STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146057	A. Building B. Wing	03/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monmouth Rehab and Nursing	117 South I Street Monmouth, IL 61462

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on interview, record review, and observation the facility failed to answer call lights in a timely manner. This has the potential to affect all 37 residents residing at the facility.Findings include:The facility's Matrix (CMS 802) dated 3/17/26 documents there are 37 residents residing at the facility.The facility's Resident Call Bells Policy dated 11/05/2025 documents Calls for assistance shall be answered timely. When making beds and tidying resident rooms, the cords for the communication system will be left in a standard place in all rooms. The Nursing Assistant leaving the room must ensure that the communication system is in place regardless of the residents' ability to use it.The facility's Grievance Report Form dated 7/31/25 documents Call lights are not answered timely. It seems they are worse first thing in the morning and at mealtimes.The facility's Suggestion/Complaint/Grievance Communication Form dated 11/21/2025 documents Call lights have been a complaint for some time with several residents. They are not answered timely and are worse early in the morning and at mealtimes. There was a grievance filed on 07/31/2025 in regards to the call light wait times that has not been resolved.The facility's Resident Council Meeting Minutes dated 02/20/2026 documents extended call light times, being told to wait for the next shift when light has been answered due to charting.The facility's Suggestion/Complaint/ Grievance Communication Form dated 02/23/2026 documents Several residents say that the wait times on call lights have gotten extensive. Two different situations residents waited more than an hour to be taken care of.On 3/18/26 at 10:00 AM a Resident Council meeting was held with V10 (Ombudsman), R4, R12, R20, R22, R27, and R39 in attendance. All residents in attendance are alert and cognitively intact. All residents present complained about the call lights not being answered timely. R4 reported she lives in the back hallway of the building and other residents in her hallway will start yelling because staff are not answering their call lights. R4 will then go to the nurses' station which is located in the front of the building to alert staff that a resident in the back hallway needs assistance. V10 confirmed the long wait times for call lights has been an issue for several months.On 3/19/26 at 12:00 PM the bathroom emergency light between rooms was lit up and sounding. V19 (Licensed Practical Nurse) and V20 (Registered Nurse) walked past the emergency light to the front door, turned around and walked back by the emergency light. V19 looked up at the flashing light and both V19 and V20 walked on to the nurses' station. R20 was in the bathroom on the toilet and had turned on the bathroom emergency light for assistance.On 3/20/26 at 9:15 AM V11 (Activity Director) was unable to identify the residents in the grievances that reported they were told to wait until the next shift or the residents that reported waiting over an hour for their call lights to be answered.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview and record review the facility failed to provide the Resident Council with responses, actions, and rationale taken regarding concerns. This has the potential to affect all 37 residents residing at the facility. Findings include:The facility's Matrix (CMS 802) dated 3/17/26 documents there are 37 residents residing at the facility.The facility's Resident Council Meeting and Agenda Policy revised 3/6/26 documents the purposes of the Resident Council include Residents to have input in the operation of the facility and Discussion of concerns.The facility's Resident and Family Concerns and Grievances Policy and Procedure dated 10/5/2023 documents Purpose: To provide for the prompt resolution of medical and non-medical grievances while maintaining confidentiality. Responses to and Resolution of Grievances: The facility will follow up with resident or their family members, guardian, or representative within 72 hours of the filing of the grievance.The facility's Resident Council Meeting minutes dated 11/25/25 documents Discussed previous months complaints and if those had all been resolved. Three had not. Two from July and one from October.The facility's Resident Council Meeting minutes dated 1/19/26 documents Discussed previous months complaints and if those had been resolved. Four had not. One from July and three from November and December.The facility's Resident Council Meeting minutes dated 2/23/26 documents Discussed previous months complaints and if those had been resolved. Five had not. One from July, three from November and December, and one from January.On 3/17/26 at 9:00 AM R20 stated she used to be the Resident Council President for a long time. R20 said she quit being the president because no matter how many times she brought any concerns up nothing was ever fixed or changed. R20 said We would complain about things and then never hear back anything from them (staff) and the problems would continue. The problems do still continue.On 3/17/26 at 9:55 AM V11 (Activity Director) reports there are not any Resident Council officers because the residents are exercising their rights to do so.On 3/18/26 at 10:00 AM a Resident Council meeting was held with V10 (Ombudsman), R4, R12, R20, R22, R27, and R39 in attendance. All residents in attendance are alert and cognitively intact. All residents present reported they do not get a follow up from the grievances submitted in Resident Council. R12 and R20 both reported that all grievances are filed in Resident Council so that they are anonymous. The facility does not have a Grievance/Suggestion box where grievances can be submitted anonymously. R12 stated he is concerned about retaliation from staff if the grievances are not anonymous.On 3/18/26 at 2:22 PM V11 (Activity Director) reports she gives all grievances and Resident Council Meeting minutes to V1 (Administrator).On 3/19/26 at 11:50 PM V1 (Administrator) reports that the grievances go to the Department Manager that the grievance pertains to and then the Department Manager addresses it with the staff. V1 confirmed there is not a Grievance/ Suggestion box for residents to be able to submit grievances anonymously.The facility's grievance logs dated 7/31/25 - 2/23/26 document 22 grievances and all 22 grievances were filed in Resident Council meetings. The facility provided one call light audit for documentation to verify actions were taken to address the 22 grievances.