STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146019	A. Building B. Wing	06/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wabash Senior Living & Rehab	216 College Boulevard Carmi, IL 62821

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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to notify the physician when a pressure ulcer deteriorated for 1 (R6) of 4 residents reviewed for physician notification in the sample of 40. This failure resulted in an abrasion to the right gluteus progressing to a Stage 4 pressure ulcer that became infected, requiring R6 to be hospitalized with sepsis on two occasions and requiring surgical wound debridement. The Immediate Jeopardy began on 03/23/2026 when R6's wound was identified as deteriorating and the physician was not notified to obtain new treatments or implement new interventions. The Administrator (V1) and the [NAME] President of Clinical Services (V21) were notified of the Immediate Jeopardy on 5/27/26 at 2:36 PM. The Immediacy was removed on 5/27/26, but noncompliance remains at Level Two because additional time is needed to evaluate the implementation and effectiveness of the in-service training.1. R6's admission Record with a print date of 5/26/26 documents R6 was admitted to the facility on [DATE] and included diagnoses of major depressive disorder, atrial fibrillation, obesity, osteoarthritis, and pressure ulcer of left heel. R6's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R6 is cognitively intact. This same MDS documents R6 requires substantial/maximal assistance to roll left and right in bed and is dependent on staff for transfer. Under Section M, Skin Conditions this MDS documents R6 is at risk of developing pressure ulcers with one Stage 4 pressure ulcer documented. Under Skin and Ulcer/Injury Treatments the following interventions are documented that should be implemented, pressure reducing device for chair and bed, pressure ulcer/injury care, application of nonsurgical dressings (with or without topical medications) other than to feet and applications of ointments/medications other than to feet. R6's current Care Plan documents a Focus area of I have alterations in my skin integument. See skin and wound module for sites and updates. Date Initiated: 05/19/2026. This Focus area includes the following interventions with a date initiated of 5/19/26, Float heels while in bed.Monitor for pain and offer analgesics per order.Monitor for worsening or infection and report to PCP (primary care physician) prn (as needed).Nutritional support per order.Pressure relief device to bed/chair.RD (Registered Dietitian) consult per regulatory guidelines and prn upon request.Treatment per order.Turn/repo (reposition) q (every) 2 hours as tolerated.Weekly skin assessments. Report abnorms (abnormal) to PCP prn .Wound specialist per order. This same Care Plan documents a Focus area of (R6) has actual impairment to skin integrity r/t (related to) incontinence and limited mobility and DM2 (diabetes mellitus 2) Dx (diagnosis) Date Initiated: 06/25/2024. This Focus area includes the following interventions, 12/22/25, utilize pillows to offload pressure, 1/8/26, remind/assist resident to turn/reposition at least every two hours and as needed, 7/1/24, ensure folds are clean and dry, 5/7/26, see treatment administration records for treatment orders, 1/8/26 pressure redistributing mattress on bed and position resident off affected area. R6's Braden Scale for Predicting Pressure Ulcer Risk dated 4/11/26 documents a score of 16, indicating R6 is at low risk for skin breakdown. R6's Braden Scale for Predicting Pressure Ulcer Risk dated 4/17/26 documents a score of 13, indicating R6 is at moderate risk of developing skin breakdown. R6's Skin Issues report dated 2/16/26 documents a new (continued on next page)

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

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

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	skin issue identified as an abrasion to R6's right gluteus that measures 2.62 x (by) 2.97 centimeters (cm's). R6's Progress Note dated 2/17/26 at 12:43 AM documents, Resident is back from (name of local hospital) via ambulance transport. She was admitted to the hospital due to UTI (urinary tract infection) . Skin assessment showed new abrasion to right hip, new abrasion to right gluteus, and new open lesion to coccyx. R6's Order Summary Report dated 6/1/26 includes the following order with a start date of 2/16/26. Cleanse abrasion to right gluteus with normal saline, pat dry, apply xeroform, and cover with foam dressing. Report to MD (physician) for complications. Every night shift for altered skin integrity. R6's Treatment Administration Record (TAR) dated 2/1/26 to 2/28/26 documents a physician order with a start date of 2/17/26 of, Cleanse abrasion to right gluteus with normal saline, pat dry, apply xeroform, and cover with foam dressing. Report to MD (physician) for complications. This TAR documents initials indicating the treatment was administered as ordered. R6's Skin Issues report dated 2/24/26 documents the abrasion to her right gluteus is deteriorating and measures 2.84 x 2.5 cm's. R6's Order Summary Report dated 6/1/26 includes the following order with a start date of 2/24/26, Cleanse abrasion to right gluteus with normal saline, pat dry, manukaHD, and cover with silicone super absorbent dressing. Report to MD for complications. Every night shift for altered skin integrity. R6's TAR dated 2/1/26 to 2/28/26 documents a physician order with a start date of 2/24/26 and discontinue date of 3/11/26 of, Cleanse abrasion to right gluteus with normal saline, pat dry, manukaHD, and cover with silicone super absorbent dressing. Report to MD for complications. Every night shift for altered skin integrity. This TAR documents initials indicating the treatments were administered as ordered. R6's Skin Issues report dated 3/2/26 documents the abrasion to her right gluteus as deteriorating and measures 2.94 x 2.91 cm's. R6's Skin Issues report dated 3/9/26 documents the abrasion to her right gluteus as deteriorating, non-healing, stabbing pain, with moderate purulent drainage and a faint odor. R6's Progress Notes document the following: 3/11/26, Reviewed wound review with recommendations to add 2x (times) protein at breakfast and supper. Care plan and meal tickets updated.3/11/26, Seen (V16/Wound Nurse Practitioner) NP (Nurse Practitioner) related to wound. New order to apply triad over wound bed and leave open to air every other day and PRN (as needed), POA (Power of Attorney) called. V16's (Wound Nurse Practitioner) Nursing Home Visit Progress Note for R6 dated 3/11/26 documents this is the first time R6 is being seen by V16. This Progress Note documents the area to R6's right gluteus as an unstageable pressure ulcer that measures 3.8 x 3.5 cm's (centimeters). The Progress Note documents under, Plan: Discussed with RN (Registered Nurse). Likely needs debridement but will trial on triad for 1 week. Apply a generous amount of triad over the sacrum and buttocks. Pressure relieving measures every 2 hours while in bed and every hour while in chair. We will follow up with her in 1 week. R6's Order Summary Report dated 6/1/26 includes a physician order with a start date of 3/11/26 of, Cleanse abrasion to right gluteus with normal saline, pat dry, apply triad over wound bed, and leave open to air, every other day and PRN (as needed). Report to MD for complications. Every night shift on even days for altered skin integrity. R6's TAR dated 3/1/26 to 3/31/26 documents a physician order with a start date of 3/12/26 and discontinue date of 3/31/26 of, Cleanse abrasion to right gluteus with normal saline, pat dry, apply triad over wound bed, and leave open to air, every other day and PRN (as needed). Report to MD for complications. Every night shift on even days for altered skin integrity. This TAR documents initials indicating the treatments were administered as ordered. R6's Skin Issues report dated 3/17/26 documents the area to R6's right gluteus as an abrasion that is deteriorating, non-healing, with aching pain that measures 3.88 x 3.59 cm's. R6's Progress Notes dated 3/17/26 documents, RD (Registered Dietitian) recommends adding 2x protein at breakfast and supper d/t (due to) deteriorating wounds. POA (Power of Attorney) (POA name) aware. V16's (Wound Nurse Practitioner) Nursing Home Visit Progress Note for R6 dated 3/18/26 documents the same information verbatim as V16's progress note dated 3/11/26. On 6/1/26 at 10:10 AM, V16 (Wound Nurse Practitioner) stated she signed her note from 3/11/26 on 3/18/26 and assumes that is the 3/18/26 Progress Note referenced above. V16 stated she did not see R6 on 3/18/26 but did a record (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	review including the wound modules which documented assessments including pictures of the area. R6's Dietary Note dated 3/18/26 documents, 3/11/26 RD (Registered Dietitian) reviewed wound review with recommendations to add 2 x (times) protein at breakfast and supper. Care plan and meal tickets updated. R6's Nurses Note dated 3/23/26 documents, Resident has wound to right buttock. Increased drainage, slough, and foul odor noted. Area has adipose tissue exposed. Resident needs to see doctor. May need antibiotic. Under this note there are check marks next to, Show on Shift Report, Show on 24 hour report, Show on MD/Nursing Communications Report. This Nurses Note was signed by V26 (Licensed Practical Nurse/LPN). On 5/26/26 at 2:23 PM, V26 (LPN) stated she wrote the progress note dated 3/23/26. V26 stated she printed off the progress note and left it for V17 (Physician). V26 stated she also notified V4 (DON) of the deterioration of the pressure ulcer. V26 stated she was told R6 had recently been seen, and a new treatment had been put in place. V26 stated she assumed it had been taken care of because the physician had already been notified. V26 stated she didn't know at the time R6 was being followed by V16 (Wound Nurse Practitioner). When asked if she documented the notification to V17 (Physician), V26 stated if it wasn't documented in the progress note it wouldn't be documented. V26 stated she also discussed the deterioration of the pressure ulcer with V2 (Infection Preventionist/Wound Nurse). On 5/26/26 at 3:23 PM, V21 (Vice President of Clinical Services) showed this surveyor a line on the bottom of R6's 3/23/26 progress note that says MD/Nursing Communication. The box is checked next to it. When asked where it is documented and what V17 ordered when he was notified, V21 stated he wanted V16 (Wound Nurse Practitioner) to see and treat the pressure ulcer. The facility was unable to provide reproducible evidence V17 was notified and what V17's response was. R6's Skin Issue report dated 3/24/26 documents the pressure ulcer to R6's right gluteus as an abrasion that is deteriorating, non-healing, increased smell, intermittent pain, and moderate purulent drainage. This report documents the pressure ulcer measures at 3.88 x 4.21 cm's.R6's Skin Issue report dated 3/31/26 documents the pressure ulcer to R6's right gluteus as an abrasion that is deteriorating, red and bleeding, increased smell, heavy purulent drainage, and a strong odor after cleaning that measures 6.85 x 4.61 cm's. A telephone communication from V16 (Wound NP) provided to this surveyor by the facility dated 3/31/26 documents, Received notification from ADON (Assistant Director of Nursing who is now V4/DON) at (name of