STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146076	A. Building B. Wing	02/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Goldwater Care Clinton	1 Park Lane West Clinton, IL 61727

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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 0689 Level of Harm - 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 observation, interview and record review the facility failed to provide supervision in a resident bathroom and the dining room and failed to remove a mechanical lift sling from the wheelchair to prevent falls, and failed to implement fall interventions, complete a fall assessment for five of six residents (R1, R17, R21, R23 and R112) reviewed for accidents on the sample list of 46. These failures resulted in R21 falling in the dining room and suffering a fractured clavicle and laceration to the back of the head when staff were not present supervising, R23 falling and suffering an acute fracture to the tailbone when R23 slid out of the wheelchair after staff failed to remove the mechanical lift sling, and R112 falling in the bathroom and suffering a hematoma to R112's right cheek/neck area and a laceration to R112's cheek requiring adhesive skin closures when staff turned away from R112. Findings include: The facility's Fall Prevention Program Policy dated 11/28/12 with a revision on 11/21/17 documents that the purpose of this policy is to assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Guidelines for this policy include methods to identify risk factors, methods to identify residents at risk, use and implementation of professional standards of practice and adherence to manufacturer's recommendation in use of alarm and medical devices and special care equipment. 1.) R21's Minimum Data Set (MDS) dated [DATE] indicates the resident has moderate cognitive impairment and diagnoses of Parkinsonism and Dementia. The MDS further documents that the resident does not have the ability to safely ambulate ten feet due to medical condition and safety concerns. The Nursing Note dated 1/19/26 documents that at 6:35 pm a Certified Nurse Assistant (CNA) called out for help in the 100-hall dining room. Writer responded immediately and observed resident laying on the floor on her right side. Wheelchair was behind her, broom at her side. Resident from dining room witnessed fall and stated resident was standing up trying to sweep the floor, appeared to lose her balance and fall. When asked resident what happened, resident stated I don't know. Visible head wound to right side of head with moderate bleeding noted. Resident complained of right shoulder and right hip pain. Pressure applied to head wound. No further injuries were noted at this time. Resident is on anticoagulant therapy. Medical Doctor (MD) notified and gave order to send to ER for eval/treat. R21's X-ray Report dated 1/19/26 documents an acute fracture of the distal clavicle was identified. (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 0689 Level of Harm - Actual harm Residents Affected - Few	R21's Care Plan dated 12/23/25 documents that the resident is at risk for falls related to a history of falls. Interventions include frequent checks on the resident (initiated 12/21/25) and increased supervision during mealtimes (initiated 11/26/25). On 2/10/26 at 10:09 a.m., V8, CNA, stated R21 is confused and has to be monitored very closely and checked at least every 15 minutes if not more. On February 10, 2026, at 10:58 a.m., V25, CNA, stated that she was aware of R21's fall but was unsure whether she was working at the facility when the incident occurred. During the same interview, V25 confirmed that R21 requires monitoring at least every 15 minutes, or more frequently as needed. V25 explained that staff are expected to maintain continuous observation of R21 to ensure her safety. She further stated that staff on the Hall, where R21 resides, make efforts to keep R21 in close proximity to staff at all times, either at the nurse's station with nurses and CNAs or engaged in activities. On 2/10/26 at 11:09 a.m., V26 CNA stated she was not present when R21 fell on 1/19/26, as she left at 6:00 p.m. that day and most residents were still in the dining room. V26 confirmed that R21 was at the dining room table when she left. V26 stated she was later informed that R21 and another resident were in the dining room when R21 got up and attempted to sweep the floor. V26 stated R21 is always confused and requires constant supervision, stating, If I'm going to be honest, staff always have to keep a very close eye on (R21), but sometimes that is very difficult to do when caring for all the other residents too. V26 stated that R21 is able to stand independently and is mobile but very unstable when up. On 2/10/26 at 11:45 a.m., R41 stated he was in the dining room with R21 when she fell. R41 stated that R21 was in her wheelchair, grabbed a broom, and began sweeping. R41 further stated that R21 then got out of her wheelchair and continued sweeping. R41 stated he turned his back for just a second, and when he did, R21 fell. R41 stated there were no staff in the dining room at the time of the fall, only himself and another resident who is cognitively impaired (name unknown). R41 stated staff had not been in the dining room that evening for quite some time and that R21 is often left on her own. R41 added that other residents frequently have to look after R21 and remind her to sit down. R41's MDS dated [DATE] documents a BIMS (Brief Interview for Mental Status) score of 14, indicating R41 is cognitively intact. On 2/10/26 at 9:59 a.m., V15, Registered Nurse (RN), stated that R21 falls frequently and that her Care Plan documents the need for close attention from staff. V15 reported there is no specific time frame for frequent checks, but staff are expected to keep an eye on R21. V15 added that if she were working on the floor, R21 would remain with her at all times because she requires one-on-one supervision. V15 also stated she is unsure why R21's Care Plan includes an intervention for increased supervision in the dining room during mealtimes. On 02/10/2026 at 2:36 p.m., V14, Regional Nurse Consultant/Interim Director of Nursing, stated there should always be a staff member present in the dining room to provide supervision for R21 as well as other residents. V14 explained that the timing of checks for R21 depends entirely on her behavior at the time, confirming that there are occasions when R1 requires constant direction. V14 further stated staff should have remained in the dining room until all residents had left. 2.) R23's MDS dated [DATE] documents that the resident is cognitively intact and has diagnoses of Multiple Sclerosis, Demyelinating Disease of the Central Nervous System, Muscle Wasting and (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Atrophy (multiple sites), Polyneuropathy, and Abnormal Posture. The MDS further documents that R23 is dependent on staff for all aspects of mobility and requires substantial to maximal assistance with bathing. On 2/8/2026 at 10:31 a.m., R23 stated that (on1/31/26) V24, CNA, and V23, Licensed Practical Nurse (LPN), transferred her to the shower chair using a mechanical lift and left the mechanical lift sling beneath her. R23 confirmed that V23 left the room, and V24 did not pick up the mechanical lift straps from the floor before pushing the shower chair. R23 stated the straps became caught in the wheels, causing the chair to come to an abrupt stop and thrusting her forward. R23 reported that she began to slide out of the chair, and V24 called for help. R23 stated V23 returned to the room and was sent to retrieve the mechanical lift while V24 attempted to hold her in the shower chair with her body. R23 stated that before they could get her back into the shower chair with the mechanical lift, she was dropped to the floor. R23 reported experiencing excruciating pain from the fall, was sent to the local emergency department, and was diagnosed with a broken tailbone. The Computed Tomography (CT) Report dated 1/31/26 documents There is angulation at the sacrococcygeal junction (tailbone). This is new in comparison to the prior CT. No additional fractures are appreciated. On 2/09/26 at 11:54 a.m., R94 (R23's former roommate) stated she was present when R23 slid out of the shower chair. R94 stated she did not witness the incident but heard commotion and V24 calling for help. On 2/09/26 at 11:24 a.m., V24 CNA stated that while preparing resident R23 for a shower, R23 slid from the shower chair. V24 stated that earlier, V23 LPN had assisted in transferring R23 into the shower chair using a mechanical lift and then left the room. V24 stated that after V23 exited, R23 requested her bra. V24 stated R23 adjusted herself in the chair and began sliding. V24 confirmed that the mechanical lift sling was still beneath R23 and was slick, contributing to the slide. V24 stated she attempted to hold R23 in the chair using her body and called for help. V24 stated R94, R23's roommate, activated the call light and then entered the hallway with her walker to seek assistance. V24 stated that V23 and another CNA (unknown name) responded, but before they could reposition R23 into the lift, R23 fell to the floor. On 2/10/26 at 8:22 a.m., V23, LPN stated he was the nurse on duty the day R23 slid out of the shower chair. V23 reported that he assisted V24 with transferring R23 into the shower chair, spotting V24 during the mechanical lift transfer, and then left the room. V23 confirmed that the mechanical lift sling was left beneath R23 and stated this was common practice, noting that CNAs typically provide R23's bath with assistance from only one staff member. On 2/11/26 at 9:25 a.m., V20 CNA stated that she works at the facility through an agency but is frequently assigned to R23. V20 stated R23 is dependent on staff for activities of daily living (ADLs) and confirmed that R23 is fully aware of her surroundings, describing her as totally with it. On 2/11/26 at 9:36 a.m., V29, CNA, stated that R23 requires assistance with all activities and prefers to use the Reclining Shower Chair, and be wheeled to the shower room. V29 stated R23 is cognitively aware and is able to make her needs known. On 2/9/26 at 3:20 PM, V14 Interim DON/Regional Nurse Consultant stated she was aware of the incident in which R23 slid out of the shower chair. V14 indicated that, given R23's current condition, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	two staff members should have been present at all times to complete shower tasks. V14 further stated that the mechanical lift sling should have been removed from beneath R23 before the CNA attempted to move the shower chair. 