STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146172	A. Building B. Wing	12/12/2025

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Spring Creek	777 Draper Avenue Joliet, IL 60432

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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 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 observation, interview and record review, the facility failed to maintain a resident's bodily privacy. This applies to 1 of 1 resident (R96) reviewed for resident's dignity in the sample of 27. The findings include:On 12/11/25 at 10:14 AM, R96 was sitting on the floor, in the common area across from the nurses station, in front of the elevator. R96's pants were pulled down to his knees. R96's penis was not contained in the incontinence brief. V29 (Social Services Director) was sitting at the nurses station with his back towards R96. On 12/11/25 at 10:16 AM, V30 (CNA/Certified Nursing Assistant) stepped off of the elevator and saw R96 sitting on the floor. V30 alerted V29 and they walked over to R96 and assisted him with getting up from the floor. When R96 stood up, his penis was fully exposed outside of the incontinence brief. On 12/11/2025 at 11:10 AM, V29 stated R96 had a behavior of undressing in public places. V29 stated R96 should not have been in the common area undressed. V29 stated it is not appropriate, and other residents may not feel happy about it. V29 stated he was sitting at the nurses station texting the DON (Director of Nursing) while R96 was sitting on the floor undressed. R96's admission Record showed R96 was admitted to the facility on [DATE], with multiple diagnoses which included encounter for surgical aftercare, autistic disorder, epilepsy, dementia, schizophrenia, impulse disorder, and intellectual disabilities. R117's MDS (Minimum Data Set) dated 10/05/25 showed R96 had severe cognitive impairment. The same MDS showed R96 had behavioral symptoms that intrudes on the privacy of others and disrupts care or living arrangement. R96's Progress Notes dated 12/11/25 at 10:53 AM, showed Resident in and out of resident's rooms, unable to redirect. Pushing past staff. Laying on the floor exposing self.The facility's Policy and Procedure Dignity revised 01/25 showed, Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality. Staff shall promote, maintain and protect resident's privacy, including bodily privacy during assistance with personal care and during treatment procedures.

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 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to allow prompt access to requested personal funds. This applies to 1 of 1 resident (R117) reviewed for resident's personal funds in the sample of 27. The findings include:On 12/09/25 at 11:45 AM, R117 was sitting in a wheelchair in his room. R117 stated he asked V28 (Assistant Administrator/Human Resources) for $40 from his personal funds account three weeks ago. R117 stated he never received the requested money.On 12/11/2025 at 8:58 AM, V28 stated R117 had a balance $160 dollars in his account. V28 stated two weeks ago R117 asked for $40. V28 stated she did not get a chance to go to the bank to get the money. V28 stated residents should not have to wait for two weeks or more to get requested money from their account. V28 stated she was the only person who could get money from the bank. R117's admission Record showed R117 was admitted to the facility on [DATE], with multiple diagnoses which included hemiplegia and hemiparesis, morbid obesity, diabetes, major depressive disorder, and polyosteoarthritis. R117's MDS (Minimum Data Set) dated 11/17/25 showed R117 was cognitively intact. The facility's Resident Personal Funds policy dated 05/14 showed, Our facility manages the personal funds of residents when such request is made by the resident. The resident may choose to have the facility hold, safeguard, and manage his/her personal funds.

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review the facility failed to report an allegation of abuse.This applies to 1 of 2 residents R121 reviewed for allegations of abuse in a sample of 27.Findings include:R121's MDS (Minimum Data Set) dated 10/16/25 shows she is cognitively intact. R121's diagnoses includes Arnold Chiari Syndrome, craniofacial dysostosis, monocular exotropia right eye, seizures. Scoliosis, dysthymic disorder. Current care plan includes R121 has a selfcare deficit. R121 is usually continent of bowel and bladder. She has limited use of extremities and uses a motorized wheelchair for locomotion. She requests bedpan during the night, uses a push pad call light system 1 to 1 staff assist with meals. Interventions include 1 assist with dressing, assist to toilet 1 person assist, provide extensive assist with toileting and toilet hygieneOn 12/09/2025 at 11:44 AM, R121 stated she requested toileting assistance and to be showered from V26, Certified Nurse Assistant (CNA). R121 stated her period had started and she needed to be toileted. R121 stated V26 told her to go to the toilet in her pants and that she did not change period pads. R121 stated this statement was very upsetting to her as she is continent and cognitively intact. R121 stated she reported the incident directly to V1 Administrator. R121 stated V26 told her she never would have said that to her if she knew she was in her right mind.On 12/09/2025 at 1:24 PM, V1 Administrator stated he had not submitted a report to IDPH (Illinois Department of Public Health). V1 stated R121 told him V26 CNA did not provide her shower and refused to change her period pad.On 12/10/2025 at 3:51 PM, V2 DON (Director of Nursing) stated V26 CNA was fired for refusing to toilet R121, taking long breaks and her bad attitude. V2 stated she heard V26 refusing to toilet R121.On 12/11/2025 at 12:50 PM, V2 DON stated she had told V1 Administrator about V26 refusing to toilet R121, but she did not remember when she told him.On 12/11/2025 at 2:39 PM, V1 Administrator stated V26 was fired for taking long breaks, her attitude and not meeting the standards of the facility. V1 stated V26 did not refuse to toilet R121. V1 stated he had looked at V26 discharge form. V1 stated refusing to toilet someone who is alert oriented, and continent of bowel and bladder is not abuse. V1 Administrator confirmed he was the abuse coordinator and allegations of abuse are reported to him.The Corrective Action