facility) insuring I was coming to the NH (nursing home) on 04/01/2026 due to deteriorating wound. Plans to round at (name of facility) tomorrow 04/01/2026. R6's Progress Notes dated 4/1/2026 documents, Wound Nurse here to see. Received order to start Doxycycline 100 mg (milligrams) BID (twice daily) x (times) 7 days. Multi Vitamin with minerals, Prostat 30 ml (milliliters) BID, obtain u/a (urinalysis) with c&s (culture and sensitivity). Res (resident) aware. V16's (Wound Nurse Practitioner) Nursing Home Visit Progress Note for R6 dated 4/1/2026 documents, . I did see the patient about 3 weeks ago and it was noted to have some necrotic tissue. RN (Registered Nurse) reports that it has significantly declined since previous visit. Assessment: 1. Pressure injury of right buttocks, unstageable.Plan: Discussed with RN. Will have her set up an appointment tomorrow for up (sic) in office debridement. Wound cultures taken. Patient to have a debridement for (sic) at 3:00 p.m. V16's (Wound Nurse Practitioner) Nursing Home Visit Progress Note for R6 dated 4/2/26 documents, History: the patient is a 60 y.o. (year old) female with a past medical history notable for type 2 diabetes, obesity, AFib (atrial fibrillation), GERD (gastroesophageal reflux disease), hypertension, SVT (supraventricular tachycardia), recurrent UTI's (urinary tract infections) who initially presented to the wound clinic for debridement of right buttocks wound. The patient resides at (name of nursing home) where I have been following her just recently for right buttocks wound. I initially saw her on 03/11 for unstageable wound. She was using triad to try chemical debridement. I followed up with her on 04/01 and the wound had significantly deteriorated. Discussed with patient and plan was made for debridement in office. Wound cultures were obtained. She presented today for debridement. Debridement was started in the office and quickly realized that it was significantly deeper than expected. I did discuss with (name of doctor) who did a debridement. It extended deep into (continued on next page)

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F 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	subcutaneous fat. Decision was made to admit patient and plan for for (sic) their debridement in the operating room. Recommend: Will plan for further debridement in OR (operating room) tomorrow. Okay for diabetic diet tonight. NPO (nothing by mouth) at midnight. Consent for debridement. IV (intravenous) antibiotics with Zosyn based on prelim cultures growing gram neg (negative) rods. Hospitalists consult for medical management. Will restart home medications. Continue with foley catheter. R6's local hospital record dated 4/3/2026 documents surgical debridement of the Stage 4 pressure ulcer to right buttocks (gluteus). This local hospital record documents under the physician Progress Note dated 4/4/26, Was called in early this morning for persistent bleeding. She had gone in and out of an SVT (supraventricular tachycardia) (she has history of and possible AFib) even in the operating room but when she did it last night, she was started on Lovenox. And then started to bleed through her dressing. Due to her persistent problems with hypotension and dysrhythmia, eventually required pressors she was transferred to (name of regional hospital) . R6's Wound Culture results dated 4/4/26 documents many (4 plus) proteus mirabilis, moderate (3 plus) gram negative rods, and moderate (3 plus) enterococcus faecalis. R6's regional hospital record admission date 4/4/26 documents, .The patient presents to (initials of regional hospital) a transfer from (name of local hospital) for evaluation of shock.Shock, hemorrhagic versus septic.Large stage IV (4) buttock pressure wound s/p (status post) debridement at (name of local hospital), wounds polymicrobial, on empiric antibiotics.On arrival to our hospital patient was in shock with low blood pressures, tachycardia. [NAME] count was elevated.Urine cultures showed Proteus mirabilis and Enterococcus aerogenes. Wound culture was growing Proteus mirabilis, Enterococcus faecalis and Serratia fonticuli. Patient was started on broad-spectrum IV antibiotics.Sepsis is present and due to pressure ulcer.Admitting Diagnosis 1. Septic versus hemorrhagic shock: Patient did receive 3 units of PRBC (packed red blood cells) transfusion.Stage IV decubitus ulcer in right buttock with superimposed infection.Hospital Course: 60 y.o. (year old) female with a past history significant for AFib, on Eliquis and metoprolol, type 2 DM (diabetes mellitus), HTN (hypertension), obesity, SVT, anxiety, neuropathy, stage IV chronic decutibitus ulcer with recent debridement admitted on [DATE] with complaints of bleeding from her surgical site. She began to decline hemodynamically requiring pressors at the outside hospital. She received 3 units of PRBC and then was requested for transfer to (name of regional hospital) for further management.On arrival to our hospital patient was in shock with low blood pressure, tachycardia. [NAME] count was elevated . On 5/26/26 at 10:49 PM, V28 (Registered Nurse) stated she was the nurse who did the first assessment on the pressure ulcer on R6's right gluteus. V28 stated the area was deteriorating and when she came back to work on 2/24/26 there was a new treatment order in place. This surveyor reviewed the Skin Issue reports from 3/9, 3/17, 3/24, and 3/31 with V28. V28 stated she would take pictures when she did the treatments so if the wound nurse came in, she would have updated pictures to review. When asked if she notified any physician of the deterioration to that pressure ulcer during the time frame of 3/9-3/31, V28 stated she assessed the area, took picture, and placed in on her report for day shift to see. V28 stated she didn't remember if there were any changes or any communication back to her related to the deterioration. On 5/26/26 at 10:44 AM, when asked if he was notified between 3/17 and 3/31/26 of any changes/deterioration to the pressure ulcer located on R6's right gluteus, V17 (Physician) stated he had reviewed R6's medical record and he didn't find any notifications from the facility. V17 stated someone may have said something to him in passing. V17 stated he couldn't say if he was notified of the deterioration but there was no documentation of notification. V17 stated V16 (Wound Nurse Practitioner) should have been notified and he knew she had said she would follow up in a week and then didn't. V17 stated if she had been notified, they could have been more aggressive with the treatment. When asked if the outcome would have been different if the area had been treated sooner V17 stated, I can't say. When asked for any documentation to show the facility had reported the deterioration in R6's wound to V16 and/or V17 between 3/11/26 and 3/31/26, an email was provided to this surveyor dated 3/18/26 documenting a message from V16 (Wound Nurse Practitioner) of, Late (continued on next page)

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She was getting ready to take a shower. Stage 4 pressure ulcer with slough present at bottom of the wound. She does have some maceration and opening surrounding the wound. This is likely from drainage in poor securement. R6's Order Summary Report dated 6/1/26 includes a physician order with a start date of 5/6/26 to, Cleanse wound with normal saline apply santyl into wound bed, cover with wound vac one time a day every Mon (Monday), Wed (Wednesday), Fri (Friday) for wound. R6's Skin Issues report dated 5/8/26 documents the Stage 4 pressure ulcer as stable and measures 7.18 x 5.65 x 3 cm's. R6's Skin Issues report dated 5/13/26 documents the Stage 4 pressure ulcer with no measurements or assessment. R6's Skin Issues report dated 5/15/26 documents the Stage 4 pressure ulcer as deteriorating with measurements of 6.69 x 8.28 x 5 cm's. On 05/18/2026 at 10:21 AM, R6 was laying in bed, covered with a blanket and denied concerns with care. There was a foul odor noted in R6's room. On 5/19/26 at 8:12 AM, this surveyor began observation of wound care with V4 (DON) present and V18 (LPN) administering care. V18 administered a treatment to R6's abdominal fold. When this surveyor inquired about the drain tubes noted on R6's back, V18 stated that was her wound vac. V18 stated that treatment was not scheduled for this date and observation would need to be done on the next day. The foul odor in the room seemed to dissipate after the abdominal fold was cleaned. On 5/20/26 at approximately 1:00pm this surveyor was told by V4 (DON) and V21 (Vice President of Clinical Services) the Nurse Practitioner (V16) had assessed R6 this morning and changed the dressing to the pressure ulcer on R6's right gluteus. V4 stated R6 was being sent to the hospital for admission for surgical debridement. This surveyor was unable to observe the wound prior to R6 leaving the facility. R6's Progress Notes dated 05/20/2026 documents the following: Seen by NP (V16) related to wound. Order given for resident to be a direct admit for surgical debridement and IV antibiotics. Wet to dry dressing completed at bedside by NP, POA (Power of Attorney) and resident aware. Res (resident) left via facility to (name of local hospital) direct admit, Report called to floor nurse. V16's history and physical note for R6 dated 5/21/26 documents, The patient is a 60 y.o. (year old) female with a past medical history.stage IV pressure ulcer who has been followed at (name of facility). Upon rounds yesterday, it was noted that the wound had significantly deteriorated, foul odor, Bedside debridement was done. Decision was made to admit the patient for possible surgical debridement and IV antibiotics. The patient was admitted .She was started on IVF (intravenous fluids) and IV (intravenous) antibiotics with Zosyn and vancomycin. Overnight, she went into SVT with HR (heart rates) sustained in the 150's. IV labetolol was attempted without success. Impression: 1. Sepsis- likely secondary to infected Stage IV pressure ulcer vs (versus) UTI (urinary tract infection). 2. Necrotic Stage IV pressure ulcer. 3. SVT - likely reactive secondary to sepsis. 4. Hypokalemia 5. Uncontrolled DM (diabetes mellitus) II (2) 6. Chronic indwelling catheter. On 5/25/26 at 11:04 PM, V24 (LPN) stated she remembered the pressure ulcer on R6's right gluteus deteriorated very fast. V24 stated it went from bad to horrible. V24 stated R6 didn't like to turn and reposition but she would encourage her to do so. When asked if she ever notified the physician of the pressure ulcer deteriorating, V24 stated the way they do it at the facility is different. V24 stated, When we submit something to the physician it feels like it hangs in the balance. When asked what that meant, V24 stated they put the information on V17's desk at the facility. When asked how she would notify the physician of a wound deteriorating, V24 stated, We would put it on his desk. V24 stated she thought V17, or his nurse practitioner came in every weekday. When asked if there (continued on next page)

