels sprouts, a cookie, and beverages. When asked how lunch was, R20 stated, I don't have teeth and I can't eat the meat. It's tough. R20 pointed to pieces of meat he had attempted to chew but had to spit out because they were tough. The pork appeared dry. The Brussels sprouts appeared pale and mushy. On 2/22/26 at 12:30 p.m., the surveyor requested to sample the pork roast and Brussels sprouts. Even with gravy, the meat was very difficult to cut and chew and was dry. The Brussels sprouts were mushy and watery and had very little taste. 3. On 2/22/26 at 12:45 p.m., the surveyor took the remainder of the pork roast to V6, Regional Nurse, and demonstrated how difficult it was to cut and chew. V6 verified the pork was tough and the Brussels sprouts were mushy and pale. On 2/24/26 at 9:43 a.m., V11, Registered Nurse (RN), stated R7 and R19 have voiced concerns to her regarding cold and undesirable food on several occasions. On 2/24/26 at 10:27 a.m., R19 stated she is often served cold food, with breakfast being the worst. R19 stated the steamed vegetables the facility serves are mushy and unappealing. R19 stated the food is often bland and the meat is frequently difficult to chew. 4. On 2/24/26 at 1:18 p.m., R19 was observed sitting in her room in a wheelchair with a plate of uneaten food on a bedside table. The plate contained a large portion of meat, Brussels sprouts, and mashed potatoes that appeared extremely dry. R19 stated the meat was pork and was extremely tough to cut or chew. R19 attempted to demonstrate cutting the meat with her fork but was unable to do so. R19 stated the mashed potatoes were very dry and moved them around the plate, causing them to crumble into a clumpy consistency with a powdery texture. R19 stated the Brussels sprouts were very mushy and unappealing to eat. R19 demonstrated by smashing one on the plate and stated, See how much water comes out of these? On 2/24/26 at 10:58 a.m., R7 stated she received a piece of pork loin a few days earlier at lunchtime that was cold and too tough to chew. R7 stated breakfast meals she receives at the facility are cold more often than not. R7 stated she feels the food quality at the facility is unacceptable. R19's care plan documents an admission date of 1/9/26 with diagnoses including Anxiety Disorder, Essential Hypertension, and Nondisplaced Fracture of the Seventh Cervical Vertebra. R19's undated care plan documents the resident is to receive a no-added-salt, regular-texture, thin-liquid diet. R19's Minimum Data Set, dated [DATE] documents a Brief Interview for Mental Status score of 15, indicating R19 is cognitively intact. R7's care plan documents an admission date of 1/15/26 with diagnoses including Chronic Kidney Disease Stage 4, Type 2 Diabetes Mellitus with Hyperglycemia, personal history of urinary infections, and hypertension. R7's diet order documents R7 is to receive a no-added-salt/low-concentrated-sweets diet with regular texture and consistency. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's Minimum Data Set Section C dated 1/26/26 documents a Brief Interview for Mental Status score of 13, indicating R7 is cognitively intact. 5. On 2/22/26 at 12:37 p.m., R28 was observed in the dining room consuming only 75% of her pork roast during lunch. R28 stated the meat was too tough. R28's MDS dated [DATE] documents R28 is alert and oriented. 6. On 2/22/26 at 12:37 p.m., R10 was observed in the dining room eating lunch. R10's meal included pork roast, a dinner roll, mashed potatoes with gravy, Brussels sprouts, a cookie, and two glasses of beverages. R10 stated she liked the mashed potatoes and Brussels sprouts but that the meat was tough. R10's MDS dated [DATE] documents R10 is alert and oriented.