3.) R112 's diagnosis list (printed 2/11/26) documents that R1's diagnoses include Dementia, Syncope (fainting) and Collapse, Difficulty in Walking, Muscle Wasting and Atrophy, Pain, Cognitive Communication Deficit, Depression, and Anxiety. R112's Resident assessment dated [DATE] documents R1 has severely impaired cognition and requires substantial/maximal staff assistance for transfers, including going from a seated position to a standing position. The same record documents R1 does not have behaviors, delusions, or hallucinations. R112's Fall Risk assessment dated [DATE] Completed 2/10/26 documents R112 is at risk for falls. The facility fall log (11/9/25 thru 2/9/26) documents R112 had an unwitnessed fall in the facility on 12/11/25. The facility provided a fall investigation dated 1/31/26 documenting a fall. The facility Fall Investigation dated 1/31/26 documents staff turned around as R112 stood up from the wheelchair in the bathroom of the resident room and was reaching for the towel bar then fell into the towel bar causing a laceration on the right cheek. The record further documents R112 was transferred to the hospital emergency department via ambulance for evaluation and treatment. R112's Emergency Department Report dated 1/31/26 documents R112 was diagnosed with a Facial Contusion (Acute), Soft tissue swelling of the right infraorbital region of the face with an abrasion noted about 1 centimeter in diameter at the soft tissue swelling site and required computed tomography (CT) radiographic scans to evaluate possible injuries as the physician documented there is the possibility of cervical injury depending on how hard R112's face hit the wall. The Emergency Department Note dated 1/31/26 documents adhesive skin closures were applied to R112's facial wound. The facility Fall Investigation dated 1/31/26 documents V36 (Licensed Practical Nurse) was informed by V35 (Certified Nursing Assistant) that V35 was assisting R112 from the toilet to the wheelchair, V35 stated she turned so that she could back R112 from the bathroom and when V35 turned back around V35 observed R112 had risen from the wheelchair, and was attempting to grab ahold of the towel bar. V35 stated R112 fell into the towel bar. V35 stated R112 did hit her right side of the face on the towel bar causing a laceration and swelling to the right cheek. The same investigation documents V36 entered R112's room and noted R112 laying in a low bed, noting R112's right cheek bleeding from a laceration and swollen. Nursing Progress Notes dated 1/31/26 at 7:30 PM by V36 document R112 complained of some pain to the right cheek area. V36 documents calling the primary care physician and R112 being sent to the emergency room for further evaluation. Further record review does not document a fall risk assessment following the fall dated 1/31/26. R112's Care Plan dated 05/25 was not revised after R112's documented fall on 1/31/26 with a targeted intervention. On 2/8/26 at 11:45am R112 was sitting at the dining room table. R112's right cheek and right neck (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	were discolored yellowish green transitioning into purple from the right infraorbital/cheekbone down to the collar bone. On 2/8/26 at 12:30pm R112's bathroom contained a towel rack above and to the right of the safety grab bar. The left end piece of the towel rack was loose and dislodged. On 2/8/26 at 11:45am V33, Memory Care Coordinator, stated R112 recently had a fall and R112 hit R112's cheek on the towel bar in her bathroom that causing a laceration and bruising and it is now healing. On 2/8/26 at 12:30pm V34, Certified Nursing Assistant, confirmed the towel bar remained in R112's bathroom located at R112's head height and the left end piece of the towel bar was loose and dislodged. V34 stated she was not present at the time of the fall. V34 confirmed R112 did have injuries related to hitting the towel bar upon falling. On 2/9/26 at 10:03am V38, R112 Family, confirmed she received a phone call stating R112 fell in the bathroom and hit R112's cheek on the towel bar and was being transferred to the local emergency room for further evaluation. On 2/9/26 at 12:05pm V15, Minimum Data Set/Care Plan Coordinator (MDS) stated falls are discussed in meetings, the root cause is determined and if a safety concern is identified it is addressed, and the care plan is then updated with a targeted intervention. V15 confirmed R112's care plan was not updated with an intervention following the fall documented on 1/31/26. V15 confirmed the towel bar presented a safety hazard. On 2/9/26 at 12:25pm V14, Regional Nurse Consultant (RNC), stated fall risk assessments are to be completed after a fall. V14 stated there should be 72 hour follow up charting on any resident involved in an incident/accident. V14 confirmed R112's medical record did not contain a fall risk assessment completed after the 1/31/26 documented fall. V14 confirmed R112's medical record did not contain follow up charting after the documented 1/31/26 fall. On 2/9/26 at 12:25pm V1, Admin and V14, RNC, confirmed the fall investigation for R112 dated 1/31/26 did not contain a targeted intervention, the care plan did not contain a targeted intervention, and the towel bar in R112's bathroom presented a safety hazard. On 2/10/26 at 3:50pm V18, Former Director of Nursing, stated V18 did not recall any intervention being put in place for R112's fall on 1/31/26. V18 stated the CNA should not have turned away from R112 when R112 was in the bathroom to walk around the wheelchair. V18 stated if the CNA was facing R112, the CNA would have seen R112 attempting to stand up and been able to redirect R112 to sit down and prevent the injury. On 2/11/26 The Fall Prevention Program/Policy dated 11-28-12 documents the Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. The Program further documents Care plan incorporates: Identification of all risk/issue; Addresses each fall; Interventions are changed with each fall, as appropriate- (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Preventative measures--Standards: A Fall Risk Assessment will be performed by a licensed nurse at the time of admission. The assessment tool will incorporate current clinical practice guidelines. A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. Safety interventions will be implemented for each resident identified at risk. Fall/safety interventions may include but are not limited to: The resident's environment will be kept clear of clutter which would affect ambulation and remove hazards. 4.) R1's fall prevention Care Plan with a revision date of 8/8/25 documents a 6/24/25 intervention to have floor mats on each side of bed. On 2/08/2026 at 9:14 AM, R1 was lying in bed. A fall mat was leaning against the wall by the door. There was not a fall mat in place on R1's right side of the bed on the floor. On 2/08/2026 at 1:36 PM, R1 was lying in bed. A fall mat was leaning against the wall by the door. There was not a fall mat in place on R1's right side of the bed on the floor. On 2/08/2026 at 1:36 PM, V6 Licensed Practical Nurse stated that R1 was supposed to have the fall mat on the floor on both sides of the bed when R1 is in bed. 5.) R17's fall prevention Care Plan with a revision date of 5/19/25 documents R17 is at high risk for falls. This care plan documents a 10/10/25 interventions for activities to provide working task for R17. This care plan also includes a 9/15/25 intervention for a concave mattress and a 10/29/25 intervention for skid strips to be placed by the bed. On 2/10/2026 at 3:12 PM R17 was lying in bed, R17 was lying on a regular mattress and not on a concave mattress. At this time, there were no non-skid strips observed by the bed. On 2/11/2026 at 9:53 AM, V7 Certified Nurse Assistant stated she has worked in the facility since August of this year and has taken care of R17 since starting in the facility. V7 stated she has never seen a concave mattress on R17's bed or non-skid strips on the floor. On 2/11/2026 at 8:49 AM, R17 was sitting in the television room holding a news flyer. R17 was not working on any type of a task at that time. On 2/11/2026 at 10:00 AM, V32 Activity Aide stated R17 occasionally participates in activities. V32 stated she is not familiar with the interventions about a working task for R17. V32 stated they do not always communicate the interventions to her. On 2/11/2026 at 10:04 AM, V1 Administrator stated R17's interventions of the concave mattress and the non-skid strips should have been put into place. V1 stated the intervention about the working task on R17's care plan was not measurable and unclear and that this intervention should be conveyed to the activity staff.