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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 0580 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few Note: The nursing home is disputing this citation.	was any documentation when the physician was notified, V24 stated if it isn't charted on the progress notes, the medication administration record, or treatment administration record then essentially it wasn't done. V24 stated, Do I think there wasn't anything done, I think there was but not fast enough obviously. On 5/26/26 at 3:00 PM, V4 (DON) stated R6 returned to the facility from a hospital stay on 2/16/26 with an abrasion to the right gluteus. V4 stated the area was treated with xeroform until V17 (Physician) changed the order on 2/24/26 and referred R6 to the wound specialist. V4 stated V16 (Wound Nurse Practitioner) was notified the pressure ulcer was deteriorating on 3/9/26, V16 assessed R6 on 3/11/26 and gave an order for triad. This surveyor reviewed R6's Skin Issue reports with V4 and asked if there was any physician notification when the pressure ulcer is documented as deteriorating from 3/17/26 to 3/31/26. V4 stated on 3/18/26, V16 (Wound NP) asked me if insurance covered a new treatment she wanted to order. V4 stated the insurance did not cover it so they continued the same treatment. V4 stated V16 was supposed to assess R6 on 3/25/26 but couldn't because her children were sick. When asked if any physician was notified of the deterioration of the pressure ulcer, V4 stated, I would not say so. V4 stated the physician should have been notified. When asked if any physician was notified of the deterioration of the pressure ulcer from 5/15/26 to 5/20/26, V4 stated, Not that I see. When asked if she would expect a physician to be notified, V4 stated, Oh yeah, definitely. When asked if she had any concerns with wound care at the facility, V4 stated she didn't. V4 stated they are normally good about notifying the physician if a wound/pressure deteriorates. On 5/26/26 at 12:15 PM, when asked if she was notified of a deterioration in the pressure ulcer from 5/15/26 to 5/20/26, V16 (Wound Nurse Practitioner) stated she completed a chart review on 5/14/26 but wasn't notified of any deterioration from 5/15 to 5/20/26. V16 stated when she assessed R6 on 5/20/26, she noted a foul odor in the wound, R6 appeared sick, and was tachycardic. V16 stated the pressure ulcer needed debrided and with R6's history she had her admitted to the local hospital for surgical debridement in the operating room. V16 stated when they did the debridement the bone was exposed. This surveyor asked if R6 had osteomyelitis and V16 stated she was surprised that she didn't, but all the tests were negative. When asked if she had any concerns with wound care at the facility, V16 stated she thought they did a great job with wound care, but they needed protocols in place on when to get the wound specialist involved. On 5/26/26 at 10:44 AM, V17 (Physician) stated he thought wound care specialists were seeing R6 from 5/15/26 to 5/20/26. V17 stated he remembered talking with the facility earlier in May and they were worried about the area but V16 (Wound Nurse Practitioner) was following the pressure ulcer and had made treatment order changes. V17 stated he didn't have any documentation or remember being notified of a deterioration from 5/15 to 5/20/26. The undated facility Guidelines for Notifying Physicians of Change of Condition documents, These guidelines are intended to help ensure that 1) medical care problems are communicated to the medical staff in a timely, efficient and effective manner and that 2) all significant changes in the resident's status are assessed, documented in the medical record and communicated with the primary care physician.The charge nurse or supervisor should contact the attending physician if a clinical situation appears to require immediate discussion and management. The undated facility Assessment and documentation of wounds policy documents, The purpose of this procedure is to provide information to the primary care provider and the resident representative regarding identification of wounds/wound characteristic changes and interventions for specific risk factors.1. Report changes in wound characteristics to the PCP (primary care physician) and the resident representative.3. Document the interaction in the progress notes including the PCP whom was contacted and the resident representative. The Immediate Jeopardy that began on 3/23/26 was removed on 5/27/26 when the facility took the following actions to remove the immediacy: The facility has implemented and educated staff on notifications of the PCP (primary care physician) of changes in wound condition: Licensed Facility personnel will be or have been educated by the Administrator, (V1), DON (V4), and Regional Nurse (V21) to ensure that they are aware of policy rela

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, record review, and observation the facility failed to prevent resident to resident physical abuse for 1 of 1 (R42) residents reviewed for abuse in a sample of 52. This failure resulted in R42 being attacked on 5/19/2026 by R38, causing a skin tear to her left wrist, bruise to her left thumb, and becoming fearful for her safety.Findings Include:R42's admission Record documents an admission date of 12/18/2025 with diagnoses of type 2 diabetes mellitus without complications, unsteadiness on feet, need for assistance with personal care and muscle weakness among others. R42's MDS (Minimum Data Set) dated 3/24/2026 documents R42 with a BIMS (Brief Interview for Mental Status) score of 15 out of 15 which indicates R42 is cognitively intact. This same MDS documents R42 uses a walker for ambulation and is independent with most activities of daily living.R38's admission Record documents an admission date of 11/19/2025 and diagnoses of type 2 diabetes mellitus without complications, dementia with other behavioral disturbance and essential hypertension. R38's MDS dated [DATE] documents R38 with a BIMS score of 13 out of 15 total with indicates R38 is cognitively intact. This same MDS document R38 has no impairment to her extremities, uses a walker and a wheelchair for locomotion and is independent with most activities of daily living.On 5/20/2026 at 11:30am, R42 said two nights ago (5/19/26), R38 attacked her around 2:30am in the morning. R42 said she got up from her bedside recliner and walked to the bathroom. R42 said when she came back into the bedroom from the bathroom, R38 was on her side of the room getting into her refrigerator. R42 said when she told R38 to get out of her things, R38 became angry and violently grabbed her left wrist, hit her on the left hand and scratched R42 causing a skin tear and bruising to R42's left hand and thumb area. R42 said she was afraid of R38, and she was glad R38 was moved to another unit and won't be able to hurt her again. R42 said R38 has a mental problem and doesn't know what she is doing and has not been right since R38 recovered from a Covid-19 infection. R42 said her left hand was swollen and sore and she feared she may need an Xray.On 5/20/2026 at 11:30pm, R42's left wrist/hand was bandaged to cover a wound to her left wrist, and an observable bruise was noted to the outer base of R42's left thumb. R42's left hand/wrist was slightly swollen and R42 complained of pain to the injuries when she touched them.The facility document titled Illinois Department of Public Health Initial report documents on 5/19/2026 at 3:05am, R38 made unwanted contact with R42. Both residents were separated, and nursing assessments were completed on both residents. R42's Progress Note entry dated 5/19/2026 at 3:56am documented R42 received a new wound with partial skin flap loss. Wound acquired in house. Wound length 1.84 cm (centimeters) with width of 1.59cm, no depth was recorded.The facility investigation of this incident included written statements from V10 (Registered Nurse) and V11 (Certified Nursing Assistant).V10's written statement documented the following occurred on the night of 5/19/2026: I was at lunch, was notified of resident-to-resident altercation. I came back in and took statements from both residents. (R38) made unwanted contact to R42's left forearm and wrist. R38 was in fridge by R42's chair and R38 came at R42 and caused skin tears and a bruise to her left forearm/hand. Administrator, Power of Attorney, medical doctor and Assistant Director of Nursing aware, see nurse's notes for more information. R42's Progress Note dated 5/19/26 at 3:10am documents CNA staff heard yelling coming from (R42's) room. Staff went to check on residents. (R42) was standing in front of her recliner chair and roommate was standing next to her bed when staff walked in the room. (R42) stated that she had been in her bathroom and she came out and (R38) was standing next to (R42's) chair (and was in R42's) fridge. (R42) stated that (R38) called her by her sister's name and then made unwanted contact with her left arm/wrist. Residents immediately separated. Skin assessment completed and skin tear noted to left outer wrist and bruising noted to left thumb. Skin tear cleansed with normal saline, patted dry and steri-strips applied. Administrator notified. Medical doctor (was) notified via fax. (R42) is own responsible party (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and aware.On 5/21/2026 at 12:10pm, V10 said she was R38 and R42's nurse on the night of 5/19/2026 and V11 was the CNA assigned to their hall. V10 said she was at lunch when staff alerted her to a resident-to-resident altercation. V10 said she went to assess the residents and to investigate what happened. V10 said R42's said R38 attacked her and hurt her left hand/wrist by grabbing it and caused cuts on it. V20 said she had the residents separated for the night to prevent any further abuse from happening and dressed R42's injuries.V11's written statement documented the following occurred on 5/19/2026: At approximately 3:00am, I overheard residents (on assigned hall) yelling. (R42) yelled get your hands off my shit shortly after, the call light came on, as I was walking down to investigate. Upon entering the room, I observed both residents on their own respective sides of the room. (R42) stated that (R38) was getting into her things so she said to get her hands off her shit and (R42) said that (R38) attacked her. (R42) stated that she was grabbed violently, shoved and scratched. I observed a cut on the (left) forearm of (R42). I immediately notified the nursing and followed her instructions.On 5/21/2026 at 11:45am, V11 said he was at the nurse's station when he heard yelling from R42. V11 said when he entered R42's room, R38 and R42 had been arguing and R42 said R38 attacked her by violently grabbing her left wrist, hit, scratched and shoved her. V11 said R42 was scared of R38, and he escorted R38 to another room for the night. V11 said R42 had cuts on her left wrist and was bleeding, but the nurse cleaned and dressed her wounds.On 5/21/2026 at approximately 11:00am, V1 (Administrator) said he was still investigating the incident of 5/19/2026 between R38 and R42 and could not say at this point in the investigation if resident to resident abuse had occurred. V1 also said he could not say whether he would or would not substantiate if abuse had occurred for this investigation.The facility policy titled Abuse Prevention dated 8/16/2025 documents the following in part: this facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion. This facility is committed to protecting our residents from abuse by anyone including, but not limited to, facility staff, other residents, consultants, volunteers, staff from other agencies providing services to the individual, family members or legal guardians, friends and any other individuals. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Physical abuse includes but is not limited to, hitting, slapping, punching, biting and kicking.