Notice for V26 dated 12/4/25 list discharge for refusal to do work. V26 refused to toilet resident during shift, taking long breaks and attitude during counseling.The facility policy Abuse Prevention Program dated 1/2025 states residents have the right to be free from abuse, neglect, exploitation, misappropriation of property or mistreatment. To describe the process for identification, assessment, and protection of residents from abuse, neglect, misappropriation of property and exploitation will be accomplished by filing accurate and timely investigative reports. The facility has a no tolerance philosophy persons found to have engaged in such conduct will be terminated. Abuse is defined at the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review, the facility failed to provide ensure the Nurse Practitioner or MD (Medical Doctor) were notified about missed medications, and failed to perform assessments and obtain orders for the use of continuous blood glucose monitoring. This applies to 2 of 2 residents (R34, R5) reviewed for quality of care in a sample of 27.The findings include: 1) On December 9, 2025, at 12:21 PM, V9 (RN/Registered Nurse) prepared R34's medications for her. V9 said R34 refused her morning medications earlier as she was nauseous. V9 said she gave R34 Zofran earlier and she had just gone to check on her and R34 had told her she would take her medications. V9 pulled R34's medications, which included three medications that had twice daily dosing: -Amantadine hydrochloride 100 MG (milligrams) tablet, due at 9 AM and 5 PM, -Docusate sodium 100 MG tablet, due at 9 AM and 5 PM, -Gabapentin 300 MG capsule, due at 9 AM, 1 PM, and 5 PM. On December 9, 2025, at 1:05 PM, V9 administered R34's medications to her. On December 11, 2025, at 2:26 PM, V18 (NP/Nurse Practitioner) said R34 was one of her residents, and she was not contacted regarding any medications not being administered to R34. V18 said if a resident was nauseous, she expected the nurse to administer antinausea medications or call to get one ordered. V18 said she would then expect them to wait about an hour to see if the resident was able to take their medications. V18 said if a medication was due at 9 AM, the window of medication administration would be between 8 AM to 10 AM. V18 said if it was beyond that time, the nurse should be calling the doctor or NP to clarify which medications to administer. V18 said it was not up to the nurse to decide, as it could be too soon to the next dose as different medications have different half-lives and it could cause toxicity to the resident. V18 said she was not notified R34 had not taken her morning medications. On December 10, 2025, at 12:34 PM, V10 (RN) said if a resident was complaining of nausea during their medication administration time, she would provide an antinausea medication, wait 30 minutes to an hour, and then if the resident was still unable to take the medications, she would notify the doctor to let them know. V10 said if a medication was due at 9 AM and 5 PM, 1 PM could be too soon if the next dose was due at 5 PM. On December 10, 2025, at 2:22 PM, V5 (LPN/Licensed Practical Nurse) said if a resident did not receive their medications at the time due, the nurses should contact the doctor and allow the doctor to decide which medications to administer outside the medication administration window of when the medication as due. V5 said the doctor needed to decide if the resident would skip the dose or make up the dose at a different time of the day. V5 said certain medications could cause undesirable side effects. On December 11, 2025, at 2:10 PM, V2 (DON/Director of Nursing) said the nurse should contact the doctor if medications are held to be administered past the due time. V2 said it could be an overdose if the next dose was due around the same time. R34's face sheet showed she was admitted to the facility with diagnoses including atrial (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	fibrillation, hypertension, schizophrenia, cognitive communication deficit, pain, and weakness. R34's MDS (Minimum Data Set) dated October 29, 2025, showed R34 was cognitively intact. R34's POS (Physician Order Sheet) dated December 11, 2025, showed orders for Amantadine HCl- Give 1 capsule by mouth two times a day, Docusate Sodium 100 MG- Give 2 tablet by mouth two times a day, and Gabapentin Capsule 300 MG Give 2 capsule by mouth three times a day for neuropathy. R34's progress notes were reviewed, and there were no notes written by V9 (RN) showing she spoke to the doctor or NP regarding R34's medications. R34's Medication Admin Audit Report dated December 11, 2025, showed R34 was administered Gabapentin 300 MG 9 AM dose at 1:16 PM, and the 1 PM dose was signed off at 1:19 PM. The facility's Administering Medications policy revised January 2025 showed Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time, and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standards. Medications should be administered within one (1) hour of the prescribed times. The facility's Change in Resident's Condition policy reviewed January 2025 showed Nursing will notify the resident's physician or nurse practitioner when: e. It is deemed necessary or appropriate in the best interest of the resident. 2) On 12/09/2025 at 4:29 PM, R5 stated she tells the nursing staff what her blood glucose is from her CGM (Continuous Glucose Monitoring) system. The facility does not check her blood glucose with their equipment. R5 stated she manages her CGM herself. The staff provides interventions based on the readings she gets from her CGM. On 12/10/2025 at 4:15 PM, V24 (LPN) stated R5 has a CGM that she manages herself. Insulin is provided to R5 based on her monitor reading. The reading is documented in the EMR (Electronic Medical Record). Interventions related to her blood glucose are based on her readings and documented in the EMR. On 12/10/2025 at 3:51 PM, V2 DON (Director of Nursing) stated R5 has a CGM, and staff obtain and document her glucose reading from the CGM. R5 maintains and connects it herself. R5's competency for using her CGM was not assessed. V2 stated she was not aware of how QA (Quality Assurance) checks were done on R5's CGM or if she was even doing them. The staff does not have instructions or knowledge of how her equipment works. V2 stated she is unaware of facility policy regarding the use of CGM system or have manufactures instructions for the device. On 12/11/2025 at 2:39 PM, V1 Administrator stated the facility did not have policies regarding the assessment and use of CGM systems. There are no policies regarding how nurses medicate based on results from resident managed CGM devices. R5 had no physician order noted for the self-directed use of a CGM system prior to this survey. R5 had no care plan interventions in place for the use of a CGM device prior to this survey. The facility did not provide an assessment of R5's use of a CGM device. The facility policy Continuous Glucose Monitoring dated 4/25 states to obtain a physician's order, monitor device for signs of infection, follow manufacture's instruction for application, set up, care, alert setting, storage, disposal.