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately transcribe an order for Seroquel (antipsychotic), failed to administer an antiparkinsonian medication as recommended prior to meals and failed to ensure medications were taken by the resident for three of 46 residents (R7, R83 and R44) reviewed for medications in the sample list of 46 residents. This failure resulted in exacerbation of R7's behavioral symptoms related to dementia when R7 missed 13 days of R7's antipsychotic due to a transcription error. Findings Include:1.R7's Care Plan updated 11/6/25 documents the following diagnoses: Type II Diabetes, Alzheimer's Dementia, Repeated Falls, and Major Depression.R7's Minimum Data Set (MDS) dated [DATE] documents R7 has no behavioral symptoms.On 2/8/26 at 9:00AM R7 was in his bed watching television (TV). The Surveyor knocked on R7's open door. R7 shouted What and who the H*** are you. The Surveyor introduced self and identified to R7 we are here from IDPH (Illinois Department of Public Health) to talk with residents about the care they receive at the facility. R7 seemed very agitated and shouted Well if you are from the F******(expletive) state get me out of here now. I am being held prisoner. That F******(expletive) B****(expletive) had them arrest me. The Florida state police went into Georgia and arrested me and brought me to Illinois. R7 beat his fists on the bed rail and shook the bed. The Surveyor replied she could see how upset R7 was and would let him get back to his TV. R7 became even louder and continued to pound on the bed with his fists. R7 shouted You F******(expletive) B****(expletive) if you are with the state why can't you get my A**(expletive) out of here and get my money back.On 2/8/26 at 3:00PM V1, Administrator stated we are aware (R7's) behavior is escalating and he has been seen by (a contracted psychiatric provider). V14, Corporate RN and acting DON stated (R7) is very suspicious of his POA (Power of Attorney), he doesn't like women and his behavior related to Dementia is really increasing.R7's Psychiatric Notes dated 12/10/25 by V17, Physician's Assistant (PA) for psychiatric contractor document an order for: Med Changes: Patients diagnosis of Major Depressive Disorder is worsening and unstable at this visit. Increase Sertraline to 100Mg in the AM. Start Trazadone 25Mg at HS (bedtime). Start Quetiapine 25Mg PO (by mouth) every 6 hours PRN (as needed). Continue Quetiapine 50Mg (Daily) for agitation related to Dementia. Continue Memantine 5Mg daily for cognitive decline related to Dementia.R7's Medication Administration Record (MAR) for February and R7's current Physician's Order Sheet document R7's Quetiapine 50Mg was discontinued in error on 1/28/26 and no PRN doses were administered.On 2/9/26 at 2:00PM V14 acting DON verified that the Quetiapine was discontinued in error and R7 had missed doses from 1/28/26 until the surveyor brought this error to the facility's attention on 2/9/26 totaling 13 doses. On 2/10/26 at 12:30PM V17 Psychiatric PA stated It was my intention to continue (R7's) dose of 50Mg Quetiapine daily. (R7) was having increasing agitation and aggressive behavior. It is never a good idea to stop an antipsychotic without tapering and I rarely give a PRN order for antipsychotic especially in a senior, but I spent nearly an hour with (R7), and I really thought it was justified. I do believe that stopping (R7's) quetiapine so abruptly caused (R7's) behavior to escalate even more.The package insert for Seroquel revised January 2022 documents Acute withdrawal symptoms such as insomnia, nausea, and vomiting have been described after abrupt cessation of an atypical antipsychotic drugs including Seroquel.On 2/11/26 at 1:00PM V1, Administrator and V14 Acting Director of Nurses verified R7's behaviors including cursing, isolating, shouting, and refusal of care have increased since R7 has not received the correct dose of Seroquel.On 2/11/26 at 2:00PM V11, Activity Director stated Since the end of January (R7) has not come to activities at all. I have heard him in his room shouting and cursing. I was helping pass trays on Sunday (2/8/26). I took (R7's) tray to him. He pointed at the tray table, and I placed the tray on it and went to get another tray. As I was walking by his room, I heard a commotion and (R7) had knocked his tray off the table and across the room. (R7) is more agitated.2. R83's Care Plan initiated 1/7/26 documents the following diagnoses: Depressive Disorder, History of (continued on next page)

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F 0760 Level of Harm - Actual harm Residents Affected - Few	Fracture of Right Femur with Hip Replacement, and Parkinson's Disease.R83's Minimum Data Set (MDS) dated [DATE] documents R83 as moderately cognitively impaired.On 2/8/26 at 1:00PM V43 (R83's family member) stated When (R83) was ordered the Carbidopa/Levodopa we were told to always give it 30-60 minutes prior to food because high protein food interferes with the absorption of the medication. It is ordered here at 5:00AM, 11:00AM, and 5:00PM. They tell me they have one hour before and one hour after to give his medication. It is sometimes before and sometimes after and sometimes with meals and I think it's causing (R83's) Parkinson's symptoms to get worse.R83's Medication Administration Record (MAR) for February 2026 documents Sinemet Oral Tablet 25-100 MG (Carbidopa-Levodopa) Give 1 tablet by mouth three times a day related to PARKINSON'S DISEASE WITH DYSKINESIA, WITH FLUCTUATIONS. The package insert for Levodopa/Carbidopa 25/100 documents The patient should be advised that a change in diet to foods that are high in protein may delay the absorption of levodopa and may reduce the amount taken up in circulation. Excessive acidity also delays stomach emptying, thus delaying the absorption of levodopa. Iron salts (such as in multivitamin tablets) may also reduce the amount of levodopa available to the body. The above factors may reduce the clinical effectiveness of levodopa or carbidopa-levodopa therapy.On 2/9/26 at 1:30PM V13, R83's primary physician stated The timing 30-60 minutes prior to meals for (R83's) Sinemet is crucial for absorption of this medication. If it isn't given prior to meals high protein food will compete with the medication for absorption. If Sinemet is being given incorrectly I believe this is causing (R83's) increase in Parkinson's symptoms.On 2/8/26 V10, Licensed Practical Nurse verified medications are given within one hour prior or one hour after the time on the MAR. V10 stated I have 35 residents to get meds out to. Have you ever had to do that?On 2/9/26 at 2:15PM V14, Acting DON (Director of Nursing) confirmed R83's medication had been given without regard to meals.3. R44's Minimum Data Set (MDS) dated [DATE] documents R44 is cognitively intact. On 2/10/26 at 10:00AM R44 stated Sunday evening (2/8/26) the agency nurse that was working left all my evening meds on the dresser for the empty bed next to me. I didn't remember I hadn't taken them until (V28), Activity Assistant found them the next day. I missed all my evening meds.R44's MAR documents the medications due at 8:00PM include the following: Amlodipine (antihypertensive) 5Mg twice daily, Atorvastatin (anticholesterol) 40mg at bedtime daily,Lisinopril (antihypertensive) 40 mg at bedtime daily, Senna (laxative) 8.6 mg two tablets at bedtime daily, Eliquis (anticoagulant) 5 mg twice daily, Famotidine (pump inhibitor) 20mg twice daily, Keppra (Antiseizure) 1000mg twice daily, Metoprolol (Beta Blocker) 37.5 mg twice daily.On 2/10/26 at 11:00AM V14, Acting DON verified V28 found R44's 8:00PM medications in a cup. V14 verified the medications were identified as all V14's 8:00PM medications.On 2/10/26 at 11:15AM V1, Administrator verified R11 did not receive any of her 8:00PM medications on 2/8/26 as they were left in a cup sitting on the dresser by an agency nurse.The facility's policy Physician's Orders Entering and Processing revised 1/31/18 states Following a physician's visit, a licensed nurse will check for any orders that require confirmation under: Clinical, Orders, Pending Orders. The orders will be confirmed by the nurse and instructions for the order will be completed.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on interview, and record review, the facility failed to provide a registered nurse for eight consecutive hours daily. This failure has the potential to affect all 104 residents of the facility. Findings include:On 2/9/26 at 10:10am V1, Administrator, stated the facility does not have a stand-alone staffing policy and follows the minimum guidelines for nurse staffing hours including registered nurse coverage. On 2/9/26 V1, Administrator, provided nursing staffing sheets that document the facility nurses work twelve (12) hour shifts. On the following dates per the provided nurse staffing sheets, no registered nurse coverage was scheduled or available in the nursing facility:1/3/26; 1/4/26; 1/17/26; 1/18/26; 1/31/26; 2/1/26.On 2/10/26 at 3:50pm V18, Former Director of Nursing, stated V18's last day of employment in the facility was 1/30/26. V18 stated the facility did not always have a registered nurse available especially on weekends. V18 stated the facility used agency nurses to fill in when house nursing staff were unavailable, and agency Registered nurses were not always available to fill the open shifts.The Long-Term Care Facility Application for Medicare and Medicaid form dated 2/08/26 documents 104 residents reside in the facility.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on interview, and record review, the facility failed to complete a performance review of every nurse aide at least once every 12 months, and to provide regular in-service education based on the outcome of these reviews. This failure has the potential to affect all 104 residents of the facility. Findings include:On 2/9/26 review of Facility Assessment (FA) dated 2/6/26 documents: Abuse, neglect, and exploitation - training that at a minimum educates staff on: (1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property; (2) Procedures for reporting incidents, of abuse, neglect, exploitation, or the misappropriation of resident property; Reporting of Crimes (Elder Justice Act) and (3) Care/management for persons with dementia and resident abuse prevention.The FA further documents: Required in-service training for nurse aides. In-service training must: Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year. On 2/11/26 at 1:05pm V1, Administrator, and V14, Interim DON/Regional Nurse Consultant, confirmed they are unable to provide documentation of certified nursing assistant staff annual reviews and that certified nursing assistant staff completed 12 hours of continuing education.The Long-Term Care Facility Application for Medicare and Medicaid form dated 2/08/26 documents 104 residents reside in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to document food preparation temperatures on the food temperature log labeled for the main kitchen food preparation. This failure has the potential to affect all 104 residents of the facility. Findings include:On 2/8/26 at 08:10 AM, review of the main kitchen food temperature log revealed it did not contain logged food temperatures for breakfast and lunch meals for 2/5/26 and 2/6/26, and for breakfast on 2/8/26.The undated Food & Beverage Temperature Control policy documents:Purpose: To ensure residents receive safe food served at acceptable temperatures.Procedure: Food and beverage temperatures should be taken and logged upon being cooked and again prior to meal service.Documentation: Log cook and service (holding) temperatures.On 2/8/26 at 08:10 AM, V39, Cook, stated V39 did not know why the temperatures were not logged on the food temperature logs.On 2/10/26 at 1:10 PM, V3, Dietary Manager, confirmed the temperature logs should have been completed at the time of cooking the food for consumption. V3 stated V3 is unsure who or how the presented temperature logs now have temperatures filled in.

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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 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly Based on interview and record review, the facility failed to ensure required staff members attended Quarterly Quality Assurance meetings. This failure has the potential to affect all 104 residents residing in the facility. Findings:The Long-Term Care Facility Application for Medicare and Medicaid form dated 2/08/26 documents that 104 residents reside in the facility.The facility's Quality Assurance Performance Improvement Program (QAPI) Policy dated 11/28/12 with a revision on 10/24/22 documents that the committee shall meet at least quarterly to assure activities are performed and identified problems have corrective actions taken or an appropriate action plan is developed as indicated.This policy documents that the committee members include, but are not limited to, Administrator (Chairperson), Medical Director, Director of Nursing, Infection Preventionist, Wound Care Nurse (as applicable), Social Services Director, Activities Director, Dietary Manager, Housekeeping/Laundry Director, Maintenance Director, Human Resources, MDS Coordinator, and other ancillary services (Pharmacy, laboratory, Radiology, and other service providers) as indicated.On 02/11/2026 at 10:36 a.m., V1, Administrator, provided sign-in sheets for the Quarterly Quality Assurance meeting held in April 2025. The document does not include V45, Medical Director's, signature as being present at the meeting. V1 stated he was not working at the facility during the April 2025 QAA meeting and did not want to speculate but stated it is most likely that the Medical Director was not present for that meeting. V1 also provided QAA meeting minutes for December 16, 2025. V1 stated V45 was not present for this meeting but that he reviewed the information with V45 in the days following when V45 was at the facility. V1 confirmed that V45 should be present at these meetings.

