STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146040	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Jerseyville	410 Fletcher St Jerseyville, IL 62052

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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 - Minimal harm or potential for actual harm Residents Affected - Few	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 interview and record review the facility failed to report a change in condition to a resident's family/responsible party for one (R5) of 3 residents sampled for notification in a sample of 33. Findings include: R5's Undated Face Sheet, documents he was initially admitted to the facility on [DATE].R5's Quarterly Minimum Data Set (MDS), dated [DATE] R5 was cognitively intact. R5's Physician's Order Sheet (POS) dated 3/28/2026 documents a new physician's order for Ertapenem Sodium injection intravenous (IV) use 1 gram one time for UTI/proteus in urine until 4/4/2026. No documentation R5's family or responsible party was notified. R5's Medication Administration Record (MAR) dated 3/29/2026 staff documents 9 in the box for the Ertapenem IV medication. R5's Nursing Note, dated 3/29/2026 at 10:58 AM documents this writer attempted to place an IV in resident's right wrist, was unsuccessful. Resident stated he would only allow this writer to attempt one time. DON (Director of Nurses) notified and will attempt to place IV. No notification of R5's family or responsible party was notified.On 6/24/2026 at 12:52 PM V2, Director of Nurses (DON) stated when a resident has a change in condition staff are instructed to notify the resident's family and to document that in the progress notes and if it's not documented she can't prove staff called R5's family when he was transferred to the hospital and diagnosed with UTI and prescribed antibiotics.The Facility's Undated Change of Condition Policy, documents to ensure that medical care problems are communicated to the attending physician and family/responsible party in a timely, efficient and effective manner. The facility will notify the resident's physician and family when there is a significant change in the resident's physical status such as a clinical communicates such as recurrent UTI.

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide discharge planning and a letter stating when Medicare days would be exhausted for one (R4) of 3 residents at the facility sampled for resident's discharge rights in a sample of 33. Findings include: R4's Undated Face Sheet documents she was initially admitted to the facility on [DATE]. Review of R4's Electronic Medical Record including Progress Notes dated 2/2026 through 3/2026 there was no documentation of discharge planning. On 6/23/2026 at 1:00 PM V4, Social Services Director stated she started as the facility social worker in March 2026 so she wasn't working her when R4 was initially admitted to the facility on [DATE]. V4 stated after a resident is admitted to the facility, they have an initial care plan meeting where discharge planning is discussed which is 72 hours after admission and then they have Medicare meetings every Monday but she just got access to the web link for those Monday Medicare meetings so she has attending 1 or 2 of them. V4 stated it was her understanding that R4 was discharging home with family and that was the discharge plan the entire time. V4 stated she had an understanding that R4 was Medicare and she voiced she couldn't stay after she used all her Medicare days because she would be self-pay and she voiced she couldn't afford that. V4 stated she didn't know what occurred with R4's Medicare stay days because that was a billing issue. On 6/25/2026 at 2:50 PM V7, Business Office Manager stated R4's 100th Medicare day was on 3/18/2026 and staff gave R4 discharge paperwork on 3/24/2026. During the stay at one-point R4's Medicare days were updated and 10 days were used at another facility and when she realized that she updated the Medicare days left and R4 didn't have any so she issued the invoice to R4 on 3/24/2026 and R4 discharged with family on 3/25/2026. V7 confirmed that R4 was billed for her stay at the self-pay rate of $225.00 day from 3/19/2026 through 3/25/2026 and R4 was not aware her Medicare days were exhausted during that time. On 6/25/2026 at 3:50 PM V2, Director of Nurses (DON) stated she started working at the facility as the DON on 2/2/2026 and R4 was admitted to the facility on [DATE]. V2 stated she was so new as the DON she wasn't doing 72 hour admission care plan meeting or anything like that and stated she stays out of billing for the most part because