STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146119	A. Building B. Wing	02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven on the River	320 South 2nd Street Grayville, IL 62844

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to maintain a resident's right to receive timely care and be treated with dignity for 4 of 18 residents (R2, R5, R6 and R12) reviewed for resident rights in a sample of 18. This failure has the potential to affect 26 residents residing on the North Hall.The findings include:1. R2's admission record, dated 02/02/26, documents an admission date of 11/23/2022 with diagnoses in part of chronic respiratory failure with hypoxia, type 2 diabetes mellitus, morbid obesity, lack of coordination, and hypertensive heart and chronic kidney disease with heart failure.R2's Care Plan documents a focus are with a date initiated of 08/27/25, of R2 is at risk for impaired skin integrity r/t (related to) history of vascular wounds, hx (history) of MASD (Moisture Associated Skin Damage): refusing to be turned and repositioned and prefers to lie in one position: dx (diagnosis) DMII (Diabetes Mellitus Type 2), chronic resp (respiratory) failure with hypoxia, COPD (Chronic Obstructive Pulmonary Disease), candidiasis, HTN (Hypertension), gout; renal disease; noncompliance with diabetic tx (treatment) regimen; takes SQ (subcutaneous) insulin; CHF (Congestive Heart Failure); has sensory impairment; skin is constantly moist r/t incontinence and perspiration; confined to bed; unable to make major changes in position without assistance requires max assist. Another focus area, with a date initiated of 10/20/25, R2 has ADL (Activities of daily living) self-care performance deficit r/t requiring extensive assistance with most ADL's r/t reduced mobility, lack of coordination, impaired mobility, weakness with an intervention of encourage resident to use call light when assistance is needed.R2's Minimum Data Set (MDS), dated [DATE], documents in Section C a Brief Interview for Mental Status (BIMS) score of 14, which indicates R2 is cognitively intact. Section GG documents R2 is dependent on staff for toileting and repositioning. Section H documents R2 has an indwelling catheter and is always incontinent of bowel.On 01/22/26 at 10:35AM, R2 stated she had to wait over 30 minutes last night for someone to come answer her call light. R2 said she is glad she really didn't need anything important. R2 had her call light on to see what all staff were working on 01/21/26 for the 6p to 6a shift. R2 stated, They must not have a lot of staff because it took forever for them to answer my light, and when someone did answer my light, it was (V1, Administrator) who answered my call light. R2 said that she has problems like this all the time, especially in the evening where it will take the staff 30 minutes to an hour to answer her call light. R2 said usually they have just 1 certified nurse assistant on her hall and 1 certified nurse assistant on the other hall. 2. R5's admission Record, dated 02/02/26, documents admission to the facility on [DATE], with diagnoses of Parkinson's disease, COPD, panic disorder, and fibromyalgia.R5's Care Plan, documents a focus area with a date initiated of 12/28/2021 R5 has self-care deficit as evidenced by: needs assistance with Adl's other lack of coordination, other abnormalities of gait and mobility, unsteadiness on feet, Parkinson's and another focus area of at risk for falls and injuries r/t medications: psychotropic meds/diuretic meds/cardiovascular meds/pain meds medical (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	factors: pain with intervention on 09/23/23 of call don't fall sign in room and keep call light within reach.R5's MDS, dated [DATE], Documents in Section C a BIMS score of 10, which indicates R5 has moderately impaired cognition. Section GG documents R5 require set-up and clean up help with toileting hygiene and bed to chair and chair to bed transfers. Section H documents R5 is occasionally incontinent with bladder and bowel.On 01/28/26 at 1:29PM, R5 who was alert and oriented to person place and time stated she had to wait over an hour several nights ago for someone to answer her light on evening shift. R5 stated her bed was soaked, and she was freezing from laying in her urine. R5 said she gets mad about having to wait for staff to answer the call light, but she knows they don't have a lot of staff working, so she tries to be patient. R5 said if she is still in her wheelchair, she will hit her call light and wheel out to the hall just to see if she can find a staff member to help her out.3. R6's admission record, dated 02/02/26, documents R6 was admitted to the facility on [DATE], with diagnoses of permanent atrial fibrillation, chronic respiratory failure, type 2 diabetes mellitus, unsteadiness on feet, lack of coordination, and chronic pain.R6's Care Plan documents a focus area with a date initiated of 12/07/25 of the resident (R6) is (Specify high, moderate, low) risk for falls r/t with intervention of be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. The resident needs prompt response to all request for assistance. R6's MDS, dated [DATE], Documents in Section C a BIMS score of 14, which indicates R6 is cognitively intact. Section GG documents R6 is dependent with toileting hygiene. Section H documents R6 is always incontinent of bladder and bowel.On 01/22/26 at 2:21PM, R6 stated last night, she had her call light on several times, and she had to wait at least 30-45 minutes for a staff member to come answer her light. R6 said she rang her call light because she needed to be changed and she had to lay in urine the whole time she waited. 4. R12's admission Record , dated 02/02/26, documents an admission date of 05/14/21 and diagnoses of hemiplegia and hemiparesis, type 2 diabetes mellitus, COPD, morbid obesity, personal history of transient ischemic attack diagnoses of acute respiratory disease, neurocognitive disorder with Lewy bodies, dementia in other disease classified elsewhere, unspecified severity, with other behavioral disturbance, stiffness right knee, pain, diarrhea, cellulitis of right toe, depression, osteoarthritis, obstructive sleep apnea, normal pressure hydrocephalus, hyperlipidemia and Parkinson's disease.R12's Care Plan documents a focus area ,with a date initiated of 10/31/25, of R12 has an ADL self-care performance deficit r/t dx (diagnosis): hemiplegia and hemiparesis following CVA (Cerebral Vascular Accident) affecting left, non-dominant side; diabetes with peripheral angiopathy; COPD; obesity; phlebitis; heart disease; a-fib (atrial fibrillation); mood disorder; anxiety; PVD (Peripheral Vascular Disease); vision impairment; Anemia; dorsalgia; depression. Another