STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146100	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass County Senior Living & Rehabilitation LLC	530 East Beardstown Street Virginia, IL 62691

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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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to secure a treatment orders promptly, and delayed the implementation of new interventions once skin breakdown was discovered to prevent worsening of a pressure wound for one of two residents (R23) reviewed for pressure ulcers in the sample of 24. These failures resulted in R23's facility acquired pressure wound worsening to a stage three.Findings include:The Prevention of Pressure Ulcers/Injuries policy dated 07/2017 documents The purpose of this procedure is to provide information regarding the identification of pressure ulcer/injury risk factors and interventions for specific risk factors. Risk Assessment 4. Inspect the skin on a daily basis when performing or assisting with personal care or ADL's (Activities of Daily Living). a. Identify any signs of developing pressure injuries (i.e. (example), non-blanchable erythema). b. Inspect pressure points (sacrum, heels, buttocks, coccyx, elbows, ischium, trochanter, etc. (etcetera). Prevention Nutrition 1. Monitor the residents for weight loss and intake of food and fluids. 2. Include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. Mobility/Repositioning 1. Choose a frequency for repositioning based on the resident's mobility, the support surface and use, skin condition and tolerance, and the resident's stated preferences. 3. At least every two hours or as tolerated reposition residents who are reclining and dependent on staff for repositioning. 4. Reposition more frequently as needed, based on the condition of the skin and the resident's comfort. Monitoring 1. Evaluate, report and document potential changes in skin. 2. Review the interventions and strategies for effectiveness on an ongoing basis.The Pressure Ulcer/Skin Breakdown - Clinical Protocol dated 04/2018 documents Cause Identification 1. The physician will help identify factors contributing or predisposing residents to skin breakdown; for example, medical comorbidities such as diabetes or congestive heart failure, overall medical instability, cancer or sepsis causing a catabolic state, and macerated or friable skin. Treatment/Management 2. The physician will help identify medical interventions related to wound management; for example, treating a soft tissue infection surrounding an ulcer, removing necrotic tissue, addressing comorbid medical conditions, managing pain related to the wound or to wound treatments.R23's Face Sheet documents that R23 is a [AGE] year-old that admitted to the facility on [DATE] with diagnoses which included Mild Protein-Calorie Malnutrition, Peripheral Vascular Diseases, and Age-Related Osteoporosis. On 2/2/26 a diagnosis of Influenza A Virus with Respiratory Manifestations was added and on 2/11/26 a diagnosis of Pressure Ulcer of Right Buttock, Stage three was added.R23's Care Plan documents that R23 has potential impairment to her skin related to fragile skin. Date Initiated 12/2/24. R23 has an Activity of Daily Living self-care performance deficit related to weakness and limited Range of Motion of bilateral upper and lower extremities. Interventions - Bed Mobility R23 requires total assistance by two staff to turn and reposition in bed. R23 is maximal/substantial assistance for one to two staff for transferring. Date Initiated 12/2/24. R23 has an actual alteration in skin integrity-new wound on coccyx. Interventions - See wound doctor weekly, alternating air loss mattress to bed, pressure reducing cushion in recliner, follow treatment orders, and apply barrier cream with incontinent care. Date Initiated 2/11/26. This same care plan does not document new interventions after R23's coccyx wound was identified on 2/6/26 until 2/11/26, five (continued on next page)

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

