STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146148	A. Building B. Wing	03/04/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Arc at Hickory Point	565 West Marion Avenue Forsyth, IL 62535

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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 0557 Level of Harm - Actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to treat residents with respect and dignity for one (R76) of three residents (R75, R60, R76) reviewed for respect and dignity in the sample list of 37 residents. This failure resulted in R76 feeling embarrassed and degraded with a low self-esteem after staff continued the incontinence check after R76 stated R76 had notified staff that R76 was continent of urine.Findings Include:R76's Medical Record reviewed documents R76 was admitted to the facility on [DATE] from a local hospital with Diagnoses of Seasonal Allergic Rhinitis, Polyneuropathy, Long Term (Current) Use Of Oral Hypoglycemic Drugs, Presence Of Right Artificial Knee Joint, Aftercare Following Joint Replacement Surgery, Chronic Obstructive Pulmonary Disease, Autoimmune Hepatitis, Presence of Left Artificial Shoulder Joint, Asthma, Hypoxemia, Type 2 Diabetes Mellitus Without Complications, and Parkinsonism.R76's assessment record reviewed V6 admission Nurse/License Practical Nurse, documents on the admission assessment dated [DATE] at 09:57AM under subsection K; bowel and bladder that R76 is always continent of bowel and bladder.The same admission assessment under F, the neurological section, documents Neuro: R76 is alert to person, place, time, situation, and is verbally appropriate. On 03/03/26 at 09:50AM, V27 Certified Nursing Assistant (CNA) stated that the staff should read the care plan and if a resident is continent staff should ask the resident if the resident needs assistance to the restroom but should not insist that the bed/resident be checked for incontinence if alert resident states they are dry.On 03/03/26 at 11:40AM, V30 (R76's) Family Member, stated that R76 was feeling embarrassed and degraded with a low self-esteem after staff continued an incontinence urine bed check at 04:00AM on 2/25/26 after R76 stated R76 told staff that R76 was continent of urine and did not need the bed checked for urine incontinence.On 3/4/26 at 10:16AM, V6 admission Nurse/License Practical Nurse (LPN), stated the staff should follow the care plan and check/change the residents who are incontinent of urine and ask continent residents if they need assistance in getting to the bathroom. V6 stated the staff should be following the residents wants and needs.On 3/4/26 at 10:16AM, V1 Administrator and V23 Corporate Nurse stated a resident has the right to be treated with dignity and make the choice if the resident needs to be checked and changed or if they need assistance to the restroom. The Resident Rights policy dated 12/2025 documents the Purpose is to promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her abilities. The same policy documents under the guidelines documents Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement. The facility will not hamper, compel, treat differentially, or retaliate against a resident for exercising his/her rights. Facility practices designed to support and encourage resident participation in meeting care planning goals as documented in the resident assessment and care plan are not interference or coercion.The Bowel & Bladder- Assessment & Toileting Programs dated 01 /2026 documents Purpose: Based on the (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 0557 Level of Harm - Actual harm Residents Affected - Few	resident's comprehensive assessment the facility will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel or bladder functioning as possible. The same program documents under Guidelines: Subsection 3. If the resident is identified as continent, the voiding diary, Restorative Incontinence Observation, and toileting program will not be completed.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview and record review, the facility failed to ensure an oxygen cylinder was secured and stored properly for two residents (R71 and R1) in a sample list of 37 residents. Findings Include: On 3/01/2026 at 8:35AM, R71 had a portable oxygen cylinder located on the left side of R71's bed, not secured and not in use by the resident. R71 stated R71 does not use oxygen. On 03/01/2026 at 9:05AM, R1 had a portable oxygen cylinder located by the entry door inside R1's room. R1 stated R1 use to use oxygen and a BiPAP (Bilevel Positive Airway Pressure) machine but no longer uses either. R71's Physician Orders documented on 2/21/26, R71 receives two liters of Oxygen via Nasal Cannula every shift for Shortness of Breath. R1's Physician Orders dated on 1/27/26 Documents R1 is to receive Oxygen at three liters via nasal canula and Continuous Positive Airway Pressure (CPAP) machine. On 3/1/2026 at 1:25PM, V7 (Maintenance Director) stated there shouldn't be portable oxygen cylinders in the room as the oxygen cylinders are only for going out of the building for appointments.