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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. Based on observation, interview, and record review the facility failed to ensure proper infection prevention and control practices related to oxygen administration for one (R73) of three residents reviewed for Respiratory Care out of a sample list of 45 and the facility failed to accurately document and analyze facility infections. This failure has the potential to affect all 104 residents currently residing at this facility.Findings:1. R73's undated Care Plan documents an admission date to the facility of 7/13/2023 with the following diagnoses: Malignant Neoplasm of Colon, Unspecified; Vitamin Deficiency, Unspecified; Hyperlipidemia; Excoriation Disorder; Squamous Blepharitis.R73's Minimum Data Set (MDS) Section C, dated 01/25/2026, documents R73 with a Brief Interview of Mental Status (BIMS) score of 11, indicating moderate cognitive impairment.On 2/08/2026 at 9:34 AM, R73 was sitting in a wheelchair with a nasal cannula applied, with the other end of the cannula attached to a portable oxygen tank hanging on the back of R73's wheelchair. The nasal cannula applied to R73's nose was undated. Located behind R73 was an oxygen concentrator with an undated nasal cannula attached, with the other end of the cannula draped over R73's siderail of the bed, touching the floor.The facility's Oxygen and Respiratory Equipment Changing/Cleaning Policy, dated 09/08/2016, documents the following:Nasal cannulas are to be changed weekly and as needed.Whenever possible, residents using a portable oxygen tank will be switched to a room oxygen concentrator while in their room.A plastic bag with a zip lock or drawstring will be provided to store the cannula when it is not in use. It will be dated with the date the tubing was changed.On 02/10/2026 at 10:35 AM, V12, Licensed Practical Nurse (LPN), stated residents' nasal cannulas should be stored in the provided plastic bag when not in use. 2. The facility's Long-Term Care Application for Medicare and Medicaid dated 2/8/2026 documents a total of 104 residents.On 2/8/26 at 8:00 AM, a sign was taped to the front door documenting that there were active cases of COVID-19 in the facility.On 2/11/2026 at 10:55 AM, V12, Acting Director of Nursing, stated the facility started having positive COVID-19 cases in December 2025.The facility's infection summary report for December 2025 and January 2026 documents zero COVID infections.On 2/10/2026 at 2:50 PM, V12, Acting Director of Nursing, stated the infection summary reports for December 2025 and January 2026 did not capture the facility's COVID infections.The Infection Surveillance, Tracking, and Quality Assurance Reporting Policy dated 11/28/2012 documents that the purpose of this policy is to identify, monitor, track, and report infections. This policy also documents that the facility will record infections, analyze the data, and provide training as needed.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to designate one or more individuals as infection preventionist. This failure has the potential to affect all 104 residents currently residing at this facility.Findings:The facility's Long-Term Care Application for Medicare and Medicaid dated [DATE] documents a total of 104 residents.On [DATE] at 9:17 AM, V12, Acting Director of Nursing (DON), stated the facility does not currently have a certified Infection Preventionist. V12 further stated that her certification has expired and she is currently working on completing the required tasks to obtain her Infection Control Certification.The undated Department Head list does not include an employee listed as Infection Control and Prevention.

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F 0944 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct mandatory training, for all staff, on the facility?s Quality Assurance and Performance Improvement Program. Based on interviews and record review, the facility failed to provide Quality Assurance and Performance Improvement (QAPI) training for staff. This failure has the potential to affect all residents residing in the facility. Findings:The facility's Long-Term Care Facility Application for Medicare and Medicaid dated 2/08/26 documents a total census of 104 residents.The Facility Assessment Tool, which is undated, documents that the facility will provide staff with the necessary training, education, and competencies to deliver the level and types of care required for its resident population. This assessment tool includes a list of training topics, which specifically references the Quality Assurance and Performance Improvement (QAPI) program.On 2/17/2026 at 10:32 a.m., V1, Administrator stated he could not provide documentation showing that QAPI training for staff had been completed. V1 further stated he was not aware that QAPI training was required for staff and commented, I haven't done that type of training here or at any other facility I've been at.

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F 0949 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide behavior health training consistent with the requirements and as determined by a facility assessment. Based on Interview and record review the facility failed to provide behavioral health training to all direct care staff. This deficiency has the potential to affect all resident who reside in the facility.Findings Include: The facility's Long-Term Care Application for Medicare and Medicaid dated 2/8/26 documents the census as 104 residents residing at the facility.On 2/17/26 at 10:00AM V1, Administrator and V14, Acting DON (Director of Nursing) verified they cannot provide documentation of Behavioral Health training for any staff was conducted in the 12 months previous to this survey.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to honor residents' right to make choices regarding the timing of their showers. This failure affects three residents (R11, R23, and R45) out of three residents reviewed for personal care choices, from a total sample of 46.The facility's Bathing - Shower and Tub Bath Policy dated 11/28/12 with a revision on 1/31/18 documents that the purpose of this policy is to ensure resident's cleanliness to maintain proper hygiene and dignity. The policy requires that residents be offered a shower, tub bath, or bed/sponge bath according to their individual preferences for timing and frequency, at least twice per week, and additionally as requested or needed.R11's Electronic Medical Record (EMR) documents that R11 was admitted to the facility on [DATE] for aftercare following joint replacement surgery of the right hip on 12/01/25.R11's Minimum Data Set (MDS) dated [DATE] documents that R11's cognition is intact and that R11 is dependent on staff for showers. R11's Care Plan dated 12/11/25 documents that R11 has Activities of Daily Living (ADL) self- care performance deficit and requires partial to moderate assistance from staff with showers. On 2/09/2026 at 9:18 a.m., R11 stated she was admitted to the facility after shattering a bone in her right leg. R11 stated the facility did not give her a choice regarding when she could receive showers. R11 stated she was assigned to Tuesday and Friday evenings but emphasized that she had no input in this schedule and that she really wants a shower. R11 stated she does not like having showers after supper. R11 explained that sometimes staff come in late in the evening to provide her shower, and although she does not want it at that time, R11 feels she has to accept because if she refuses, she would have to wait until her next scheduled shower day.R23's EMR documents an admitting diagnosis dated 12/5/25 of Multiple Sclerosis. R23's MDS dated [DATE] documents that R23's cognition is intact and requires substantial/maximal assistance for showers.R23's Care Plan dated 12/19/25 documents that R23 has an ADL self-care performance deficit with a varying level of assistance needed. This Care Plan documents an intervention that R23 usually requires substantial/maximal assistance from staff with showers.On 2/09/2026 at 11:12 a.m., R23 stated her usual shower days are Wednesday and Saturday after lunch. R23 stated that on the morning of her last fall 1/31/26, R23 accepted a shower from V24 Certified Nurse Assistant (CNA), at 5:12 AM. R23 explained that she agreed to the early shower because, if she had declined, staff would have documented it as refused, and she would not have received a shower later that day and that this happens often.R45's EMR documents an admitting diagnosis of Chronic Respiratory Failure and Multiple Sclerosis.R45's MDS dated [DATE] documents that R45's cognition is intact and that R45 requires partial to moderate assistance from staff with showers. R45's Care Plan dated 5/23/25 documents that R45 has an ADL self-care performance deficit with a varying level of assistance needed from staff related to Multiple Sclerosis. On 2/09/2026 at 9:25 a.m., R45 stated she often does not receive showers as scheduled. R45 stated her assigned shower days are Tuesday and Friday evenings. R45 stated that on one occasion, staff came at 10:00 PM to provide a shower, and on another occasion, staff asked at 3:00 AM if she wanted a shower, which she refused. R45 further stated that staff frequently tell residents they do not have enough staff to provide showers or that they are running low on supplies such as gowns and towels.On 2/10/2026 at 10:09 a.m., V8, CNA stated that staff sometimes have trouble completing scheduled showers when they are short-staffed, and she feels the facility is short-staffed often. V8 stated if showers cannot be completed during the scheduled shift, they are rescheduled for evening or night shift. V8 stated she is aware that night shift also has difficulty completing showers and that, in some cases, night shift documents the shower as resident refused.On 2/11/26 at 1:48 p.m., V42, Scheduler, stated she is responsible for scheduling resident showers and assigning CNAs. V42 stated that if a resident refuses a scheduled shower when offered, CNAs are expected to attempt to reschedule at a time that meets the resident's (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	needs. V42 confirmed that she was aware of an issue involving agency staff who indicated they do not provide showers, yet documentation reflected that showers were completed. V42 stated this was a problem that they are working to correct.