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to secure and store cleaning supplies, safely transfer residents, and implement positioning and fall interventions.This applies to 4 of 6 residents R29, R61, R106, R111 reviewed for safety hazards in a sample of 27.Findings include: 1) On 12/09/2025 at 11:12 AM, an unsecured cleaning cart in a residents' room hallway had an 8oz (Ounce) bottle of dermal wound cleanser with blue liquid, a 1qt (Quart) generic spray bottle with fluid, and a 1 qt bottle of pine cleaning product. On 12/09/2025 at 11:22 AM, V22 Housekeeper returned to the unsecured cart stating she stepped away to throw out garbage. V22 stated she retrieved the wound cleanser bottle from the trash. V22 stated she put glass cleaner in the wound cleanser bottle because her previous bottle had broken. She was going to request a new bottle from her supervisor later. V22 stated the generic spray bottle contained bleach. V22 stated the cart did not have a locked compartment to secure items. V22 stated there is a storage room where carts are kept secured when they are done cleaning. On 12/11/2025 at 9:44 AM, V25 Housekeeping Supervisor stated when the housekeepers walk away from their carts, they should be secured in the cleaning closet or garbage room. They are stored in a locked room to prevent residents from taking items from the cart and avoid any incidents of theft. V22's glass cleaner bottle had broken, but she should not have used a bottle from the trash because it is not hygienic. The SDS (Safety Data Sheet) for the germicidal bleach hazard statement states it causes skin irritation and serious eye damage. Inhalation of vapors in high concentrations may cause irritation of respiratory system. Avoid contact with eyes may cause burns. Avoid contact with skin may cause irritation. Maybe harmful if swallowed. The SDS for the glass cleaner states it is an eye irritant. Hands should be washed thoroughly after handling. Store in original container in an upright position in cool, dry area. Do not store near oxidizers, alkalizes, acids and bleach. Do not mix with other chemicals. The SDS for pine cleaner states to handle in accordance with good industrial hygiene and safety practice. The undated facility policy Housekeeping Guidelines declares the purpose is to provide guidelines to maintain a safe and sanitary environment for residents, facility staff and visitors. The policy provides no direction on the proper storage or use of hazardous cleaning products. 2. On December 9, 2025, at 10:12 AM, V6 (CNA/Certified Nurse Assistant) was assisting to transfer R111 from the bed to the high back wheelchair. V6 put her hand underneath R111's left arm, held the waistband of R111's pants and pulled her up to a standing position and pivoted her into the high back wheelchair. V6 did not use a gait belt. On December 11, 2025, at 11:31 AM, V16 (CNA) said when she transferred the residents who required a one assist, she would stand in front of them, put her right leg in front and bring the chair close to the left side, and use their waistband to hold and transfer them. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On December 11, 2025, at 11:46 AM, V4 (Restorative Nurse) said for transfers, the staff have to use a gait belt to transfer residents. V4 said the staff should not be using the residents' waistbands to transfer the residents. V4 said R111 required extensive assist with two staff for transfers and needed a staff on each side of her to assist transferring her. On December 11, 2025, at 11:38 AM, V14 (Restorative CNA) said staff should use gait belts to transfer residents who required a one assist. V14 said R111 needed two assist to transfer to the bed, adding that R11 actually had recently been changed to needing the mechanical lift to transfer instead. On December 11, 2025, at 2:10 PM, V2 (DON/Director of Nursing) said the staff should not be pulling residents by their waistbands but should use a gait belt to transfer. V2 said it was a safety concern which could hurt their skin, their pants could rip, and they could fall. R111's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis affecting right dominant side, chronic pain, failure to thrive, encounter for palliative care, repeated falls, and altered mental status. R111's MDS (Minimum Data Set) dated November 25, 2025, showed R111 required substantial assistance for sit to stand, and chair to bed to chair transfers. R111's Care Plan dated April 8, 2025, showed R111 has history of falling [related to] poor safety awareness, impulsive behavior and believe she is more independent than capable. R111's Care plan dated January 30, 2025, showed R111 has a self-care deficit with showed an intervention for extensive assist x2 for transfers and transfer with mechanical lift x2 onto shower chair. The facility's Gait Belt policy revised January 2025 showed to Place the gait belt around the resident's waist.Grab belt webbing securely at resident's back and resident's right or left side to support resident balance during transfers. 