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F 0686 Level of Harm - Actual harm Residents Affected - Few	days later.R23's Braden Scale Pressure Risk assessment dated [DATE] at 10:44 AM, documents that R23 scored a 13 indicating R23 was a moderate risk for development of pressure ulcers.The Weekly Skin Check dated 1/23/26 at 5:56 PM, documents no skin impairment.R23's Shower Sheet dated 2/6/26 at 2:30 PM, written by V18/Certified Nursing Assistant documents that R23 has an open wound on her right buttock. It was also noted on this shower sheet by V2/Registered Nurse/RN/Prior Director of Nursing/DON dated 2/7/26 that treatment was initiated and R23 would be seen by the Wound Doctor.R23's Skin Issue report written by V2/RN/Prior Director of Nursing dated 2/7/26 at 3:41 AM, documents a new issue - MASD on R23's buttock that was acquired in house. There was a presence of burning wound pain noted at dressing. The wound measured 4.83 cm (centimeters) by 7.65 cm. There was no dressing applied. This same skin assessment documents Does this resident have one or more unhealed pressure ulcers injuries. Not assessed/no information was marked.A Fax sent to V11/R23's Primary Care Physician dated 2/7/26 documents that R23 was noted to have an area of MASD (Moisture Associated Skin Damage) across buttocks with superficial open areas. Barrier cream to area twice a day and put on the list for the wound doctor to see on Wednesday (2/11/26). V11 responded on 2/9/26 Fine.R23's Nursing Note dated 2/9/26 at 1:28 PM, documents a new order for barrier cream to R23's buttock twice a day and R23 was put on the list to see the wound doctor on Wednesday (2/11/26).R23's Shower Sheet dated 2/9/26 at 2:30 PM, written by V18/Certified Nursing Assistant documents Buttocks is red/yellow, gotten worse since Friday. On this same shower sheet was written Tx (treatment) in place. This was not dated and was signed by V2/RN/Prior Director of Nursing.R23's Nursing Note dated 2/11/26 at 3:15 PM, documents that V10/Wound Doctor was at the facility to see R23 and new orders were received.R23's Initial Wound Clinic Evaluation and Management Summary dated 2/11/26 documents R23 has a stage three pressure wound that measured 2 cm by 2 cm by 0.2 cm with moderate Sero-sanguinous drainage. The wound is undergoing autolytic debridement. Dressing Treatment Plan - Alginate Calcium with silver and gauze dressing.R23's Physician Orders document Stage III (three) coccyx- apply calcium alginate with Ag (silver), cover with border gauze dressing, change daily and as needed for soiling and non-adherence. Dated 2/11/26.R23's Wound Clinic Evaluation and Management Summary dated 2/25/26 documents R23 has a stage three pressure wound that measured 1.5 cm by 1 cm by 0.2 cm with moderate Sero-sanguinous drainage. Surgical excisional debridement was done to remove necrotic tissue and establish the margins of viable tissue. Dressing Treatment Plan - Alginate Calcium with silver and gauze dressing.R23's Treatment Administration Record/TAR for February 2026 documents Barrier Cream every evening and night shift for MASD to buttock. Start Date 2/9/26 at 3:00 PM. Discontinued 2/11/26 at 1:12 PM. The same TAR documents Stage III (three) coccyx- apply calcium alginate with Ag (silver), cover with border gauze dressing, change daily and as needed for soiling and non-adherence. Start Date 2/11/26 at 10:00 PM. There is no documentation for treatment started from the date R23's wound was identified on 2/6/26 until 2/9/26, three days later.On 3/3/26 at 8:36 AM, V15/Licensed Practical Nurse went to R23's room to do R23's dressing change. R23 was dependent on V15 to turn and reposition R23 so V15 could do the dressing change. R23 was very thin, weak, and slightly confused. R23 stated she did not know she had a wound on her buttock. The wound was on R23's right buttock. The wound was a small open area. V15 applied the calcium alginate and covered it with a dressing. On 3/2/26 at 12:13 PM, V2/Registered Nurse/Prior Director of Nursing stated that she was working night shift and the morning of 2/7/26 V2 saw on R23 shower sheet that a wound was documented. V2 stated that when she assessed R23's wound, V2 thought it was a moisture associated wound. Barrier cream was already being used on R23 when R23 was incontinent and V2 did not request a new treatment. There was no other treatment ordered until 2/11/26 when V10/Wound Doctor came to the facility and reclassified the wound as a stage three pressure ulcer. V2 also stated that prior to 2/6/26 R23 had been very sick with Influenza A and had not been getting out of bed.On 3/2/26 at 12:47 PM, V11/Primary Care Physician stated that R23's wound was caused by pressure.On 3/3/26 at 11:59 AM, V10/Wound Doctor stated that R23's wound was a stage three (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	pressure ulcer.On 3/3/26 at 10:43 AM, V17/Current DON verified a wound was found on R23 during R23's shower on 2/6/26. There was not an order put in for any treatment until 2/9/26 when barrier cream was ordered. That order was discontinued on 2/11/26 when the order for calcium alginate was given by the wound doctor on 2/11/26. V17 also verified the Care Plan did not have any new interventions put in place when the wound was found on 2/6/26. There were no new interventions until the wound doctor classified the wound as a pressure ulcer.