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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 treat residents with dignity and respect, and provide care for each resident in a way that promotes their quality of life. This failure affected three of three residents (R3, R12, R18) reviewed for dignified care on the sample list of 37.Findings Include: The Facility's Resident Rights for People in Long-Term Care Facilities policy dated November 2018 documents the facility must treat each resident with dignity and respect and must care for each resident in a manner that promotes their quality of life. 1. R3's Minimum Data Set, dated [DATE] documents R3 is cognitively intact and requires staff assistance for showering, transfers, hygiene and toileting. On 2/22/26 at 9:33 AM R3 stated she does not like how the staff always rush through things when providing her care. R3 stated she feels like staff view her as a task and not a human. The staff don't seem caring and do not provide thorough care. R3 stated staff often rush through her showers and she doesn't feel clean and doesn't get dried off completely before they are trying to put on her clothes. R3 stated staff often will provide incontinence care and assist her when she is wet but often do not change her bedding when it is soiled and instead just throw another sheet on top of the dirty one. R3 stated she believes she should feel comfortable and well cared for and she does not. On 2/22/26 at 9:35 AM R3's bed was covered with multiple blankets. One blanket appeared soiled and had another blanket folded and laid on top of it. On 2/23/25 at 11:00 AM R3's bed had the same blankets on it from the day before but had an added folded up sheet in the middle of her bed that was visibly soiled. 2. R12's Minimum Data Set, dated [DATE] documents R12 is cognitively intact and requires staff assistance for showering, transfers, hygiene and toileting. On 2/22/26 at 9:33 AM R12 stated staff are always rushed. They seem disinterested and most of them don't seem to really care. Many staff make it seem as though you are bothering them. 3. R18's Minimum Data Set, dated [DATE] documents R18 is cognitively intact and requires staff supervision for showering, transfers, hygiene and toileting. On 2/22/26 at 10:35 AM R18 stated staff all appear rushed or have bad attitudes. Staff make it seem like they never have time to care for residents. R18 stated he can do a lot for himself, but his roommate (R5) needs a lot of help. Staff often tell R5 they will be back to help him and don't return for over an hour. R18 stated the housekeeping staff quickly clean around everything and never move anything or take the time to thoroughly clean the floors, around the edges, or underneath things. R18 stated he would like the staff to appear like they are here to care for people not just cash a paycheck. 2/23/26 at 2:40 PM V2 Director of Nurses confirmed staff should be moving at the resident's pace and not make them feel rushed. Staff should create a caring environment where residents feel well cared for and comfortable. Staff should be completing things thoroughly and with the residents' needs and feelings in mind.

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide necessary feeding assistance for a resident who was observed eating with his hands. This failure affected one (R4) of three residents reviewed for nutrition from a total sample of 37 residents.Findings include:On 02/22/2026 at 8:28 a.m., R4 was observed lying in bed with the head of the bed elevated, eating breakfast using his fingers, and no eating utensils were present on the tray. R4's meal consisted of scrambled eggs, a pancake with syrup, sausage, and cream of wheat, with cranberry juice and water provided. R4 was unable to answer questions and responded only with yes/no answers.On 02/24/2026 at 8:15 a.m., V19 (R4's family member) stated that R4 wants to be independent and that his stroke affected his right side, making it more difficult for him to use utensils with his left hand. V19 stated he does not know how R4 would feel knowing he was having to use his hands to eat. V19 further stated that he does not feel the facility has done much to help R4 maintain the abilities he had regained while receiving therapy at the hospital following his stroke. V19 recalled an occasion during a visit when R4 was served spaghetti and was eating it with his hands. V19 stated that R4 remains in bed most of the time, and although he had hoped to eventually take R4 home to live with him, he no longer feels this is possible because R4 has lost significant functional ability and now requires around-the-clock care. V19 stated he believes R4 would benefit from therapy but was told at admission that the facility did not currently provide therapy services.R4's Electronic Medical Record (EMR) documents