focus area with a date initiated of 02/10/2022 of R12 is at risk for falls, risk for injury from falls with an intervention of encourage use of call light.R12's MDS, dated [DATE], documents in Section C a BIMS score of 15, which indicates R12 is cognitively intact. Section GG documents R12 is dependent with toileting hygiene and transfers. Section H documents R12 is always incontinent of bladder and bowel.On 01/22/26 at 10:42AM, R12 stated she was on her call light for over 30 minutes last night. R12 said she called the nurses' station even to see if she could get some help. R12 said she needed to be changed because she had an incontinent episode and was just lying there waiting on someone to come answer her light. R12 said finally, V2 (Director of Nursing) finally came and answered her light. R12 stated it happens often in the evening time waiting on staff to answer the call lights andshe just has to sit there and wait it might take 30-45 minutes, sometimes an hour, for them to answer the call lights.On 01/21/26 at 6:36PM, V2 (Director of Nursing) stated they only had V19 (Certified Nurse Assistant/CNA) and V18 (CNA) in the facility working the floor at this time. V2 (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	said they had one CNA call in and another CNA hadn't called at all or showed up. V2 said they had an agency nurse that was the nurse on duty working tonight who had never been at the facility before. V2 said she did have another CNA, V14, coming back into the facility to help out on the floor.On 01/21/26 at 6:45PM, V19 (CNA), who was working on North Hall, was observed taking residents outside to go smoke. There was no other CNA observed working on North Hall. On 01/21/26 at 6:50PM, observed 4 call lights going off down North Hall in 4 separate rooms.On 01/21/26 at 7:00PM, V19 (CNA) walked in from outside with the residents and she stated one of the residents wasn't feeling good. Call lights were still going off on North Hall in the rooms previously observed.On 01/21/26 at 7:03PM, V2 asked V19 (CNA) to go down to a room and get the vital machine and take the resident who was feeling sick vitals who was in the dining room. Call lights were still going off on North Hall in the rooms previously observed.On 01/21/26 at 7:06PM, V19 (CNA) answered the phone. V19 appeared very upset and said R12 had called and was wanting help. Call lights were still going off on North Hall in the 4 rooms previously observed.On 01/21/26 at 7:15PM, an unknown resident's voice was heard yelling from North Hall for help. Call lights were still going off on North Hall in the rooms previously observed.On 01/21/26 at 7:21PM, V19 (CNA) went into a room to answer the call light. Call lights were still going off in 3 of the 4 rooms previously observed.On 01/21/26 at 7:22PM, V1 (Administrator) went into a room to answer the light call.On 01/21/26 at 7:23PM, call light was off in room that had previously been activated.On 01/21/26 at 7:41PM, observed V14 (CNA) arriving at the facility to clock in.On 01/21/26 at 7:50PM, observed room [ROOM NUMBER] call light was off.On 01/29/26 at 11:09AM, V1 (Administrator) stated he feels like staff answer the call lights in a timely manner. V1 said it just depends on the CNA. V1 said he doesn't think if they have only 1 CNA down a hall that the CNA should be taking the residents out to smoke and leaving no staff on the hallway.The facility daily census, dated 01/20/26, documents a total of 26 residents reside on the North Hall. A review of facility policy titled Answering the Call light (revised 08/2008) documents under Purpose The purpose of this procedure is to respond to the residents requests and needs.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety 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 follow physician's orders and failed to assess and monitor a resident's declining condition for 1 of 3 residents (R1) reviewed for quality of care in a sample of 18. This failure resulted in R1's hospital admission for acute kidney injury and hyperkalemia requiring emergent dialysis and subsequent death.This failure resulted in Immediate jeopardy, which was identified to have begun on 12/28/25 when the facility failed to obtain physician ordered labs of CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel) and TSH (Thyroid-stimulating hormone) for R1. The facility failed to follow up on UA (Urinalysis) and Culture and Sensitivity lab results that was ordered for R1 on 12/28/25. The facility failed to notify the physician of a decline in R1's condition. This failure resulted in R1 not getting timely medical treatment, which resulted in R1 being sent out the hospital on [DATE] by V25 (Family Member) and requiring emergent dialysis and then transferred to palliative care, and R1 's death on 01/21/26. V1 (Administrator) was notified of the Immediate Jeopardy on 1/29/26 at 4:38PM. The immediacy was removed on 1/30/26, but non-compliance remained at a Level Two because additional time is needed to evaluate the implementation and effectiveness of In-service training.The Findings include:1.R1's admission Record documents an admission date of 12/26/25, with diagnoses of acute on chronic combined systolic (congestive) and diastolic heart failure, dysphagia, chronic obstructive pulmonary disease, pneumonitis due to inhalation of food and vomit, acute kidney failure, emphysema, type 2 diabetes mellitus, and secondary hyperparathyroidism.R1's Minimum Data Set (MDS), dated [DATE], documents in Section C, Cognitive Patterns, a Brief Interview for Mental Status (BIMS) score of 15, which indicates R1 is cognitively intact. Section GG, Functional Abilities, documents toileting as substantial/maximal assistance. Section H, Bladder and Bowel, documents appliances as indwelling catheter.R1's Care Plan documents a focus area of R1 is at risk for alteration in psycho-social well-being d/t (due to) mood state, health decline and facility placement with a date initiated of 01/02/26. R1 has another focus area of R1 has noted delirium or an acute confusional episodes AEB (as evidenced by) him being easily distracted at times date initiated 01/02/26 with an intervention of report abnormal lab results to the MD (Medical Doctor). Another documented focus area is R1 has potential nutritional problem r/t (related to) dysphagia, therapeutic diet of NAS (No Added Salt)/LCS (Low Concentrated Sweets), mechanical soft per SLP (Speech Language Pathologist) diet restrictions with interventions of provide, serve diet as ordered, monitor intake and record every meal. There were no documented focus area on Diabetes Mellitus or Indwelling Catheter.R1's Progress Note, dated 12/28/25 at 2:00PM, documents Resident