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Facility failures resulted in two deficient practices.A. Based on interview and documents review, the facility failed to conduct an annual Legionella Risk Assessment to assess where Legionella and other opportunistic waterborne pathogens can grow and spread. This has the potential to affect all 37 residents residing at the facility. B. Based on observation, interview and record review, the facility failed to utilize Enhanced Barrier Precautions as ordered per policy for two of four residents (R6, R15) reviewed on Enhanced Barrier Precautions, in a sample of 28.Findings include:A. The Facility Resident Census Roster and Facility Matrix/802, dated 3/17/26, were reviewed. The Census Roster documented 37 Residents resided in the Facility.The Legionella Risk Assessment (complete annually or upon disruption of the water source) not dated, was not completed.On 3/19/26 at 1:23 PM, V9 (Maintenance Director) stated the Legionella Risk Assessment has not been completed since he has been here approximately 3 1/2 years ago.B. The Facility Resident Census Roster and Facility Matrix/802, dated 3/17/26, were reviewed. The Census Roster documented 37 Residents resided in the Facility.Enhanced Barrier Precautions policy revised 10/28/24, documents handwashing must be conducted after touching blood, body fluids, secretions, excretions and contaminated items, immediately after gloves are removed and between tasks and procedures on the same resident. Personal Protective Equipment (gloves and gowns) for Enhanced Barrier Precautions is necessary when performing high-contact care activities.1. R6's Physician Order dated 2/10/26, documents Enhanced Barrier Precautions.R6's current care plan documents, R6 has a wound and Enhanced Barrier Precautions were initiated on 01/23/2026. Interventions include Isolation Personal Protective Equipment (PPE) available at the entrance room and staff to wear PPE for high-risk activities per protocol.On 3/17/26 at 1:30 PM, V4 (Licensed Practical Nurse) was observed to don non-sterile gloves, apply lotion to R6's bilateral lower extremities, place the lotion on the resident's bed, rub the lotion in R6's lower extremities, pick up the lotion and put the lotion on the bedside table with gloves still donned, remove gloves, wash hands and pick up the lotion bottle, carry the lotion to the treatment cart and place the lotion in a drawer of the treatment cart without disinfecting the bottle of lotion and did not don a gown during high contact cares.Throughout the survey on 3/17/26 through 3/19/26, R6 did not have an Enhanced Barrier Precaution sign posted nor was Personal Protective Equipment available for use outside the room.2. R15's Physician Order dated 3/10/26, documents Infection precautions - enhanced barrier Staff wear gown/gloves when in direct patient contact.R15's current care plan documents Enhanced Barrier Precautions during personal care were initiated on 03/10/2026.On 3/17/26 at 10:15 AM, V4 (Licensed Practical Nurse) was observed to don non-sterile gloves, remove R15's elastic wraps on bilateral lower extremities, assess/rub/feel the lower extremities of R15's skin, reach for the lotion on bedside table, apply lotion to bilateral lower extremities, place lotion bottle back on bedside table, remove gloves, wash hands, then pick up the contaminated bottle of lotion with bare hands and place the bottle on the treatment cart without disinfecting the bottle of lotion and did not don a gown during high-contact cares.On 3/17/26 at 3:30 PM, V2 (Director of Nursing) confirmed gloves and gowns should be worn during high contact care. Enhanced Barrier Signs should be posted and a PPE cart should be available outside the resident's door when on Enhanced Barrier Precautions.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure a reliable operating nurse call light system to alert staff in the event of an emergency or if a resident needs assistance. This has the potential to affect all 37 residents residing at the facility. Findings include:The facility's Matrix (CMS 802) dated 3/17/26 documents there are 37 residents residing at the facility.The facility Resident Call Bells Policy dated 11/5/2025 documents The facility will be adequately equipped to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area from each resident's bedside, toilet and bathing facilities. Calls for assistance shall be answered timely.Procedure:The communication system shall be checked regularly to ensure operability and that it can be reached by the resident.A tap bell supply/hand bells will be available to be used in the case of communication system malfunction. In the event the primary communication system malfunctions, a tap/hand bell shall be issued to each resident to call for assistance with and shall serve as the new communication system until the primary communication system is functioning again.The facility's undated Maintenance Director job description documents duties include assure proper maintenance and running condition of all equipment including all nurses' call station systems.The facility's Grievance Log entry dated 11/21/25 documents Call lights not working. Working on getting quotes and a repair plan.On 3/18/2026 at 10:00 AM during the facility Resident Council meeting V10 (Ombudsman) reports the facility has a ghost light system meaning one call light when activated may trigger other call lights on or if one call light is turned off it will turn them all off so then staff have to go room to room. R20 reports she has been woken up in the night by staff asking her if it was her call light on because they do not know which call light is on. On 3/18/2026 from 11:15 AM through 11:17 AM, room [ROOM NUMBER], 16, and 20's bathroom call lights were