that R4 was admitted to the facility on [DATE].R4's Minimum Data Set (MDS) dated [DATE] documents that R4 has the following health conditions: aphasia, hemiplegia or hemiparesis (right side), and dysphagia.R4's MDS dated [DATE] documents that R4 requires partial to moderate staff assistance with eating, defined as the helper performing less than half of the effort. This level of assistance is described as the helper lifting, holding, or supporting the resident's trunk or limbs while providing less than half of the total effort required.R4's MDS dated [DATE] documents that R4 has severe cognitive impairment.R4's Care Plan dated 3/7/2024 documents that R4 is dependent on staff to complete activities of daily living tasks and requires one-person assistance.On 02/24/2026 at 9:00 a.m., V14, Licensed Practical Nurse (LPN) and MDS Coordinator, stated she is responsible for the facility's restorative program, which she took over in December. She reported that she is new to the role and still learning the processes. V14 stated that V18, Restorative CNA, is the program aide who works directly with residents and would have more information regarding interventions in place for R4. V14 stated she was aware that R4 uses his hands to eat finger foods and was unsure whether any therapy assessments had been completed to determine if R4 would benefit from modified utensils or plates.On 02/24/2026 at 10:52 a.m., V18, Restorative CNA, stated she is familiar with R4 and reported that he is impaired on his right side and requires supervision for eating. V18 stated that the CNAs are primarily performing restorative tasks with R4. V18 was unable to provide documentation showing that R4 was participating in the Restorative Program as outlined in his Care Plan.On 02/24/2026 at 1:29 p.m., V2, Director of Nursing (DON), stated that R4 is a hand eater and is provided finger foods. V2 stated she does not believe R4 has participated in any type of Occupational Therapy and that she is only aware of Restorative Therapy provided by the facility.The policy documents that guidelines for this policy are in accordance with the comprehensive assessment. Together with respect for individual resident needs and choices, the facility provides care and services for a variety of activities, including eating meals and snacks.This policy documents that the professional team, in collaboration with the resident and/or resident representative:Will recognize and evaluate an inability to perform ADLs or risk for decline in any ability to perform ADLs.Will develop and implement interventions in accordance with the resident's evaluated needs, goals for care, and preferences and will address the identified limitation in the ability to perform ADLs.Will monitor and evaluate the resident's response to care plan interventions and treatments.Will revise the approaches to care as appropriate.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to assess residents using antipsychotics, failed to identify and track resident specific targeted behaviors, and failed to follow physician's order for gradual dose reduction for three residents (R43, R13, R2) of five residents reviewed for psychotropics in a sample list of 37 residents.Findings Include: 1. R43's Medication Administration Record (MAR) for February 2026 includes a current order initiated 1/29/26 for Seroquel Oral Tablet 25 mg (Quetiapine Fumarate): give 1 tablet by mouth two times a day for Major Depressive Disorder and Anxiety. On 2/22/26 at 9:15 a.m., R43 was seated in a wheelchair in her room. R43 reached down with her right hand several times as though she was picking something up from the floor. There was nothing visible that she was reaching for. On 2/24/26 at 2:00 p.m., V2, Director of Nursing, verified no baseline assessment was performed when R43 was ordered Seroquel in January. V2 provided a generic list of behaviors and interventions to support that the facility is tracking behaviors; however, when asked if R43 regularly picks up invisible objects from the floor, V2 stated, All the time. We are afraid she will fall, so we monitor her. V2 verified the facility is not tracking that behavior and has not identified an effective intervention related to it. 2. R13's Medical Diagnoses List dated February 2026 documents R13 is diagnosed with Schizoaffective Disorder, Bipolar Disorder, Anxiety, and Depression. R13's Physician Order Sheet documents R13 was started on Lurasidone (antipsychotic) 40 milligrams per day on 5/8/25 for bipolar disorder. This medication had a dosage increase on 2/5/26 to 60 milligrams per day. R13's Behavior and Psychotropic Medication Reviews from 10/1/25 and 12/1/25 did not include Lurasidone. On 2/23/26 at 2:45 p.m., V6, Regional Clinical Nurse, confirmed the facility did not complete quarterly psychotropic medication assessments for R13's antipsychotic medication, Lurasidone. V6 confirmed the facility should be monitoring this medication closely and that the quarterly assessments should include all psychotropic medications. 