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview and record review the facility failed to date a multi dose insulin pen when opened for one (R56) of five residents reviewed for medication administration on the sample list of 46.Findings include: On 2/09/2026 at 12:13 PM, V12 Licensed Practical Nurse administered 10 units of Insulin Aspart to R56 using a multi-dose insulin pen. This insulin pen had previously been opened and used and was not dated. At that time, V12 confirmed that R56's multi dose insulin pen had been previously opened and not dated when opened. V12 stated the opened insulin pen should be dated. The facility's Injectable Medication Administration policy with the revision date of November 2021 documents a procedure to date injectable medication when opened.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure influenza and pneumococcal vaccinations was offered and documented in the medical record. This failure affected five of five (R15, R4, R2, R63, and R12) residents reviewed for Infection Control out of a sample list of 46.1.R15's undated Care Plan documents an admission date to the facility as 02/11/2025 with the following diagnosis: Iron Deficiency, Lipoprotein Deficiency, Vascular Dementia, Mild, With Anxiety, Depression, Restless Legs Syndrome, And Chronic Pain.R15's medical record does not document that a pneumococcal vaccine nor a influenza vaccine was offered to R15. R15's Minimal data set dated [DATE] documents R15 with a Brief Interview for Mental Status score of six indicating severe cognitive impairment.R15's medical record does not document that a pneumococcal nor an influenza vaccine was offered to R15.On 2/17/2026 at 10:32 AM V41, R15's family member, stated she does not recall being informed of immunizations during the admission process at this facility.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding Influenza and Pneumococcal immunizations for R15. 2. R4's medical record does not document that a pneumococcal nor an influenza vaccine was offered to R4.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding Influenza and Pneumococcal immunizations for R43. R2's medical record does not document that a pneumococcal nor an influenza vaccine was offered to R2.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding Influenza and Pneumococcal immunizations for R4. 4. R63's medical record does not document that a pneumococcal nor an influenza vaccine was offered to R63.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding Influenza and Pneumococcal immunizations for R63R63's undated Care Plan documents an admission date to the facility as 05/02/2025 with the following diagnosis: Hypothyroidism, Unspecified, Gastro-Esophageal Reflux Disease Without Esophagitis, Major Depressive Disorder, Recurrent, Overactive Bladder, and Calculus of Kidney.R63's Minimal data set dated [DATE] documents R63 with a Brief Interview of Mental Status score of 13 indicating cognitively intact. On 2/17/2026 at 11:15 AM R63 stated she does not recall being educated or questioned about influenza nor pneumococcal immunizations at time of admission to this facility. 5. R12's medical record does not document that a pneumococcal nor an influenza vaccine was offered to R12.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding Influenza and Pneumococcal immunizations for R12. The Influenza and Pneumococcal Immunizations policy dated 11/28/2012 documents the resident's medical record should include documentation regarding whether the resident received or did not receive the influenza immunization.On 2/17/2026 at 11:35 AM V12, Acting Director of Nursing stated she was unable to provide documentation on the administration of influenza and Pneumococcal vaccines for R15, R4, R2, R63 and R12.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure COVID-19 vaccinations are offered and documented. This failure affected five of five (R15, R4, R2, R63, and R12) residents reviewed for Infection Control out of a sample list of 46.Findings:1.R15's undated Care Plan documents an admission date to the facility as 02/11/2025 with the following diagnosis: Iron Deficiency, Lipoprotein Deficiency, Vascular Dementia, Mild, With Anxiety, Depression, Restless Legs Syndrome, And Chronic Pain.R15's medical record does not document that a pneumococcal vaccine nor a influenza vaccine was offered to R15. R15's Minimal data set dated [DATE] documents R15 with a Brief Interview for Mental Status score of six indicating severe cognitive impairment.R15's medical record does not document that a COVID-19 immunization was offered or administered to R15.On 2/17/2026 at 10:32 AM V41, R15's family member, stated she does not recall being informed of immunizations during the admission process at this facility.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding COVID-19 for R15.2. R4's medical record does not document that a COVID-19 immunization was offered or administered to R4.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding COVID-19 immunizations for R43. R2's medical record does not document that a COVID-19 immunization was offered or administered to R2.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding COVID-19 immunizations for R4.4. R63's medical record does not document that a COVID-19 immunization was offered or administered to R63.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding COVID-19 immunizations for R63.R63's undated Care Plan documents an admission date to the facility as 05/02/2025 with the following diagnosis: Hypothyroidism, Unspecified, Gastro-Esophageal Reflux Disease Without Esophagitis, Major Depressive Disorder, Recurrent, Overactive Bladder, and Calculus of Kidney.R63's Minimal data set dated [DATE] documents R63 with a Brief Interview of Mental Status score of 13 indicating cognitively intact. On 2/17/2026 at 11:15 AM R63 stated she does not recall being educated or questioned about COVID-19 immunizations at time of admission to this facility.5. R12's medical record does not document that a COVID-19 immunization was offered or administered to R12.On 2/11/2026 at 10:55 AM, V12 (Acting Director of Nursing) stated she was unable to produce documentation regarding COVID-19 immunizations for R12.On 2/17/2026 at 11:35 AM V12, Acting Director of Nursing stated she was unable to provide documentation on the administration of COVID-19 vaccines for R15, R4, R2, R63 and R12.The facility's COVID-19 Vaccination Guidelines- Resident and Employees policy dated 12/23/2020 documents The resident's medical record includes documentation that indicates, at minimum, the following:That the resident or resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; andEach dose of COVID-19 vaccine administered to the resident, orIf the resident did not receive the COVID-19 vaccine due to medical contradictions or refusal.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on interview and record review the facility failed to obtain consents for psychotropic medications for one (R17) of five residents reviewed for unnecessary medications on the sample list of 46.Findings include: R17's medical record contains an order dated 4/13/2025 for Olanzapine (anti-psychotic medication) 2.5 milligrams (mg) one tablet orally at bedtime, an order dated 2/6/2025 for Citalopram Hydrobromide (anti-depressant) 10 mg one tablet daily and an order dated 4/13/2025 for Trazodone (anti-depressant) 100 mg one tablet at bedtime. R17's medical record does not contain consents for these medications. On 2/10/2026 at 9:00 AM, V1 Administrator stated there were no consents for R17's use of psychotropic medications. The facility's psychotropic medication policy with revision date of 2/01/2018 documents psychotropic medication shall not be administered without the informed consent of the resident and/or resident's representative.