observed to be blinking quickly and audibly alarming. There were not any residents in the rooms.On 3/18/2026 at 11:18 AM, V8 (Registered Nurse) stated I have heard that when the shower room's emergency light is turned on, it also turns on those other rooms (14, 16 and 20).On 3/18/2026 at 11:23 AM, V9 (Maintenance Director) stated he was aware of the call-lights in room [ROOM NUMBER], 16 and 20 turning on when the front hall shower room emergency light is activated. V9 stated the call light system needs to be replaced and the corporation had an estimate done for a replacement system a couple of months ago.On 3/18/2026 between 1:00 PM and 1:30 PM Call lights for each room and bathroom were checked and verified by V12 (RN). V12 reports there have been problems with the call light system. Findings included:room [ROOM NUMBER]'s room call light was activated and the call light indicator outside of rooms [ROOM NUMBERS] lit up.The emergency call light in the bathroom shared by rooms [ROOM NUMBERS] was activated and the indicator light outside of the room did not light up.room [ROOM NUMBER]'s room call light was activated and the call light indicators outside of the room and on the call light board at the nurses station did not light up.The shower room's emergency call light was activated and the indicator light outside of the room.On 3/18/2026 at 1:55 PM the call light board at the nurses station was sounding, but there were no lights lit up to indicate which call light was on. V13 (CNA) went to each hallway and verified there were no call light indicator lights outside of any resident room lit up. V13 reports the call light system has not been working correctly for a while and when this happens she has to go to each room and check the call light on the wall in each room. V13 verified it was the call light in room [ROOM NUMBER] that was on.On 3/18/2026 at 2:55 PM V9 (Maintenance Director) reports he had two electronic companies come to the facility and report the call light system needs replaced and there was an estimate given to the corporate office to replace the call light system. V9 reports he does not conduct an audit of the call light system. V9 stated, I might if I had a functioning system.On 3/19/2026 at 9:00 AM V15 (Regional Director of Plant Services) reports the corporation uses a work order system for any maintenance notifications of malfunctioning equipment and audits. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V15 reports the work order system has a module that is to be used to inspect call lights and it is to be done monthly.On 3/19/2026 at 8:42 AM V14 (CNA) reports the call light in the shower room sometimes works and sometimes it doesn't. V14 reports when the call board system is sounding but there is not a light lit up on the board or outside of a room it is usually on the front hall, but it has happened on the back hall as well.On 3/19/2026 at 8:46 AM V16 (CNA) reports when the shower room call light is activated multiple call light indicators outside of the rooms will light up. V16 reports when the call system only sounds the staff split up and go to different hallways to find the call light that is on.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 residents were monitored, assessed, interventions were implemented, changes in conditions were identified in a timely manner, appropriate notifications were made, and outcomes investigated for 5 of 5 residents (R6, R15, R37, R43, R48) with a change in condition in a sample of 28.Findings include: 1.R37's Nurse's Notes dated 3/4/2026 documents R37 returned from a hospital stay. Resident is in Contact and Airborne Precautions in a private room at this time for ten days from the point of contact. Coarse crackles throughout all lobes of her lungs. R37's Nurse's Notes dated 3/5/26 at 1:15 AM document that resident is on isolation related to Influenza A. No respiratory assessment or vital signs noted. R37's Nurse's Notes after her admission assessment dated [DATE] do not contain any physical assessments of R37. No targeted assessments related to current Influenza A for which she was in transmission-based precautions. No generalized skilled nursing assessments of R37 while she was in transmission-based precautions. To include no vital signs documented on 3/6; 3/8; 3/9; 3/10; 3/12; or 3/13. On 3/11/2026 at 10:30 AM V1 (Regional Administrator) confirmed there were no targeted or general physical assessments of R37 after her hospitalization and while she was in transmission-based precautions and being acutely ill due to Influenza A. We should be assessing anyone who is sick every shift until they are stable for 72 hours. The Change in Condition policy revised 9/21/25, documents a full assessment by the nursing staff will include but not limited to full set of vital signs, level of consciousness, respiratory status including lung sounds, abdomen including last bowel movement and urine properties, functional status, pain and glucometer test if diabetic or decreased level of consciousness, notify physician, notify family and initiate vital signs every shift for a minimum of 72 hours or until condition has stabilized. The Charting and Documentation policy revised 11/5/19, documents medical record entries shall be made by the person providing or supervising/observing the service documented. Narrative documentation/Progress Notes will be documented on the premise of charting by exception. Documentation will include information on assessment, notifications, interventions and evaluation including but not limited to incidents/accidents, change in condition, physician notification, responsible party notification, refusal of medications/treatment or recommendations, status updates and transfers or discharges. The Neuro/Head Trauma Assessment form documents to Assess as follows: a) initial, b) every 15 minutes x 4, c) every 1 hour x 4 hours, d) every 4 hours x 8 hours, e) every shift for the remainder of the 24 hours. 