3. R2's Minimum Data Set (MDS) dated [DATE] documents that R2 has active psychiatric diagnoses that include Anxiety, Depression, Psychotic Disorder, and Schizophrenia. Section E of the same MDS indicates that R2 did not exhibit any behavioral symptoms during the assessment period, including no documented physical, verbal, or other behavioral expressions. R2's Progress Notes dated 2/12/2026 document that a Medication Regimen Review (MRR) was completed by the pharmacist, who then provided a monthly report to the Director of Nursing (DON) for necessary follow-up actions. A Monthly Pharmacist Report to the Attending Physician/Prescriber dated 2/12/2026 documents that (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's condition is stable. The pharmacist recommended attempting a Gradual Dose Reduction (GDR) of Mirtazapine from 7.5 milligrams (mg), taken by mouth at bedtime, to 3.75 mg, taken by mouth at bedtime. R2's Physician's Order Sheet documents an active order for Mirtazapine Oral Tablet 7.5 mg, to be administered as one tablet by mouth at bedtime for mood and behavioral symptoms. R2's February 2026 Medication Administration Record (MAR) documents that R2 continues to receive Mirtazapine 7.5 mg by mouth at bedtime for mood and behavior. On 2/24/26 at 1:58 p.m., V15, Licensed Practical Nurse (LPN)/MDS Coordinator, stated she has not communicated the pharmacist's recommendation for GDR of Mirtazapine dated 2/12/2026 for R2 to the psychiatrist or attending physician. V15 stated she typically waits until the psychiatrist visits residents on Thursdays and added that the psychiatrist probably won't agree anyway, stating that in the past he documented that a dose reduction was contraindicated. On 2/24/2026 at 1:29 p.m., V2, Director of Nursing (DON), stated she had not contacted the psychiatrist or attending physician about the pharmacist's recommended Mirtazapine dose reduction for R2, saying that this is V15's responsibility and that she does not have the psychiatrist's contact information. The facility's Psychotropic Medication Policy (not dated) states, This facility shall ensure that residents do not receive psychotropic drugs unless such therapy is necessary to treat a specific condition diagnosed by the attending physician or psychiatric consultant. Attempts will be made to reduce or discontinue use of such medications whenever possible without compromising residents' health and safety, ability to function appropriately, or the safety of others. The policy further states, Licensed nurses, in conjunction with the pharmacist and physician, shall be responsible for monitoring and assessing the resident's responses to antipsychotic drug therapy by reviewing behavior tracking tools, nursing progress notes, physician orders, and observation of resident behaviors. Licensed nurses shall document in the record and care plan the specific behavioral symptom(s) for which the drug was ordered. This behavior identification step is critical for proper monitoring and should be a specific behavior (e.g., biting, scratching, kicking, hitting, etc.).

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to develop a care plan to address a resident's hearing loss and implement interventions to maintain or improve his communication for one of 16 (R20) residents reviewed for care plans in the sample of 37.Findings include: R20's Minimum Data Set (MDS) dated [DATE] documents R20 is alert and oriented and has moderate hearing loss.R20's care plan, reviewed on 1/27/2026, does not include a care plan addressing R20's moderate hearing loss or interventions to assist R20 with communicating his needs effectively.On 2/22/2026 at 9:34 a.m., R20 was sitting at bedside eating breakfast but did not respond when this surveyor spoke with him. The surveyor attempted several times, speaking in a loud tone of voice, to communicate with R20 and asked if he was alright. R20 gestured toward his ear and stated, I cannot hear. R20 stated he does not have a hearing aid. R20 reported he told the facility he wanted a hearing aid and that the facility was supposed to schedule an appointment, but he did not know what happened with it. R20 stated he cannot hear anything out of his left ear and only a little out of his right ear. At that time, there were no alternative communication devices available in the room. This surveyor used paper and pen to communicate with R20, and he was able to answer questions appropriately.On 2/23/2026 at 8:31 a.m., R20 was lying in bed and was able to understand what the surveyor was saying as long as he could read her lips.On 2/23/2026 at 9:47 a.m., V4, Licensed Practical Nurse (LPN), confirmed