has not taken any food/nectar thick liquids this shift. Refuses to even with strong coaching from staff and family. Bladder palpated/firm. #16fr (French) foley [NAME] [sic] (Catheter) anchored with 450 mls. (milliliters) clear yellow urine received. Resident has not responded verbally this day. Squints eye closed. Did respond to insertion of Foley. (Medical Doctor) notified of resident condition and condition. Awaiting further orders at this time.R1's Progress Note, dated 12/28/25 at 2:37PM, documents, new orders rec'd (recorded) from (V27-Medical Doctor) start Megace Elixir 800mg once a day CBC (Complete Blood Count), CMP (Comprehensive Metabolic Panel), TSH (Thyroid-Stimulation Hormone), UA (urinalysis) and Urine Culture start protein supplement each meal TID (three times a day) have nutrition see patient have psychiatrist see patient.R1's Order Summary documents the following orders: Catheter- Record output from urinary catheter every shift order date of 01/07/26, with an order status of discontinued; Lasix 20mg by mouth one time a day related to acute on chronic combined systolic (Congestive) and diastolic (Congestive) heart failure, with an order date of 01/076/26, with an order status of discontinued; CMP (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(Complete Metabolic Panel), TSH (Thyroid-Stimulation Hormone), CBC (Complete Blood Count) one time only for per lab parameters until 12/29/25, with an order date of 12/28/25 and a start date of 12/29/25; UA (Urinalysis) with C &S (Culture and Sensitivity) only for prophylaxis until 12/29/25 with an order date of 12/28/25 and a start date of 12/29/25; Accucheck in the morning for DMII (Diabetic Mellitus type 2), with an order date of 12/26/25 and a start date of 12/27/25.R1's Order Summary does not document an order for an indwelling catheter or an order for instant glucose in December or January. R1's Progress Note, dated 01/11/26 at 5:55PM, documents, (V25-family member) coming to the nurses station saying her brothers blood sugar is low at 70 asking for orange soda, liquid glucose given. Now on [sic] hour later she states she is calling 911 because her brother cannot breathe and his glucose is low. Sats 92 on room air respers [sic] (respirations) even and unlabored. Resident has no pain, skin warm and dry. Pulse 74 glucose 117, bp (blood pressure) 112/64. Advised her that this is not an emergency situation.R1's Progress Note, dated 01/11/26 at 6:24PM, Resident leaving with EMS (Emergency Medical Services).R1's Progress Note, dated 1/12/2026 at 12:57 AM, documents, admitted [sic] to (name of out of state hospital) in (room number). Waiting on nephrologist to make rounds in the morning to decide any further medical decisions .dialysis.R1's Medication Administration Record for 01/01/26 to 01/31/26 documents accucheck in the morning for DMII (Diabetes Mellitus type 2) 5:00AM with a start date 12/27/25 and a D/C (discontinued) date of 01/13/26. On 01/04/26, 1/8/26, and 1/11/26 there is no accucheck documented.R1's Treatment Administration Record for 01/01/26 to 01/31/26 documents Catheter: record output from urinary catheter every shift start date of 01/07/26 and a discontinued date of 01/13/26. Recorded amounts documented: 01/07/26 night 200, 01/08/26 day 300cc (cubic centimeter) and night 400, 01/09/26 day 300 and night 450, 01/10/26 day none recorded and night 350, 01/11/26 day 200 and night none recorded.R1's ambulance Prehospital Care Report, dated 01/11/26 at 6:11PM, documents under narrative was dispatched to (the facility) for a [AGE] year old male with a possible UTI (Urinary Tract Infection) and low blood sugar. Upon our arrival, the patient was found in his room with his sister. The nurse had said she did not call 911 that it was the sister even though they could not find any reason to send him to the hospital. The sister informed us that she had given him glucose after the nurse had thrown it at her to do herself when she had refused. The nurse refused to come into the room and assist in moving the patient or talk to anyone once we entered the room. The sister said after she gave him the glucose the patient was a little more awake, she fed him fruit that also helped his sugar and made him feel a little more awake. The sister and patient wanted him to go (Local Hospital) due to the possibility of a UTI that has been getting worse over the past week and no one doing anything about it. He had a catheter in place and it was cloudy with specks of blood in it. He said it has been burning and lower abdomen sore feeling the need to urinate but cannot. He was placed on oxygen 3 L/Min (Liters per minute) by nasal cannula on scene and it helped bring his oxygen level up. Spo2 (Saturation of Peripheral oxygen) at 5:21PM was 89%.R1's Local hospital records, dated 01/11/26, documents under Medical Decision Making: [AGE] year-old Caucasian male who is brought in by EMS (Emergency Medical Services) after stating that he feels horrible in the nursing home he is there for rehab after having an illness which put him in the hospital. He states that he is not getting any better he feels weaker he has been hurting in his whole-body for last couple days he has a urinary catheter in because of urinary retention, but is not putting out urine and the while area is hurting. Discussion of management or test interpretation with external provider document called (outside hospital) transfer center for a bed for acute renal failure needing dialysis at 7:32PM. Clinical Impression: 1. Acute renal failure 2. Hyperkalemia.R1's hospital records from the out of state hospital, dated 01/11/26 ,documents under hospital course: This 66 yo (year (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	old) male with PMHX (Past Medical History) significant for IDDMII (Insulin Dependent Diabetes Mellitus Type 2), COPD (Chronic Obstructive Pulmonary Disease), HTN (Hypertension), hyperlipidemia, hyperthyroidism, GERD (Gastroesophageal Reflux Disease), CKDIIIa (chronic kidney disease stage 3) and RA (Rheumatoid Arthritis). Patient transferred from SNF (Skilled Nursing Facility) to OSH (Outside hospital) ER (emergency room) with lethargy and decreased UOP (urinary output) from foley (catheter). He was transferred from OSH ER to (outside hospital) with BUN (Blood Urea Nitrogen) 90, creatinine >7, & K (potassium) 6.4 for higher level of care. Nephrology consulted, dialysis access was emergently placed and HD (hemodialysis) run after inadequate response to medical treatment for hyperkalemia. MWFT (Mid Way Feeding Tube) placed for medications and nutrition. Patient failed swallow and SLP (Speech Language Pathologist) noted results of recent MBSS (Modified Barium Swallow Study). SLP recommended PEG (Percutaneous