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F 0577 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, interview, and record review the facility failed to ensure state survey results were accessible and contained all surveys which were completed in the last year. This failure had the potential to affect all 59 residents residing in the facility.On 3/1/2026 at 10:58 AM, R4, R22, R26 and R27 were interviewed for resident council meetings. On 3/1/2026 at 11:50 AM, during the resident council meeting, R4, R22, R26, R27 stated they were unaware of where the state survey inspection results were located. On 3/1/2026 at 12:00 PM, V12 (Receptionist) stated the survey book is located in the foyer in a drawer. V12 pointed to a four-drawer dresser in the foyer. A picture frame propped up on the dresser contained a sign that stated, Survey Results. At that time, the survey book was not located on top of or in the dresser. V1 (Administrator) confirmed it was not accessible to the residents as it was located in her office. V1 and V2 (Regional Director of Operations) stated that the book was missing surveys and needed to be updated. On 3/1/2026 at 12:20 PM, V2 stated the survey book was missing the 5/1/2025 annual survey, 5/8/2025 complaint, 6/6/2025 certification revisit, 6/24/2025 complaint follow-up, 6/30/2025 annual prep certification, 8/1/2025 follow up complaint, 8/17/2025 licensure survey, 8/25/2025 licensure follow up, 9/16/2025 Facility reported incident times two, 9/18/2025 complaint, 10/14/2025 complaint, 11/18/2025 follow up to 9/23/2025, 12/15/2025 follow up complaint, 1/15/2026 complaints times four, and the 2/17/2026 complaint. The facility's Long Term Care Application for Medicaid and Medicare signed by V1 Administrator documents there are 59 residents residing in the facility.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to complete wound assessments/measurements at least weekly and implement interventions to prevent wounds for three residents (R1, R6, R36) of five residents reviewed for wounds in a sample list of 37 residents.Findings Include: Facility Skin Condition Assessment & Monitoring – Pressure and Non – Pressure revised on 12/2025 documents a skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and is necessary. This also documents that residents identified will have a weekly skin assessment by a licensed nurse. Also, a wound assessment will be initiated and documented in the resident chart when a pressure and/or other non-pressure skin conditions are identified by licensed nurse. This document also states that wound assessment and monitoring that a licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes if Observations are acute, physician and responsible party will be notified by charge nurse. Notifications will be documented in the residents' clinical record. 1.) On 03/01/2026 at 9:05AM, R1 was observed lying in bed eating breakfast. R1 stated R1 had a wound on admission, and it had healed and then reopened almost a month ago. Wound Notes Documented on 1/15/26 documents Wound Comments: Writer to room for skin reassessment and perform wound care. Patient (R1) has stage 3 pressure injury to sacrum, and IAD/MASD (Incontinence-Associated Dermatitis/Moisture-Associated Skin Damage) noted to peri-rectal area. Recommend zinc paste as needed. No other open areas or skin concerns noted. Patient remains on low air loss mattress. Nursing Progress Note documented on 2/5/2026 states Guest (R1) has open area to coccyx. NP (Nurse Practitioner) made aware and new orders to cleanse coccyx with generic wound cleanser, pack wound with calcium alginate, cover with boarder foam daily PRN (as needed) until healed. Wound nurse aware. Wound Notes Documented on a stage three pressure ulcer on coccyx measuring in centimeters 0.60 Long x 0.40 Wide x 0.10 Deep, with orders dated on 2/26/26 Coccyx: Cleanse area with NS (Normal Saline), apply collagen powder cover with bordered gauze, there is also an order dated on 2/5/2026 to Cleanse coccyx with generic wound cleanser, pat dry, pack with calcium alginate, cover with foam dressing daily PRN until healed with a discontinued date of 3/2/2026. The Minimum Data Set (MDS) dated [DATE] Documents R1 does not have a pressure ulcer. On 3/2/2026 at 8:50AM, V8 (Licensed Practical Nurse) stated that R1 has a pressure ulcer to the coccyx area and daily treatments are completed at bedtime. On 3/2/2026 at 9:35AM, V6 (Licensed Practical Nurse) stated that R1 had a wound on R1's coccyx area and completed wound rounds with the wound doctor. V6 stated that the pressure ulcer developed on 2/5/2026 and new orders were received. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2.) On 3/01/26 at 8:36AM, R6 was observed sitting in R6's wheelchair in R6's room. A sign was posted on the wall above R6's bed that reads, Heels must be floated while in bed. R6 stated R6 has sores that developed from lying in bed too much when R6 was first admitted to the facility. R6 also stated that R6 does not wear anything on R6's feet at night and only uses a Santa pillow between R6's legs. R6's electronic medical record (EMR) documents that R6 was admitted to the facility on [DATE]. R6's Minimum Data Set (MDS) dated [DATE] documents that R6's cognition is intact. The quarterly review of R6's MDS dated [DATE], Section M, documents that R6 has unhealed pressure ulcers, including two Stage 2 pressure ulcers and two Stage 3 