2. R6 was admitted on [DATE] with diagnoses of Venous Insufficiency, Alzheimer's Disease, Dementia, Right ankle and foot Gout, Dysphagia and Atrial Fibrillation. On 3/17/26 at1:30 PM, V4 (Licensed Practical Nurse) stated I need to call Hospice to report a change (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	in condition. She didn't eat supper last night or breakfast this morning. I think she is transitioning (final stage of the dying process). The Progress Notes included a Physician Assistant visit note on 3/10/25 which documented no new findings. As of 3/18/26 at 9:25 AM, R6's Progress notes did not include any assessment of R6's condition change, Hospice notification, physician notification or family notification. The Hospice visit note dated 3/19/26 documents R6's lungs sound were congested and diminished, weak moist cough, representative wishes to treat symptoms, an antibiotic and a steroid medication was ordered to treat symptoms, the facility nurse reported during this hospice visit R6 had remained in bed the past 3 days due to increased weakness and fatigue, sleeping the majority of the time and has been refusing food/fluids and medications, although drank 240 milliliters of water during hospice visit. On 3/19/26, R6 was transferred to a private room for the dying process. 3. R15 was admitted on [DATE] with diagnoses of Dementia, Atrial Fibrillation, Cellulitis of lower extremities, Age related Cataracts, Heart Failure and Osteoarthritis. The Physician Orders document R15 was on antibiotics 2/24/26 through 3/5/26 for cellulitis of lower extremities and a Urinary Tract Infection. The Progress Notes between 2/19/26 and 3/5/26 did not include documentation that R15 refused cares or exhibited agitation behaviors. On 3/5/36 at 1:30 AM, R15 refused to get into bed; 3/8/26 at 8:33 PM, refused shower three times; and on 3/10/26 at 8:17 PM, refused to have leg wraps removed and had agitation. The Progress Notes between 3/5/26 and 3/11/26 do not include any other documentation that assessments were conducted or interventions implemented for the new onset of behaviors. The record does not include urinary assessments such as output, color, clarity, smell or pain associated with urination. On 3/11/26 at 6:42 AM, the Progress Note documents the Nurse was at Nurses' station when she heard someone yelling that R15 was on the floor. Upon entering R15's room, she was observed lying on her left side with head pointed toward the door, the overhead light was off and the room was dark. R15 was incontinent of bladder, and her pants were down by her ankles. R15 had a hematoma the size of a tennis ball on her left side forehead and bruising noted on left knee. Notifications were made and R15 was sent to the hospital and returned later the same day. The Progress Notes continue to document R15's refusal of cares. On 3/13/26, a urinalysis was ordered, abnormal results were reported on 3/14/26 and antibiotics were ordered 3/16/26. R15's current care plan documents her call light will be within reach when in her room and will be encouraged to use it for assistance and she will have a safe environment with glare-free light, a working and reachable call light and personal items within reach. Throughout the survey on multiple occasions on 3/17/26, 3/18/26 and 3/19/26, R15 was observed in bed or in her wheelchair next to the bed with no light on and the call light not within reach. On 3/18/26 at 11:54 AM, R15 was in her wheelchair sitting to the right of her bed. The call light was hanging from the wall between each bed (left side of her bed), behind a nightstand and was unreachable. A light hanging on the right side of the wall behind her bed did not have a knob/switch or pull cord to turn light off or on. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/18/26 at 11:56 AM, R34 (R15's roommate) stated R15's light has not worked since R15 has been in the room and the ceiling light switch was on the wall next to the door entrance/exit. R34 stated We can't use the light (ceiling light) because it blinds you, it's so bright. (R15) can't reach her lights anyway. She asks me or I just help her. The ceiling light was turned on and it was unable to be looked at due to its brightness. 4. R43 was admitted on [DATE] with diagnoses of Wedge Compression Fracture of Thoracic Spine, urinary Retention, Type 2 Diabetes Mellitus and Reflex Neuropathic Bladder. R43's Progress Note dated 1/19/26 at 3:54 AM, documents R43 was complaining of lower abdomen and penis pain. The indwelling catheter was changed, urine was flowing and pain was gone. There was no further Nursing documentation in the Progress Notes, assessments were conducted or that vital signs were conducted between 1/19/26 at 3:15 PM and 1/21/26 at 4:12 AM. On 1/21/26 at 4:12 AM, R43's Progress Note documents the nurse entered R43's room to administer morning medications and get a blood sugar and found R43 unresponsive to name, breathing rapidly, conducted vital signs: blood pressure 70/40 mmhg (millimeters of mercury), which was a much lower blood pressure than previous blood pressures), respirations 30 breathes per minute (12-20 breathes per minute are within normal range), oxygen saturation at 45% (90% and above is within normal limits), pulse was 46 beats per minute (60-90 beats per minute are within normal range) and no temperature was recorded. R43 was transferred to the hospital via Ambulance. The Emergency Department Provider Notes dated 1/21/26 at 4:31 AM, documents upon arrival, R43 had an elevated heart rate, rapid breathing, low blood pressure, mouth was extremely dry, lungs had congestion, felt warm to touch, aroused to voice only and urine was cloudy. The Clinical Impression was documented as Severe Sepsis (a life-threatening condition where an infection triggers organ dysfunction, requiring urgent medical intervention to prevent death), Altered Mental Status and Urinary Tract Infection with hematuria (blood). The Discharge Summary documented R43 was placed on comfort care and expired on 1/25/26. R43's record did not include documentation there was an inquiry into R43's hospitalization outcome, discharge disposition or that a discharge summary completed. 