Endoscopic Gastrostomy) placement. GI(Gastrointestinal) consulted for EGD (Esophagogastroduodenoscopy) to eval potential causes for severe dysphagia & consideration for PEG. Palliative care consultation requested to help further delineate goals of cares patient's wishes seemed to oscillate. While here, Rocephin and doxycycline continued to cover for possible CAP (Community-Acquired Pneumonia) Given constellation of Sx (Symptoms) and imaging, there was concern for nephrotic syndrome. Kidney bx (biopsy) recommended but not pursued due to Plavix use. Edema improved since HD initiated. Ultimately, patient elected to stop hemodialysis. He was evaluated for inpatient hospice and discharged there when bed became available. He was discharged to hospice on 01/21/26.On 01/20/26 at 12:22PM, V6 (Assistant Director of Nursing) said she was the nurse taking care of R1 on 01/11/26. V6 said she didn't take over R1's care until around 4:30PM on 01/11/26. V6 said the other nurse (V8, Registered Nurse/RN) didn't leave until around 5:00PM that day. V6 said V8 had been R1's nurse all day. V6 said she has maybe taken care of R1 one other time during the day shift and one night shift. V6 said V25 came out and was asking for an orange soda she didn't know who it was for, if it was for R1 or herself (V25). V6 saidV25 went and got change and came back to get the soda. V6 said V25 came out saying R1's sugar was running low. V6 said she didn't know how V25 knew R1's blood sugars were running low. V6 said V25 said his blood sugar was running in the 60's. V6 said she gave V25 a tube of instant glucose. V6 said she doesn't know why she gave it to V25 to give to R1. V6 said she doesn't know if V25 should have administered the instant glucose or not. V6 said V25 had a device to tell her what R1's blood sugars were. V6 said she didn't check R1's glucose at the time V25 said it was low. V6 said V25 said R1's blood sugars were running low all day. V6 said V25 had some kind of device in her hand waving it around. V6 said V25 was mad. V6 said V25 stated R1's blood sugars were 69 and 65. V6 said V25 was saying blood sugars were low but the dinner tray was coming in a few minutes. V6 said V25 gave the instant glucose to R1, and she told me she was going to call 911 because she felt that he was neglected. V6 said she went and got his vital signs after the sister told her that. V6 said she told V25 it wasn't an emergent situation and R1's vitals were normal. V6 said sometimes R1 wouldn't respond to staff. V6 said she tried to call V1 (Administrator) and V2 (DON) to let them know what was going on, but she was unable to get ahold of either of them and they didn't call her back. V6 said she wasn't able to print off any of R1's paperwork to be able to send to the hospital with R1 because the printer wasn't working. V6 stated she told V2 before the weekend that she wasn't able to print out papers. V6 said R1 didn't have any oxygen on and his oxygen saturation was 92% on room air. V6 said she doesn't think R1 had an order for oxygen. V6 said she thinks R1 did get breathing treatments earlier that day before R1 went to the hospital. V6 said R1 recently had gotten a catheter in as well at the facility.On 01/20/26 at 1:24PM, V8 (RN) said she remembers being told R1 went out to the hospital. V8 said she took care of R1 on 01/11/26 from 7AM to around 4:30PM-5:00PM. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	V8 said R1 wasn't complaining of any pain, shortness of breath, or low blood sugars. V8 said R1 had oxygen orders as needed. V8 said R1 wasn't on oxygen on 01/11/26. V8 said R1 only got oxygen to maintain his oxygen levels on room air. V8 said R1 had 4+ pitting edema to both of his lower extremities when he was admitted to the facility. V8 said R1 did have an indwelling catheter in, and she was the one who put the catheter in. V8 said a Certified Nurse Assistant had told her R1 hasn't urinated in several hours, so she put a catheter in and got back urine right away. V8 said V25 was concerned about R1's urine. V8 said R1 wasn't drinking a lot, and they were trying to encourage him to drink fluids often. V8 said R1 already had a history of kidney and bladder issues. V8 said she told R1 all the time that he needed to eat and drink. V8 said R1 didn't really complain of any pain or discomfort to the catheter area, the only thing R1 complained about was feeling sick.On 01/20/26 at 2:21PM, V16 (Certified Nurse Assistant/CNA) stated R1 wasn't really drinking very well while at the facility.On 01/21/26 at 11:02AM, V12 (Certified Nurse Assistant) stated she wasn't really taking care of R1 on 01/11/26. V12 said she did go in with V6 (RN) on 01/11/26 to take R1's blood sugar and vitals after V25 called 911. V12 said she was with V6 and R1's oxygen levels were within normal limits, but R1 was acting like he couldn't breathe. V12 said she was working on 12/28/25 when V8 was going to send R1 out to the hospital. V12 said V8 went in to check on R1, she said R1 wasn't responding to anyone then he was in the bathroom and took himself and was talking.On 01/21/26 at 11:20AM, V15 (CNA) stated he didn't really take care of R1; he only went over to take care of R1 when he went over to take the food trays or pick them up or to maybe check on him. V15 said he remembers R1 being out of it and he would try to wake him up. V15 said he emptied R1's urinary catheter bag a couple of times and R1 would have very little urine in his indwelling catheter bag. V15 saidthey tried to get R1 to drink; he said R1 liked tea and he would get R1 tea, but he really wouldn't drink much. V15 said R1 was a poor eater.On 01/21/26 at 11:26AM, V14 (Certified Nurse Assistant) stated on 1/11/26, V6 (Assistant Director of Nursing) told her V25 was calling 911 and said we weren't taking care of R1. V14 said she was the one to check R1's oxygen level. V14 said she had to go in and take the Spo2 monitor off of R1's finger.On 01/20/26 2:40PM, R1's lab results per orders documented on 12/28/25 were unable to be located in R1's chart. These lab results were requested from V2 (Director of Nursing) at this time.On 01/21/26 at 12:13PM, V2 (Director of Nursing/DON) stated R1 did have an order for CBC, CMP, TSH, and UA with culture and sensitivity. V2 stated the UA was completed and she did not have the results of the UA or the culture and sensitivity back yet. V2 said the CBC, CMP, and TSH were ordered on 12/28/25 but the nurse who put the order in put the order on the wrong flow sheet, which they don't use anymore. V2 said the orders did not populate to the EMAR (Electronic Medication Administration Record) for the nurse to obtain. V2 said the labs were never done because of this.On 01/21/26 at 2:30PM, R1's urinalysis culture