3. On December 10, 2025, at 3:01 PM, V8 (CNA) and V6 (CNA) hooked R61 to the mechanical lift to transfer R61 from the wheelchair to the bed. R61 had fall mats down and in place on both sides of her bed. V8 lifted R61 from the wheelchair using the mechanical lift and moved the mechanical lift towards R61's bed. V8 rolled the mechanical lift over the fall mat on the right side of the bed and lowered R61 into the bed. R61's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis affecting right dominant side, pain in left knee, altered mental status, and speech disturbances. R61's MDS dated [DATE], showed R61 had moderate cognitive impairment and was unable to transfer herself in or out of the chair or bed. R61's Care Plan dated February 18, 2025, showed R61 was at risk for falls [related to] hemiplegia. On December 11, 2025, at 11:46 AM, V4 (Restorative Nurse) said fall mats should be moved prior to the resident being transferred back into bed. V4 said the fall mat should be up when transferring the resident because it could cause the mechanical lift from being able to roll over them and get under the bed properly. V4 said the base of the mechanical lift needed to be properly underneath the bed. On December 11, 2025, at 2:10 PM, V2 (DON/Director of Nursing) said fall mats should not be down when transferring a resident back to bed as it was a tripping hazard and could also cause the mechanical lift to tip. The facility's Safety and Supervision of Residents policy revised March 2025 showed the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	facility-oriented and resident-oriented approaches to safety are used together to implement systems approaches to safety, which consider the hazards identified in the environment and individual resident risk factors and then adjust interventions accordingly. 4. R29's fall care plan said he was at a high risk for falls. The care plan included an intervention initiated on 9/02/2025 to provide R29 with a chair appropriate for his stature and on 12/05/2025 for staff to be educated on fall prevention and strategies in keeping him safe. On 12/09/2025 at 10:20 AM, R29 was in the dining room in his (specialized high-back) chair. R29 appeared uncomfortable with his unsupported legs dangling and resting his head on the right armrest. At 10:50 AM, R29 remained in the dining room sitting in a (specialized high-back) chair in a slouched position. R29 appeared uncomfortable. R29 had a shorter stature, and his legs were dangling unsupported because the chair's leg rest and footrest were missing. R29 was confused and non-interviewable. On 12/10/2025 at 11:50 AM, R29 was in the dining room sitting unsafely across the seat of his (specialized high-back) chair with his legs placed over the left armrest. Nursing staff were present but failed to assist R29 with safe positioning. R29's chair again had no leg rest or footrest attached. The facility's Fall Incident report from October to December 2025 said R29 had fallen four times. On 10/07/2025, 11/01/2025, 11/12/2025, and 12/04/2025, R29 was observed on the floor in front of his wheelchair in the nursing common areas. 5. R106's fall care plan said he was at a high risk for falls. The care plan included an intervention initiated on 11/07/2025 to provide a non-slip material device to his chair. R106's care plan was last updated on 11/20/2025 with an intervention to provide non-slip seating material when up in the chair. On 12/09/2025 at 10:45 AM, R106 was in the dining room in a (specialized high-back) chair leaning and resting his head on the right arm rest. R106 did not have a non-slip material in his seat. On 12/11/2025 at 10:20 AM, R106 was in the dining room in a high-back wheelchair. R106 again did not have a non-slip material in his seat. Also, R106's feet were dangling because they were unsupported. The wheelchair did not have a footrest attached. The facility's Fall Incident report from November-December 2025 said R106 had fallen four times. On 11/07/2025, 11/19/2025, 11/23/2025, and 12/08/2025, R106 was observed on the floor in front of his (specialized high-back) chair in the dining room. On 12/11/2025 at 10:30 AM, V7 (Certified Nurse Assistant/CNA) said there was a posted communication sheet for high-risk fall residents throughout the nursing unit to ensure staff were aware and implement their identified safety precautions. V7 said R29, R106, and R27 were also frequent fallers as indicated in the posted communication sheet. On 12/11/2025 at 10:40 AM, V3 (Assistant Director of Nursing/ADON) said R29, R106, and R27 had recurrent falls and required staff to monitor them closely for their safety. V3 assessed R106 and said he did not have his non-slip device intervention in place. V3 said staff were expected to implement the specific fall interventions as indicated in the fall communication sheet. On 12/11/2025 at 12:20 PM, V4 (Restorative Nurse) said residents were assessed and evaluated after (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	a fall incident with the goal to identify the root cause. V4 said once the IDT (Interdisciplinary Team) reviews a fall incident, they then develop resident-centered interventions with the purpose to prevent injury or reoccurrences. V4 said then residents' care plans were updated to communicate the interventions to the staff. V4 continued to say staff should be monitoring and assisting residents with safe sitting positioning to prevent injury or accidents. The facility's policy titled Safety and Supervision of Residents, dated 03/2025, said the facility strives to make the environment as free from accident hazards as possible. Resident safety, supervision, and assistance to prevent accidents are facility-wide priorities. They use facility systems and resident-oriented approaches to implement safety. They address resident safety and accident hazards via an individual approach. The IDT team will analyze risk factors based on observations and information reviewed. Then they implement interventions by communicating specific interventions to all relevant staff, assigning responsibility for carrying out interventions, providing training as necessary, ensuring that interventions are implemented and documented.