R20 is hard of hearing. V4 stated R20 does not have a hearing aid and that no other communication devices are used, other than speaking louder and repeating themselves when communicating with R20.On 2/23/2026 at 12:01 p.m., V2, Director of Nursing (DON), stated R20 is hard of hearing and does not have a hearing aid because he keeps losing them. V2 confirmed there are no alternative communication devices used, and staff just have to speak louder for R20 to hear them.On 2/24/2026 at 9:07 a.m., V13, Social Services Director (SSD), stated, R20 is hard of hearing, but a lot of it is selective hearing. Yes, he is hard of hearing. He does not have a hearing aid. He was seen by audiology on 1/27/26. I think they were trying to get him one, but I don't think he will wear them. He never had one that I know of. He is the one that wants to be left alone. We just communicate like normal; he will usually ask what you said, and we just repeat it.On 2/24/2026 at 1:15 p.m., V2 stated she expects the V15 MDS Coordinator to include a care plan and interventions for residents who have sensory impairments.On 2/24/2026 at 1:26 p.m., V15 stated she was never asked to create a care plan for residents with sensory impairments such as impaired hearing. V15 stated she does not complete this assessment and that it is usually the Social Services Director who performs it.The facility's policy, Care Plan (Comprehensive), updated October 2022, documents, An individualized comprehensive care plan that includes measurable objectives and a timetable to meet the resident's medical, nursing, mental, and/or psychological needs is developed for each resident.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure staff provided appropriate intervention to assist a resident with moderate hearing loss to communicate his needs effectively for one of one resident (R20) reviewed for hearing loss in the sample of 37. Findings include:R20's Minimum Data Set (MDS) dated [DATE] documents R20 is alert and oriented and has moderate hearing loss.R20's care plan, reviewed on 1/27/2026, does not include a care plan addressing R20's moderate hearing loss or interventions to assist R20 with communicating his needs effectively.On 2/22/2026 at 9:34 a.m., R20 was sitting at bedside eating breakfast but did not respond when this surveyor spoke with him. The surveyor attempted several times, speaking in a loud tone of voice, to communicate with R20 and asked if he was alright. R20 gestured toward his ear and stated, I cannot hear. R20 stated he does not have a hearing aid. R20 reported he told the facility he wanted a hearing aid and that the facility was supposed to schedule an appointment, but he did not know what happened with it. R20 stated he cannot hear anything out of his left ear and only a little out of his right ear. At that time, there were no alternative communication devices available in the room. This surveyor used paper and pen to communicate with R20, and he was able to answer questions appropriately.On 2/23/2026 at 8:31 a.m., R20 was lying in bed and was able to understand what the surveyor was saying as long as he could read her lips.On 2/23/2026 at 9:47 a.m., V4, Licensed Practical Nurse (LPN), confirmed R20 is hard of hearing. V4 stated R20 does not have a hearing aid and that no other communication devices are used other than speaking louder and repeating themselves when communicating with R20.On 2/23/2026 at 12:01 p.m., V2, Director of Nursing (DON), stated R20 is hard of hearing and does not have a hearing aid because he keeps losing them. V2 confirmed there are no alternative communication devices used and that staff just have to speak louder for R20 to hear them.On 2/24/2026 at 9:07 a.m., V13, Social Services Director (SSD), stated, R20 is hard of hearing, but a lot of it is selective hearing. Yes, he is hard of hearing. He does not have a hearing aid. He was seen by audiology on 1/27/26. I think they were trying to get him one, but I don't think that he will wear them. He never had one that I know of. He is the one who wants to be left alone. We just communicate like normal; he will usually ask what you said, and we just repeat it.The facility's policy dated 04/2007, Sensory Impairments - Clinical Protocol, documents, As part of the initial assessment, the staff and physician will help identify individuals with sensory impairments, including hearing, taste, vision, smell, and touch. For a resident with impaired hearing, the staff will check for cerumen and may (as indicated) help the individual obtain a hearing evaluation, hearing aid, or employ written or other means to communicate with the individual.