5. R48 was admitted on [DATE] with diagnoses of Cerebral Infarct, Alzheimer's Disease and Chronic Obstructive Pulmonary Disease. On 1/12/26 at 8:00 AM, The Physician documents in the Progress Notes that R48 had a fall, the hospital was concerned with lower back issues, had x-rays taken and there were no fractures noted. The nursing staff also stated that R48 has been having a little bit of a cough. The Physician is okay to go ahead and swab for a 4 Plex (Influenza A/B, RSV and COVID) test. On 1/12/26 at 12:31 PM, the nurse's progress note documents R48 had a deep cough, lung sounds were abnormal, and the Physician was notified. On 1/13/26, the Physical Therapy note documents R48 had a decrease in strength, balance, transfers, ambulation and ability to perform activities of daily living. On 1/15/26 at 7:05 AM, the Progress Note documents the nurse was alerted by the kitchen staff R48 was on the floor in the dining area. The Progress Note documents R48 was actively bleeding from her nose and had no other visible trauma. R48 was transferred to the hospital for evaluation due to being on a blood thinner and the amount of blood coming from her nose. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Emergency Department note documents R48 had a ground level fall resulting in facial trauma, nasal fracture with hematoma (blood clot), facial bruising and laceration on her arm. R48 was sent back to the nursing home. The record did not include documentation that neurological assessments or assessments of other body systems were conducted from when R48 returned from the Emergency Department on 1/15/26 at 10:55 AM and 1/16/26 at 10:26 AM when evaluated by the Physician and ultimately sent to the Emergency Department due to increased lethargy, decreased orientation, not alert to baseline, blood pressure of 200/163 laying down and 120/70 when sitting up and fluctuating, decrease in oxygen saturations, pupils pinpoint (indicates a neurological issue) and not reactive to light. The Hospital's Discharge summary dated [DATE] documents R48 was admitted with nasal bone fracture, facial ecchymosis and a laceration on her arm following a ground level fall (1/15/26) with concern for possible recurrent stroke and sepsis in the context of urinary tract infection and acute kidney injury or chronic kidney disease. R48 was discharged from hospital with Hospice services. R48's record did not include documentation the Plex 4 test was conducted, ongoing assessments of cough and decline in condition, neurological checks and body system assessments were conducted, that the Interdisciplinary Group evaluated R48's fall and/or discharge, nor was there an inquiry into R48's hospitalization outcome, discharge disposition or a discharge summary completed. On 3/19/26 at 12:31 PM, V2 (Director of Nursing) stated she didn't know what a 4 Plex test was and the tests were not in the facility for use. V2 stated any COVID, Influenza or RSV test would be retrieved from the local hospital and brought back to the facility for use. V2 was unaware that R48 had sustained a fall on 1/15/26. V2 stated R48 fell on 1/5/26 and broke her nose but was fine after and went to the hospital on 1/15/26 because she had a change in condition and never came back. V2 was unable to state the reason R48 did not return from the hospital. On 3/20/26 at 2:00 PM, V1 (Administrator) reviewed R6, R15, R43 and R48's records and agreed changes in conditions, post fall assessments, discharge dispositions, interventions, etc. were not documented, implemented or followed up on. V1 stated it was unable to be determined if the nurses or other staff members were providing appropriate cares and identifying and reporting changes in a resident's condition.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, record review, and interview, the facility failed to ensure residents had functioning lights in their rooms for three (R12, R15, R29) of three residents reviewed for comfortable home like environment in a total sample of 28.Findings include:The facility's undated Maintenance Director Job Description documents The primary purpose of this position is to maintain the orderly functioning of all equipment in the facility including the kitchen, laundry, heating, air conditioning, and elevators as well as purchasing necessary supplies for repairs, maintenance, and emergencies.The facility's Resident Council Meeting minutes dated 01/19/26 documents concerns were raised that some light bulbs need replaced.On 3/18/26 during the Resident Council Meeting R12 who is alert and oriented reported he is unable to turn his overbed light on when he is in bed because there is not a chain or string on the light and it has been that way since he moved to that room. R12 reported V9 (Maintenance Director) was aware and came into R12's room some time ago and observed that there was not a chain or string on the overbed light so that R12 could turn the light on from his bed.On 3/18/26 between 11:50 AM and 1:00 PM, the following was observed:1.R29's overbed light did not have a string which could be reached from the bed.2.R15 has a light hanging on the right side of the wall behind her bed. The light did not have a knob/switch or pull cord to turn light off or on. R34 (R15's roommate) who is cognitively intact stated R15's light has not worked since she has been in this room and the light on the ceiling's switch was on the wall next to the door entrance/exit. R34 stated We can't use the light (ceiling light) because it blinds you it's so bright. R15 can't reach the lights. She asks me or I just help her. The ceiling light was turned on and it was so bright it could not be looked at directly.3.R12's overbed light did not have a chain or cord for R12 to be able to turn the light on and off when he is in bed. The wall switch by the entrance/exit door to room switched off and on and it controls the upper half of the overbed lights in the room. R12 present and reports if he wants a light on then all of the lights in the room have to be on and that is not fair to R27 (R12's roommate). R27's overbed light does have a string attached so that R27 can turn his overbed light on and off while he is in bed.