there is so much nursing responsibilities but she understands discharge starts on admission and her understanding was that R4 was admitted to the facility for skilled therapy/ rehabilitation and the discharge plan was to return home with her family. V2 stated she didn't know anything about Medicare/Skilled but her understanding was that 10 Medicare days were used prior to R4's admission and they Medicare billing report wasn't updated in a timely manner from the other facility so when the facility billing staff were aware of the update to R4's Medicare days R4 was given an invoice and she was discharged home with family the next day. V2 stated she understood R4 didn't get discharge notice but it was because the facility thought she had 10 additional Medicare stay days and she didn't. On 6/25/2026 at 4:13 PM V1, Administrator stated the facility does not give any documentation or letter to residents when they exhaust their Medicare days. On 6/25/2026 at 4:33 PM V1 stated the facility does not have a discharge policy.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the Facility failed to ensure Residents' allergies were being followed/honored for 1 of 3 residents (R3) reviewed for allergies in the sample of 31. This failure resulted in (R3) being exposed to bleach which was listed as an allergy for her, and being sent to the hospital. Findings include:A. R3's Physician Order Sheet for June 2024 documents a diagnosis of burns involving 20-29% of body surface with 20-29% third degree burns; essential (primary) hypertension; type 2 diabetes mellitus with unspecified complications; personality disorder, anemia; unspecified post-traumatic stress disorders, hypothyroidism. R3's Minimum Data Set (MDS) dated [DATE] documents she is cognitively intact for decision making of activities of daily living. She has no impairment on her upper or lower extremities. She uses a wheelchair and needs assistance with most ADL's. (activities of daily living). R3's Medical Records under allergies document R3 was allergic to bleach. R3's Care Plan does not document anything related to a bleach allergy. R3's Initial Incident Report dated 4/17/2026 at 8:30 AM, (R3) is a [AGE] year-old female resident that resides at (Facility) with a BIMS (Brief Interview for Mental Status) of 15 (cognitively intact). (R3) has a diagnosis of burns involving 20-29% of body, HTN (hypertension); type 2 diabetes, Personality disorders, Anemia, PTST (post traumatic stress disorder); Solitary Pulmonary Nodule, Protein Calorie Malnutrition, GERD, Hypothyroidism, and pain. Social Service Director informed Administrator of an allegation of abuse. Staff member suspended immediately, MD (Medical Doctor), police, RP (Responsible Party) and Ombudsman notified. Investigation initiated, final to follow. R3's Final Incident Report dated 4/17/2026 at 8:30 AM, (R3) is a [AGE] year-old female resident that resides at (Facility). (R3) has a diagnosis of, but not limited, to personality disorders, PTSD (post-traumatic stress disorder), pulmonary nodule, and hypothyroidism, BIMS (Brief Interview of Mental Status). (R3) reported feelings of neglect to the SSD (Social Service Department). Initial interventions; (R3) sent to the ER (emergency room) per her request. Staff member suspended pending investigation. Initiated staff education. Initiated staff and resident interviews. Reported allegation to (State), MD (Medical Doctor), Ombudsman, RP (Responsible Party), police were notified. Investigation: (R3) made a statement of neglect to SSD (Social Service Director) who reported to the administrator. (R3) stated her response for making the allegation is that she requested to go to the hospital because she was in anaphylactic shock. When asked why she felt that she was in anaphylactic shock, (R3) stated that they used bleach in my room to clean up a red (powdered drink mix) stain. When asked why she felt it was neglect, she stated they know I'm allergic to bleach and they used it in my room. Prior to this allegation, (R3) was noted to be going home that afternoon. She also was noted to be outside cursing and having a behavioral episode toward staff before the allegation. Staff members were interviewed, statements show that (R3) asked the housekeeping staff to clean her room due to her spilling (powdered drink mix). Housekeeping staff entered the room, there were two small spots on the floor, which they did spray with cleaner and wipe up, they proceeded to mop the entire room, not with a bleach substance. (R3) was asked to remain out of her room until the floor dried. She did not follow instructions, entered the room, exited