pressure ulcers, which were not present on admission. R6's Care Plan dated 12/9/25 documents that R6 has actual skin impairment, including pressure injuries to R6's inner left and right ankles, outer left ankle, and the inside of the right foot. Care Plan interventions dated 11/11/25 document that staff are to encourage R6 to wear heel protectors while in bed and encourage R6 to float R6's heels while in bed. V24 Family Nurse Practitioners (FNP) wound care notes dated 2/18/26 document an off`loading recommendation for R6 to wear heel protectors to the lower legs to prevent further pressure on the affected areas. On 3/4/26 at 10:44AM, V1 Administrator stated staff should have been following provider recommendations for R6 to wear heel protectors while R6 is in bed or documenting R6's refusal. 3.) R36's Minimum Data set completed 2/18/26 documents R36 was admitted on [DATE]. R36's Wound Clinic Consult dated 2/12/26 documents R36 was admitted with wounds to her bilateral lower extremities and left heel. R36's Medication Administration Record (MAR) for March 2026 includes treatment orders initiated 2/12/26 for treatments to her left heel, bilateral groin, and abdominal fold. On 3/1/26 at 8:45AM R36 was seated in a recliner in her room. R36's left heel was covered by a gauze wrap with yellow staining to the heel area. The dressing was not dated and appeared soiled. There is no documentation included in R36's medical record to indicate weekly wound assessments or measurements. On 3/4/26 V6, Licensed Practical Nurse (LPN) Wound Nurse verified R36 was admitted with multiple wounds and continues to have active treatments in place. V6 also verified the MDS documentation was not accurate. V6 stated we only document weekly if there are any new open areas. If there are no new open areas, we just initial the MAR (Medication Administration Record) as skin check completed. If the wound doctor sees the resident, then the full assessment is done. It looks like (R36) has not seen the wound doctor. I think (R36) was missed.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to administer oxygen as ordered by the physician, change oxygen tubing and humidification weekly, and prevent possible cross contamination for four (R19, R36, R51, R58) of six residents reviewed for oxygen on a sample list of 37 residents. Findings:Findings Include: 1. R58's Care Plan revised 2/12/26 documents (R58) has altered respiratory status/difficulty breathing related to Pulmonary Hypertension, Obstructive Sleep Apnea, and Disorders of the Diaphragm. R58 has a current physician's order initiated 2/28/26 for continuous oxygen per nasal cannula at 3 liters per minute. On 3/1/26 at 9:30AM, R58 was observed resting in bed. The oxygen concentrator was set at 3 liters per minute, but the cannula and tubing in place to R58 was not attached to the concentrator. R58 stated R58 felt short of breath. V8 Licensed Practical Nurse (LPN) was notified. V8 went to R58's room and connected the tubing to the concentrator. V8 stated They must have forgotten to hook up the tubing when they put (R58) to bed. On 3/3/26 at 2:00PM. V58 was resting in bed. R58 complained of feeling short of breath. R58 stated part of my diaphragm is paralyzed and I get short of breath The oxygen concentrator was off, and the tubing and cannula were coiled up on top of the concentrator. V4 Certified Nurse's Aide (CNA) was notified. V4 replaced the cannula to R58's nose. V4 stated (R58) is supposed to have oxygen all the time at 3 (liters per minute). V4 turned on the concentrator to 3 liters per minute. 2. R36 has a current physician's order for Oxygen 2 liters per minute per nasal cannula while sleeping due to Sleep Apnea. R36 stated I wear oxygen at night, but I don't need it during the day. On 3/1/26 at 9:30AM, R36 was observed sitting in R36's room in a recliner. The oxygen concentrator was in the room tubing was attached and the nasal cannula was on the floor. The tubing and the empty humidifier bottle were not dated, and the cannula was covered in a crusty dry white matter. On 3/4/26 at 9:00AM, V6 Licensed Practical Nurse (LPN) verified (R58) has an order for continuous oxygen and should have it in place at all times and the cannula should not be on the floor and it is the facility's policy to date oxygen tubing and change it at least weekly. 3.) On 3/01/26 at 8:51AM, a sign reading Oxygen in Use was posted on R19's door and R19 was observed lying on R19's back in bed watching television. R19's oxygen tubing was on the floor, and R19's oxygen concentrator was running in the bathroom. R19 stated R19 has only been wearing R19's oxygen at night and that staff sometimes assist him with the tubing and concentrator, but not often. R19's Minimum Data Set (MDS) dated [DATE] documents R19 has the following active medical (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	conditions, Chronic Obstructive Pulmonary Disease (COPD), Chronic Respiratory Failure with Hypoxia and dependence on supplemental Oxygen. Section J of this MDS indicates that R19 experiences shortness breath with exertion, when sitting at rest, and when lying flat. Section O of this same MDS documents that R19 requires respirator treatment with continuous Oxygen therapy. R19's physician's order dated 1/27/26 documents, Oxygen at 2 liters per minute via nasal cannula every shift. R19's Care Plan dated 1/30/26 documents that R19 has COPD and Chronic Respiratory Failure with Hypoxia with an intervention of Oxygen at 2 liters per minute via nasal cannula continuously. R19's Medication Administration Record (MAR) for January, February, and March 2026 documents staff signatures indicating administration of oxygen at 2 liters per minute via nasal cannula continuously; the order is dated 1/27/26. On 3/02/26 at 11:35AM, V6 Licensed Practical Nurse (LPN) stated R19 has a physician's order for oxygen at 2 liters per minute via nasal cannula to be worn continuously. V6 confirmed that R19 should be wearing oxygen at all times. 