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review the facility failed to ensure an effective treatment was implemented for a newly identified wound and report worsening of the wound for 1 of 4 (R9) residents reviewed for quality of care in the sample of 40. This failure resulted in deterioration of R9's arterial wound to the right leg.Findings Include:R9's admission Record with a print date of 5/26/26 documents R9 was admitted to the facility on [DATE] with diagnoses that include iron deficiency anemia, depression, cognitive communication deficit, muscle weakness, hypertension, diabetes, and chronic obstructive pulmonary disease.R9's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score of 03, indicating a severe cognitive deficit.R9's current Care Plan documents a Focus area of, I have the potential/actual risk for pressure ulcer development or altered skin integrity r/t (related to) impaired mobility. 05/12/2026 Unstageable pressure ulcer Right lateral calf with an initiation date of 09/15/2025. This Focus area includes the following interventions dated 9/15/25: educate family/caregivers as to causes of skin breakdown, follow facility policies/protocols for the prevention/treatment of skin breakdown, obtain and evaluate lab/diagnostic work as ordered, pressure reduction mattress, evaluate skin changes, and evaluate nutritional status. This Focus area includes the following interventions dated 5/14/26: cleanse skin tear to right calf with normal saline, pat dry, apply medihoney and collagen to wound and cover with bordered gauze daily.On 05/18/2026 at 10:25 AM, R9 was lying in bed with heel protectors in place and partially covered. R9 denied all concerns with care.R9's Skin Issue report dated 4/10/26 documents a new unstageable pressure ulcer/injury, acquired in house, to the right lateral calf that measures 4.65 x 2.3 cm (centimeters) with onset unknown.R9's Order Details document on 4/11/26 V30 created the order to change dressing to inner right lower leg every other day and V17 (Physician) didn't sign the order until 5/6/26. This order was discontinued on 5/7/26.R9's Order Summary Report dated 4/1/26 to 5/21/26 documents the following physician orders: Change drsg (dressing) to inner RLL (right lower leg) QOD (every other day) every 48 hours for altered skin integrity with a start date of 4/11/26 and an order status of discontinued and no documented end date. Change drsg to inner RLL QOD every day shift, every other day for altered skin integrity with a start date of 4/13/26 and an order status of discontinued and no documented end date.On 5/27/26 at 12:07 PM, V30 (LPN) stated she worked on 4/9 and 4/11 and was off work on 4/10/26. This surveyor reviewed the physician order dated 4/11/26 with V30 and she stated that order wasn't for the right lateral calf. Then V30 stated she wasn't sure what area that order was for. V30 stated the way the order was written would mean she called V17's (Physician) office and got the order. V30 stated she didn't work on 4/10/26 and reviewed her notes and stated she didn't have anything documented on 4/11/26, and she would have documented it. V30 stated, maybe V4 (Director of Nurses) told her to put the orders in. V30 was unable to recall what wound was treated, how the orders were obtained, or who she spoke with for the orders.On 5/27/26 at 10:44 AM, V17 (Physician) stated his notes document he was notified of the area to R9's right lateral calf on 4/7/26 and he implemented pressure-reducing interventions at that time. V17 stated the facility staff were to elevate R9's lower extremities and reduce pressure.On 5/26/26 at 3:00 PM, V4 (Director of Nurses) stated the wound on R9's right lateral calf was identified on 4/10/26. This surveyor reviewed R9's Treatment Administration Record (TAR) and physician orders with V4 and asked where the treatment for the area was. V4 stated the treatment to the right lower inner leg was the treatment that was ordered for the wound located on R9's right lateral calf. This surveyor asked what kind of dressing should have been used since the order documents change dressing with no specific dressing documented. V4 stated it was probably a dry dressing. When asked how the nurses would know that, V4 stated, they wouldn't. When asked how the nurses would know the wound they were treating was on the right lateral calf when the order documents the right lower inner leg, V4 stated, they wouldn't.R9's Progress Notes document the following:4/17/26: unstageable pressure ulcer to right (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	lateral calf, deteriorating, 5.02 cm x 2.44 cm x 0 cm, no tunneling or undermining.4/22/26: Seen (V16-Wound Nurse Practitioner) related to wound on right calf. Ordered triad to wound bed and cover with dry dressing. POA (Power of Attorney) called. Unable to reach.V16's (Wound Nurse Practitioner) Progress Note for R9 dated 4/22/26 documents, She was seen today at (name of facility).I have seen patient for various pressure sores during her NH (nursing home) stay. I was asked to evaluate the patient for right calf wound. RN (Registered Nurse) reports worsening of right calf wound. Unsure what caused the wound, but it is getting worse. There are no wound orders in. Under Assessment documents Non-pressure chronic ulcer of right calf, unspecified ulcer stage. Under Plan documents Some sloughing on the wound bed. Will do triad every other day and cover with dry dressing. May switch to collagen next week. Obtain arterial and venous dopplers.R9's Order Summary Report dated 4/1/26 to 5/21/26 includes the following physician orders: Cleanse right calf with normal saline, pat dry, apply triad and cover with dry dressing. In the morning every other day for Wound care with a start date of 4/22/26 and no discontinue date documented but discontinued documented under order status.On 5/26/26 at 3:00 PM, V4 (Director of Nurses) stated she assumed V17 (Physician) was notified when the area was first identified and V16 (Wound Nurse Practitioner) was notified after that. V4 stated V16 was coming every two weeks but comes weekly now. This surveyor reviewed R9's Skin Issue report dated 4/17/26 when it documents the wound deteriorated and asked V4 if any physician was notified of the deterioration. V4 stated, No, just 4/21/26. When asked why a physician was not notified of the deterioration V4 stated, lack of communication. When asked who the lack of communication was between, V4 stated the floor nurses know to let the nurse manager, power of attorney, and physician know if an area deteriorates. V4 stated they (administration) should have caught it when they came to work on 4/18/26. V4 stated she would expect the nursing staff to make all necessary notifications when a wound is deteriorating. V4 stated there was no communication documented with V17 (Physician). V4 stated the facility staff should have called V17.On 5/27/26 at 10:44 AM, V17 (Physician) stated he didn't have any documentation from 4/7/26 to 4/17/26 and didn't have documentation that he had ordered a treatment for the wound. V17 stated he typically goes along with whatever the facility recommends for treatments.V16's (Wound Nurse Practitioner) Progress Note for R6 dated 5/6/26 documents, She did have arterial Dopplers that showed severe arterial stenosis of the bilateral lower legs. She is allergic to contrast dye but does have a referral placed for vascular surgery.Assessment: 1. Peripheral artery disease. 2. Arterial leg ulcer. 3. Skin tear of left lower leg without complication, subsequent encounter.Plan: Switch dressings to right lower leg to Medihoney and collagen. Cover with dry dressing. Change every other day.On 5/21/26 at 9:56 AM, V30 (Licensed Practical Nurse/LPN) administered treatments with V2 (Infection Preventionist) present. V30 cleaned the wound on the back of R9's right calf with normal saline, patted it dry, covered with medihoney, collagen powder, and covered with a border foam dressing using current standards of practice. The area was open with slough present. V30 and V2 stated it started as a skin tear, and they didn't know how it deteriorated.On 5/26/26 at 12:05 PM, V16 (Wound Nurse Practitioner) stated she was notified of the wound to R9's right lateral calf on 4/21/26 and saw her on 4/22/26. V16 stated there were no orders for treatment prior to that. When asked when she would expect to be notified of a new area. V16 stated ideally, I would have liked to have seen her on 4/10/26 but for sure on 4/17/26 when it looked a lot worse. When asked how they knew what treatment to administer if she hadn't seen her, V16 stated, I don't know if they have protocols in place. When asked if she had seen her sooner and treatments had been implemented if the outcome would be different, V16 stated if she had been notified, she would have ordered something and hopefully prevented it from getting to the sloughy way it looked on 4/17/26. V16 stated after it was treated with triad it looked better and smaller.The facility undated Treatments/Wound Care policy documents, The purpose of this procedure is to provide guidelines for the care of wounds to promote healing. Preparation: 1. Verify that there is a physician's order for this procedure.Reporting: 1. Notify the supervisor if the resident refuses the wound care. 2. Report other information in accordance with facility policy and professional standards of practice.