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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 the facility failed to notify the physician and dietician of a significant weight loss for one (R112) of three residents reviewed for physician notification in the sample list of 46. Findings include:R112 's diagnosis list (printed 2/11/26) documents that R1's diagnoses include Dementia, Syncope (fainting) and Collapse, Difficulty in Walking, Muscle Wasting and Atrophy, Pain, Cognitive Communication Deficit, Depression, and Anxiety.R112's Resident assessment dated [DATE] documents R1 has severely impaired cognition and requires substantial/maximal staff assistance for transfers, including going from a seated position to a standing position. The same record documents R1 does not have behaviors, delusions, or hallucinations.R112's undated weight list documents on 2/1/2026 at 09:52am R112 weighed 128.2 pounds and on 1/5/2026 at 11:37am R112 weighed 137.0 pounds, a weight loss of 6.6%.On 2/9/26 review of Weights Policy dated 10-17-19 revised documents the following: Guidelines:I. Each resident shall be weighed on admission and at least monthly thereafter, or in accordance with Physician orders or plan of care.2. Residents identified at nutritional risk may be weighed weekly or bi-weekly as per physician order or Interdisciplinary Team recommendation.3. Re-weight should be obtained if there is a difference of 5 pounds or greater (loss or gain) since previous recorded weight.4. Re-weight should be taken as soon as possible after an unanticipated weight change is noted and prior to calling the physician (Usually within 72 hours).6. Undesired or unanticipated weight gains/loss of 5% in 30 days, 7.5% in three months, or 10% in six months shall be reported to the physician, Dietician and/or Dietary Manager as appropriate.On 2/9/26 at 12:25pm V14, Interim DON/Regional Nurse Consultant, confirmed R112's medical record does not contain Physician, Dietician and/or Dietary Manager notifications. V14 confirmed the record does not contain a reweigh of R112 despite a deficit of 8.8 pounds (-6.6%) from January 2026 to February 2026. V14 confirmed R112's care plan does not contain a targeted intervention with regards to significant weight loss.On 2/9/26 at 1:05pm V3, Dietary Manager, confirmed R112 had a significant weight loss of 8.8 pounds (-6.6%) from January 2026 to February 2026. V3 confirmed R112's medical record did not contain a reweight for R112. V3 stated the nursing department is responsible for notifying the physician, registered dietician and family. V3 confirmed R112's record does not contain documentation of notifications of physician, registered dietician and family.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure the right to be free from chemical restraints by failing to implement alternatives to psychotropic medications, failing to monitor for tardive dyskinesia, and failing to gradually reduce psychotropic medication for one (R17) of five residents reviewed for unnecessary medications on sample list of 46. Findings include: The facility's Psychotropic Medication-Gradual Dosage Reduction policy with a revision date of 2/1/18 documents residents are not given psychotropic drugs unless necessary. This policy documents the plan to alternatives to psychotropic medications shall be incorporated into the care plan with suitable goals and approaches. This policy documents residents on anti-psychotic drug therapy will be monitored for tardive dyskinesia side effects every six months through the use of the AIMS (Abnormal Involuntary Movement Scale). This policy also documents that gradual dose reductions will be attempted at least twice yearly and the physician will document a clinical rationale if a reduction is declined. R17's medical record contains an order dated 4/13/2025 for one 2.5 milligram (mg) tablet of Olanzapine (anti-psychotic medication) at bedtime, an order dated 2/6/2025 for one 10 mg tablet of Citalopram Hydrobromide (anti-depressant) daily, and an order dated 4/13/2025 for one 100 mg tablet of Trazodone (anti-depressant) at bedtime. R17's medical record documents R17 has diagnoses of Dementia without Behavioral Disturbance, Psychotic Disturbance, Bipolar Disorder, Depression, and Anxiety. R17's medical record does not contain documentation of alternatives used instead of the psychotropic medications, does not document monitoring R17 for tardive dyskinesia, does not document behavioral interventions, or that a gradual dose reduction was ordered. R17's care plan dated 10/4/25 documents the use of antianxiety, anti-depressant, and antipsychotic medications. This care plan does not include alternatives used instead of the psychotropic medications or behavioral interventions. On 2/10/2026 at 9:00 AM, V1 Administrator confirmed that R17's medical record did not contain alternatives used instead of the psychotropic medications, did not contain documentation that an AIMS assessment was completed, did not document behavioral interventions for R17, and did not document any gradual dose reductions.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to accurately code a minimum data set assessment for one (R17) of 32 residents reviewed for assessments on the sample list of 46. Findings include: R17's medical record documents R17 was sent to the hospital and diagnosed with a left arm fracture on 10/9/2025 following a fall that same day. R17's Quarterly Minimum Data Set (MDS) assessment dated [DATE] documents R17 has fallen since the last assessment and documents a zero for major injuries since the last assessment. On 2/08/2026 at 9:49 AM, V15 MDS Coordinator stated the fall with fracture that occurred on 10/9/25 is a major injury and should have been captured on R17's 11/15/25 quarterly MDS assessment.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to develop a care plan for constipation for two (R1, R17) of 32 residents reviewed for care plans on the sample list of 46. Findings include: 1. R1's medical record documents R1 was admitted to the facility on [DATE] with a diagnosis of Constipation. R1's Progress Note dated 10/31/25 written by V39 Nurse Practitioner documents a plan to monitor bowel movements daily, give laxative and/or stool softener as needed for constipation, notify provider if no bowel movement within three days, increase hydration, fiber intake, and physical activity, and to limit narcotic use. R1's Care Plan with revision date of 9/5/25 does not include a plan of care or interventions for constipation. On 2/09/2026 at 11:41 AM, V14 Interim Director of Nursing (DON) stated there should be a care plan developed addressing the constipation for R1. V14 stated R1 does not have a care plan for constipation. 2. R17's Physician's Order Sheet documents an order dated 10/10/25 for Hydrocodone-Acetaminophen (opioid) 5 milligram-325 milligram, one tablet every four hours as needed for pain. R17's care plan with a review date of 1/27/26 does not include a care plan or interventions for constipation. On 2/11/2025 at 3:54 PM, V14 Interim DON stated any resident taking an opioid is expected to have a care plan for constipation.