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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 record review and interviews the facility failed to ensure a Registered Nurse (RN) worked at least eight hours daily. This failure has the potential to affect all 26 residents residing within the facility.Findings include: The facility's Nurse Schedule, January 1st through February 28th, 2026, documents the facility did not have the services of a registered nurse at least eight hours a day on 01/31/26, 2/14/26, 2/15/26, and 2/28/26.On 3/1/26 at 11:24 AM V2/RN/Prior Director of Nursing verified the provided nurse schedules were accurate and on 1/31/26, 2/14/26, 2/15/26, and 2/28/26 no RN worked those days. V2/DON stated, I am responsible for scheduling the nurses. We have a hard time finding any RNs to work. That's why we cannot provide RN coverage eight hours per day. It's been like that since I started in August 2025.The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 3/1/26 and signed by V1/Administrator documents 26 residents reside within 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 ensure that the food items opened in the kitchen's dry storage, refrigerator and freezer were dated and labeled. These failures have the potential to affect all 26 residents residing in the facility.Findings include: The facility's Food Storage (Dry, Refrigerated, and Frozen) Policy, dated 3/31/25, documents Guidelines: Food shall be stored on shelves in a clean, dry area, free from contaminants. Food shall be stored at appropriate temperatures and using appropriate methods to ensure the highest level of food safety. Procedure: 1. a. All food items will be labeled. The label must include the name of the food and the date by which it should be sold, consumed, or discarded.On 3/1/26 at 8:43 AM, a tour was conducted with V7/Cook. The facility's stand-up freezer in the kitchen contained a one-gallon clear baggy with two egg rolls (undated/labeled and not stored in original packaging) and a half-opened bag of frozen dinner rolls (undated/labeled). The stand-up refrigerator/freezer located in the kitchen had an opened 3/4 full bottle of a high calorie/high protein nutritional supplement (undated). V7 verified the egg rolls, dinner rolls, and nutritional supplements were all opened and undated and should have been labeled with an open date.On 3/1/26 at 8:46 AM, a tour was conducted with V6/Dietary Manager. A kitchen cabinet contained an opened 1/2 full 18 oz (ounce) bottle of Ground Cinnamon (undated) and an opened 1/4 full 10 oz of Ground [NAME] (undated). V6 stated all opened foods/spices should be labeled with an open date and use by date and verified the Ground Cinnamon and Ground [NAME] were not dated when opened.The facility's CMS (Centers for Medicare and Medicaid Services) Form 671 dated 3/1/26 and signed by V1/Administrator documents 26 residents reside within the facility.

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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 review, the facility failed to notify the resident's physician in a timely manner following a significant change in condition (fall with head injury) while receiving an anticoagulant medication Eliquis, for one (R27) of one resident reviewed for physician notification out of a sample list of 24. Findings include:The facility's Change in a Resident's Condition or Status policy, revised 5/2017, documented the facility shall promptly notify the resident, the resident's attending physician, and the resident's representative of changes in the resident's medical or mental condition and/or status. The policy further documented the nurse will notify the resident's attending physician or on-call physician when there has been an accident or incident involving the resident and document the notification in the resident's medical record.R27's Risk Management Assessment documented R27 experienced a fall on 2/27/26 in his room while with Certified Nursing Assistants (CNAs). R27's Nurse Progress Note dated 2/27/26 at 7:33 AM documented that at approximately 6:00 AM a CNA notified the nurse that the resident had fallen. Upon entering the room, the nurse observed R27 lying on the floor but still in a seated position in his wheelchair, lying on his back with his head under a pillow. CNAs reported they were dressing the resident when he leaned back and the wheelchair tipped backward, causing him to fall onto the floor. A head-to-toe assessment identified an abraded area to the back of the resident's head, dark red in color and approximately the size of a quarter. Vital signs and neurological checks were within normal limits. R27 was assisted back to bed by three staff members, and anti-tippers were applied to the back of the wheelchair as an immediate intervention.R27's Pain Comprehensive assessment dated [DATE] documents Resident is unable to describe pain just says, back of my head.R27's Physician Orders revealed R27 was prescribed Eliquis Oral Tablet 5 milligrams (mg) twice daily, related to chronic embolism and thrombosis of unspecified deep veins of the left