4. R51's Care Plan with a revision date of 12/17/25 documents, R51 has altered respiratory status and difficulty breathing related to Shortness of Breath and Atelectasis. This care plan includes an intervention to apply oxygen at two liters via nasal cannula continuously. R51's Physician Order dated 12/8/25 documents an order to administer two liters of oxygen continuously. On 3/01/2026 at 9:01 AM, R51 was sitting in a wheelchair in R51's room. R51 was not wearing oxygen. An oxygen concentrator was plugged into an outlet against the wall. Oxygen tubing was connected to a humidification water bottle; this bottle was dated 12/8. The humidification bottle was empty. The nasal cannula attached to concentrator was not dated. On 3/02/2026 at 9:35 AM, R51 was sitting in a wheelchair in R51's room. R51 was not wearing oxygen. An oxygen concentrator was plugged into an outlet against the wall. Oxygen tubing was connected to a humidification water bottle; this bottle was dated 12/8. The humidification bottle was empty. The nasal cannula attached to concentrator was not dated. On 3/02/2026 at 11:40 AM, R51 was sitting at a dining table. R51 was not wearing oxygen from 11:40 AM to 11:55 AM. On 3/02/2026 at 12:55 PM, V6 Licensed Practical Nurse walked into R51's room and confirmed the date on the empty humidification bottle was 12/8. At that time, V6 looked up R51's orders and stated R51 had an order for two liters of oxygen to be administered continuously. V6 checked R51's pulse oximetry and it read 96 percent. V6 did not apply oxygen to R51 after looking at the order and checking R51's pulse oximetry. On 3/03/2026 at 9:33 AM, R51 was sitting in a wheelchair in R51's room. R51 was not wearing oxygen. On 03/02/2026 at 1:05 PM, V1 Administrator stated V1 would expect R51 to be wearing oxygen as ordered by the physician.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure medications were available by the pharmacy for two (R10, R150) of 16 residents reviewed for medications on the sample list of 37 residents. Findings Include: 1.) On 3/02/2026 at 8:15 AM, R10 stated when R10 was admitted (1/30/26) and readmitted (2/15/26) to the facility, R10's pain medication was not given because the facility did not have it. R10's physician orders dated 1/30/26 documents an order for Oxycodone Hydrochloride 30 milligrams (mg) one tablet by mouth every morning and at bedtime. R10's Medication Administration Record (MAR) for January 2026 documents R10's Oxycodone was not administered and to see progress note on 1/30/2026 and 1/31/2026. R10's progress notes for 1/30/26 at 7:56 PM does not document why the Oxycodone was not administered. R10's progress note dated 1/31/26 at 6:38 PM documents the Oxycodone was not available. R10's Medical Record does not document an attempt to call the backup pharmacy to obtain R10's Oxycodone. R10's MAR for February of 2026 documents R10's Oxycodone was not administered on 2/15/26 at 8:00 AM or 8:00 PM and documents to see progress notes. R10's progress notes dated 2/15/26 at 10:17 AM documents the Oxycodone was not administered due to being unavailable. On 3/2/26 at 1:04 PM, V1 Administrator stated R10 did not get the Oxycodone as ordered by the physician on 1/30/26, 1/31/26, or 2/15/26. V1 stated the nurse on duty should have called the backup pharmacy to obtain R10's Oxycodone. 2. R150's Medication Administration Record (MAR) for March 2026 includes a current order for Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT (Fluticasone-Umeclidinium-Vilanterol)1 puff inhale orally one time a day for SOB (Shortness of Breath)/wheezing. This same MAR documents on 3/2/26 this medication was not given. R150's progress note dated 3/2/26 at 11:36AM documents Trelegy Ellipta Inhalation Aerosol Powder Breath Activated 100-62.5-25 MCG/ACT 1 puff inhale orally one time a day for SOB/wheezing Unavailable will arrive tonight. R150's Minimum Data Set (MDS) dated [DATE] documents R150 is cognitively intact. On 3/3/26 R150 stated They didn't have my Trelegy for three days. I really need that for my breathing. V22 Licensed Practical Nurse (LPN) stated I work here quite a bit from agency. There is a problem having all the medication available sometimes. It just takes one click on the computer to reorder. I'm not sure why it gets missed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. A. Based on Observation, Interview and Record Review, the facility failed to implement enhanced barrier precautions and Contact Precautions in accordance with facility policy for two residents (R71 and R61) on