the room within seconds of entering, stating they used bleach, and she is in anaphylactic shock. (R3) was assessed immediately; no finding of anaphylactic shock or any allergic reaction were noted. (R3) proceeded to go to the dining room, outside to smoke, and back into the dining room to speak with residents and staff. After (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that (R3) went to the SSD (Social service Director) to report her allegation. Upon her allegation and request that she was still in anaphylactic shock she was transported to the hospital. En route to the hospital (R3) made the allegation to the police department and they arrived at the facility. Police assisted with the investigation due to (R3) allegation that staff knowingly harmed her with bleach. Upon return a few hours later from the ER (Emergency Room), there were no findings of anaphylactic shock noted. (R3) discharged to home on 4/17/26 per original plan of care. A follow up call was made and she said she is doing well. R3's Medical Records does not document any vitals were taken on 4/17/2026. On 6/24/2026 at 3:53 PM, V26, Housekeeping stated, I remember (R3) came to me and asked me if I was cleaning her hall and I told her yes. She asked me if I could come clean her room because she had spilt some red (powdered drink solution) on her floor and she did not want it to stain. I was never told (R3) had any allergies to bleach. When we went into (R3's) room we sprayed bleach on area with a cleaner that had bleach in it and is used in nursing homes and then we mopped the floor. We always use bleach in anything that is white including towels, sheets and to my knowledge (R3) has never had a reaction. I was never told not to use bleach on (R3's) stuff or that (R3) had a bleach allergy. Statement from V26, Housekeeper undated documents, (R3) told me this morning she spilt (powdered drink solution) on her floor and needed her room to be cleaned first. When we go to her room there were only two dots of (powdered drink solution) on the floor so it got sprayed with two dots of bleach because it was red (powdered drink solution) and it stains and immediately got wiped up, the room did not smell like bleach at all, She came walking down the hall and politely got asked not to go into her room because the floor had just been mopped. She then started to walk faster and immediately went into her room. On 6/24/2026 at 4:14 PM, V23, Housekeeping Supervisor stated, (R3) was mad at me prior to the incident with the bleach. I had to do a room move with her and she was not happy with me after that. (R3) approached (V26, Housekeeper) because she said she has spilt some red punch on her floor. (R3) was not in the room at the time we cleaned it. I sprayed bleach on the area, it was not very big, and then we mopped the entire floor. Nobody ever communicated to me that (R3) was allergic to bleach. I had no idea. The floor was still wet and we told (R3) to wait until the floor dried. (R3) had been outside smoking a cigarette and she walked over the wet floor and into her room and then came out and said we had used bleach, and we were putting her in anaphylactic shock, and she left and walked up the hallways. I do not remember her breathing different or acting differently. V23, Housekeeper statement undated statement documents, Went to (R3's) room to assist housekeeper with cleaning. Resident has two small spills of red (powdered drink solution). I sprayed it with bleach and instantly wiped up the spots. Met (R3) in hallway and informed her that the floor was wet, to please wait a minute; she instantly started walking faster and entered her room. There was no smell of bleach. She came out of her room saying I put her in shock. I went straight to the nurse. On 6/25/2026 at 8:42 AM, V25, Medical Records stated, (R3) came into my office and said (V23) had sprayed bleach in her room and she was allergic to bleach, and she was in shock and needed to go to the hospital. (V5, Transportation) went and got her nurse (V24) and she checked (R3) out, and she was talking normal and breathing normal and appeared okay. (R3) has a history of making things up. (V23) said she (R3) had two small spots on her floor that she cleaned up with bleach and then she mopped the floor. (R3) was told not to go into her room until the floor was dry but she went into the room anyway. (V24) sent her out to the hospital. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V25, Medical Records statement dated 4/17/2026 documents, (R3) came into the office saying that she was in anaphylaxis due to 'bleach allergy.' Resident did not appear to be in any distress. Resident stated that she would go to the hospital; (V5, Transportation) went to get her nurse. The nurse came to check on her, then went to call for ambulance. R3'S Police Report dated 4/17/2026 documents, she is a resident at (Facility). (R3) stated she is deathly allergic to bleach. (R3) stated the staff at (Facility), and the house keeping supervisor, (V23), knew of her allergy. (R3) stated she and (V23) used to be friends, but recently, (V23) and her had a falling out. (R3) stated she had spilled some red (powdered drink solution) the night before. (R3) stated she told (V23), and she had asked if she could clean it up. (R3) stated, she was later talking with some people, when (V23) walked by. (R3) stated (V23) told her they had mopped her room and the floor was wet. (R3) stated (V23) never told her she used bleach. (R3) stated she had a recording of the conversation. In the recording, (V23) states, Your room's done. It's wet. (R3) stated she walked into her room, and she began to have an allergic reaction. (R3) stated she went to the front office. (R3) stated she told the social worker, (V4, Social Service Director), what had happened and that she needed an ambulance. (R3) stated (V23) did not call an ambulance, but asked to see her phone to review the recording. (R3) stated she had to ask again for an ambulance, before one was contacted. (V24) stated (R3) said it feels like the staff does not listen to her, and that she had recorded (V23) telling her the room was wet, but she left out that she had used bleach. When (R3) asked to go to the hospital (V23) had (V25) get (V24), and they had (V24) call. (V1) stated there is a note in her chart that (R3) is allergic to bleach. (V1) stated (R3) has never brought bleach allergy up as a problem. (V1) stated (R3's) bathroom and the community towels are cleaned with bleach. (V26) stated she was unaware of (R3's) bleach allergy. After speaking with (V23), it was determined no charges would be filed. (V23) did not mean to cause (R3) any harm. If (R3) was injured from the bleach, it was due to an accident, not on purpose. On 6/25/2026 at 8:49 AM, V24, Licensed Practical Nurse (LPN) stated, I was passing out meds on my hall when (R3) came out of her room and she was yelling and hollering and saying (V23) had used bleach in her room and she was allergic to bleach. She went up front to the business office, and they called me, and I went and assessed her, and she seemed okay, but she was demanding to be sent to the hospital, so I sent her out. I am not sure if I took any vitals on her, but she was talking and acting like normal. I have no idea if she is allergic to bleach. V24, Licensed Practical Nurse (LPN) dated 4/17/2026 documents, I was walking down C hall to give meds to another resident when (R3) approached me stating that housekeeping used bleach in her room and that she was going into 'anaphylactic shock.' Housekeeping Supervisor stated at that time that she informed resident not to enter the room due to it just being mopped. (R3) was yelling about bleach use and housekeeping informed her that she used a small amount to remove a (powdered drink solution) stain on the floor. There was no bleach odor in room. Resident proceeded to services office and informed resident would like to go to the ER (emergency room). This nurse called 911. R3's Hospital Records dated 4/17/2026 documents, [AGE] year-old female to the emergency department from work by ambulance after allergic reaction being exposed to bleach. Reports it makes her throat swell shut. In the past reports she needed steroids, Benadryl, epinephrine, and famotidine. Her workplace gave her Tylenol PM because it did not have regular Benadryl. EMS gave her IV Benadryl and Solumedrol. Will add famotidine 40 mg IV in the emergency department. Did not warrant epinephrine at this point. No lip or tongue swelling. She reports she feels like it is harder to breathe. No other acute issues. Does have skin graft multiple areas from portable heater blowing up on her within the last year. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/24/2026 at 2:04 PM, V4, Social Service stated, (R3) came to me, related to an incident where bleach was sprayed in her room, and she wanted to be sent out to the hospital. The nurse came and checked her out and sent her to the hospital. When she came back, she packed up her stuff and went home. She was supposed to go home on Friday originally. We did an investigation, and it was unfounded. (R3) was told not go into her room because the floor was wet, and she went in the room anyway. R3's Progress Notes dated 4/17/2026 at 1:15 PM, Note Text: resident returned from hospital. She walked straight to her room, started to pack her belongings. A CNA helped her bring her belongings to son's car. As she was walking past the nurses' station, I asked if she wanted her meds to take home and how she was feeling. She denied any distress at the time. Then went to the kitchen, as we were packing her meds, to get some food. We handed her meds, and she left the facility. On 6/24/2026 at 10:01 AM, V1, Administrator stated (R3) made an allegation of abuse because of some bleach, and I did an investigation, and had no findings. On 6/24/2026 at 10:30 AM, V2, Director of Nursing stated. If a resident has an allergy, I would not expect any staff to have that item near the resident or any potential for exposure that could cause a reaction. If a resident has an allergy to bleach, I would not expect bleach to be used. R3's Investigation Report dated 4/16/2026 documents, 8:26 am received a call from SSD that (R3) claims the housekeeping supervisor was rude to her and was on her way to the hospital because she has a bleach allergy and was in 'anaphylactic shock' 8:30 am resident was leaving in ambulance. 8:30 am spoke with Housekeeping Supervisor and told her she was suspended. Collected statements from staff members. 9:13 am emailed reportable to corporate for review. 9:30 am police entered to question staff- allegation that resident requested 911 several times before staff would do it and that staff used bleach in her room. 9:30 am to 11 :00, police interviewed staff in administrator's office. Housekeeping Supervisor- stated she was explaining the cleaning plan to her staff this morning and said they would clean (R3's) room last because she is discharging today and would be a deep clean. (R3) walked by and heard it and asked to have her room cleaned because she spilt (powdered drink liquid) all over the floor. (V26) Housekeeper and (V23), Housekeeping Supervisor went to C7 and saw two tiny dots of red (powered drink liquid) on the floor. (V23) sprayed a dot of bleach on each mark and wiped it up. (V26) swept the floor and then (V23) mopped the whole room. When they came out, (V23) told (R3) her room was just cleaned and mopped, so her floor is wet, and to wait a few minutes before going in; (R3) walked really fast to get to the room and immediately came out and said 'you used bleach and put me in anaphylactic shock' then walked up the hallway. On 6/25/2026 at 11:01 AM, V1, Administrator stated, (R3) doesn't like (V23). She was upset with (V23) after we had to have a room change for her. I interviewed staff and they told me (R3) was outside smoking and when she went to go back to her room the housekeeping had cleaned some areas with bleach on her floor, and she stated she was allergic to bleach. (V23) told her the floor was wet and to wait before going into her room, which she ignored. All staff interviewed stated (R3)was talking normally and going around telling everyone she was allergic to bleach and (V23) used bleach in her room. (V4) said that (R3) was going around talking to staff and residents but her voice did become softer and they sent her out to the hospital. The nurses confirmed she did have an allergy to bleach. But, only a small amount of bleach was used on the floor to get off the red (powered drink solution) that was on her floor. On 6/30/2026 at 9:20 AM, V22, Medical Director stated, he did not believe (R3) had a true allergy to (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented that as well. V2 stated staff notified R5's physician on 3/30/2026 that the IV was not able to be started and R5's physician ordered the same medication in an IM dose and that was administered per physician's orders starting on 3/31/2026. V2 stated she understands the delay in medical treatment. The Facility undated change of condition policy documents, Purpose: To ensure that medical care problems are communicated to the attending physician or authorized designee and family/ responsible party in a timely, efficient, and effective manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146040	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Jerseyville	410 Fletcher St Jerseyville, IL 62052