and sensitivity report was provided and documented a collection date of 12/30/25 and printed date of 01/21/26 at 12:30PM. This report documented final: > 100,000 CFU/ML (Colony-forming units per milliliter) Pseudomonas fluorescens and >100,000 CFU/ML Enterococcus Faecalis.On 1/21/26 at 1:25PM, V8 (RN) stated, I went into (R1's) room on 12/28/25 and (R1's) eyes were closed and (R1) didn't look right. (R1) was breathing normal but wasn't responding. I rubbed (R1's) shoulder and took my fingers and tapped (R1) on the cheek. I looked at (R1's) eyes, but (R1) didn't respond so I did a sternal rub and called (V27, MD) and took (R1's) vitals. He has been in fluid retention and he did grunt when I put a catheter in (R1). V8 said she put a catheter in R1 because he wasn't urinating. V8 said she went to the nurse's station to get paperwork ready to send R1 out. After she called V27, R1 had got himself up to go to the bathroom. V8 said she notified V27 who didn't order anything new, just that we didn't have to send R1 out to the hospital now. V8 said R1 was having (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	urinary retention, but it was because R1 wasn't drinking. V8 said she kept encouraging R1 to drink and he wouldn't. V8 said V27 gave an order for labs and urine. V8 said she didn't know if she got the urine sample when she put the catheter in R1 or not. V8 said she put all of this in the chart. V8 said she also put all of this on her report sheet for the next shift coming on. V8 said she put the indwelling catheter in when the CNA said R1 didn't have any output. V8 remembered she got around 450 ml of clear urine back. V8 said she put the indwelling catheter in when she did the assessment on R1 and then called the doctor, and he was ok with V8 putting in the indwelling catheter and gave V8 an order. V8 said she also reported the output to V27. V8 said V27 also put R1 on Megace to help with R1's appetite. V8 said sometimes R1 wouldn't respond or talk to staff.On 01/21/26 at 6:21PM, V18 (CNA) stated R1 was pretty sickly and R1 would hurt all the time when he moved. V18 said they put a catheter in R1 while he was at the facility. V18 said R1 would say that he had to pee all the time. V18 said R1 didn't have a lot of urine output. V18 said she would try to get R1 to drink.On 01/22/26 at 11:30AM, V22 (CNA) stated R1 did have some shortness of breath at times, but the nurse would check his oxygen level, and it would be good. V22 stated R1 wasn't really eating or drinking well.On 01/22/26 at 11:42AM, V2 (DON) stated they don't monitor fluid intake on a resident unless there is an order from the doctor, even if a resident has a catheter.On 01/22/26 at 12:47PM, V20 (CNA) stated R1 did have some shortness of breath at times. V20 said they would go get the nurse and she would check the oxygen levels and then go give R1 a breathing treatment.On 01/27/26 at 10:05AM, V25 (Family Member) stated R1 was admitted to the facility with a blood glucose sensor on so that way you can monitor his blood sugars with a phone. V25 said on 01/11/26 at 5:19PM, she went to see R1 and his blood sugars were low at 69 when she got to the facility. V25 said the monitor had shown her R1's blood sugars had been in the 60's all day on 01/11/26. V25 said when she got to the facility R1 was shaking and could hardly breathe. V25 said while R1 was at the facility, he never had oxygen on because he didn't have an order from the hospital for it when he was admitted . V25 said R1 had been on oxygen prior to him even going to the hospital prior to his admission to the facility. V25 said when she called 911 on 01/11/26, when the ambulance arrived, they said R1's oxygen level was 89% and they put oxygen on him right away to help get R1's oxygen level up, and they asked why R1 was not on oxygen. V25 said when she got to the facility, she told the nurse R1's blood sugars had been low all day and the nurse threw a tube of stuff at me and a spoon and told me to give it to (R1). V25 said she guessed it was something to help bring R1's blood sugars up. V25 said the nurse didn't give her any instructions on how to administer it or anything. V25 said she gave R1 the whole tube of medication. V25 said the nurse never came in to check what R1's blood sugars were. V25 said after the tube of medication was given, she was able to get R1's blood sugars up some and he was acting a little better. V25 said after a little bit, R1's blood sugars started dropping again, she could see it on the app on the phone. V25 said she went out and asked for an orange soda because R1 liked orange soda and the nurse told her they didn't have any soda; she would have to get it out of the vending machine. V25 said that she went out to get some change from her car for the vending machine. V25 said she gave R1 several things to help elevate R1's blood sugars. V25 said she asked the nurse about R1 going to the emergency room and she asked if they needed to call 911 or if she had to call 911. V25 said the nurse said it wasn't an emergent situation. V25 said the nurse didn't even come in and check R1's vitals until she called 911. V25 said after she called 911, the nurse then came in and checked R1's blood sugar and vitals. V25 said the nurse never came into R1's room until she called for an ambulance and then the nurse informed her that since it wasn't an emergent situation that she might have to bring R1 back by car or find another way to get him back to the facility. V25 said when the ambulance (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	arrived, they asked about why R1 wasn't on oxygen and why there was no urine in R1's indwelling catheter bag. V25 said the only drainage that was in R1's bag was some sludgy stuff that was in the tube of the bag. That was the only output R1 had. V25 said R1 was so bad when they got to the hospital, they had to send him out to another hospital right away to do dialysis on him. V25 said R1 was so bad they ended up putting him on palliative care. V25 said R1 expired of renal failure. V25 said R1 was also not eating or drinking well while he was at the facility.On 01/27/26 at 10:35AM, V4 (Regional Nurse in training/Previous DON) stated he knows R1 didn't like his pureed diet and he doesn't know what they did without looking in the chart about his diet. V4 said residents who have congestive heart failure or who are on dialysis are some of the residents they usually do input and output on, but only if the doctor ordered it. V4 said every now and then we get a standing order to push fluids, it depends on the doctor if they want input and output. V4 said they should be documenting if a resident isn't eating or drinking. V4 said family would be ok to give instant glucose