a sample list of 37 residents reviewed for transmission-based precautions. This deficient practice had the potential to increase the risk of transmission of multidrug-resistant organisms and communicable infections to other residents and staff. B. Based on observation, interview, and record review the facility failed to appropriately sanitize a glucometer between use on multiple residents for one resident (R33) of one resident reviewed for glucometer sanitization in a sample list of 37 residents. Findings Include: A. Facility Enhanced Barrier and Contact Precautions revised on 12/25 with chronic wounds or indwelling medical devices during high-contact resident care activities. This policy also documents Standard Precautions must be followed with all cares including gown and gloves must worn when providing the following cares: Dresing, Bathing/Showing, Providing Hygiene, Changing Linens, Incontinence Care, Medical Device Care, and Wound Care. On 3/01/2026 at 8:35AM, R71 had no signage on the door for enhanced barrier precautions for R71's Blister from a diagnosis of Cellulitis and Congestive Heart Failure. On 3/01/2026 at 8:44AM, R61 had no Contact Precautions signage on the door. R1 has a Right Above the knee amputation, a Peripherally Inserted Central Catheter (PICC Line) and an eye infection that R1 was getting antibiotics for. On 3/01/2026 at 8:45AM, R61 had no enhanced barrier precautions signage on the door. R61 has a below the knee amputation which is wrapped. V4 was assisting residents with breakfast in gown, mask with no gloves. There was no enhanced barrier precautions signage on the door. On 3/01/2026 at 8:45 AM, V4 (Certified Nursing Assistant) stated yes she should be wearing gloves and that she believes that R4 has an eye infection but stated maybe it was from the wound. On 3/1/2026 at 1:30PM, V1 (Administrator) Confirmed the staff should be following Enhanced Barrier Precautions for any open area on any residents. B. R33's Medication Administration Sheet (MAR) for March 2006 includes a physician's order initiated 2/27/26 for blood sugars BID (Twice Daily) every morning and at bedtime for diabetes. On 3/3/26 at 9:52AM, V22 Licensed Practical Nurse (LPN) was observed cleaning a glucometer on the medication cart. V22 stated V22 had just finished checking a blood sugar on another resident and was cleaning the glucometer to use it to check R33's blood sugar. V22 stated V22 was using alcohol wipes, but she knew it should be bleach wipes. V22 also stated I specifically asked the housekeeping supervisor for bleach wipes for this cart this morning and was told we are not allowed to have bleach wipes on the medication cart. On 3/3/26 at 11:00AM, V1 Administrator verified the medication cart should be stocked with bleach wipes and the glucometer should be cleaned with bleach wipes. V1 stated V1 would take care of it. The facility's Glucometer Cleaning Policy revised January of 2026 documents Purpose: To prevent the growth and spread of microorganisms and bloodborne pathogens. Guidelines: The blood glucose (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	monitor should be cleaned and disinfected between each resident test. Procedure: 1. Put on nonsterile gloves. 2. Inspect for blood, debris, dust, or lint anywhere on the meter. 3. To clean and disinfect the meter, use appropriate bleach wipe disinfectant. 4. Wipe meter with bleach wipe/towel until all surfaces of the glucometer are visibly wet and note kill time of the product. Do not wipe inside battery compartment, code chip port, or test strip port. 5. Discard the bleach wipe/towel. 6. Place the glucometer on a clean surface such as a paper towel and allow it to dry for no less than 3 minutes, according to manufacturer's instructions.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 and record review, the facility failed to answer call lights in a timely manner for one (R76) of three residents (R75, R60, R76) reviewed for call lights in the sample list of 37 residents.Findings Include:Grievance forms dated December 8 and 28, 2025 and February 3 and 26, 2026, all document residents having to wait extended times for help with various activities.Resident Council Minutes dated February 6, 2026, document six residents attended the meeting and documented staff need to answer call lights quicker.R76's Medical Record reviewed 2/24/26 documents R76 admitted to the facility on [DATE] from a local hospital with Diagnoses of Seasonal Allergic Rhinitis, Polyneuropathy, Long Term (Current) Use Of Oral Hypoglycemic Drugs, Presence Of Right Artificial Knee Joint, Aftercare Following Joint Replacement Surgery, Chronic Obstructive Pulmonary Disease, Autoimmune Hepatitis, Presence Of Left Artificial Shoulder Joint, Asthma, Hypoxemia, Type 2 Diabetes Mellitus Without Complications, and Parkinsonism.On 03/03/26 at 09:50AM, V27 Certified Nursing Assistant (CNA) stated that the staff should answer the call lights in a timely manner but that does not always happen.On 03/03/26 at 11:40AM, V30 (R76's) Family Member stated that R76 did not have a call light answered in a timely manner. V30 stated R76 had to wait for over 30 minutes for a call light to be answered on 02/25/26. V30 stated upon approaching the nurse's station multiple staff members were