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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 obtain orders and implement interventions for 1 (R6) of 4 residents reviewed for pressure ulcers in the sample of 40. This failure resulted in an abrasion to the right gluteus deteriorating and becoming infected, requiring R6 to be hospitalized with sepsis on two occasions and requiring surgical wound debridement and the development of a Stage 2 pressure ulcer on R6's left heel. Findings Include:1. R6's admission Record with a print date of 5/26/26 documents R6 was admitted to the facility on [DATE] and included diagnoses of major depressive disorder, atrial fibrillation, obesity, osteoarthritis, and pressure ulcer of left heel. R6's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R6 is cognitively intact. This same MDS documents R6 requires substantial/maximal assistance to roll left and right in bed and is dependent on staff for transfer. Under Section M, Skin Conditions this MDS documents R6 is at risk of developing pressure ulcers with one Stage 4 pressure ulcer documented. Under Skin and Ulcer/Injury Treatments the following interventions are documented that should be implemented, pressure reducing device for chair and bed, pressure ulcer/injury care, application of nonsurgical dressings (with or without topical medications) other than to feet and applications of ointments/medications other than to feet. R6's current Care Plan documents a Focus area of I have alterations in my skin integument. See skin and wound module for sites and updates. Date Initiated: 05/19/2026. This Focus area includes the following interventions with a date initiated of 5/19/26, Float heels while in bed.Monitor for pain and offer analgesics per order.Monitor for worsening or infection and report to PCP (primary care physician) prn (as needed).Nutritional support per order.Pressure relief device to bed/chair.RD (Registered Dietitian) consult per regulatory guidelines and prn upon request.Treatment per order.Turn/repo (reposition) q (every) 2 hours as tolerated.Weekly skin assessments. Report abnorms (abnormal) to PCP prn .Wound specialist per order. This same Care Plan documents a Focus area of (R6) has actual impairment to skin integrity r/t (related to) incontinence and limited mobility and DM2 (diabetes mellitus 2) Dx (diagnosis) Date Initiated: 06/25/2024. This Focus area includes the following interventions, 12/22/25, utilize pillows to offload pressure, 1/8/26, remind/assist resident to turn/reposition at least every two hours and as needed, 7/1/24, ensure folds are clean and dry, 5/7/26, see treatment administration records for treatment orders, 1/8/26 pressure redistributing mattress on bed and position resident off affected area. R6's Braden Scale for Predicting Pressure Ulcer Risk dated 4/11/26 documents a score of 16, indicating R6 is at low risk for skin breakdown. R6's Braden Scale for Predicting Pressure Ulcer Risk dated 4/17/26 documents a score of 13, indicating R6 is at moderate risk of developing skin breakdown. R6's Skin Issues report dated 2/16/26 documents a new skin issue identified as an abrasion to R6's right gluteus that measures 2.62 x (by) 2.97 centimeters (cm's). R6's Progress Note dated 2/17/26 at 12:43 AM documents, Resident is back from (name of local hospital) via ambulance transport. She was admitted to the hospital due to UTI (urinary tract infection) . Skin assessment showed new abrasion to right hip, new abrasion to right gluteus, and new open lesion to coccyx. R6's Order Summary Report dated 6/1/26 includes the following order with a start date of 2/16/26. Cleanse abrasion to right gluteus with normal saline, pat dry, apply xeroform, and cover with foam dressing. Report to MD (physician) for complications. Every night shift for altered skin integrity. R6's Treatment Administration Record (TAR) dated 2/1/26 to 2/28/26 documents a physician order with a start date of 2/17/26 of, Cleanse abrasion to right gluteus with normal saline, pat dry, apply xeroform, and cover with foam dressing. Report to MD (physician) for complications. This TAR documents initials indicating the treatment was administered as ordered. R6's Skin Issues report dated 2/24/26 documents the abrasion to her right gluteus is deteriorating and measures 2.84 x 2.5 cm's. R6's Order Summary Report dated 6/1/26 includes the following order with a start date of 2/24/26, Cleanse abrasion to right gluteus with normal saline, pat dry, manukaHD, (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	and cover with silicone super absorbent dressing. Report to MD for complications. Every night shift for altered skin integrity. R6's TAR dated 2/1/26 to 2/28/26 documents a physician order with a start date of 2/24/26 and discontinue date of 3/11/26 of, Cleanse abrasion to right gluteus with normal saline, pat dry, manukaHD, and cover with silicone super absorbent dressing. Report to MD for complications. Every night shift for altered skin integrity. This TAR documents initials indicating the treatments were administered as ordered. R6's Skin Issues report dated 3/2/26 documents the abrasion to her right gluteus as deteriorating and measures 2.94 x 2.91 cm's. R6's Skin Issues report dated 3/9/26 documents the abrasion to her right gluteus as deteriorating, non-healing, stabbing pain, with moderate purulent drainage and a faint odor. R6's Progress Notes document the following: 3/11/26, Reviewed wound review with recommendations to add 2x (times) protein at breakfast and supper. Care plan and meal tickets updated.3/11/26, Seen (V16/Wound Nurse Practitioner) NP (Nurse Practitioner) related to wound. New order to apply triad over wound bed and leave open to air every other day and PRN (as needed), POA (Power of Attorney) called. V16's (Wound Nurse Practitioner) Nursing Home Visit Progress Note for R6 dated 3/11/26 documents this is the first time R6 is being seen by V16. This Progress Note documents the area to R6's right gluteus as an unstageable pressure ulcer that measures 3.8 x 3.5 cm's (centimeters). The Progress Note documents under, Plan: Discussed with RN (Registered Nurse). Likely needs debridement but will trial on triad for 1 week. Apply a generous amount of triad over the sacrum and buttocks. Pressure relieving measures every 2 hours while in bed and every hour while in chair. We will follow up with her in 1 week. R6's Order Summary Report dated 6/1/26 includes a physician order with a start date of 3/11/26 of, Cleanse abrasion to right gluteus with normal saline, pat dry, apply triad over wound bed, and leave open to air, every other day and PRN (as needed). Report to MD for complications. Every night shift on even days for altered skin integrity. R6's TAR dated 3/1/26 to 3/31/26 documents a physician order with a start date of 3/12/26 and discontinue date of 3/31/26 of, Cleanse abrasion to right gluteus with normal saline, pat dry, apply triad over wound bed, and leave open to air, every other day and PRN (as needed). Report to MD for complications. Every night shift on even days for altered skin integrity. This TAR documents initials indicating the treatments were administered as ordered. R6's Skin Issues report dated 3/17/26 documents the area to R6's right gluteus as an abrasion that is deteriorating, non-healing, with aching pain that measures 3.88 x 3.59 cm's. R6's Progress Notes dated 3/17/26 documents, RD (Registered Dietitian) recommends adding 2x protein at breakfast and supper d/t (due to) deteriorating wounds. POA (Power of Attorney) (POA name) aware. V16's (Wound Nurse Practitioner) Nursing Home Visit Progress Note for R6 dated 3/18/26 documents the same information verbatim as V16's progress note dated 3/11/26. On 6/1/26 at 10:10 AM, V16 (Wound Nurse Practitioner) stated she signed her note from 3/11/26 on 3/18/26 and assumes that is the 3/18/26 Progress Note referenced above. V16 stated she did not see R6 on 3/18/26 but did a record review including the wound modules which documented assessments including pictures of the area. R6's Dietary Note dated 3/18/26 documents, 3/11/26 RD (Registered Dietitian) reviewed wound review with recommendations to add 2 x (times) protein at breakfast and supper. Care plan and meal tickets updated. R6's Nurses Note dated 3/23/26 documents, Resident has wound to right buttock. Increased drainage, slough, and foul odor noted. Area has adipose tissue exposed. Resident needs to see doctor. May need antibiotic. Under this note there are check marks next to, Show on Shift Report, Show on 24 hour report, Show on MD/Nursing Communications Report. This Nurses Note was signed by V26 (Licensed Practical Nurse/LPN). On 5/26/26 at 2:23 PM, V26 (Licensed Practical Nurse/LPN) stated she wrote the progress note dated 3/23/26. V26 stated she printed off the progress note and left it for V17 (Physician). V26 stated she also notified V4 (DON) of the deterioration of the pressure ulcer. V26 stated she was told R6 had recently been seen, and a new treatment had been put in place. V26 stated she assumed it had been taken care of because the physician had already been notified. V26 stated she didn't know at the time R6 was being followed by V16 (Wound Nurse Practitioner). When asked if she documented the notification to V17 (Physician), V26 stated if it wasn't documented (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	in the progress note it wouldn't be documented. V26 stated she also discussed the deterioration of the pressure ulcer with V2 (Infection Preventionist/Wound Nurse). On 5/26/26 at 3:23 PM, V21 (Vice President of Clinical Services) showed this surveyor a line on the bottom of R6's 3/23/26 progress note that says MD/Nursing Communication. The box is checked next to it. When asked where it is documented and what V17 ordered when he was notified, V21 stated he wanted V16 (Wound Nurse Practitioner) to see and treat the pressure ulcer. The facility was unable to provide reproducible evidence V17 was notified and what V17's response was. R6's Skin Issue report dated 3/24/26 documents the pressure ulcer to R6's right gluteus as an abrasion that is deteriorating, non-healing, increased smell, intermittent pain, and moderate purulent drainage. This report documents the pressure ulcer measures at 3.88 x 4.21 cm's.R6's Skin Issue report dated 3/31/26 documents the pressure ulcer to R6's right gluteus as an abrasion that is deteriorating, red and bleeding, increased smell, heavy purulent drainage, and a strong odor after cleaning that measures 6.85 x 4.61 cm's. A telephone communication from V16 (Wound NP) provided to this surveyor by the facility dated 3/31/26 documents, Received notification from ADON (Assistant Director of Nursing who is now V4/DON) at (name of facility) insuring I was coming to the NH (nursing home) on 04/01/2026 due to deteriorating wound. Plans to round at (name of facility) tomorrow 04/01/2026. R6's Progress Notes dated 4/1/2026 documents, Wound Nurse here to see. Received order to start Doxycycline 100 mg (milligrams) BID (twice daily) x (times) 7 days. Multi Vitamin with minerals, Prostat 30 ml (milliliters) BID, obtain u/a (urinalysis) with c&s (culture and sensitivity). Res (resident) aware. V16's (Wound NP) Nursing Home Visit Progress Note for R6 dated 4/1/2026 documents, . I did see the patient about 3 weeks ago and it was noted to have some necrotic tissue. RN (Registered Nurse) reports that it has significantly declined since previous visit. Assessment: 1. Pressure injury of right buttocks, unstageable.Plan: Discussed with RN. Will have her set up an appointment tomorrow for up (sic) in office debridement. Wound cultures taken. Patient to have a debridement for (sic) at 3:00 p.m. V16's (Wound NP) Nursing Home Visit Progress Note for R6 dated 4/2/26 documents, History: the patient is a 60 y.o. (year old) female with a past medical history notable for type 2 diabetes, obesity, AFib (atrial fibrillation), GERD (gastroesophageal reflux disease), hypertension, SVT (supraventricular tachycardia), recurrent UTI's (urinary tract infections) who initially presented to the wound clinic for debridement of right buttocks wound. The patient resides at (name of nursing home) where I have been following her just recently for right buttocks wound. I initially saw her on 03/11 for unstageable wound. She was using triad to try chemical debridement. I followed up with her on 