lower extremity, with a start date of 2/19/26.R27's Nurse Progress Note dated 2/28/26 at 4:00 AM documented V11 (R27's Physician) was notified by fax and indicated to continue to monitor the resident following the fall and staff would continue to follow the plan of care.On 3/02/2026 at 12:55 PM, V12 (Certified Nursing Assistant/CNA) stated she and V14 (CNA) had transferred R27 to his wheelchair using a mechanical lift. V12 stated she could not locate R27's shirt and believed it might be underneath him. V12 stated she lifted R27's legs up while he was seated in the wheelchair to check underneath him and the wheelchair tipped backward, causing R27 to fall backward and strike his head on the floor. V12 stated V14 went to notify the nurse. On 3/02/2026 at 1:45 PM, V11 (R27's Physician) V11 stated she would trust the nurse to call if there was a significant change and indicated that if a resident fell from a wheelchair and hit their head there would be impact and the physician should have been notified by phone rather than by fax since R27 was receiving a blood thinner and fell backwards from his wheelchair and hitting the back of his head.On 3/03/2026 at 2:00 PM, V15 (Director of Nursing) stated the Medical Director should have been notified by phone regarding R27's accident on 2/27/26. V15 confirms she cannot find documentation that V11 was notified of R27's accident by phone.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to document an appropriate diagnosis and target behaviors to warrant the use of anti-psychotic medications for two of six residents (R1 and R29) reviewed for anti-psychotic medication use with the diagnosis of Dementia in the sample of 24. Findings include: The facilities Psychotropic Medication Use Policy, dated 2/2025, documents Policy Statement: Residents do not receive psychotropic medication that are not clinically indicated and necessary to treat a specific condition documented in the medical record. Policy Interpretation and Implementation: 2. Medications in the following categories are considered psychotropic medications and are subject to prescribing, monitoring, and review requirements specific to psychotropic medications: Antipsychotics. 3. Psychotropic medication management is an interdisciplinary process that involves the resident, family, and/or the representative and includes: A. determining adequate indications for use. Assessment and Evaluation of the Resident: 1. When determining whether to initiate, modify, or discontinue medication therapy, the interdisciplinary team conducts and documents an evaluation of the resident. The evaluation includes the residents: A. Physical, behavioral, mental, and psychosocial status. Adequate Indications for Psychotropic Medication Use: 1. Adequate indication for use refers to the identified, documented clinical rationale for administering medication that is based on: C. Manufacturer's recommendations, clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that support the use of the medication. 1.R29's Face Sheet documents R29 is an eight-five-year-old female who admitted to the facility on [DATE] with the following, but not limited to, diagnoses: Parkinson's Disease, Dementia with Mood Disturbance, Neurocognitive Disorder with Lewy Bodies, Abnormal Weight Loss, History of Falling, and Hypertension. R29's PASRR (Preadmission Screening and Resident Review), dated 3/1/26, does not show that R29 has a serious mental illness or an intellectual/developmental disability. The same PASRR documents that R29 is taking Seroquel (antipsychotic medication) 50 mg (milligrams) twice a day for Dementia. R29's Order Summary Report, dated 3/1/26, documents an order for Seroquel 50mg at lunch and Seroquel 50mg at bedtime for Dementia with Mood Disturbance (start date 2/27/26). This same Order Summary Report documents R29 receives Hospice Services with a start date of 2/13/26. R29's current Care Plan does not document that R29 receives Seroquel or an antipsychotic medication. This same care plan does not include targeted behaviors or non-pharmacological interventions to address targeted behaviors for the use of R29's Seroquel. R29's MDS (Minimum Data Set) Assessment, dated 2/20/26, documents R29 is severely cognitively impaired. On 3/1/2026 at 10:07 AM R29 was lying in bed. R27 was confused and unable to answer questions appropriately. A large yellowing bruise was observed to R27 right cheek and eye. R27 had no behaviors observed at this time. On 3/2/26 at 10:10 AM resident was sitting in a high back padded wheelchair in the day room at a table. R27 was calm and cooperative with no behaviors observed. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/2/26 at 10:13 AM V13/CNA (Certified Nursing Assistant) stated she has witnessed R27 kick and hit staff during cares but has not witnessed R27 harming herself or other residents. V13 stated she knows R27 has had a few falls and tries to get up on her own since her admission. On 3/2/26 at 3:08 PM V17/Current Director of Nursing stated the only diagnoses she sees for the use of R27's Seroquel is Dementia which is not appropriate diagnosis for the use of Seroquel and that R27 is not harmful to self or others that she is aware of. V17 also verified there are no identified targeted behaviors for the use of R27's Seroquel or R27 receiving Seroquel on R27's Care Plan. 2. R1's Face Sheet documents that R1 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, and Vascular Dementia, Mild, with Other Behavioral Disturbances. R1's PASRR dated 2/3/26 documents that the PASRR does not show that R1 has a serious mental illness or an intellectual/developmental disability. The same PASRR documents that R1 is taking Quetiapine (anti-psychotic medication) 50 mg (milligrams) daily and 75 mg daily for Vascular Dementia with Behaviors. R1's Physician Orders printed 3/2/26 document orders for Quetiapine Fumarate 50 mg in the morning for vascular dementia with behaviors (start date 12/19/25) and Quetiapine Fumarate 75 mg at bedtime for vascular dementia with behaviors (start date of 12/18/25). R1's Care Plan documents that R1 has potential behaviors due to vascular dementia and takes oral medication for sexual behaviors. Start Date 12/18/25. R1 has a behavior problem of making sexual comments and physical sexual acts. Intervention- Administer antipsychotic medication as ordered. Start date 1/18/26. On 3/1/26 at 10:10 AM, R1 was lying in bed. R1 was calm and pleasant. R1 had no complaints or concerns about his care. On 3/2 and 3/3/26 R1 was observed in the dining room during breakfast and lunch. On both days R1 was calmly waiting for the meal to be served. R1 was not heard making any inappropriate comments or seen doing anything inappropriate. On 3/1/26 at 2:15 PM, V1/Administrator/R1's Power of Attorney stated that R1 is taking an antipsychotic because of his dementia that causes R1 to be sexually inappropriate. V1 also stated that R1 says sexually inappropriate comments to staff but not to residents. On 3/3/26 at 11:20 AM, V15/Licensed Practical Nurse and V20/Registered Nurse in a joint interview both stated that R1's only behavior is that R1 says sexual things to staff and that R1 is easily redirected.

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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 observation, interview, and record review, the facility failed to ensure the comprehensive care plan was revised to reflect current interventions implemented for mobility and fall prevention for one (R26) of one resident reviewed for care plan revision in a sample of 24 residents.Findings include: The facility's Care Plans, Comprehensive Person-Centered policy revised 12/2016 documents Assessments of residents are ongoing, and care plans are revised as information about the residents and the residents condition changes. On 3/03/2026 at 9:30 AM, R26 was observed lying in bed with the bed pushed against the wall and a fall mat positioned next to the bed. A high-back wheelchair with a foot board and stability cushion was observed in R26's room.On 3/03/2026 at 9:32 AM, R26's Comprehensive Care Plan did not include the fall mat next to the bed as a fall intervention and did not contain documentation of a scoop mattress. Further review revealed the care plan documented a non-slip mat was to be used in R26's wheelchair to prevent R26 from slipping out of the chair; however, no non-slip mat was observed in R26's wheelchair.On 3/03/2026 at 9:28 AM, V22 (Occupational Therapy Assistant) stated R26 was no longer receiving therapy services. V22 stated staff had been repositioning R26 in the wheelchair because the resident frequently places her legs over the side while sitting in the wheelchair. V22 further stated a stability cushion had been implemented because R26 was sliding forward and leaning while seated in the wheelchair.On 3/03/2026 at 10:00 AM, V15 (Director of Nursing) confirmed the fall mat, stability cushion, foot board, and scoop mattress were not included in R26's care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to provide ordered medication for one of one resident (R17) reviewed for quality of care in the sample of 24.Findings include:The Ombudsman Residents' Rights Booklet documents Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide services to keep your physical and mental health at their highest practical levels.R17's Face Sheet documents that R17 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Age Related Osteoporosis, Chronic Fatigue, Muscle Weakness, and Genetic Related Intellectual Disability.R17's Hospital Discharge Medication List dated 2/6/26 at 11:43 AM, documents Testosterone Transdermal Gel 20.25 mg (milligram)/1.25 gm (gram) Apply two pumps transdermal one time a day to R17's shoulders. R17's Nursing Note written by V20/Registered Nurse/RN dated 2/6/26 at 3:44 PM, documents V20 called V21/Hospital Doctors office to clarify R17's medication. It was confirmed that R17 was prescribed Testosterone Gel two pumps once daily to R17's bilateral shoulders. R17's Physician Order dated 2/15/26 documents Testosterone Transdermal Gel 20.25 mg/1.25 gm Apply two pumps transdermal one time a day to bilateral shoulders related to Age-Related