going on break, while multiple call lights were activated. V30 stated the call lights above the door were lit as well as sounding an alarm at the nurse's station.On 3/4/26 at 10:16AM, V6 admission Nurse/License Practical Nurse (LPN), stated staff should answer the call light in under 10 minutes and should not be exiting the unit if call lights are activated. V6 stated V6 is not aware of any staff not responding to call lights before going to break.On 3/4/26 at 10:16AM, V1 Administrator, and V23 Corporate Nurse stated staff should answer a call light in under 10-15 minutes to meet resident needs and should not be going to break or exiting the unit until the call lights are answered and needs have been met for the residents. V1 stated V1 is not aware of staff not responding to call lights before going to break off the unit.The Call Light policy dated 01/2026 documents: The purpose of this policy is to respond to residents' requests and needs in a timely and courteous manner. The same policy documents Guidelines: Resident call lights will be answered in timely manner. Subsection 2 documents: All staff should assist in answering call lights. Nursing staff members shall go to resident rooms to respond to call system and promptly cancel the call light when the room is entered. 3. Bathroom lights should be viewed as emergencies and immediate attention will be given.

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. Based on observation, interview, and record review the facility failed to assess the ability to self-administer medications for one of one resident (R10) on the sample list of 37 residents. Findings include: The Facility's Self Administration of Medication policy dated 4/2025 documents residents who request to self-administer drugs will be assessed using the Self Administration of Medications tool at the time of admission to determine if the practice is safe. 0n 3/1/2026 at 9:10 AM, a bottle of liquid Mucinex containing dextromethorphan 20 milligrams (mg), guaifenesin 400 mg, and phenylephrine 10 mg, a roller-ball tube of Aspercream (4% lidocaine), and a can of 4% lidocaine was sitting on R10's over the bed table. On 3/2/2026 at 9:05 AM, a bottle of liquid Mucinex, a roller tube of Aspercream, and a can of 4% lidocaine was sitting on R10's over the bed table. On 3/2/2026 at 1:32 PM, R10 stated R10 self-administers the Mucinex for congestion. R10 stated R10 self-administers the lidocaine and Aspercream which are used for pain management. R10's Electronic Health Record did not contain an assessment to determine R10's ability to self-administer medications. This medical record did not contain a Self-Administration of Medications tool. On 3/2/2026 1:50 PM, V1 Administrator stated R10 did not have an assessment to self-administer medications and R10 should not be self-administering medications.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide clean bedding for one (R43) of 43 residents reviewed for environment on the sample list of 37 residents.Findings include: R43's admission Minimum Data Set assessment dated [DATE] documents R43 is cognitively intact. This assessment documents R43 requires partial to moderate assistance with activities of daily living. On 3/03/2026 at 9:28 AM, R43 was lying in bed. R43's pillowcase had brown smearing across the top of the pillowcase by R43's face. R43 was lying between the top sheet and the bottom sheet. Scattered brown crumbs were scattered along R43's upper body on top of the bottom sheet. R43 stated R43 eats in the bed and R43 would like to have clean bedding. R43 stated R43's bedding has not been changed since her room move on 2/21/26. R43's Daily Census in R43's Electronic Medical Record documents R43 moved rooms on 2/21/26. On 3/03/2026 at 9:33 AM, R43 was sitting in R43's wheelchair in R43's room. R43 stated R43's bedding had not been changed. R43's pillowcase had the same brown smearing across the top and the scattered brown crumbs remained scattered on top of the bottom sheet. On 3/03/2026 at 10:52 AM, V20 Certified Nurse's Assistant (CNA) stated bedding is supposed to be changed when soiled. On 3/4/26 at 10:35AM, V23 Corporate Registered Nurse/RN stated, I believe we change the bed linens daily when the resident gets up, but they certainly should be changed any time they are soiled particularly with feces.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. Based on interview and record review the facility failed to ensure the right to be free from chemical restraints by failing to assess the need for a psychotropic medication, failing to develop a plan of care for an antidepressant used for insomnia and failing to implement non-pharmacological interventions for insomnia for one (R10) of five residents reviewed for unnecessary medications on the sample list of 37 residents. Findings include: R10's Medication Administration Record (MAR) shows an order for mirtazapine (antidepressant) oral tablet 7.5 mg (milligrams) give 7.5 mg at bedtime for depression and insomnia start on 2/19/2026 at 8:00 PM. R10's Physician Progress Note dated 2/19/2026 written by V18 (Physician's Assistant) documents R10 was seen by V18 that day. V18 documented that R10 reported R10, can't sleep. This note documents V18 prescribed mirtazapine 7.5 mg at bedtime