04/01 and the wound had significantly deteriorated. Discussed with patient and plan was made for debridement in office. Wound cultures were obtained. She presented today for debridement. Debridement was started in the office and quickly realized that it was significantly deeper than expected. I did discuss with (name of doctor) who did a debridement. It extended deep into subcutaneous fat. Decision was made to admit patient and plan for for (sic) their debridement in the operating room. Recommend: Will plan for further debridement in OR (operating room) tomorrow. Okay for diabetic diet tonight. NPO (nothing by mouth) at midnight. Consent for debridement. IV (intravenous) antibiotics with Zosyn based on prelim cultures growing gram neg (negative) rods. Hospitalists consult for medical management. Will restart home medications. Continue with foley catheter. R6's local hospital record dated 4/3/2026 documents surgical debridement of the Stage 4 pressure ulcer to right buttocks (gluteus). This local hospital record documents under the physician Progress Note dated 4/4/26, Was called in early this morning for persistent bleeding. She had gone in and out of an SVT (supraventricular tachycardia) (she has history of and possible AFib) even in the operating room but when she did it last night, she was started on Lovenox. And then started to bleed through her dressing. Due to her persistent problems with hypotension and dysrhythmia, eventually required pressors she was transferred to (name of regional hospital) . R6's Wound Culture results dated 4/4/26 documents many (4 plus) proteus mirabilis, moderate (3 plus) gram negative rods, and moderate (3 plus) enterococcus faecalis. R6's regional hospital record admission date 4/4/26 documents, .The patient presents to (initials of (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	regional hospital) a transfer from (name of local hospital) for evaluation of shock.Shock, hemorrhagic versus septic.Large stage IV (4) buttock pressure wound s/p (status post) debridement at (name of local hospital), wounds polymicrobial, on empiric antibiotics.On arrival to our hospital patient was in shock with low blood pressures, tachycardia. [NAME] count was elevated.Urine cultures showed Proteus mirabilis and Enterococcus aerogenes. Wound culture was growing Proteus mirabilis, Enterococcus faecalis and Serratia fonticuli. Patient was started on broad-spectrum IV antibiotics.Sepsis is present and due to pressure ulcer.Admitting Diagnosis 1. Septic versus hemorrhagic shock: Patient did receive 3 units of PRBC (packed red blood cells) transfusion.Stage IV decubitus ulcer in right buttock with superimposed infection.Hospital Course: 60 y.o. (year old) female with a past history significant for AFib, on Eliquis and metoprolol, type 2 DM (diabetes mellitus), HTN (hypertension), obesity, SVT, anxiety, neuropathy, stage IV chronic decutibitus ulcer with recent debridement admitted on [DATE] with complaints of bleeding from her surgical site. She began to decline hemodynamically requiring pressors at the outside hospital. She received 3 units of PRBC and then was requested for transfer to (name of regional hospital) for further management.On arrival to our hospital patient was in shock with low blood pressure, tachycardia. [NAME] count was elevated . On 5/26/26 at 10:49 PM, V28 (Registered Nurse/RN) stated she was the nurse who did the first assessment on the pressure ulcer on R6's right gluteus. V28 stated the area was deteriorating and when she came back to work on 2/24/26 there was a new treatment order in place. This surveyor reviewed the Skin Issue reports from 3/9, 3/17, 3/24, and 3/31 with V28. V28 stated she would take pictures when she did the treatments so if the wound nurse came in, she would have updated pictures to review. When asked if she notified any physician of the deterioration to that pressure ulcer during the time frame of 3/9-3/31, V28 stated she assessed the area, took picture, and placed in on her report for day shift to see. V28 stated she didn't remember if there were any changes or any communication back to her related to the deterioration. On 5/26/26 at 10:44 AM, when asked if he was notified between 3/17 and 3/31/26 of any changes/deterioration to the pressure ulcer located on R6's right gluteus, V17 (Physician) stated he had reviewed R6's medical record and he didn't find any notifications from the facility. V17 stated someone may have said something to him in passing. V17 stated he couldn't say if he was notified of the deterioration but there was no documentation of notification. V17 stated V16 (Wound NP) should have been notified and he knew she had said she would follow up in a week and then didn't. V17 stated if she had been notified, they could have been more aggressive with the treatment. When asked if the outcome would have been different if the area had been treated sooner V17 stated, I can't say. When asked for any documentation to show the facility had reported the deterioration in R6's wound to V16 and/or V17 between 3/11/26 and 3/31/26, an email was provided to this surveyor dated 3/18/26 documenting a message from V16 (Wound Nurse Practitioner) of, Late follow up entry-Discussed treatment options with (V4 - Director of Nurses/DON) at (name of facility). Insurance does not pay for santyl, will apply Triad daily. There is no evidence in this email documenting V16 had been notified of R6's wound deteriorating. On 5/26/26 at 12:15 PM, V16 (Wound NP) stated she was notified on 3/9/26 R6 had a wound that had deteriorated. V16 stated the treatment R6 received from 2/7/26 until she saw her on 3/11/26 would have been a discharge order from the hospital and/or from her primary care physician (V17). V16 stated if she had been notified prior to 3/09/26 she could have placed orders and prevented it from getting as bad as it did. V16 stated on 3/18/26 she reviewed R6's chart including the wound module which documents assessments including pictures of the area and spoke with V4 (DON) about changing the treatment. V16 stated the insurance wouldn't cover the preferred treatment of santyl so they continued the original treatment order of Triad. V16 stated the next notification she received from the facility was on 3/31/26 that showed signs of infection and deteriorating. V16 stated she was going to the facility on 4/1/26 to do rounds and planned to see her then. When asked why she was talking about changing the treatment on 3/18/26, V16 stated she reached out to V4 after she (V16) did a chart review. V16 stated she was not notified of any change in R6's condition from (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R6's Skin Issues report dated 5/13/26 documents the Stage 4 pressure ulcer with no measurements or assessment. R6's Skin Issues report dated 5/15/26 documents the Stage 4 pressure ulcer as deteriorating with measurements of 6.69 x 8.28 x 5 cm's. On 05/18/2026 at 10:21 AM, R6 was laying in bed, covered with a blanket and denied concerns with care. There was a foul odor noted in R6's room. On 5/19/26 at 8:12 AM, this surveyor began observation of wound care with V4 (DON) present and V18 (LPN) administering care. V18 administered a treatment to R6's abdominal fold. When this surveyor inquired about the drain tubes noted on R6's back, V18 stated that was her wound vac. V18 stated that treatment was not scheduled for this date and observation would need to be done on the next day. The foul odor in the room seemed to dissipate after the abdominal fold was cleaned. On 5/20/26 at approximately 1:00pm this surveyor was told by V4 (DON) and V21 (Vice President of Clinical Services) the Nurse Practitioner (V16) had assessed R6 this morning and changed the dressing to the pressure ulcer on R6's right gluteus. V4 stated R6 was being sent to the hospital for admission for surgical debridement. This surveyor was unable to observe the wound prior to R6 leaving the facility. R6's Progress Notes dated 05/20/2026 documents the following: Seen by NP (V16) related to wound. Order given for resident to be a direct admit for surgical debridement and IV antibiotics. Wet to dry dressing completed at bedside by NP, POA (Power of Attorney) and resident aware. Res (resident) left via facility to (name of local hospital) direct admit, Report called to floor nurse. V16's history and physical note for R6 dated 5/21/26 documents, The patient is a 60 y.o. (year old) female with a past medical history.stage IV pressure ulcer who has been followed at (name of facility). Upon rounds yesterday, it was noted that the wound had significantly deteriorated, foul odor, Bedside debridement was done. Decision was made to admit the patient for possible surgical debridement and IV antibiotics. The patient was admitted .She was started on IVF (intravenous fluids) and IV (intravenous) antibiotics with Zosyn and vancomycin. Overnight, she went into SVT with HR (heart rates) sustained in the 150's. IV labetolol was attempted without success. Impression: 1. Sepsis- likely secondary to infected Stage IV pressure ulcer vs (versus) UTI (urinary tract infection). 2. Necrotic Stage IV pressure ulcer. 3. SVT - likely reactive secondary to sepsis. 4. Hypokalemia 5. Uncontrolled DM (diabetes mellitus) II (2) 6. Chronic indwelling catheter. On 5/25/26 at 11:04 PM, V24 (LPN) stated she remembered the pressure ulcer on R6's right gluteus deteriorated very fast. V24 stated it went from bad to horrible. V24 stated R6 didn't like to turn and reposition but she would encourage her to do so. When asked if she ever notified the physician of the pressure ulcer deteriorating, V24 stated the way they do it at the facility is different. V24 stated, When we submit something to the physician it feels like it hangs in the balance. When asked what that meant, V24 stated they put the information on V17's desk at the facility. When asked how she would notify the physician of a wound deteriorating, V24 stated, We would put it on his desk. V24 stated she thought V17, or his nurse practitioner came in every weekday. When asked if there was any documentation when the physician was notified, V24 stated if it isn't charted on the progress notes, the medication administration record, or treatment administration record then essentially it wasn't done. V24 stated, Do I think there wasn't anything done, I think there was but not fast enough obviously. On 5/26/26 at 3:00 PM, V4 (DON) stated R6 returned to the facility from a hospital stay on 2/16/26 with an abrasion to the right gluteus. V4 stated the area was treated with xeroform until V17 (Physician) changed the order on 2/24/26 and referred R6 to the wound specialist. V4 stated V16 (Wound Nurse Practitioner) was notified the pressure ulcer was deteriorating on 3/9/26, V16 assessed R6 on 3/11/26 and gave an order for triad. This surveyor reviewed R6's Skin Issue reports with V4 and asked if there was any physician