Osteoporosis (Start Date 2/16/26).R17's Nursing Note written by V2/RN/Prior Director of Nursing dated 2/23/26 at 12:28 PM, documents that V2 contacted V11/R17's Primary Care Physicians Office regarding the script for R17's Testosterone Cream. V2 explained the facility needed a script, alternative medication, or to discontinue the order.R17's Nursing Note written by V15/Licensed Practical Nurse dated 2/26/26 at 3:17 PM, documents that V15 called the pharmacy to inquire about R17's Testosterone Cream that was not delivered last night (2/25/26).R17's Medication Administration Record for February 2026 documents an Order for Testosterone Transdermal Gel 20.25 mg/1.25 gm Apply two pumps transdermal one time a day at 5:00 AM to bilateral shoulders related to Age-Related Osteoporosis (Start Date 2/7/26). This Order was Discontinued on 2/15/26 with none of the medication given. On 2/16/26 the same medication was ordered to start on 2/16/26 at 5:00 AM. The Testosterone Transdermal Gel was not given until 2/27/26 at 5:00 AM. R17's Care Plan documents that R17 is a new admit from the hospital. The Goal is a smooth transition from the hospital to the facility with the goal of providing continuity of care after R17's recent hospitalization. Intervention - Give discharge medication per discharge summary. The Care Plan also documents (R17) requires use of Box Warning Medication (Testosterone Gel). Related to Diagnosis of Hypothyroidism, Low Testosterone, Clotting Issues. Date Initiated 2/11/26. Intervention- Administer box warning medication as ordered by MD (Medical Doctor).On 3/1/26 at 10:31 AM, R17 was sitting in his recliner wearing a hooded sweatshirt and covered with a blanket. R17 was unable to answer questions appropriately. On 3/2/26 at 2:45 PM, V1/Administrator stated that when R17 admitted R17 was supposed to get the Testosterone cream. The pharmacy would not fill the script because they said it was a narcotic, and the doctor had to sign the script. V11/R17's Primary Care Physician was contacted several times and V11 did not sign the script for a couple of weeks.On 3/2/26 at 3:06 PM, V16/Pharmacist stated that the Testosterone cream was originally ordered on 2/6/26 then discontinued on 2/15/26. The order was put in again by a nurse on 2/16/26 and the pharmacy still could not fill the order because it was not signed by a doctor. On 2/25/26 the pharmacy got an order signed by V11/R17's Primary care Physician and the pharmacy then filled the order. V16 also stated that when a resident first goes to the facility the nurses put the orders in to send them to the pharmacy. If the order includes a narcotic the pharmacy will not fill that order until they get written authorization from the doctor.On 3/3/26 at 10:43 AM, V17/Current Director of Nursing stated that she was not working at the facility when R17 was not getting his Testosterone cream. V17 stated that she sees that R17 should have been getting medication when R17 admitted to the facility on [DATE] and that he did not get it until 2/27/26. V17 also stated that she cannot find a policy that addresses medication not being delivered or given as ordered.

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	146100	A. Building B. Wing	03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Cass County Senior Living & Rehabilitation LLC	530 East Beardstown Street Virginia, IL 62691

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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 - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to ensure residents were free from accident hazards and received adequate supervision and assistive devices to prevent accidents for one (R27) of one resident reviewed for accidents in the sample list of 24. This failure resulted in (R27), a resident prescribed a blood thinner (Eliquis), falling from a wheelchair and striking his head on the floor, sustaining a large, painful discolored area to the back of the head. Findings include: The facility's Change in a Residents' Condition or Status policy revised 5/2017 documents our facility shall promptly notify the resident, his or her attending Physician, and representative of changes in the resident's medical/mental condition and/or status (changes in level of care, resident rights, etcetera) The Nurse will notify the residents attending physician on call when there has been an accident or incident involving the resident. The nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status. R27's Minimum Data Set Assessment (MDS) dated [DATE] documents R27 is severely cognitively impaired. This same MDS documents, R27, requires substantial/maximum assistance for transfers and is dependent on staff for dressing.R27's care plan documents R27 is at risk for falls due to his cognitive status and prior history of falls and is at risk for abnormal bleeding or hemorrhage related to the use of anticoagulant therapy related to personal history of pulmonary embolism.R27's Physician Orders revealed R27 was prescribed Eliquis Oral Tablet 5 milligrams (mg) twice daily, related to chronic embolism and thrombosis of unspecified