for Insomnia. On 3/3/2026 at 10:30 AM, R10 stated R10 has had a problem with sleeping R10's whole life from working swing shifts. R10 stated R10 preferred to fall asleep with the television on or R10 will read to help with falling asleep. R10's Electronic Medical Record does not contain an assessment for R10's Remeron or that nonpharmacological interventions were attempted for Insomnia. R10's Antidepressant Care Plan dated 2/24/26 does not document R10's diagnosis of Insomnia or interventions for the Insomnia. On 3/3/2026 at 12:45 PM, V1 (Administrator) confirmed R10 was not assessed for the use of psychotropic medications used for insomnia, R10 is not monitored for Insomnia, a plan of care was not developed for Insomnia, and nonpharmacological interventions were not put into place. The Facility's Behavior Service Program policy dated 3/2025 documents a plan of care will be developed for behaviors, the behaviors will be monitored, and interventions will be implemented.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to accurately assess wounds in the Minimum Data Set for two residents (R36, R1) of 33 residents reviewed for MDS accuracy in a sample list of 37 residents.Findings Include: R36's Minimum Data Set (MDS) completed 2/18/26 documents R36 was admitted on [DATE]. R36's Wound Clinic Consult dated 2/12/26 documents R36 was admitted with wounds to her bilateral lower extremities and left heel. R36's Medication Administration Record (MAR) for March 2026 includes treatment orders initiated 2/12/26 for treatments to her left heel, bilateral groin, and abdominal fold. On 3/1/26 at 8:45AM, R36 was seated in a recliner in R36's room. R36's left heel was covered by a gauze wrap with yellow staining to the heel area. The dressing was not dated and appeared soiled. R36's MDS dated [DATE] documents R36 was admitted without wounds of any kind. On 3/4/26, V6 Licensed Practical Nurse (LPN)/ Wound Nurse verified R36 was admitted with multiple wounds and continues to have active treatments in place. V6 also verified the MDS documentation was not accurate. Wound Notes Documented on 1/15/26 documents Wound Comments: Writer to room for skin reassessment and perform wound care. Patient (R1) has stage 3 pressure injury to sacrum, and IAD/MASD (Incontinence-Associated Dermatitis/Moisture-Associated Skin Damage) noted to peri-rectal area. Recommend zinc paste as needed. No other open areas or skin concerns noted. Patient remains on low air loss mattress. Nursing Progress Note documented on 2/5/2026 states Guest (R1) has open area to coccyx. NP (Nurse Practitioner) made aware and new orders to cleanse coccyx with generic wound cleanser, pack wound with calcium alginate, cover with boarder foam daily PRN (as needed) until healed. Wound nurse aware. Wound Notes Documented on a stage 3 pressure ulcer on coccyx measuring 0.60 Long x 0.40 Wide x 0.10 Deep, with orders dated on 2/26/26. Coccyx: Cleanse area with NS (Normal Saline), apply collagen powder cover with bordered gauze, there is also an order dated on 2/5/2026 to Cleanse coccyx with generic wound cleanser, pat dry, pack with calcium alginate, cover with foam dressing daily PRN until healed with a discontinued date of 3/2/2026. MDS dated [DATE] Documents R1 does not have a pressure ulcer. On 3/2/2026 at 8:50AM, V8 (Licensed Practical Nurse) stated R1 has a pressure ulcer to the coccyx area and daily treatments are completed at bedtime. On 3/2/2026 at 9:35AM, V6 (Licensed Practical Nurse) stated R1 had a wound on R1's coccyx area and completed wound rounds with the wound doctor. V6 stated that the pressure ulcer developed on 2/5/2026 and new orders were received. V6 stated while completing wound rounds on R1. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Skin Condition Assessment & Monitoring – Pressure and Non – Pressure revised on 12/2025 documents a skin condition assessment and pressure ulcer risk assessment (Braden) will be completed at the time of admission/readmission. The pressure ulcer risk assessment will be updated quarterly and is necessary. This also documents that residents identified will have a weekly skin assessment by a licensed nurse. Also, a wound assessment will be initiated and documented in the resident chart when a pressure and/or other non-pressure skin conditions are identified by licensed nurse. This document also states that wound assessment and monitoring that a licensed nurse shall observe condition of wound incision daily, or with dressing changes as ordered. Observations such as drainage, dehiscence, redness, swelling, or pain will be documented in the nurse's notes if Observations are acute, physician and responsible party will be notified by charge nurse. Notifications will be documented in the resident's clinical record.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to provide shaving assistance for one resident desiring to be shaved (R58) of three residents reviewed for shaving in a sample list of 37 residents. Findings Include:R58's Minimum Data Set (MDS) dated [DATE] documents R58 is cognitively intact and dependent on staff for personal hygiene including shaving.On 3/1/26 at 9:40AM, R58 was observed resting in R58's bed. R58 had coarse gray facial hair approximately 1/4 inch long on R58's face and chin. When asked if R58 preferred to be unshaven R58 stated no I like to shave every day. I like to be clean shaven. I've never been one to wear a beard, but I can't do it myself and they tell me they can't do that for me.On 3/2/26, V23 Corporate Registered Nurse (RN) verified it is the facility's policy to offer a shave as often as the resident prefers to be shaved. V23 also confirmed the CNA staff are expected to shave each resident as per their preference.