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to implement nutritional interventions for a resident (R10) with a known significant weight loss. This failure resulted in R10 experiencing additional significant weight loss of 10.3% in one month. The facility also failed to serve residents double portions as ordered.This applies to 3 out of 4 (R10, R27, and R106) residents reviewed for nutrition in a sample of 27.The findings include:1. R10's nutritional care plan initiated on 11/03/2025 said he was at risk for compromised nutritional status. The care plan's goal was for R10 not to experience any further weight loss. The interventions included for R10 were to serve his nutritional diet as ordered.On 12/09/2025 at 12:55 PM, R10 was confused in the dining room for lunch. R10 was thin and appeared frail. V4 (Restorative Nurse) served him his lunch, which included single portion servings of regular turkey, mashed potatoes, and mixed vegetables. V4 reviewed R10's ticket and said he did not receive the double portions as indicated on his meal tray.R10's meal ticket said he was to receive double portions for all his meals.On 12/10/2025 at 12:55 PM, R10 was sleeping in the dining room. R10 was not served his lunch during the meal service. At 1:30 PM, R10 was still sleeping in the dining room. V11 (Licensed Practical Nurse/LPN) said R10 did not eat lunch because he was sleeping, and they would offer him two peanut butter and jelly sandwiches later. V11 said she was unsure if R10 ate breakfast. Then V11 checked R10's EMR (Electronic Medical Record) meal intake documentation and said R10's last recorded meal was on 11/30/2025. At 2:30 PM, V11 said R10 was able to wake up and ate one peanut butter and jelly sandwich.R10's EMR meal intake document, reviewed for the past 30 days, showed his meal intake was last recorded on 11/30/2025. The document showed a total of fifteen meal intake entries in the 30-day lookback period for R10.On 12/11/2025 at 11:20 AM, V3 (Assistant Director of Nursing/ADON) obtained R10's standing weight and said his weight was 131.8 lbs. (pounds). V3 said R10 had known weight loss recently, and the dietician (V17) was aware. V3 said residents' weights were monitored weekly, and if ordered more frequently.R10's EMR recorded weights:09/05/2025 159.2 lbs (standing)10/14/2025 138.0 lbs (standing)11/04/2025 147.0 lbs (standing)12/05/2025 145.7 lbs (standing)On 12/11/2025 at 1:55 PM, V17 (Registered Dietitian) said she was aware of R10's ongoing weight loss. V17 said on 11/04/2025 she reviewed R10's nutrition, and R10 was identified to have significant weight loss for the past three and six months and a significant weight gain in one month. V17 continued to say that R10's BMI (body mass index) was 19.9 (below normal range). V17 said R10 was already receiving a nutritional supplement of 240 milliliters (ml) three times a day, and she did not make any additional recommendations. V17 said reviewing R10's weights now, she suspects his weight gain in November was possibly an error weight. V17 said on 11/20/2025, the facility informed her of R10's family's request for double portions for his meals due to his weight loss. V17 said she was now very concerned regarding R10's additional significant weight loss of 10.3 % in one month. V17 said she was not on-site and was dependent on nursing staff to accurately and consistently document meal intakes and weights to assess residents' nutritional needs. V17 said R10's last recorded meal intake was on 11/30/2025. V17 said if R10's weight and nutritional intake had been monitored more closely; his significant weight loss could have been prevented.V17's Dietary Progress Note dated 11/14/2025, said res (resident) with hx (history) of weight loss; res triggered for sig (significant) weight loss x 3 and 6 months, sig weight gain x 1 month this month. The note said R10's nutritional interventions were a 240 ml nutritional drink with meals, spill proof cup, and his meal intake was reviewed and varied from 26-100%. The note said No new nutrition recommendation, continue with current dietary interventions as tolerated. Will continue to monitor weight changes per facility protocol. Plan: Continue to follow with RD (registered dietician) available for consult PRN (as needed).V17's Dietary Note dated (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	12/11/2025 (during survey), said res with hx of weight loss; res with additional sig weight loss this month, weight dropped from 145 to 131.8# this week, res with underweight BMI at 17.9.On 12/11/2025 at 1:40 PM, V18 (General Nurse Practitioner) said she was not aware of R10's weight loss. V18 said she expected the facility to monitor residents' weight monthly and if needed more frequently to ensure weight loss was identified. V18 continued to say the facility's dietician was also to be monitoring and managing residents' weights, intake, and nutritional needs with the goal to ensure their nutritional needs were met.The facility's policy titled Weight Assessment and Interventions, dated 01/2025, said the facility was to ensure that residents were to be monitored for undesirable weight loss or gain so appropriate interventions can be put in place in a timely manner. The residents would be weighed, and the dietician would review the recorded weights to identify and address weight issues. The dietician would also discuss findings with the IDT (Interdisciplinary Team) with the goal identify possible interdisciplinary approaches and interventions. 2. On 12/09/2025 at 12:55 PM, V14 (Certified Nurse Assistant/CNA) was feeding R106 his lunch in the dining room. R106's meal included single portion servings of mechanical turkey, mashed potatoes, and mixed vegetables. V14 said R106's ticket said he was to receive double portions for his lunch but did not receive them.On 12/10/2025 at 12:25 PM, V14 was feeding R106 his lunch in the dining room. R106 was served single portions of mechanical spaghetti and mixed vegetables. V14 said R106 again was not served double portions as indicated on his meal ticket.R106's meal ticket said he was to receive double portions for all his meals.3. On 12/09/2025 at 1 PM, R27 was being assisted with his lunch in the dining room. R27's meal included single portion servings of mechanical turkey, mashed potatoes, and mixed vegetables. V14 said R27's ticket said he was to receive double portions for his lunch, but he did not receive them.On 12/10/2025 at 1 PM, V7 (CNA) was feeding R27 his lunch in the dining room. R27 was served single portions of mechanical spaghetti and mixed vegetables. V7 said R27 was not served double portions as indicated on his meal ticket.R27's meal ticket said he was to receive double portions for all his meals.On 12/11/2025 at 11 AM, V21 (Dietary Manager) said meal trays were prepared by the dietary staff in the kitchen. V21 said staff were expected to review the ticket menus to ensure nutritional interventions, such as double portions, were served as ordered. V21 said nutritional interventions were specific dietary recommendations to meet the needs of the residents. V21 said he was not notified that R10, R27, and R106 did not receive double portions for their lunch as ordered.The facility's policy titled Double Portions, dated 04/2023, said residents with double portions orders will be given double entree, double side, and double starch at meals as reflected in their diet orders.