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on interview and record review the facility failed update a residents Care Plan to include a significant weight loss for one of 46 residents (R81) reviewed for Care Plans on the sample list of 46. Findings Include: R81's Census form dated 2/17/26 documents R81's admission date as 7/11/25. R81's weights are documented from 7/13/25 to 2/9/26 in the EMR (Electronic Medical Record). R81's weight on 7/13/25 was 175.0 pounds. R81's weight on 2/9/26 was 114.6 pounds which equals R81 losing 60.4 pounds. R81's care plan dated 2/4/26 does not address R81's weight loss. V15, Care Plan Coordinator stated on 2/12/26 at 2:30 PM I did not realize the care plan did not document the weight loss. I know we addressed (R81) needing a special diet, but we did not document anything about weight loss. The facility's policy titled Comprehensive Care Plan with revision date of 11/17/17 states, To develop a comprehensive care plan that directs the care team and incorporates the resident's goals preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview, and record review, the facility failed to complete neurological checks after an unwitnessed fall and a fall with a head injury for one (R112) of three residents reviewed for assessments in a sample list of 45. Findings include:On 2/9/26 review of Fall Prevention Program dated Revisions: 11-21-17 documents Purpose: To assure the safety of all residents in the facility, when possible. The program will include measures which determine the individual needs of each resident by assessing the risk of falls and implementation of appropriate interventions to provide necessary supervision and assistive devices are utilized as necessary. Standards: A Fall Risk Assessment will be performed at least quarterly and with each significant change in mental or functional condition and after any fall incident. The same policy further documents Documentation in nurses' notes is to include the following a. A description of the occurrence, the extent of injury (if any), the assessment of the resident, vital signs, treatment rendered, and parties notified. b. A minimum of seventy-two (72) hours (longer, if indicated) of documentation by all three shifts on resident status after the incident. Vital signs, mental and physical state, follow-up, tests, procedures, and findings are to be documented.The facility fall log (11/9/25 thru 2/9/26) documents R112 had an unwitnessed fall in the facility on 12/11/25. The facility provided fall investigation dated 1/31/26 documents a fall for R112.The facility Fall Investigation dated 1/31/26 documents staff turned around as R112 stood up from the wheelchair in the bathroom of the resident room and was reaching for the towel bar then fell into the towel bar causing a laceration on the right cheek. The record further documents R112 was transferred to the hospital emergency department via ambulance for evaluation and treatment.On 2/10/26 R112's Medical Record review documents V36, License Practical Nurse, created a fall assessment for the documented fall dated 1/31/26.On 2/10/26 R112's Medical Record review documents NEURO CHECKS- 72 HR (Neurological Checks for 72 Hours) assessments were created after the falls dated 1/31/26 and 12/11/25. Review of these neurological checks documents the assessments were not completed as required.On 2/11/26 at 1:05pm V14, Interim DON/Regional Nurse Consultant, confirmed Neuro-Checks are to be completed as written on the neuro-check assessments contained in the medical record. V14 stated neurological checks are to be initiated after a fall that involved the head or any unwitnessed fall. V14 confirmed the neuro-checks assessments in R112's medical record dated 12/11/25 and 1/31/26 are not completed at this time.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to implement resident centered interventions for one resident with dementia (R7) of six residents reviewed for Dementia in a sample of 46.Findings Include: R7's Care Plan, updated 11/6/25, documents the following diagnoses: Type II Diabetes, Alzheimer's Dementia, Repeated Falls, and Major Depression.R7's Minimum Data Set (MDS) dated [DATE] documents that R7 has no behavioral symptoms.On 2/8/26 at 9:00 AM, R7 was in his bed watching TV. The Surveyor knocked on R7's open door. R7 shouted, What and who the H*** are you? The Surveyor introduced herself and explained to R7 that she was here from IDPH (Illinois Department of Public Health) to talk with residents about the care they receive at the facility. R7 seemed very agitated and shouted, Well, if you are from the F****** (expletive) state, get me out of here now. I am being held prisoner. That F****** (expletive) B**** (expletive) had them arrest me. The Florida state police went into Georgia and arrested me and brought me to Illinois. R7 beat his fists on the bed rail and shook the bed. The Surveyor replied she could see how upset R7 was and would let him get back to his TV. R7 became even louder and continued to pound on the bed with his fists. R7 shouted, You F****** (expletive) B**** (expletive), if you are with the state, why can't you get my A** (expletive) out of here and get my money back?On 2/8/26 at 3:00 PM, V1, Administrator, stated, We are aware (R7's) behavior is escalating, and he has been seen by a (contracted psyche provider). V14, Corporate RN and acting DON, stated, (R7) is very suspicious of his POA. He doesn't like women, and his behavior related to dementia is really increasing.On 2/11/26 at 1:00 PM, V1, Administrator, and V14, Acting Director of Nursing, verified R7's behaviors, including cursing, isolating, shouting, and refusal of care, have increased since R7 has not received the correct dose of Seroquel.On 2/11/26 at 2:00 PM, V11, Activity Director, stated, Since the end of January, (R7) has not come to activities at all. I have heard him in his room shouting and cursing. I was helping pass trays on Sunday (2/8/26). I took (R7's) tray to him. He pointed at the tray table, and I placed the tray on it and went to get another tray. As I was walking by his room, I heard a commotion, and (R7) had knocked his tray off the table and across the room. (R7) is more agitated.R7 does not have a dementia care plan in place to address the increased dementia-related behaviors.On 2/18/26 at 11:00 AM, V1, Administrator, verified an updated dementia care plan was not put in place to address the escalating behaviors.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review the facility failed to administer medications as ordered by the physician for one (R111) of five residents reviewed for medication administration on the sample list of 46. These failures resulted in two medication errors out of 29 opportunities resulting in a 6.9% medication error rate. Findings include:On 2/09/2026 at 8:45 AM, V10, Licensed Practical Nurse, was pulling R111's medications out of the medication cart. At that time, V10 stated she did not have Calcium 600 milligrams or Omeprazole 20 milligrams to administer to R111. V10 stated the facility does not have these medications in stock. V10 confirmed that the Omeprazole and Calcium were not administered as ordered by the physician.R111's Medication Administration Record for February of 2026 includes an order dated 1/13/26 for calcium 600 milligrams, give one tablet by mouth one time a day, and an order dated 10/17/25 for omeprazole 20-milligram capsule, one capsule a day. This administration record documents see progress note under the administration box for the calcium and the omeprazole dated 2/9/26 at 8:00 AM.R111's progress note dated 2/9/26 at 8:50 AM documents that the Omeprazole and Calcium were unavailable.The facility's Medication Administration policy dated November 2021 documents that medications should be administered as ordered by the physician.

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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 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview, and record review the facility failed to ensure liquids provided at the bedside were thickened as ordered by the physician for one (R107) of 32 residents reviewed for hydration on the sample list of 46.Findings include:R107's physician's order dated 12/23/25 documents R107 is to receive nectar thickened liquids. R107's care plan with a revision date of 12/24/25 documents R107 requires nectar thickened liquids. On 2/08/2026 at 11:25 AM, a glass of thickened liquids and a glass of regular water were sitting on R107's bedside table. R107 stated she took her morning medications with the glass of regular water and not the thickened liquids. On 2/08/2026 at 1:38 PM, V6 Licensed Practical Nurse confirmed that R107's liquid order is nectar thick and that R107 should not have regular water at the bedside. On 2/08/2026 at 1:48 PM, the glass of regular consistency water was still sitting on R107's bedside table. On 2/08/2026 at 1:51 PM, V8 Certified Nurse Assistant stated R107 is not able to get up on her own and get her own water and that a staff member would have had to place the regular water on the bedside table. V8 confirmed that R107 should receive thickened liquids not regular water.