if the resident isn't taking the instant glucose for staff, but a nurse should be monitoring the blood sugar before and after administering the instant glucose. V4 said, If a resident appears short of breath, I would take the oxygen saturation and if that comes back ok, I wouldn't go off of just that,I would probably administer oxygen around 2 liters. A nurse can start the oxygen then let the doctor know. In a critical situation a nurse can insert an indwelling catheter and then notify the doctor.On 01/27/26 at 1:46PM, V27 (Medical Doctor/MD) said his parameters for blood sugars are anything below 70 he would want them to give him a call, but that is a judgement call. He saidthe nurses deal with it a lot so he wouldn't necessarily need the nurse to call him if they had the blood sugar back up with juice or food. V27 said he wasn't aware R1 was given instant glucose. V27 said he doesn't know if a nurse should use instant glucose with a blood sugar of 67; he said he would expect the nurse to use critical judgement. V27 said he would expect a nurse to check a residents blood sugar before administering instant glucose and about 20-30 minutes after administering it. V27 said he is not aware of R1 having any urinary retention and he wasn't aware of R1 having an indwelling catheter put in or of him giving any order for an indwelling catheter. V27 said if a resident isn't eating or drinking well, he would expect the nurse to use her judgement call on when to call him. V27 stated he does not remember ordering a CBC, CMP, TSH, and a urine with Culture and Sensitivity. V27 said if he did order labs, he would expect those labs to be done in a timely manner, and he would expect the nurses to notify him what the lab results were. V27 said if the CMP had been done, it would help show if R1 had renal issues; it would have been helpful. V27 said with the outputs R1 had, he didn't think R1 had oliguria (abnormally low urine output). He said, We look at the resident for all kinds of things not just the urine output. We look for dehydration and we also look at the physical appearance of the resident as well to see if there is something going on with them. We look for low blood pressure and high pulse. V27 said he would give an order to monitor output when a resident has an indwelling catheter if there is a reason for the indwelling catheter.On 01/27/26 at 2:10PM, V5 (Regional Operations) stated she would assume for the reason they didn't have output monitoring on the day R1 had his catheter inserted on 12/28/25, was because they switched V2 from the MDS (Minimum Data Set) position to the DON position and she did the admission audits with her MDS assessments, but with everything changing she didn't have a chance to get to the MDS yet for R1. When V2 did do R1's assessment, V2 got an order to monitor the output for R1. V5 said V2 usually would review the charts and make sure all the orders are in correctly and she will catch stuff the nurse missed like R1's output order. V5 said if they put an indwelling catheter in a resident, they should put an order in the physician orders for the indwelling catheter. V5 said the labs on R1 were missing because the person putting the order (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	in put the order on the wrong flow sheet and not on the TAR (Treatment Administration Record) to let the staff know the labs needed to be done. V5 said this is something they didn't know until this happened to R1. V5 said with the new system, this didn't communicate over.On 01/28/26 at 10:16AM, V28 (Nephrologist) stated outputs of 700ml in 24 hours and 750ml in a 24-hour period aren't good outputs. V28 said those might be indicators of some renal problems or of poor fluid intake. V28 said there are several things that could cause a lower output. V28 also stated 350 ml and 200ml in a 12-hour period is not a good output as well. V28 said it could be indicators of renal failure or renal insufficiency. V28 said it would be hard to tell without looking at R1's lab results. V28 said if lab work was ordered that lab work should have been completed. V28 said it is a red flag as to why they weren't completed. V28 said if the labs would have been completed on the date that they were ordered it could have shown or indicated R1 was having renal insufficiency or renal failure. V28 said R1 already had renal problems prior to his admission to the hospital on [DATE]; he had an acute kidney injury. V28 said if you are putting a urinary catheter in for urine retention, you would most definitely monitor the output. V28 said that urinary retention, unresponsiveness, and confusion could all be indicators of renal problems such as insufficiency and failure, but without the labs being completed it is hard to say what was all going on at the time. V28 said if they had gotten the CBC and CMP it could have given the facility a better picture of what the resident had going on. V28 said if the labs had shown an elevated BUN and Creatine that it depends on how elevated it was, that could have been indicator of renal problems. V28 said if the levels were elevated, they should have notified the patient's doctor, and he would have decided if the resident needs to be sent to the hospital. V28 said, If the levels were high and he had the decreased output I would hope the primary physician would have sent the patient out to the hospital. V28 said she doesn't know if getting the labs completed on 12/28/25 would have changed the outcome of R1's death. V28 said it is hard to say 100% if the facility had completed the labs that R1 wouldn't have passed away. V28 said there are just too many ifs like did R1 have other things going on along with his renal problem. V28 said they could have maybe treated him sooner, but she doesn't know if the outcome would have been any different; it is so hard to say. V28 said by the time she treated R1 that his creatine was 7.7 and his BUN was 90. V28 said she needed to do a biopsy on his kidney, and they were unable to because R1 was on Plavix and they would have to hold it for several days and with everything going on he really didn't need the Plavix to be held. So, with the renal failure and everything else R1 had going on, the family and resident decided on palliative care. On 01/29/26 at 11:09AM, V1 (Administrator) stated even with a catheter unless a doctor orders for outputs to be recorded, they do not monitor outputs unless they have an order. V1 said that on 01/11/26 the nurse working called him and said R1's blood sugar was 70 and his oxygen level was 92% on room air and he doesn't remember the blood pressure and pulse, but they were within normal range. V1 said his outlook on 01/11/26 when R1 was sent out was the