notification when the pressure ulcer is documented as deteriorating from 3/17/26 to 3/31/26. V4 stated on 3/18/26, V16 (Wound NP) asked me if insurance covered a new treatment she wanted to order. V4 stated the insurance did not cover it so they continued the same treatment. V4 stated V16 was supposed to assess R6 on 3/25/26 but couldn't because her children were sick. When asked if any physician was notified of the deterioration of the pressure ulcer, V4 stated, I would not say so. V4 stated the physician should have been notified. When asked if any physician was notified (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	of the deterioration of the pressure ulcer from 5/15/26 to 5/20/26, V4 stated, Not that I see. When asked if she would expect a physician to be notified, V4 stated, Oh yeah, definitely. When asked if she had any concerns with wound care at the facility, V4 stated she didn't. V4 stated they are normally good about notifying the physician if a wound/pressure deteriorates. On 5/26/26 at 12:15 PM, when asked if she was notified of a deterioration in the pressure ulcer from 5/15/26 to 5/20/26, V16 (Wound Nurse Practitioner) stated she completed a chart review on 5/14/26 but wasn't notified of any deterioration from 5/15 to 5/20/26. V16 stated when she assessed R6 on 5/20/26, she noted a foul odor in the wound, R6 appeared sick, and was tachycardic. V16 stated the pressure ulcer needed debrided and with R6's history she had her admitted to the local hospital for surgical debridement in the operating room. V16 stated when they did the debridement the bone was exposed. This surveyor asked if R6 had osteomyelitis and V16 stated she was surprised that she didn't, but all the tests were negative. When asked if she had any concerns with wound care at the facility, V16 stated she thought they did a great job with wound care, but they needed protocols in place on when to get the wound specialist involved. On 5/26/26 at 10:44 AM, V17 (Physician) stated he thought wound care specialists were seeing R6 from 5/15/26 to 5/20/26. V17 stated he remembered talking with the facility earlier in May and they were worried about the area but V16 (Wound Nurse Practitioner) was following the pressure ulcer and had made treatment order changes. V17 stated he didn't have any documentation or remember being notified of a deterioration from 5/15 to 5/20/26. 2. R6's Wound Ostomy Eval and Treat note with a service date of 4/5/26 documents, Left posterior heel: area of callous-like skin with circumferential blanchable erythema. Unknown etiology but cannot r/o (rule out) pressure component. Recommendations: Left heel- 1. Cleanse wound with soap and water daily. Use remedy cleanser in green and white bottle. No Hibiclens. 2. Cover with a 4x4 foam bordered (mepilex) dressing. Date and time dressing. 3. Remove dressing daily to cleanse and assess wound then reapply. 4. Dressing should be changed when drainage is visible to the edges of the foam pad. It may be used for up to 7 days. 5. Notify physician. for no improvements or concerns. R6's Skin Issues report dated 4/11/26 does not document an area to R6's left heel. R6's Order Summary Report dated 6/1/26 does not document treatment orders or preventative measures for the area to R6's left heel. R6's Skin Monitoring: CNA (Certified Nurse Assistants) Shower Review sheets dated 5/1, 5/4, 5/6, 5/8, and 5/15/26 do not document an area on R6's left heel. On 5/19/26 at 8:12 AM, V18 (LPN) administered treatment to R6's abdominal fold with V4 (DON) present. After the treatment was completed per current standards of practice, this surveyor asked R6 if she had any other pressure ulcers/sores. R6 stated she did on her heels. This surveyor observed both feet lying flat on the bed. When asked if they did treatments on her heels, R6 stated they were usually propped up on pillows. When asked why they weren't propped up now R6 responded that she wasn't sure. When asked how long they had been flat on the bed, R6 stated, since last night. This surveyor, with the assistance of V18, observed both of R6's heels. The right heel was pink/red with no open areas or sores. The left heel had a dark red/black area that was closed and soft to touch (per V18/LPN). When asked if they were aware of the area prior to this observation, V18 and V4 both stated they were not. R6's Progress Notes document the following:5/19/26 at 2:00 PM, Resident stated t

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to promote dignity for 4 of 7 (R9, R29, R50, and R54) residents reviewed for resident rights in the sample of 40. Findings Include: 1. R9's admission Record with a print date of 5/21/26 documents R9 was admitted to the facility on [DATE] with diagnoses that include dysphagia, depression, cognitive communication deficit, and diabetes. R9's Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status (BIMS) score of 03, indicating a severe cognitive deficit. R9's current Care Plan documents a Focus area of, Nutritional Risk r/t (related to) dx (diagnosis) DM (diabetes mellitus) type 2, depression. Below IBWR (ideal body weight range) with recent wt (weight) gain. Varied intake leaves 25% or more uneaten. 4/10/26 change from reg (regular) cons (consistency) to mech (mechanical) soft. Date Initiated: 09/16/2025. This Focus area includes the interventions of: serve diet as ordered and encourage oral intake. 2. R29's admission Record with a print date of 5/22/26 documents R29 was admitted to the facility on [DATE] with diagnoses that include dementia, anxiety, and need for assistance with personal care. R29's MDS dated [DATE] documents a severe cognitive impairment. R29's current Care Plan documents a Focus area of, I am demonstrating poor appetite and fluid intake Date Initiated 07/03/2025. This Focus area includes interventions of administer supplements as ordered, and assist with intake as needed. 3. R50's admission Record with a print date of 5/22/26 documents R50 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's disease, dysphagia, and adult failure to thrive. R50's MDS dated [DATE] documents a BIMS score of 00, indicating a severe cognitive deficit. R50's current Care Plan documents a Focus area of Nutritional Risk- Alzheimer's, severe dementia with agitation, anxiety, failure to thrive .Date Initiated: 04/15/2025. This Focus area includes intervention of review and monitor weights as ordered. 4. R54's admission Record with a print date of 5/22/26 documents R54 was admitted to the facility on [DATE] with diagnoses that include dysphagia, diabetes, and heart disease. R54's MDS dated [DATE] documents a severe cognitive deficit. R54's current Care Plan documents a Focus area of, I have dementia and require assistance with various aspects of my life with ADLs (Activities of Daily Living), medical needs, personal preferences, mobility, and some communication challenges .Date Initiated: 07/15/2025. This Focus area includes interventions of assess with daily activities and respect individual dignity and autonomy. On 5/18/26 at 12:09 PM, the noon meal of country fried steak, corn, noodles, mashed potatoes, gravy, and mandarin oranges was served to the residents in the dining room. R9, R29, R39, R54, and R90 were sitting at one table. R90 was served her meal at 12:09 PM. R9 was served her meal at 12:14 PM, R39 was served their meal at 12:16 PM, R54 was served their meal at 12:17 PM. At 12:29 PM, an unknown staff member asked where R29's meal was at. R29's meal was served at 12:31 PM. On 5/19/26 the noon meal of ravioli, breadstick, carrots, salad, and cake was served. R9, R28, R50, and R54 were sitting at the same table. R28 was served his meal at 12:06 PM. At 12:15 PM R9 asked, Am I gonna get my food. At 12:21 PM, R9 asked, Where's my food. At 12:33 PM, R50 was served his meal, and at 12:40 PM R54 was served his meal. R9's meal was not served until 12:43 PM. On 5/20/26 at 10:44 AM, V29 (Activities Director) stated the tables observed on 5/18 and 5/19/26 are where the residents who require assistance with eating sit. V29 stated the Certified Nursing Assistants pass the hall trays and then go to the dining room to assist the residents. V29 stated they try to put the meal tickets in order so all of the residents at a table get served at the same time. V29 stated they try to serve everyone at the same time and it usually works that way. V29 stated she wasn't sure what happened on 5/18 and 5/19/26. V29 stated everyone sitting at a table should get their meal close to the same time. V29 stated they don't want a resident sitting and watching another resident eat. The facility policy titled The Dining Experience: Staff Roles dated 2016 documents, Staff will strive to enhance the resident's quality of life while serving meals that meet nutritional needs, (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	offers choice, is served with dignity and considers the person-centered care plan. Staff will offer personal attention to each resident and monitor the resident and monitor the resident's satisfaction and food intake .The staff will promote resident independence and dignity in the dining room.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on interview, observation, and record review the facility failed to follow the menu and serve the complete serving size of altered diet textures for 5 (R9, R18, R34, R64, R87) of 5 residents reviewed serving sizes in a sample size of 40. Findings include: The diet spreadsheet dated day 9 lunch documents: pureed country fried steak # 6 scoop (5.33 ounces), thick cream gravy 2 ounces, mashed potatoes with thick gravy #8 scoop, pureed seasoned pasta #8, pureed buttered soft bread #16, and pureed mandarin oranges #10. The diet spreadsheet dated day 9 lunch dental soft (mechanical soft) documents: ground country fried steak with cream gravy #8 scoop (4 ounces), mashed potatoes with gravy #8 scoop, seasoned pasta #8 scoop, buttered soft bread 1 slice, and Mandarin oranges #8 scoop. The diet spreadsheet dated day 12 lunch documents: pureed panko mustard chicken #6 scoop, pureed scalloped potatoes #8 scoop, pureed pickled beets #12 scoop, pureed buttered bread #16 scoop and pureed peach parfait #8 scoop. The diet spreadsheet dated day 12 lunch dental soft (mechanical soft) documents: ground panko mustard chicken with gravy #8 scoop, scalloped potatoes #8 scoop, chopped pickled beets 4 ounces, soft buttered bread 1 slice, and chopped peach parfait 1 each. 1.R34's admission Record documents an admission date of 03/09/26 with diagnoses including: bronchopneumonia, Alzheimer's disease, peripheral vascular disease, and severe protein calorie malnutrition. R34's Order Summary Report documents a dietary order for regular diet, pureed texture, regular liquid consistency, fortified pudding at lunch/supper, whole milk with meals, ice cream at lunch and supper with a start date of 03/10/26 and an order status of active. On 05/18/26 at approximately 12:20 PM, R34 received approximately 0.5 of a #8 (4 ounces) scoop of the pureed country fried steak. On 05/21/26 at approximately 12:22 PM, R34 received approximately 0.66 of a #6 (5.33 ounce) scoop of pureed panko mustard chicken. 