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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the Facility failed to ensure meals were being served at regular times and without long waits. This has the potential to affect all 58 residents living in the facility. Findings include: On 6/24/2026 at 9:30 AM, in the main dining room area there is a bulletin board that documents scheduled mealtimes for breakfast at 7:30 AM, lunch at 11:30 AM, and dinner at 5:00 PM. On 6/24/2026 at 9:39 AM, V1, Administrator stated lunch was served at 11:30 AM, daily. On 6/24/2026 at 12:05 PM, V34 was the only staff in the kitchen. The dining room is full of residents sitting at tables waiting for their lunch. On 6/24/2026 at 12:10 PM, all food was placed on the steam table and V34, Dietary Manager took the temperatures. Residents were waiting in the dining room to be served lunch. On 6/24/2026 during the lunch service the last resident was served at 1:18 PM, for a total of one hour and 48 minutes lunch service for 59 residents. R31's Minimum Data Set (MDS) dated [DATE] document R31 was cogntively intact for decision making for activities of daily living. On 6/24/2026 at 3:00 PM, R31 stated they have had issues related to the food being cold and they have discussed this at the Resident Council Meetings with the food being cold and having to wait so long. If you were in a restaurant you would get up and leave after an hour. Lunch is supposed to be at 11:30 AM. Breakfast is at 7:30 AM, lunch at 11:30 AM, and dinner at 5:00 PM. R30's MDS dated [DATE] document R30 was cogntively intact for decision making for activities of daily living. On 6/24/2026 at 3:04 PM, R30 stated the food is cold at times and we have complained about having to wait so long for food in the dining room. Lunch is supposed to be at 11:30 AM. April's Resident Council Meeting Notes dated 4/7/2026 documents, Residents express their concern about meals being late. On 6/30/2026 at 10:20 AM, V36, Corporate Dietician stated she expects meals to be served at reasonable time without waiting and waiting over an hour for service was too long for 59 residents. The CMS 802 Form provided by the facility on 6/23/2026 documents a total of 58 residents living in the facility. The Resident Right Policy with a revision date of 11/2018 documents, Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146040	A. Building B. Wing	06/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evercare of Jerseyville	410 Fletcher St Jerseyville, IL 62052

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure food is stored and prepared in a manner which prevents potential contamination for 4 of 25 residents (R11, R30-R32) reviewed for food temperatures in the sample of 32. Findings inclue:On 6/25/2026 at 11:30 AM, V34, Dietary Manager was placing items from the oven into the steam table. V34, took the temperatures and recorded them in her Food logbook with no issues. No additional food temperatures were taken during the entire meal service, which lasted one hour and 48 minutes for the food service for 59 residents. During the lunch service after the last person had been served on 6/25/2026 from 1:01 PM-1:19 PM, R11, R30, R31 and R32 were all served the corn. On 6/25/2026 at 1:19 PM, the temperatures were taken with a calibrated metal thermometer, and the following items were not above 135 degrees Fahrenheit. The corn was 103.0 F, the mechanical stew registered at 104.0F. R31's Minimum Data Set (MDS) dated [DATE] document R31 was cogntively intact for decision making for activities of daily living. On 6/24/2026 at 3:00 PM, R31 stated they have had issues related to the food being cold and they have discussed this at the Resident Council Meetings. R31 stated his corn was cold today. R30's MDS dated [DATE] document R30 was cogntively intact for decision making for activities of daily living. On 6/24/2026 at 3:04 PM, R30 stated the food is cold at times and we have complained. My corn was cold today too. On 6/25/2026 at 1;20 PM, V34, Dietary Manager stated all food being held on the steam table should always be at least 135 degrees or higher before serving. I did not realize it took that long to serve everyone out today. On 6/30/2026 at 10:20 AM, V36, Corporate Dietician stated she would expect all food on the steam table to be held at least 135 degrees or higher to prevent bacterial growth and protect residents, who are often older or have weakened immune systems. The Food Hold Temperature Policy dated 10/1/2025 documents, Foods will be cooked to the appropriate internal temperatures to prevent food borne. The major cause of food borne illness are improper cooking, cooling, reheating, and holding temperatures, illness. [NAME] food to the proper temperatures and take the temperature with a clean and sanitized probe thermometer. Reheat food in the oven and check temperatures before placing on a steam table or hot holding unit. Never use the steam table to reheat food. Hold all hot foods at 135 degrees F and check temperatures frequently.