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow physician's orders for oxygen for three residents (R22, R33, R55) of three residents reviewed for oxygen in a sample list of 37.Findings Include: 1. R55's Physician's Order Sheet (POS) includes an order dated 12/8/25 for oxygen at two liters per minute as needed. R55's progress notes document that R55 received oxygen on 12/8/26 at three liters per minute from 1:38 PM until 11:39 PM. There is no physician's order authorizing oxygen at three liters per minute for R55. On 2/24/26 at 1:13 PM, V2, Director of Nursing, verified that R55's oxygen was increased to three liters per minute without a physician's order. V2 stated, The nurse increased the oxygen flow rate when R55's oxygen saturation went lower and he became short of breath. My expectation would be that the nurse should call the doctor to obtain an order as soon as possible after increasing the oxygen flow rate. 2. On 2/22/2026 at 9:24 AM, R33 was sitting in his wheelchair in the dining room. R33 had a portable oxygen tank on the back of his chair. The tank was observed to be empty, as evidenced by the needle on the pressure gauge being in the red zone, indicating no oxygen. R33's Face Sheet, printed 2/24/26, documents diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Obstructive Sleep Apnea, and Chronic Respiratory Failure with Hypoxia. R33's physician's order dated 5/13/25 documents, Oxygen at 2 liters per minute via nasal cannula every shift. R33's care plan dated 3/11/2024 documents, The resident has shortness of breath (SOB) related to COPD. He uses oxygen at 2 liters via nasal cannula continuously. On 2/24/2026 at 8:19 AM, V12, Licensed Practical Nurse (LPN), stated that the red zone on the pressure gauge of an oxygen tank means it is empty. V12 stated staff check residents' oxygen tanks when getting them up for the day. V12 further stated that Certified Nursing Assistants (CNAs) notify the nurse if the oxygen tank is empty and needs replacement, and that nurses also check residents' oxygen tanks when they are in common areas. On 2/24/2026 at 1:15 PM, V2, Director of Nursing (DON), stated she expects nurses to monitor residents who require oxygen and replace portable oxygen tanks before they become empty. 3. On 2/22/26 at 8:40 a.m., R22 was observed lying flat on her back in bed with the head of the bed only slightly elevated. R22 did not complain of difficulty breathing; however, her respirations appeared slightly labored when she spoke. R22 had a nasal cannula in place with oxygen flowing at 6 liters from an oxygen concentrator, and the humidification water canister attached to the concentrator was empty. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/23/26 at 10:35 a.m., R22 was observed lying flat on her back in bed. The shower aide stated she had just completed giving R22 a bed bath and was repositioning her before leaving the room. R22's bed remained flat. R22's nasal cannula was in place, and oxygen was running at 5.5 liters. On 2/23/26 at 11:12 a.m., R22 was again observed lying flat on her back with the bed flat. The oxygen concentrator was running at 5.5 liters via nasal cannula. On 2/24/26 at 8:30 a.m., R22 was observed sleeping in her bed with the head of the bed slightly elevated to approximately 20 degrees. Oxygen was running at 4.5 liters. R22 appeared to be breathing heavily while sleeping. R22's Minimum Data Set (MDS) dated [DATE] documents respiratory diagnoses including Chronic Obstructive Pulmonary Disease (COPD), Acute Respiratory Failure with Hypoxia, and Chronic Pulmonary Embolism. Section J of this MDS indicates that R22 experiences shortness of breath with exertion, when sitting at rest, and when lying flat. R22's Care Plan dated 8/14/2025 documents that the resident has COPD and emphysema and uses oxygen continuously at 2 liters. The care plan includes an intervention to keep the head of R22's bed elevated to help alleviate COPD symptoms and to position the resident in Fowler's position to facilitate breathing. Another listed intervention is to monitor R22 for difficulty breathing during exertion. R22's Care Plan dated 2/20/2026 documents that the resident has a terminal diagnosis of Heart Failure with Preserved Ejection Fraction, with the stated goal of care being to keep R22 comfortable. R22's electronic medical record (EMR) documents that a modification to the MDS is currently in progress due to a significant change in R22's condition. R22's EMR documents a physician's order dated 8/8/2024 for oxygen at 2 liters per minute via nasal cannula. R22's Treatment Administration Record (TAR) for February 2026 documents staff signatures indicating administration of oxygen at 2 liters per minute via nasal cannula; the order is dated 5/14/2026. R22's EMR documents an oxygen saturation of 85% on 2/23/2026 at 10:58 a.m. On 2/23/26 at 2:22 p.m., V4, Licensed Practical Nurse (LPN), and the writer observed R22 in her bed. At that time, V4 checked R22's oxygen concentrator settings and stated, Oh yes, R22 is often