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to transfer a resident to the hospital with written explanation to the receiving hospital about the resident's condition for one resident (R37) of three residents reviewed for transfer to the hospital in a total sample of 28. Findings include:The Facility's undated Transfer Agreement with (Local Hospital System) documents that the facility will Transfer all necessary medical records, or in the case of an emergency, as promptly as possible, transfer and abstract of the pertinent medical and other records necessary in order to continue to the patient's treatment without interruption and to provide identifying and other information, including medical, social, nursing and other care plans. Such information shall also include, without limitation and if available, current medical findings, diagnoses, advanced medical directives, rehabilitation potential brief summary of the course of treatments at the Transferring Facility, nursing, dietary information, ambulation status and pertinent administrative and social information. The Facility's Resident Transfer and Discharge Policy dated 11/2025 documents the purpose of the policy as to ensure that (This Facility) Properly documents resident transfers and discharges; has a standardized discharge planning process that addresses residents' discharge goals and needs, and involves residents and IDT (Interdisciplinary Team). R37's Medical Record documents that she was admitted [DATE] with diagnosis to include but not limited to COPD (Chronic Obstructive Pulmonary Disease), Pneumonia and Sepsis. Throughout the survey R37 was able to answer all questions appropriately other than having a hard time finding the correct word. When words were provided, she would confirm or deny which word she meant. R37's Nurse's Notes dated 3/2/26 at 1:52PM V20 (Registered Nurse) documented that R37 was being sent to the emergency room due to leaning, drooling and slurred speech. R37's chart did not show any documentation of a full physical assessment, vital signs, blood sugar results or pulse oximetry. On 3/19/26 at 12:15 PM V20 (Registered Nurse) stated she did not fill out any discharge paperwork because it was just an ER visit. V20 confirmed that she did not inform the receiving facility (local emergency room) in writing of what R37's assessment results at the facility were, what she had done so far, the family's contact information, list of current medications or advanced directive status. On 3/19/26 at 12:18 PM V7 (Registered Nurse) stated Nope, we just call report, we haven't sent out transfer forms for a while now. On 3/19/26 at 1:00 PM V1 (Regional Administrator) stated All staff should be using our standardized transfer form that communicates all of the required information to the hospitals. Those forms should be used. V1 (Regional Administrator) confirmed there was no transfer form in place for R37 and that there should have been.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. Based on observation, interview and record review the facility failed to ensure a resident maintained the ability to walk for one resident (R20) of twelve residents whose ADL (Activity of Daily Living) were reviewed in a total sample of 28.Findings include:The Facility's Activities of Daily Living policy dated 03/17/2025 documents Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. The Facility's Activities of Daily Living policy documents Care and services to improve, prevent and/or minimize functional decline will include appropriate restorative plans, appropriate pain management, as well as treatment for depression and symptoms of depression. Appropriate restorative plans may include but not limited to the following areas: 1. Range of Motion (passive or active) 2. Splint/Brace assistance 3. Bed Mobility 4. Transfers 5. Walking 6. Dressing and/or grooming 7. Eating and/or swallowing.R20's Occupation Discharge summary dated 12/2026 documents Transfer program established/Trained: walk to/from meals with use of FWW (Front wheeled walker), gait belt, wc (wheelchair) follow as needed and SBA (Standby Assist.) R20's Walking electronic documentation task documented N/A for all shifts for 02/01/26 through present. Throughout the survey R20 propelled herself to and from meals in her wheelchair. On 3/18/26 R14 CNA (Certified Nurse Aide) stated that R20 isn't on a walking program as far as I know, She usually rolls herself wherever she wants to be.On 3/17/26 R20 stated They (CNA staff) used to come in and walk me to and from meals, but they don't anymore I don't know why.On 3/19/26 1050AM V17 (COTA/Certified Occupational Therapy Assistant) stated that R20 should be walking to and from meals. V17 stated (R20) can do it with distant supervision, but she tends to comply and walk for a month or so then she quits and then loses her endurance and ends back on therapy. V17 stated that the staff should be encouraging and/or walking with R20 to and from meals. V17 stated it would be the expectation if R20 was not walking that the staff document why she didn't. Walk to dine programs have been a problem in this building, they don't get done regularly unless someone complains. On 3/19/26 V2 (Director of Nursing) R20's walking documentation did not document any walking for R20 throughout February or March 2026.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation and record review the facility failed to perform a urinary catheter flush in a way that prevented cross contamination of clean areas for one (R14) of two residents reviewed for catheter care in a total sample of 28.Findings include:The facility's Indwelling Catheter policy dated 12/23/2023 documents Only persons (facility staff personnel, family members, or patients themselves) who know the correct technique of aseptic insertion and maintenance of the catheter should handle the catheters. Irrigation:5. Put on gloves6. Remove catheter from catheter drain bag7. Cleanse catheter tubing with alcohol8. Connect syringe to catheter tubing9. Flush catheter by inserting the water from syringe into the catheter. Remove syringe10. Cleanse end of catheter tubing and catheter drain bag with alcohol and reconnect to catheter drain bag12. Place syringe and other equipment into plastic bag13. Remove gloves and wash hands. On 03/18/2026 at 11:15 AM V4 (LPN) donned PPE gloves and gown outside of the room and entered room and shut door with gloved hands then removed gloves and washed hands and donned new gloves. V4 then opened the package containing the syringe for the flush, opened the Acetic Acid bottle and drew up solution into the syringe. V4 then laid the syringe on the bedside table and then with gloved hands moved R14's walker, pulled up the leg of R14's pants. V4 then opened two alcohol swabs and laid the swabs directly on the outside packaging, then disconnected the foley drainage bag from the inserted tubing and handed the drainage bag from the inserted tubing to R14 who then rolled it back and forth in his fingers while V4 was performing care. V4 picked up one alcohol swab and wiped the insertion end of the catheter tubing and then began flushing the catheter slowly. R14 requested she quit flushing after around 25 milliliters of Acetic Acid had been instilled and V4 complied. V4 then wiped both ends of the catheter tubing with alcohol swabs. V4 manipulated the catheter tubing directly outside R14's urethra until R14 said ok. V4 then pulled R14's pants up, put his walker back where R14 wanted it and moved R14's bedside table back within reach. V4 then removed gloves and gown and washed her hands.