2.R64's admission Record documents an admission date of 03/14/24 with diagnoses including: gastro-esophageal reflux disease, history of transient ischemic attack and cerebral infarction. R64's Order Summary Report documents a dietary order for regular diet with pureed texture with regular liquid consistency with a start date of 08/20/25 with an order status of active. On 05/18/26 at approximately 12:17 PM, R64 received approximately 0.5 of a #8 (4 ounces) scoop of the pureed country fried steak and approximately 0.5 of a #8 scoop of mashed potatoes. On 05/21/26 at approximately 12:11 PM, R64 received approximately 0.66 of a #6 (5.33 ounce) scoop of pureed panko mustard chicken and approximately 0.66 of a #8 scoop of pureed scalloped potatoes. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3.R87's admission Record documents an admission date of 07/16/24 with diagnoses including: hemiplegia and hemiparesis following nontraumatic intracerebral hemorrhage affecting left non-dominant side, aphasia, dementia, abnormal weight loss, and dysphagia. R87's Order Summary Report documents a dietary order for regular diet with pureed texture with regular liquid consistency, 2x protein at breakfast, and whole milk in place of menu milk with a start date of 03/12/26 with an order status of active. On 05/18/26 at approximately 12:15 PM, R87 received approximately 0.5 of a #8 (4 ounces) scoop of the pureed country fried steak and approximately 0.5 of a #8 scoop of mashed potatoes. On 05/21/26 at approximately 12:08 PM, R87 received approximately 0.66 of a #6 (5.33 ounce) scoop of pureed panko mustard chicken and approximately 0.66 of a #8 scoop of pureed scalloped potatoes. 4.R9's admission Record documents an admission date of 09/11/25 with diagnoses including: dysphagia, iron deficiency, gastro-esophageal reflux disease, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. R9's Order Summary Report documents a regular diet with mechanical soft texture, regular liquid consistency, 2x protein at breakfast/lunch, whole milk with meals, super cereal with breakfast, fortified pudding with lunch/dinner, ice cream with lunch/dinner and extra butter to hot vegetables and extra gravy/sauces with a start date of 04/29/26 and an order status of active. On 05/18/26 at approximately 12:15 PM, R9 received approximately 0.5 of a #8 (4 ounces) scoop of the ground country fried steak and approximately 0.5 of a #8 scoop of mashed potatoes. On 05/21/26 at approximately 12:08 PM, R9 received approximately 0.66 of a #8 scoop of ground panko mustard chicken and approximately 0.66 of a #8 scoop of scalloped potatoes. 5.R18's admission Record documents an admission date of 12/01/23 with diagnoses including: Alzheimer's disease, dysphagia, dementia, iron deficiency, and edema. R18's Order Summary Report documents a dietary order of regular diet with mechanical soft texture with regular liquid consistency with an order date of 11/26/25 and an order status of active. On 05/18/26 at approximately 12:17 PM, R18 received approximately 0.5 of a #8 scoop of the ground country fried steak and approximately 0.5 of a #8 scoop of mashed potatoes. On 05/21/26 at approximately 12:10 PM, R18 received approximately 0.66 of a #8 scoop of ground panko mustard chicken and approximately 0.66 of a #8 scoop of scalloped potatoes. On 05/21/26 at 3:10 PM, V1 (Administrator) stated the menu should be followed, therefore, full scoops of the mechanically altered diets should be served. The facility policy titled, Menu Planning and Requirements documents: Menus are planned to provide nourishing, palatable, attractive meals that meet the nutritional needs of residents served, (based on age, size, gender, physical activity and state of health), in accordance with the Dietary Reference intakes/Recommended Dietary Allowances as issued by the Food and Nutrition Board of the National Research Council, of the national Academy of Sciences, unless otherwise contraindicated by medical (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conditions and needs. 1. The use of standard, acceptable menu planning tools are employed to create menus. Such tools include the 2010 Dietary Guidelines for Americans publication/recommendations and the USDA's choose my plate tool.

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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. Based on interview, observation, and record review the facility failed to provide a resident access to personal property for 1 of 1 resident (R80) reviewed for resident rights in a sample of 40.Findings Include:R80's admission Record documents an admission date of 6/27/2025 with diagnoses of type 2 diabetes mellitus, muscle weakness, dysphagia and venous insufficiency among other. R80's MDS (Minimum Data Set) dated 3/13/26, documents a BIMS (Brief Interview for Mental Status) score of 15 out of 15 total which indicates R80 is cognitively intact. This same MDS documents R80 has impairment to bilateral legs, uses a wheelchair for locomotion, is dependent on staff for toileting and needs substantial/maximum assistance with showers and dressing.On 5/18/2026 at approximately 9:15am, R80 said about a week ago, he was moved to this new room on a different hall because he and his roommate got into a fight. R80 said the facility did not move his belongings when they moved him and it has been over a week since he had access to his belongings. R80 said he was very mad at the facility for not moving his belongings yet. R80 said he's been asking for the staff to bring his belongings to his new room every day since moving, but they had not done it yet. R80's Progress Note in the medical record dated 5/11/2026 at 15:28 (3:28pm), documented R80 and his roommate had an altercation and R80 was temporarily moved to a new room.On 5/19/2026 at 10:30am, V5 (Housekeeper) was cleaning rooms on the hall where R80 previously resided. V5 said R80 moved to a different hall about a week ago. V5 entered R80's old room on the previous hall and verified R80 did not have his personal belongings yet as the belongings were still in the old room. V5 said she would move the belongings after while when she could get to it.On 5/19/2026 at 11:30am, V6 (Housekeeper) said on 5/11/26, R80 was moved to a different hall. V6 said the housekeeping staff are responsible for moving resident belongings when they move rooms and should have moved R80's belongings the same day he was moved. V6 said that is how things are usually done.On 5/19/2026 at 11:30am, R80's personal belongings were observed to still be in R80's old room and had not been moved to R80's new room on a different hall.On 5/19/2026 at 11:46am, V3 (Corporate Administrator) was asked what he felt was a reasonable time for a resident to wait before their personal belongings were moved due to a room change and V3 answered, 8 days.On 5/19/2026 at 12:24pm, V7 (Housekeeper) said when a resident moves from one room to another room, their belongings are moved immediately to the new room by housekeeping staff. On 5/20/2026 at 3:00pm, R80 was observed with his personal belongings in his new room. The facility's admission contract under the section titled Residents' Rights documents the following in part: As a long-term care resident in Illinois, you are guaranteed certain rights, protections and privileges according to state and federal laws. Your personal property rights, you have the right to keep and wear your own clothing, you may keep and use your own property, you have the right to expect your facility to have a safe place where you can keep small valuables which you can get too daily.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to implement care plan fall interventions for 1 of 6 residents (R81) reviewed for accidents in the sample of 40. Findings Include: R81's admission Record documents an admission date of 12/1/23 with diagnoses including dementia, Alzheimer's disease, repeated falls, insomnia, and polyneuropathy. R81's Minimum Data Set (MDS) dated [DATE] documents R81 has a Brief Interview for Mental Status (BIMS) score of 99 indicating resident was unable to answer questions due to her poor cognition which puts her at risk for poor self-safety awareness. The same MDS documents R81 requires assistance of a walker for ambulation, requires supervision and/or touch assist for transfers from bed to chair, sitting to standing and transition from lying to sitting on side of bed, and R81 has a history of falls. R81's Fall Risk assessment dated [DATE] documents a fall risk score of 14 indicating R81 continues to be at risk for falls. R81's Care Plan documents a focus area for increased risk of falls. Interventions for this focus area includes an assist bar added to left side of bed to assist with balance before standing dated 11/14/25. On 5/20/26 at 9:41 AM, R81's bed was observed, with V9 (Memory Care Director) present, to have no assist bar on either side of R81's bed. V9 (Memory Care Director) verified there was no assist bar on either side of R81's bed. This surveyor and V9 verified R81's most recent care plan in her electronic health record an assist bar to the left side of R81's bed is listed as a fall intervention. V9 agreed R81 should have the assist bar on her bed if it is a fall intervention. V9 denied the lack of an assist bar increased R81's risk of falls because she is strong and has good mobility. However, V9 did agree if the assist bar is ordered as a fall intervention, then it should be in place on R81's bed. On 05/21/2026 at 8:20 AM, an assist bar was observed attached to R81's bed frame. On 5/21/26 at 8:23 AM, V14 (Registered Nurse) stated she does remember seeing R81's assist bar on side of her bed in the past but can't remember the last time she saw it. V14 stated she would expect the assist bar to be on the bed if ordered or implemented as a fall precaution. V14 stated one of the possible risks if an assist bar isn't on the bed frame would be an increased risk of falls/injuries. On 5/21/26 at 12:54 PM, V1 (Administrator) stated he is familiar with R81, but he is not familiar with her fall precautions without looking them up. V1 stated he would expect the fall precaution of an assist bar to be implemented if recommended by the interdisciplinary team or ordered by the physician. V1 stated if it is not implemented or removed it could increase R81's risk for falls or injuries from falls. The facility's fall policy with a revision date of March 2018 documents, Staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. The same document includes staff will identify and implement relevant interventions to try to minimize serious consequences of falling.