deep veins of the left lower extremity, with a start date of 2/19/26. R27's Fall Risk assessment dated [DATE] documents R27 is at risk for falls.R27's Risk Management Assessment documented R27 experienced a fall on 2/27/26 in his room while with Certified Nursing Assistants (CNAs). R27's Nurse Progress Note dated 2/27/26 at 7:33 AM documented that at approximately 6:00 AM a CNA notified the nurse that the resident had fallen. Upon entering the room, the nurse observed R27 lying on the floor but still in a seated position in his wheelchair, lying on his back with his head under a pillow. CNAs reported they were dressing the resident when he leaned back and the wheelchair tipped backward, causing him to fall onto the floor. A head-to-toe assessment identified an abraded area to the back of the resident's head, dark red in color and approximately the size of a quarter. Vital signs and neurological checks were within normal limits. R27 was assisted back to bed by three staff members, and anti-tippers were applied to the back of the wheelchair as an immediate intervention.R27's Electronic Medical record does not contain measurements for the abrasion on the back of R27's head.R27's Pain Comprehensive assessment dated [DATE] documents Resident is unable to describe pain just says, back of my head.R27's Nurse Progress Note dated 2/28/26 at 4:00 AM documented V11 (R27's Physician) was notified by fax and indicated to continue to monitor the resident following the fall and staff would continue to follow the plan of care.On 3/1/26 at 11:00 AM, R27 was sitting up in his wheelchair with a mechanical lift sling underneath him and a baseball sized discolored area on the back of R27's head. On 3/02/2026 at 12:09 PM, V13 (Certified Nursing Assistant/CNA) stated she was working day shift on 2/27/26 when R27 fell. V13 stated she was not in the room at the time of the fall, but V12 and V14 (CNAs) were in the room. V13 stated she was asked to assist with getting R27 off the floor. V13 further stated V12 reported that after placing the resident in the wheelchair she lifted R27's legs to look underneath him for a shirt, at which time the wheelchair tipped backward and the resident fell.On 3/02/2026 at 12:45 PM, V2 (Former Director of Nursing) stated she was currently typing V12 and V14's witness statements related to R27's 2/27/26 fall investigation. V2 stated she had been instructed by V1(Administrator) that she was not allowed to provide the original witness statements because they were considered part of the facility's Quality Assurance (QA) process. V2 stated she was instructed to retype V12 and V14's witness statements and provide the typed versions instead. V2 further stated (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the surveyor could attempt to contact V12 (CNA) directly but indicated V12 would likely not answer the phone.On 3/02/2026 at 12:55 PM, V12 (CNA) stated she and V14 (CNA) had transferred R27 to his wheelchair using a mechanical lift. V12 stated she could not locate R27's shirt and believed it might be underneath him. V12 stated she lifted R27's legs up while he was seated in the wheelchair to check underneath him and the wheelchair tipped backward, causing R27 to fall backward and strike his head on the floor. V12 stated V14 went to notify the nurse. On 3/02/2026 at 1:15 PM, V1 (Administrator) stated the facility did not have to provide the witness statements from the 2/27/26 fall investigation because they were part of the facility's Risk Management Quality Assurance process.On 3/02/2026 at 1:45 PM, V11 (R27's Physician) V11 stated she would trust the nurse to call if there was a significant change and indicated that if a resident fell from a wheelchair and hit their head there would be impact and the physician should have been notified by phone rather than by fax since R27 was receiving a blood thinner and fell backwards from his wheelchair and hitting the back of his head.On 3/2/26 at 1:50 PM, V1 provided V12 and V14's original witness statements to incident on 2/27/26.R27's Fall Witness/Last Interaction statement dated 2/27/26 from V12 (CNA) at 6:00 AM, documents V12 and V14 transferred R27 to his chair while getting R27 ready. We were unable to find his shirt and thought we may have sat him on it. V12 checked under R27's legs and the wheelchair fell back.R27's Fall Witness/Last Interaction statement dated 2/27/26 from V14 (CNA) documents At about 6:05 AM we had just transferred R27 to his wheelchair and we could not find his shirt we had layed out for him. We thought it could possibly be underneath R27 in his wheelchair so V12 lifted R27's legs attempting to see if the shirt was underneath him when his wheelchair fell over backwards. On 3/03/2026 at 2:00 PM, V15 (Director of Nursing) stated the Medical Director should have been notified by phone regarding R27's accident on 2/27/26. V15 confirms she cannot find documentation that V11 was notified of R27's accident by phone. V15 further confirms R27's Fall investigation is not included in R27's Medical Record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to