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to reweigh a resident with a significant weight loss for one resident (R1) of three residents reviewed for weight loss in a total sample of 28. Findings include:The Facility's Weight Assessment and Interventions dated December 30, 2024, documents The nursing staff will measure resident weights on admission, and then weekly for four weeks. If no weight concerns are noted at this point, weights will be measured monthly The Facility's Weight Assessment and Interventions dated December 30, 2024, documents any weight change of 5 pounds or more within 30 days will be retaken the next day for confirmation. If the weight is verified, nursing will notify: a. The provider b. Dietary manager/dietician. R1's Medical Record documents he was admitted to the facility on [DATE] with diagnosis to include but not limited to Hemiplegia and Hemiparesis after Cerebral Infarction, Noncompliance with cares and Displaced Trimalleolar Fracture. R1's weight dated 2/2/26 was 142 pounds. R1's weight dated 3/5/26 was 127.5 pounds. On 3/18/26 at 11:00 AM V2 (Director of Nursing) confirmed that R1 did not have his admission weights done on the day of admission and then weekly and that the second time R1 was weighed there was a 14.5 pound difference and R1 should have been reweighed the next day (3/6/26) V2 (DON) confirmed there was no documentation of weekly admission weights or any reweigh of R1 after the 14.5 pound difference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on interview and record review, the facility failed to ensure medical records were accurately documented with resident assessments for one of twelve residents (R48) reviewed for accurate documentation in a sample of 28.Findings include:The Charting and Documentation policy revised 11/5/19, documents medical record entries shall be made by the person providing or supervising/observing the service being documented. Narrative documentation/progress notes will be documented under the premise of charting by exception. It is anticipated that all routine care and services will be delivered within established standards of professional practice and regulatory guidance and may not be reflected in the medical record. Documentation will include information on assessment, notifications, interventions and evaluation including but not limited to incidents/accidents, change in condition, physician notification, responsible party notification, refusal of medication/treatment or recommendations, education provided, status updates/summaries as required. Transfer, discharge or leave of absences.On 3/18/26, R48's record was reviewed. The record noted R48 was on neurological checks following a fall with head trauma per policy. The electronic record did not include post fall neurological checks.On 3/18/26 at 11:45 AM and 2:45 PM and on 3/19/26 at 11:45 AM, R48's neurological assessment monitoring post fall, on 1/15/26 were requested. On 3/19/26 at 2:15 PM, V2 (Director of Nursing) provided R48's Neuro/Head Trauma Assessment form dated 1/15/26. Each assessment entry beginning 1/15/26 at 7:05 AM through 1/17/26 3rd shift is documented in the same handwriting, although the nurse's initials for each entry were unique.On 3/19/26 at 2:30 PM, V1 (Administrator) reviewed the Neuro/Head Trauma Assessment form and agreed each of the neurological assessments were documented in the same handwriting. V1 stated the record appeared to be falsified.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure hospice communication was coordinated and the required documents were available and accessible to the facility staff for one resident (R6) reviewed for hospice care management in a sample of 28. Findings include:The Hospice Care policy revised 8/25/25, documents the facility will work in coordination with the contracted hospice agency to provide a safe continuum of care for the resident's end of life. The Hospice agency will participate in the residents' plan of care and provide services/supplies outside the general as needed procedures and be available 24 hours a day.R6 was admitted on [DATE] with diagnoses of Venous Insufficiency, Alzheimer's Disease, Dementia and Dysphagia. R6 elected Hospice Benefits on 9/24/25.R6's current Care Plan lacked specific Hospice responsibilities/interventions or that R6 was utilizing a self-adjusting and alternating pressure mattress.The Hospice binder located at the nurse's station included a Hospice Plan of Care dated 9/24/25 through 12/22/25. The binder did not include an updated Hospice Plan of Care, visit notes, visit update notes, which Hospice providers were involved with R6's care, frequency of visits and/or responsibilities of those providers or correspondence between facility and Hospice staff.On 3/17/26 at 10:28 AM, V4 (Licensed Practical Nurse) performed skin care treatment to R6's bilateral lower extremities and on 3/17/26 at 1:30 PM, V4 stated I need to call Hospice and report a change in condition. (R6) did not eat supper last night or breakfast this morning. V4 stated she didn't know if Hospice staff participated in the facility's Interdisciplinary Team meetings and that the Hospice nurse usually receives a verbal report from the facility nurses prior to their visit.On 3/17/26 at 9:47 AM, 10:48 AM, 12:46 PM, 1:30 PM, 2:30 PM and 3:32 PM, R6 was observed to have a