left at 6 liters because of shortness of breath. R22 is hospice, so it's okay to turn it up. Sometimes the facility staff turns it up and sometimes hospice does. V4 further stated that at lunchtime that day, V5, Certified Nursing Assistant (CNA), notified her that R22 was screaming, I need air, I can't breathe, help me. V4 stated she offered to send R22 to the hospital, but R22 declined and subsequently settled down. On 2/23/26 at 2:26 p.m., V5, CNA, stated that while staff were passing meal trays, R22 began screaming, I need air and help me. V5 stated he notified V4, LPN, who then assessed the resident. V5 confirmed that the nasal cannula was in R22's nostrils and that the oxygen concentrator was running, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stating that the water was bubbling. On 2/24/2026 at 1:29 p.m., V2, Director of Nursing (DON), stated that R22 often yells at staff to increase her oxygen flow because she feels she cannot breathe and that R22 has experienced a recent decline in condition. V2 stated she plans to educate nursing staff regarding adjusting oxygen settings without obtaining a physician's order. Policy Review The facility's Oxygen Administration policy dated March 2004 documents that the purpose of the procedure is to provide guidelines for safe oxygen administration. The policy states that, in preparation for this procedure, staff should: Verify that there is a physician's order for the procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess any special needs. Assemble equipment and supplies as needed. The policy further states that the following equipment and supplies are necessary: Portable oxygen cylinder (secured to stand) Nasal cannula or mask as ordered Humidifier bottle No Smoking/Oxygen in Use signs Regulator Personal protective equipment (e.g., gowns, gloves, mask, as needed) The policy also states that before administering oxygen, and while a resident is receiving oxygen therapy, staff should assess for: Signs or symptoms of cyanosis (bluish tone to skin or mucous membranes) Signs or symptoms of hypoxia (rapid breathing, rapid pulse, restlessness, confusion) Signs or symptoms of oxygen toxicity (tracheal irritation, difficulty breathing, slow or shallow respirations) Vital signs Lung sounds (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arterial blood gases and oxygen saturation, if applicable Other laboratory results (hemoglobin, hematocrit, complete blood count), if applicable

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to implement interventions to maintain expanded barrier precautions (EBP) for one resident (R25) who has open wounds of five residents reviewed for EBP in a sample list of 37.Findings include:R25's Care Plan initiated 2/22/26 includes the following diagnoses: presence of left artificial hip joint, presence of cardiac pacemaker, malignant neoplasm of abdomen, cataract, atrial fibrillation and flutter, hypertension, chronic obstructive pulmonary disease, congestive heart failure, wound of left great toe, peripheral vascular disease, and chronic kidney disease stage III.R25's Minimum Data Set (MDS) dated [DATE] documents R25 is cognitively intact.R25's wound assessment dated [DATE] documents R25 has an unstageable pressure ulcer on his left heel.On 2/22/26 at 9:00 a.m., R25's door was open to the hall. There was no sign on the door or anywhere else visible to indicate R25 was on Enhanced Barrier Precautions (EBP). There was no dirty linen or red trash container in or near R25's room. R25 was seated on the edge of his bed. R25 denied that staff who enter his room wear gowns or gloves when they are performing his daily wound care. R25 had a gauze wrap on his left foot and ankle and was wearing a heel protector. There was no personal protective equipment (PPE) in or near R25's room.On 2/23/26 at 10:00 a.m., there was no sign on the door or anywhere else visible to indicate R25 was on EBP. There was no dirty linen or red trash container in or near R25's room. There was no personal protective equipment (PPE) in or near R25's room.On 2/23/26 at 11:00 a.m., V2, Director of Nursing, and V3, Assistant Director of Nursing (ADON) and Infection Preventionist, were asked if R25 should be on EBP. Both stated that R25 is on EBP. After checking R25's room, V2 and V3 verified R25 did not have precautions in place.The facility's policy, Enhanced Barrier Precautions, revised 3/21/24, states, It is the practice of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms. The policy further states, Clear signage will be posted on the door or wall outside of the resident's room indicating the type of precautions, required PPE, and high-contact care activities that require the use of gown and gloves.