replace oxygen tubing and humidifier bottle for one two residents (R1) reviewed for oxygen in the sample of 24.Findings include:The facility Oxygen Administration policy dated 10/2010 documents The purpose of this procedure is to provide guidelines for safe oxygen administration.The Administering Medication through a Small Volume (Handheld) Nebulizer dated 10/2010 documents The purpose of this procedure is to safely and aseptically administer aerosolized particles of medication into the resident's airway. Steps in the Procedure 30. Change equipment and tubing every seven days, or according to facility protocol.R1's Face Sheet documents that R1 is a [AGE] year-old that was admitted to the facility on [DATE] with diagnoses which included Acute Respiratory Failure, Chronic Obstructive Pulmonary Disease, and Vascular Dementia, Mild, with Other Behavioral Disturbances.R1's Care Plan documents that R1 is at risk for Respiratory complications and requires oxygen. Start date 12/8/25.On 3/2/26 at 2:30 PM, R1 was sitting in his room wearing oxygen. The humidifier bottle that was attached to the oxygen concentrator was dated 2/22/26.On 3/2/26 at 2:35 PM, V15/Licensed Practical Nurse verified that the humidifier bottle was dated 2/22/26. V15 stated that the humidifier bottle should have been changed on the night shift (3/1/26) along with the oxygen tubing. On 3/3/26 at 11:15 AM V20/Registered Nurse stated that oxygen tubing/nebulizer equipment and humidifier bottles are to be changed every seven days on Sunday nights. On 3/3/26 at 12:30 PM, V17/Current Director of Nursing stated that she does not see in the oxygen policy that the oxygen tubing and humidifier bottles should be changed every seven days but that is standard procedure. V17 also stated that oxygen equipment is handled the same as nebulizer equipment.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to apply a gown prior to providing high-contact care for a resident with a wound for one of one resident (R6) reviewed for EBP (Enhanced Barrier Precautions) in the sample of 24. Findings include: The Enhanced Barrier Precautions Sign, undated, documents Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and Staff Must Also: Wear gloves and a gown for the following High-Contact Resident Care Activities- Dressing, Bathing/Showering, Transferring, Changing Lines, Providing Hygiene, Changing Briefs or Assisting with Toileting, Device Care or Use: Central Line, Urinary Catheter, Feeding Tube, Tracheostomy, Wound Care (any skin opening requiring a dressing).The facility's Enhanced Barrier Precautions Policy, dated 3/28/24, documents Definition: EBP (Enhanced Barrier Precautions) expand the use of PPE (Personal Protective Equipment) and refer to an infection control intervention designed to reduce transmissions during MDRO's (Multidrug-Resistant Organisms) that employs targeted gown and glove use during high contact resident care activities. The use of gown and gloves for high-contact resident care activities is indicated for residents with chronic wounds or indwelling medical devices, regardless of their MDRO status, in addition to residents who have [NAME] infection or colonization with CDC (Centers of Disease Control) targeted or other epidemiologically important MDRO when contact precautions do not otherwise apply. Policy and Interpretation: EBP will be instituted for those residents deemed to be at high risk for MDROs with any of the following: Wounds and/or indwelling medical devices even if the resident is not known to be infected or colonized with MDRO. Wounds generally include chronic wounds, not shorter-lasting wounds, such as skin breaks or skin tears covered with an adhesive bandage or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and venous stasis ulcers. EBP should be used for any resident who meets the above criteria, wherever they reside in the facility. Examples of high-contact resident care activities requiring gown and glove use for EBP include Dressing, Bathing/Showering, Transferring, Providing Hygiene, Changing Linens, Changing Briefs or assisting with toileting needs, Device Care of Use (Central Line, Urinary Catheter, Feeding Tube, and Tracheostomy/Ventilator, and Wound Care (any skin opening requiring a dressing).R6's Order Summary Report, dated 3/3/26, documents Stage II coccyx-apply Calcium Alginate with Silver, cover with border gauze dressing, change daily and as needed for soiling or non-adherence every night shift for wound healing. On 3/2/26 at 10:00 AM, V15/LPN (Licensed Practical Nurse) was preparing wound treatment for R6's pressure sore to R6's coccyx. Upon entering R6's room, R6's door had a sign that stated R6 was in EBP. V15 donned on gloves, performed R6's wound treatment. R6's wound was located on R6's coccyx, open, and had small amount of drainage. V15 never applied a gown during the entire wound procedure. On 3/2/26 at 10:07 AM V15/LPN verified he did not wear a gown during R6's wound care and should have. V15 stated, I knew I was forgetting something. We (staff) should be wearing gowns and gloves for any resident with an open wound.