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview, and record review, the facility failed to follow gastrostomy tube feeding orders, label feeding bottles, and maintain the tube site.This applies to 1 out of 3 (R7) residents reviewed for gastrostomy tubes in a sample of 27.The findings include: On 12/09/2025 at 10 AM, R7 was in bed receiving his g-tube (gastrostomy tube) feeding via a pump. R7's hanging feeding was in a clear bag connected to a water bag, both were not labeled. R7 had an open g-tube feeding bottle of (Nutritional Product) on his bedside table.On 12/10/2025 at 11:40 AM, R7 said he was dependent on staff for his care, and his feeding was just disconnected. R7's gastrostomy tube site did not have a dressing and had brown-thick adherent drainage around his tube.On 12/11/2025 at 9 AM, R7 was in bed connected to his g-tube feeding. R7's hanging feeding bag again was not labeled with the type of feeding being infused. The pump had a beeping alarm notifying that the pump was inactive. At 9:25 AM, V27 (Wound Nurse) assessed his tube site, and again there was brown-thick adherent drainage around his tube. V27 said nurses should be assessing and cleaning tube sites to prevent complications.At 10:15 AM, R7's pump was still beeping. V19 (Registered Nurse/RN) assessed the feeding infusion and said she was unsure of the type of feeding that was hanging because it was not labeled. V19 said feeding bags should be labeled accurately to ensure the correct feeding was being infused.R7's tube feeding care plan said nursing staff was to utilize clinical standards of practices when managing his tube to prevent complications. The care plan's interventions included infuse feeding as ordered and check tube site regularly for drainage.R7's order summary report said he was to receive (Nutritional Product) 1.5 g-tube feeding, and if needed, could be supplemented with (Nutritional Product) 1.5. There was also an order to clean the g-tube site with normal saline daily and as needed.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview and record review, the facility failed to ensure medications were administered in accordance with physician orders to maintain a medication error rate of less than 5%. There were 38 opportunities for error with 4 medication errors, resulting in an error rate of 10.53%.This applies to 1 of 3 residents (R34) observed during medication pass.The findings include: On December 9, 2025 at 12:21 PM V9 (RN/Registered Nurse) was preparing R34's medications. V9 said she did not administer R34's medications at 9 AM as R34 was nauseous. At 1:05 PM, V9 finished preparing R34's medications and administered them to her. V9 came back to the computer and signed off her medication and said she had completed administering R34's medications. Upon medication reconciliation, the following medication errors were found: 1. Amantadine Hydrochloride (HCL) 100 MG (Milligram) oral tablet, to be administered at 9 AM and 5 PM, was administered at 1:05 PM. 2. Docusate Sodium 100 MG oral tablet, to be administered at 9 AM and 5 PM, was administered at 1:05 PM. 3. Gabapentin 300 MG oral capsule, to be administered at 9 AM, 1 PM, and 5 PM, was administered at 1:05 PM. 4. Multiple Vitamin Tablet, to be administered at 9 AM, was not administered to R34. On December 10, 2025 at 12:34 PM, V11 (LPN/Licensed Practical Nurse) said there was a medication administration window, which meant if medications were due at 9 AM, they could be administered between 8 AM to 10 AM. V11 said if medications were given outside the window, it could have interactions with the next dose of the medications due. On December 11, 2025 at 2:10 PM, V2 (DON/Director of Nursing) said the nurse should contact the doctor if medications due at a certain time are past the window of administration. V2 said it can cause an overdose of the medications. On December 11, 2025 at 2:26 PM, V18 (NP/Nurse Practitioner) said the window of time for the 9 AM medication pass would be from 8 AM to 10 AM. V18 said if it was beyond the time frame, the nurse should be calling the doctor or NP to clarify which medications to administer. V18 said it could be too soon for the next dose, as different medications have different half-lives or effectiveness, which could negatively affect the resident and potentially cause toxicity if given too close together.R34's face sheet showed she was admitted to the facility with diagnoses including atrial fibrillation, hypertension, schizophrenia, cognitive communication deficit, pain, and weakness. R34's MDS (Minimum Data Set) dated October 29, 2025 showed R34 was cognitively intact. R34's POS (Physician Order Sheet) dated December 11, 2025 showed orders for Amantadine HCl- Give 1 capsule by mouth two times a day, Docusate Sodium 100 MG- Give 2 tablet by mouth two times a day, Gabapentin Capsule 300 MG- Give 2 capsule by mouth three times a day for neuropathy, and a Multiple Vitamin Tablet to be given one time a day. R34's progress notes were reviewed, and there were no notes written by V9 (RN) regarding consultation with a doctor or Nurse Practitioner to administer medications beyond the medication administration window. R34's Medication Admin Audit Report dated December 11, 2025 showed the following for December 9, 2025: R34's Amantadine HCl due at 9 AM was signed off as administered by V9 at 1:15 PM, Docusate Sodium due at 9 AM was signed off by V9 at 1:15 PM, Gabapentin 300 MG due at 9 AM, was signed off by V9 at 1:16 PM, and the 1 PM dose was signed off at 1:19 PM. R34's Multiple Vitamin Tablet due at 9 AM was signed off by V9 at 1:18 PM. The facility's Administering Medications policy revised in January 2025 showed Medications shall be administered in physician's written/verbal orders upon verification of the right medication, dose, route, time, and positive verification of the resident's identity when no contraindications are identified, and the medication is labeled according to accepted standards. Medication should be administered within one (1) hour of the prescribed times.