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to complete infection surveillance documentation and ensure one resident (R25) met the criteria for initiation of an antibiotic of four residents reviewed for antibiotic stewardship in a sample of 37 residents. Findings Include:R25's Care Plan initiated 2/22/26 includes the following diagnoses: Presence of Left Artificial Hip Joint, Presence of Cardiac Pacemaker, Malignant Neoplasm of Abdomen, Cataract, Atrial Fibrillation and Flutter, Hypertension, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Wound of Left Great Toe, Peripheral Vascular Disease, and Chronic Kidney Disease Stage III. R25's Minimum Data Set (MDS) dated [DATE] documents R25 is cognitively intact. R25's Wound assessment dated [DATE] documents R25 has an unstageable pressure ulcer in his left heel and left great toe. R25's Medication Administration Record (MAR) for February documents a physician's order dated 2/5/26 for Bactrim Oral Tablet 400-80 MG(Sulfamethoxazole-Trimethoprim) Give 1 tablet by mouth every 12 hours for Wound Infection w/ cellulitis for 14 Days. This medication is documented as not given past 2/11/26 as R25 was hospitalized at that time. R25's hospital record dated 2/11/26 documents the reason for hospitalization was a ruptured abscess of the scrotum. R25's Medication Administration Record (MAR) for February also documents a physician's order dated 2/18/26 (upon return from the hospital) for Sulfamethoxazole-Trimethoprim Oral Tablet 400-80 MG (Sulfamethoxazole-Trimethoprim) Give 2 tablet by mouth two times a day for abscess for 2 Administrations. This was documented as given.The facility's infection tracking and trending for February does not include data for R25. There is no documentation to ensure R25 met the criteria for initiation of an antibiotic or the antibiotic chosen was the correct antibiotic. No cultures are documented in R25's medical record.On 2/23/26 at 2:10PM V3 Assistant Director of Nursing and Infection Preventionist stated, I guess I just missed (R25) on the tracking and verified she could not locate a McGreer Criteria or other Antibiotic Stewardship Assessment. On 2/24/26 V2, Director of Nursing verified that R25's infection should have been included in the tracking and an assessment for the appropriate use of the antibiotic should have been completed but was not. The facility's policy Antibiotic Stewardship guidelines reviewed 4/29/25 states Purpose: The purpose of antimicrobial stewardship is to promote the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration, and route of administration to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance.The purpose of the antimicrobial stewardship program is to improve antimicrobial stewardship practices and to monitor outcomes and antimicrobial use.Responsible Party: Infection Control/ QAPI Committee_____ Antimicrobial Stewardship Program will be to improve patient outcomes through optimization of antimicrobial therapy by selection of appropriate antibiotic dose, route, and duration of treatment.Potential benefits include the following: Improve patient safety by decreasing side effects and toxicity. Support the education of all healthcare providers, patients and families about antimicrobial stewardship practices including antimicrobial resistance and appropriate antimicrobial use. Minimize the development of antimicrobial resistance by appropriately selecting antibiotics. Reduce the rates of facility-acquired infections. Reduce risk of Clostridium difficile infections, disruption of normal flora and the emergence of multidrug-resistant organismsGuidelineThe facility will incorporate all seven core elements outlined by the CDC. Leadership Commitment: The facility leadership is committed to provide the necessary resources Accountability: The physician, nursing, and pharmacy are the leads responsible for promoting and overseeing antibiotic stewardship activities. Drug Expertise: The facility maintains a consultant pharmacist/other individual with antibiotic stewardship-specific drug expertise Action: The facility will implement policies and procedures to improve antibiotic use Tracking: The facility will monitor antibiotic use and outcomes (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from antibiotic use. Reporting: The facility will provide regular feedback on antibiotic use and resistance to prescribing clinicians, nursing staff, and other relevant staff Education: The facility will provide resources to clinicians, nursing staff, residents, and families about resistance and appropriate antibiotic use. The facility will utilize McGeer's criteria when considering initiation of antibiotics. The facility will work with the hospital and the attending physician for new residents that are admitted to the facility with a physician's order for a course of antibiotics to validate criteria used for initiation of antibiotics, including culture and hospital criteria used.