dual functioning system that delivers continuous self-adjusting and alternating pressure mattress in which appeared not powered on.On 3/17/26 at 3:32 PM, V2 (Director of Nursing) was taken to R6's room and showed the alternating pressure mattress was not powered on. V2 confirmed the power light was not on and stated I don't know. The mattress doesn't seem to be flat, so I don't think it's really hurting anything. I'll call hospice and see what they say about it. On 3/17/26 at 3:55 PM, V2 stated the alternating pressure mattress was unplugged and is now working.On 3/18/26 at 9:45 AM, R6's record did not include documentation the Hospice was notified of R6's change in condition.On 3/19/26, the Hospice binder was reviewed and the Hospice nurse dated, timed and initialed to indicate a visit had been conducted the early morning of 3/19/26 although no note or status update was included.On 3/19/26 at 2:30 PM, V1 (Administrator) was notified the Hospice binder had not included an updated Hospice Plan of Care, Visit Notes or correspondence between the Hospice and facility. It was unable to be determined if Hospice was notified of R6's change in condition, if the facility or Hospice provided the air mattress or if there were instructions for the use. The facility's Care Plan did not include specific interventions and responsibilities related to Hospice.On 3/20/26 at 9:06 AM, R6 was transferred to a private room to pass peacefully.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure Influenza and Pneumococcal immunizations were offered to three of five residents (R6, R17, R37) reviewed for immunization compliance in a sample of 28.Findings include: The Influenza Vaccine policy revised 10/10/25, documents all residents will be given information on the importance of adult immunizations. Prior to administration each resident or resident's legal representative shall receive education regarding the risks, benefits and potential side effects of the immunization. Evidence of education is to be documented on the individual resident's medical record. Consent form must be signed prior to administration by the resident or responsible party after reviewing the vaccination information statement. The resident or responsible party may revoke consent by providing facility with a request in writing. Verbal consent is acceptable.The Pneumococcal Vaccination policy revised 10/28/24, documents prior to administration each resident or resident's legal representative shall receive education regarding the risks, benefits and potential side effects of the immunization. Evidence of education is to be documented on the individual resident's medical record. Consent form must be signed prior to administration by the resident or the party responsible may revoke consent by providing facility with a request in writing.1.R6's immunization record documents Pneumococcal vaccine was refused, and the Influenza vaccine was administered on 10/17/25.R6's Universal Vaccine Consent Form- Long-Term Care Facility signed by the resident's representative on 10/17/25, does not specify that vaccine information was given to the resident's representative nor the name of which vaccine is being consented for.2. R17's immunization record documents Influenza vaccine was administered on 10/17/25.R17's Universal Vaccine Consent Form- Long-Term Care Facility signed by the resident's representative on 10/17/25, does not indicated which vaccinations were accepted or declined nor that vaccine information was given to the resident's representative.3. R37's immunization record documents Pneumococcal and Influenza vaccinations were refused.R37's Universal Vaccine Consent Form- Long-Term Care Facility signed by R37 on 10/17/25, indicated she declined to receive the Influenza vaccination only and did not indicate that vaccine information was given to the resident.On 3/18/26 at 1:00 PM, V2 (Director of Nursing/Infection Preventionist) reviewed R6, R17 and R37's Universal Vaccine Consent Form-Long-Term Care Facility and agreed the consent forms were incomplete and should have indicated which vaccines were accepted or declined and which vaccine information was given to the resident or resident's representative.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on interview and record review, the facility failed to ensure COVID-19 vaccinations were offered to three of five residents (R6, R17, R37) reviewed for immunization compliance in a sample of 28.Findings include:The COVID-19 Vaccination policy dated 7/15/21, documents all residents are to be offered the COVID-19 vaccine unless the immunization is medically contraindicated. Residents and/or Residents Representatives are provided with education regarding the benefits and risks and potential side effects associated with vaccine. The medical record includes documentation that indicates the resident or resident's representative was provided education and accepts or refuses the vaccination.1.R6's immunization record does not document the COVID-19 vaccination was administered or refused.R6's Universal Vaccine Consent Form- Long-Term Care Facility signed by the resident's representative on 10/17/25, does not specify that vaccine information was given to the resident's representative nor the name of which vaccine is being consented for.2. R17's immunization record documents COVID-19 vaccination was refused.R17's Universal Vaccine Consent Form-Long-Term Care Facility signed by the resident's representative on 10/17/25, does not indicate which vaccinations were accepted or declined nor that vaccine information was given to the resident's representative.3. R37's immunization record documents COVID-19 vaccination was refused.R37's Universal Vaccine Consent Form- Long-Term Care Facility signed by R37 on 10/17/25, indicated she declined to receive the Influenza vaccination only and did not indicate that vaccine information was given to the resident.On 3/18/26 at 1:00 PM, V2 (Director of Nursing/Infection Preventionist) reviewed R6, R17 and R37's Universal Vaccine Consent Form-Long-Term Care Facility and agreed the consent forms were incomplete and should have indicated which vaccines were accepted or declined and which vaccine information was given to the resident or resident's representative.