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview, and record review the facility failed to provide pain medication when pain was present and as ordered by the physician for one (R10) of two residents reviewed for pain on the sample list of 37 residents. R10's Pain Care Plan dated 2/2/26 documents R10 has low back pain, migraines, and pain due to a left femur fracture. This care plan includes an intervention to provide pain medication as ordered by the physician. R10's physician orders dated 1/30/26 documents an order for Oxycodone Hydrochloride 30 milligrams (mg) one tablet by mouth every morning and at bedtime for pain and an order for Norco 5-325 mg one tablet every six hours as needed for pain. On 03/02/2026 at 8:15 AM, R10 stated when admitted and readmitted to the facility pain medication was not given because the facility did not have it. R10 stated when R10 receives the pain medication R10's would rate pain as a three on a one to ten scale but when R10 doesn't receive the pain medication the pain rating is an eight on a one to ten scale. R10's Medication Administration Record (MAR) for January 2026 documents R10's Oxycodone was not administered and documents to see progress note on 1/30/2026 and 1/31/2026. This MAR documents R10's pain rating as a nine on a one to ten scale on 1/30/26 and on 1/31/26. R10's progress notes for 1/30/26 at 7:56 PM does not document why the oxycodone was not administered. R10's progress note dated 1/31/26 at 6:38 PM documents the Oxycodone was not available. R10's MAR for February of 2026 documents R10's Oxycodone was not administered on 2/15/26 at 8:00 AM or 8:00 PM and documents to see progress notes. R10's progress note dated 2/15/26 at 10:17 AM documents the Oxycodone was not administered due to being unavailable. On 3/2/26 at 1:04 PM, V1 Administrator stated R10 did not get the Oxycodone as ordered by the physician on 1/30/26, 1/31/26, or 2/15/26. On 3/3/26 at 10:30 AM, R10's call light was activated outside of the room. R10 was lying in bed and stated R10 was having pain and rated the pain as an eight out of ten on a one to ten scale. At 10:35 AM, V20 Certified Nurse's Assistant (CNA) entered the room. R10 told V20 CNA that R10 was in pain and V20 CNA responded to R10 and stated V20 CNA was going to go and report the pain to the nurse (V19, Licensed Practical Nurse). On 3/3/26 at 10:43 AM, R10 stated R10 was going to activate the call light since no one has brought pain medication to R10. R10 then activated the call light. On 3/3/26 at 10:45 AM, V20 CNA answered the call light and stated V19 LPN said it was too early to receive any pain medications. R10 then asked to speak to V19 LPN. On 3/3/26 at 11:00 AM, V6 Licensed Practical Nurse entered R10's room to talk to R10 about an X-ray. R10 told V6 LPN that R10 was having pain. V6 told R10 LPN that V6 would let her nurse (V19) know R10 was having pain. R10's Medication Administration Record (MAR) dated 3/3/26 documents Oxycodone 30 milligrams was last given at 8:00 AM. This MAR documents R10's Norco 5-325 mg was last given on 3/2/26 at 1:17 PM. On 3/3/26 at 11:10 AM, V6 LPN and V19 LPN were discussing R10's pain medication and V6 stated V6 was going to call to clarify R10's pain medication orders. V19 stated V19 was going on break. On 3/3/26 at 11:40 AM, V6 LPN stated V6 after calling the physician V6 let V19 know that R10 could have one tablet of Norco 5-325 mg as ordered for pain. On 3/3/26 at 11:55 AM, V19 LPN walked to the desk at the nurse's station and when asked stated V19 has not given R10 the pain medication yet. R10's MAR documented R10 received one tablet of Norco 5-325 mg on 3/3/26 at 11:59 AM. On 3/4/26 at 1:35 PM, V1 Administrator stated R10's pain medication should have been given as soon as possible when R10's pain was reported.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to properly store medications for two (R10, R51) of 24 residents reviewed for environment on the sample list of 37 residents. Findings include: 1.) On 3/1/2026 at 9:10 AM and on 3/2/26 at 9:05 AM, a bottle of liquid Mucinex containing dextromethorphan 20 milligrams (mg), guaifenesin 400 mg, and phenylephrine 10 mg, a roller-ball tube of Aspercream (4% lidocaine), and a can of 4% lidocaine was sitting on R10's over the bed table. On 3/2/2026 at 1:32 PM, R10 stated the Mucinex, Aspercream, and Lidocaine are kept on the over the bed table and the staff does not take them out of the room. On 3/2/2026 at 1:40 PM, V6 Licensed Practical Nurse stated the Mucinex, Aspercream, and Lidocaine should not be stored on R10's over the bed table and they should be locked in the medication cart. 2.) On 3/1/2026 at 9:01 AM a medicine cup with a pill inside was sitting in the windowsill of R51's room. V6 stated that medications should not be stored in resident's rooms.