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to label and securely store drugs and biologicals for 7 out of 7 residents (R86, R111, R130, R57, R49, R73, & R91) reviewed for medications in a sample of 27.The findings include:1.On [DATE] at 1:00 PM a check of the facility's medication cart #3 was conducted with V3 ADON (Assistant Director of Nursing) and the following was found: R86's open bottle of antiacid and anti-gas without an open date on it. R111's open bottle of Levetiracetam (Keppra) (Anticonvulsant) 100mg/ml quantity 300 without an open date on it. R130's open bottle of Lactulose (Laxative) 16 oz without an open date on it. R57's open bottle of Valproate Sodium (Anticonvulsant) 250/5ml 16 oz bottle without an open date on it. The following stock medications and biologicals were found: 1 open bottle of Geri-Tussin DM 16 oz bottle (cough suppressant and expectorant) without and open date on it. 1 open bottle of Polyethylene Glycol 3350 (laxative) 17.9 oz without an open date on it. 1 open bottle of Reguloid 13 oz (Laxative) without an open date on it. 1 container with a 1/4 cup of a white powder in it that the snap-on lid was missing. The container was not labeled or dated. V3 said that the substance was a liquid thickener. On [DATE] at 1:00 PM, V3 said that she doesn't date all the medications that she opens. V3 said that the white substance should have been properly contained because if not the substance can get contaminated. V3 said that if the medications do not have an open date on them, you do not know when to dispose of them. On [DATE] at 1:33 PM, V2 DON (Director of Nursing) said that all open medications are to have an open date on them and all containers should be labeled to identify the content. V2 said that if the medication or biological is not properly contained it can become contaminated. V2 said that if a contaminated medication or biological is given to a resident, they can become ill. V2 said that if the open medication or biological is not labeled with an open date, you don't know when it is expired. V2 said that if an expired medication or biological is given to a resident, they can become ill. R57's [DATE] physician's order showed Valproate Sodium Oral Solution 250 mg/5ml give 10 ml by mouth two times a day for agitation: anxiety. R111's [DATE] physician's order showed Keppra Solution 100 MG/ML give 5ml by mouth two times a day related to epilepsy. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R130's [DATE] physician's order showed Lactulose Oral Solution 20 GM/30ml give 30 ml by mouth two times a day related to toxic encephalopathy. R86's [DATE] physician's order showed Maalox Max Oral Suspension 400-400-40 MG/5ml give 15 ml by mouth every 6 hours as needed for indigestion. The facility's Medication Storage policy dated [DATE] showed that medications and biologics are stored safely, securely, and properly. When the original seal or a manufacturer's container or vial is initially broke, the container or vial will be dated. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date or regulations/guidelines require different dating. 2. On [DATE] at 11:27 AM, R91 was sitting up in bed. R91 had a nebulizer machine and two unopened vials of Albuterol Sulfate for inhalation on the bedside table. R91 stated he adds the Albuterol Sulfate for inhalation to the machine on his own. R91 stated the nurses do not watch him as he adds the medication to the machine or applies the mask for inhalation. R91 stated he gives himself the nebulizer breathing treatment every day. On [DATE] at 4:07 PM, V2 (Director of Nursing) stated the facility did not have any residents that could self-administer medications. V2 stated no medications should be stored at the bedside unless the resident had an order for it. V2 stated residents could get hurt or take the wrong dosage if medications are left at the bedside. R91's admission Record showed R91 was admitted to the facility on [DATE] with multiple diagnoses which included chronic obstructive pulmonary disease, nuclear cataract, myopia, dementia, major depressive disorder, anxiety, and polyarthritis. R91's Order Summary Report for [DATE] showed an active order for Ipratropium-albuterol Solution 0.5-2.5 (3) mg (milligram)/mL (milliliter). Inhale orally every four hours as needed for SOB (Shortness of breath) or wheezing via nebulizer. The Order Summary Report showed no active orders for medications to be stored at the bedside. 3. R49 On [DATE], at 11:28 AM, R49 had a medication cup with a small, circular white pill inside of it, which had the letters AC 145 written on it. R49 said she was not sure what the medication was for but thought it may be her medication for high blood pressure. R49's face sheet showed she was admitted to the facility with diagnoses including hemiplegia and hemiparesis affecting left non-dominant side, hypertension, cerebral edema, and nontraumatic intracerebral hemorrhage. R49's POS (Physician Order Sheet) dated [DATE], showed an order for Chlorthalidone Tablet 25 MG (Milligrams) Give 1 tablet by mouth one time a day related to essential primary hypertension. 4. R73 On [DATE], at 10:42 AM, R73's fridge contained Fluticasone Propionate Nasal Spray 50 MCG (Micrograms). R73's fridge was not locked. R73's face sheet showed he was admitted to the facility with diagnoses including chronic obstructive pulmonary disease. R73's POS (Physician Order Sheet) dated [DATE], showed an order for Fluticasone Propionate Suspension 50 MCG/ACT (Micrograms/Activation) 1 spray in each nostril at bedtime for allergies. The facility's Storage of Medications policy revised [DATE], showed Medications and biologicals are (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review the facility failed to maintain the kitchen in a manner that prevents foodborne illness.This applies to all 114 residents receiving dietary services.Findings include:On 12/09/2025 9:40 AM, V21 Dietary Manager confirmed 114 residents were receiving dietary service on the survey start date of 12/09/25.On 12/09/2025 9:40 AM, the kitchen tour was begun with V21 Dietary Manager.Dry Storage contained a 25 lb. (Pound) bag of great northern bean that were open to air.The Kitchen cooler #2 had a facility container that contained hard boiled eggs with an expiration date of 7/14/25.A 30lb bucket of beef base was open to air with the lid sitting loosely on top of it, and a 30lb. bucket of chicken base were being stored underneath the kitchen sink.Two silver facility pans containing yellow cake were on the counter in splashing distance