nurse told me when she called that R1's family was upset wanting R1 sent out because of R1's oxygen level at 92% on room air and R1's blood sugar being 70. V1 said he told the nurse at that time those readings are within normal limits and told the nurse to explain that to the family of R1 and if the family was adamant about sending R1 out, to send him out. V1 said ultimately R1 did get sent out because the family called 911. V1 said if a resident is more cooperative with the family, he could see a nurse giving the instant glucose to the family to give, especially if the resident is in the need for the medication. V1 said he thinks it would be ok if it was supervised by the nurse. V1 said they should have a physician order for the instant glucose along with an order for an indwelling catheter. V1 stated he does not know why they put an indwelling catheter in R1. V1 said he does not know why a UA with (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	C&S, CBC, CMP and a TSH was ordered. V1 said the CBC, CMP, and TSH did not get done because the order was not generated in the MAR (Medication Administration Record). V1 said, Usually it would pop up in the MAR and then the nurse would draw the lab, but now we have an outside lab that will come weekly to do labs along with the nurses still drawing labs. The lab they sent the urinalysis to was supposed to deliver the results to the facility. Nurses should have followed up on it. V1 said he doesn't know the process V2 used to get the C and S on the urine finally. V1 said it should have been checked up previously. V1 said he would hope the doctor would send out any resident with a change in condition if it is not treatable in house. V1 said he was not aware of any problems they were having with the printer at the facility.The facility policy titled Nursing Care of the Resident with Diabetes Mellitus, with a revised date of April 2007, under Purpose documents the purpose of this guidelines are: create individualized plan for each resident with diabetes mellitus, to review the most common and serious conditions and complications associated with diabetes, to help the resident control his/her diabetes with diet, exercise, and insulin (as ordered), prevent recurrent hyperglycemia/hypoglycemia, recognize, manage, and document the treatment of complications commonly associated with diabetes; and, individualize teaching according to carefully assessed resident and family needs. Under condition associated with diabetes #3. Hypoglycemia (Blood sugar below reference ranges) signs and symptoms of hypoglycemia usually have a sudden onset and may include the following: a. weakness, dizziness, or faintness, b. restlessness and/or muscle twitching, c. tachycardia (increased heart rate), d. pale, cool, moist skin, e. excessive perspiration, f. irritability or bizarre changes in behaviors, g. blurred, or impaired vision, h. headaches, i. numbness of the tongue and lips/thick speech, j. (more serve) stupor, unconsciousness and/or convulsions; and, k. (more serv

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, observation, and record review, the facility failed to ensure sufficient staff were available to provide needed care in a timely manner. This failure has the potential to affect all 45 residents residing in the facility.The findings include:On 01/22/26 at 10:35AM, R2 who was alert to person, place, and time, stated she had to wait over 30 minutes last night for someone to come answer her call light. R2 said she is glad she really didn't need anything important. R2 had her call light on to see what all staff were working on 01/21/26 for the 6p to 6a shift. R2 stated, They must not have had a lot of staff because it took forever for them to answer my light and when someone did answer my light it was (V1, Administrator) who answered my call light. R2 said she has problems like this all the time, especially in the evening where it will take the staff 30 minutes to an hour to answer her call light, she said usually they might have just 1 certified nurse assistant on her hall and 1 certified nurse assistant on the other hall. On 01/28/26 at 1:29PM, R5, who was alert and oriented to person place and time, stated she has to wait over a half hour several nights for someone to answer her light on evening shift. R5 stated her bed was soaked, and she was freezing from laying in her urine one night recently. R5 said she gets mad about having to wait for staff to answer the call light, but she knows they don't have a lot of staff working so she tries to be patient. R5 said if she is still in her wheelchair, she will hit her call light and wheel out to the hall just to see if she can find a staff member to help her out.On 01/22/26 at 2:21PM, R6 who was alert to person, place, and time, stated last night she had her call light on several times, and she had to wait at least 30-45 minutes for a staff member to come answer her light. R6 said she rang her call light because she needed to be changed and she had to lay in urine the whole time she waited. R6 said this happens a lot on day and evening shift.On 01/22/26 at 10:42AM, R12 who was alert to person, place, and time, stated she was on her call light for over 30 minutes last night. R12 said she called the nurses' station to see if she could get someone to help her. R12 said she needed to be changed. R12 said she had an incontinent episode and was just lying there waiting on someone to come answer her light. R12 said finally V2 (Director of Nursing) came and answered her light. R12 she will have to just sit there and have to wait in the evening for someone to answer her light. R12 said she just waits for staff to answer the call light, and it may take 30-45 minutes, sometimes an hour, for them to answer the call lights.On 01/21/26 at 6:36PM, V2 (Director of Nursing) stated they only had V19 (Certified Nurse Assistant/CNA) and V18 (CNA) in the facility working the floor at this time. V2 said they had one call in and another staff member hadn't called at all or showed up. V2 said they had an agency nurse that was the nurse on duty working tonight who had never been at the facility before. V2 said she did have another CNA, V14, coming back into the facility to help out on the floor.On 01/21/26, the following observations were made:6:45PM: observed V19 (CNA) who was working on North Hall taking residents outside to go smoke. No other CNA working on North Hall.6:50PM: observed 4 call lights going off down North Hall in separate rooms.7:00PM: observed V19 (CNA) walk in from outside with the residents and she stated one of the residents wasn't feeling good. Call lights were still going off on North Hall in the 4 rooms previously noted.7:03PM: observed V2 asking