of the kitchen sink.Two red sanitization buckets were in use both testing at 400 PPM (Parts Per Million)The serving utensils in open bins were dirty with dried crusted food. Two stacks of three silver mixing bowls under the food prep counter contained crumbs and a dried white substance.On 12/11/2025 at 11:41 AM, V21 Dietary Manager stated food should be sealed to prevent damage, contamination and bacteria. Dating food items is important to assure the freshness of the food product. If food that is outdated or misdated need to be discarded because it can cause sickness. V21 stated he didn't know things should not be stored under the sink. V21 stated now I know storing under the sink can cause contamination and water could get in it. Food should not be held near the sink for the same reason water could potentially contaminate the food items. Using dirty utensils will cause cross contamination and cause sickness. I didn't know I needed a separate log for the red buckets. The red bucket sanitizer level should be 200 ppm. I knew I was supposed to keep the logs I just didn't have the room to keep them.The facility policy General Preparation & Cooking Practices dated 4/2017 states the facility will follow sanitary practices in food preparation and cooking to keep food safe. Identification of potential hazards in the food preparation process and adhering to critical control points can reduce the risk of food contamination and thereby prevent foodborne illness.The facility policy Guidelines for Labeling Unopened and Opened Food Items dated 4/2023 states any items past the use by date will be discarded of immediately. All foods that are opened are to be wrapped or put in a sealed container for storage to prevent contamination.The facility policy Storage of Dry Foods / Supplies dated 4/2017 states opened products will be labeled and stored in tightly covered containers.The facility policy Sanitizing Buckets dated 4/2022 states the facility will follow manufacturers recommendations on the amount of sanitizing solution used.

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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. Based on observation, interview, and record review, the facility failed to use PPE (Personal Protective Equipment) and perform hand hygiene when rendering care.This applies to 4 out of 4 (R7, R9, R29, and R118) residents reviewed for infection control in a sample of 27.The findings include:1. On 12/11/2025 at 10 AM, V19 (Registered Nurse/RN) was administering R9's enteral feeding via her gastrostomy tube (g-tube). R9 had an EBP (Enhanced Barrier Precaution) sign on her door. V19 was only wearing gloves when rendering care to R9. R9's care plan said she required the implementation of EBP due to her g-tube, urinary catheter, and wound. The care plan's goal was to prevent the spread of infection. 2. On 12/11/2025 at 10:15 AM, V19 (RN) was assessing and flushing R7's g-tube. R7 had an EBP sign on his door. V19 was only wearing gloves when rendering care to R7. R7's care plan said he required the implementation of EBP due to his g-tube and wound. The care plan's goal was to prevent the spread of infection. 3. On 12/11/2025 at 11:25 AM, V20 (Licensed Practical Nurse/LPN) was administering R29's bolus g-tube feeding. R29 had an EBP sign on his door. V20 was only wearing gloves when rendering care to R29. R29's care plan said he required the implementation of EBP due to his g-tube. The care plan's goal was to prevent the spread of infection. On 12/11/2025 at 2:15 PM, V2 (Director of Nursing/DON) said staff were expected to adhere to EBP when rendering direct resident care to prevent the spread of infection. The facility's policy titled Enhanced Barrier Precautions, dated 4/28/2025, said the purpose of EBP was to reduce the transmission of novel or target multidrug-resistant organisms. EBP required the use of gown and gloves during high-contact resident care activities, including when providing device care, including the handling of feeding tubes. 4. On 12/10/2025 at 3:17 PM, V23 CNA (Certified Nurse Assistant) came into R118's room closed the room door and put on gloves without performing hand hygiene. V23 then uncovered R118 unfastened the undergarment and turned her to the left side. V23 pulled back and removed the undergarment that was soaked with urine and smeared with stool. V23 then walked to the opposite side of the bed turned the call light off with soiled gloved hand, while closing the privacy curtain bumped into the over bed table knocking R118's roommates stuffed bear on the floor. V23 picked the bear up off the floor with the soiled gloves. V23 then went to R118 placing her on her back and with same soiled gloves wiped under her reddened abdominal fold and vaginal area with the same towel multiple times. V23 then turned R118 on her left side wiping her buttocks and between the gluteal cleft with the same washcloth multiple times. V23 then placed R118 on her back covered her with the blankets removed gloves and left the room. On 12/11/2025 at 12:50 PM, V2 DON (Director of Nursing) stated not cleaning residents properly during incontinence care and cause a UTI (Urinary Tract Infection). The CNAs should not wipe residents' multiple times with the same towel or touching things in the environment with soiled gloves. It is an infection control concern. Staff should perform proper hand hygiene. (continued on next page)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility policy Incontinence Care dated 1/2025 states resident will be checked periodically for bowel and / or bladder incontinence and be provided with perineal and genital care to prevent infection and improve the quality of resident's care. The facility policy Hand Hygiene dated 1/2025 state the purpose to provide guidelines on proper and appropriate hand washing and hygiene techniques that will aid in the transmission of infection. Washing hands with soap and water when hands are visibly dirty or soiled with blood or other body substances. If hands are not visible soiled use an alcohol-based hand rub. Before applying gloves and after removing gloves or other PPE (Personal Protective Equipment). After handling items potentially contaminated with blood, body fluids or secretions. Before moving from a contaminated body site to a clean body site during resident care. After providing direct resident care. After contact with inanimate objects.