V19 (CNA) to go down to room (#) and get the vital machine and take the resident who was sick vitals who was in the dining room. Call lights were still going off on North Hall in the 4 previous rooms.7:06PM: observed V19 (CNA) answered the phone she was very upset and said R12 had called and was wanting help. Call lights were still going off on North Hall in the 4 previous rooms.7:15PM: observed a resident's voice yelling from North Hall for help. Call lights were still going off on North Hall in the same (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	rooms.7:21PM: observed V19 (CNA) going into room [ROOM NUMBER] to answer the call light. Call lights were still going off in 3 rooms.7:22PM: observed V1 (Administrator) going into a room to answer the call light.7:23PM: observed another room's call light was off.7:41PM: Observed V14 arriving at the facility to clock in.7:50PM: observed room [ROOM NUMBER] call light was off.On 01/29/26 at 11:09AM, V1 (Administrator) stated he feels like staff answer the call lights in a timely manner. V1 said it just depends on the CNA. V1 said he doesn't think if they have only 1 CNA down a hall, that the CNA should be taking the residents out to smoke and leaving no other staff down the hallway.On 01/21/26 at 6:21PM, V18 (CNA) stated she doesn't feel the facility has enough staff to care for all the residents adequately. V18 said it is not that they don't schedule enough help most of the time, but it's that they have call ins and they can't get it covered. V18 said they used to have agency to cover the CNA call ins, but now they don't have agency cover the empty CNA openings, only the nurse's spots.On 01/22/26 at 9:34AM, V16 (CNA) stated, The facility 100% needs more staff. There are days when we aren't able to get all the resident care needs done. We try to get all the care provided and most of the time we are able to get it done, but other days we cannot get it all done. V16 said there are days it will take them forever to answer a residents call light. V16 stated she had to come in at 1:40AM this morning because they only had 1 CNA and 1 Nurse. V16 said when she got to the facility this morning, it was V19 (CNA) in the building and 1 agency nurse.On 1/22/26 at 9:55AM, V23 (CNA) stated he does feel the facility has a problem with not having enough staff. V23 said they have times that some of the residents won't get all of their care needs provided to them because they don't enough staff. V23 said they try to get as much resident care done as they can when they are short of staff.On 01/22/26 at 10:46AM, V17 (CNA) stated sometimes they are short of staff, but it is on night shift. V17 said she doesn't know how many staff they usually have on night shift.On 01/22/26 at 11:30AM, V22 (CNA) stated the facility has a problem with not having enough staff. V22 said they schedule staff, but most of the time they will have call ins or staff don't show up and then they are short of staff and they don't get it covered so they work short. V22 said most of the time they can get all the residents' care done, but there are times when some of the resident care needs might not get done. V22 said it is harder to get all the work done on North Hall; she said it is a more demanding hall. V22 said on day shift from 6:00AM to 6:00PM, they have 3 CNA's on North Hall and 2 on the memory care unit along with 2 nurses until around 4:30PM, then it goes down to 1 nurse.On 01/22/26 at 12:47PM, V20 (CNA) stated she usually works from 6:00PM to 6:00AM. V20 said the facility does have a problem with not having enough staff. V20 said some nights she works it is only 1 CNA on North and 1 CNA on South or memory care and 1 nurse. V20 said the facility tries to get help when they have call offs or the schedule will change and they forgot to update it.On 01/22/26 at 3:02PM, V8 (Registered Nurse/RN) states she does not feel the facility has enough staff to be able to provide care adequately to all residents.On 01/28/26 at 9:59AM, V21 (CNA) stated, There are days I feel like we don't have enough staff to care for the residents adequately. I went from day shift to night shift. Usually we have 3 CNA's on North and usually 1 CNA on South and then 1 nurse. V21 said there have been times when they have 1 CNA on North and 1 CNA on South, especially when they have call offs or people don't show up. V21 said with the weather recently, they haven't had a lot of staff.On 01/29/26 at 9:12AM, V24 (Nursing Assistant) stated she has had to work with 1 CNA on multiple occasions and had to do all the CNA work, but she said that she does it with the other CNA. V24 said she works from 6:00AM to 6:00PM. V24 said they try to meet all the resident care needs but sometimes they might not get all the care needs done because they don't have enough staff. V24 said, Yes, we have a staffing problem; they are always having problems with staff calling in and it is hard to get all the work done (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146119	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/06/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Haven on the River	320 South 2nd Street Grayville, IL 62844

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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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	when you don't have enough staff.On 01/29/26 at 11:09AM, V1 (Administrator) stated he feels the facility has enough staff to be able to provide adequate care. V1 said he was not aware of 1 CNA and 1 Nurse working from 6:00pm to 6:00AM. V1 said ideally on nights they have 2 CNA's on 1 hall and 1 on the other hall and 1 nurse.The employee time clock report titled Employee Punches and Hours by Day documents the following time clock records for 1/21/26 and 1/22/26: 01/21/26, V19 clocked in at 5:57PM and left on 1/22/26 at 6:05AM. 01/21/26, V18 (CNA) clock in at 5:57pm and clock out at 10:09PM. On 01/21/26 V14 (CNA) clock back in at 7:40PM clocked out at 11:59PM. On 01/22/26 V16 (CNA) clock in at 1:42AM and clock out at 6:12PM. Per employee punch records only 1 V19 (CNA) and 1 agency nurse in the facility from 1/21/26 at 11:59PM to 01/22/26 at 1:42AM.The facility daily census, dated 01/20/26, documents a total of 45 residents residing in the facility.The facility policy titled ‘Staffing Policy undated documents under policy: It is the policy of this facility to provide an adequate number of staff to successfully implement resident functions to meet resident needs. Under standards #2. Adequate staffing ratios, by numbers and positions required to meet the needs of the residents will be maintained, including the scheduling of relief staff during all vacations, holidays and relief periods.