STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146179	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge of Arlington Hts	1200 N Arlington Heights Rd Arlington Heights, IL 60004

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Deficiency Text Not Available

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a resident's assessment was completed accurately for 1 of 20 residents (R95) reviewed for assessments in the sample of 20. The findings include: R95's Minimum Data Set (MDS) dated [DATE] shows Discharge status: short term General Hospital (acute hospital). R95's Progress Notes dated 3/28/25 at 4:28 PM shows Resident discharged home with granddaughter, to receive home health care. Resident discharged with all scripts, paperwork and belongings. On 06/11/25 at 10:25 AM, V5 Director of Nursing said R95's MDS was done in error, R95 was not hospitalized she went home with family per the progress notes. On 06/11/25 at 11:53 AM, V1 Chief Executive Officer said the facility doesn't have a policy on assessments, they just follow the Resident Assessment Instrument (RAI) procedure and are to submit MDS assessments timely and accurately.

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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 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 ensure a cervical neck collar and ace wraps were in place as ordered, failed to clarify physician prescribed medication orders to ensure a resident received the medications and failed to perform an assessment immediately after and following a fall for 4 of 20 residents (R36, R52, R47 and R299) reviewed for quality of care in the sample of 20. The findings include: 1. On 6/9/25 11:35 AM, R36 was lying in bed and had a cast on her right lower leg. R36 said that she had a fall in the bathroom and broke her leg. On 6/10/25 at 10:20 AM, V34 (R36's Spouse) said that he came in on 5/11/25 and R36 was on the floor of the bathroom. V34 said that a male and female staff member came in and lifted her back up into her wheelchair. V34 said that a couple days later, he noticed that her leg was bruised, and her foot was pointed in an abnormal position. On 6/10/25 at 12:19 PM, V22, Certified Nursing Assistant (CNA) said that on 5/11/25, R36 had a fall in the bathroom. V22 said that R36 was holding the grab bar in the bathroom, and she began to fall. V22 said that she put her right knee onto the floor and was still standing on her left leg. V22 said that he assisted her into a sitting position and when he did that, her right leg was stuck under her weight, so he pulled her right leg out from under her to make her more comfortable. V22 said that he then went and got V32 (CNA) to assist him in getting R36 off of the floor and into her wheelchair. V22 said that V32 was in front of R36, and he was behind R36, and they lifted her off the floor and into her wheelchair. V22 said that after they got R36 into the wheelchair, he went and told the nurse, and she came in and did an assessment. On 6/11/25 at 12:51 PM, V32 said that V22 had requested her assistance to help with R36. V32 said that she entered R36's room and R36 was on the floor in the bathroom. V32 said that V22 and herself lifted R36 up from the bathroom floor with a gait belt and placed her into her wheelchair. R36's Nursing Incident Note dated 5/11/25 at 6:44 PM shows, CNA informed writer patient had slid off her WC (wheelchair) while transferring from toilet to wheelchair. Writer immediately proceeded to assess patient. Upon entering room patient on sitting up WC On 6/11/25 at 10:38 AM, V5 (Director of Nursing) said that once a resident falls, the staff should immediately call the nurse before moving the resident so the nurse can do a thorough assessment. V5 said that the resident should not be moved until the nurse does an assessment and feels it is safe to move the resident. V5 said that it is their policy for the nurse to complete a fall assessment in the computer and do follow up fall assessments every 8 hours for the next three day. V5 said that the follow up fall assessments entail asking the resident if they are having pain, checking their vitals, assessing for any bruising or other symptoms, checking for a change in mental status, mobility or change in sleep. V5 reviewed R36's electronic medical record and said that she does not see that any fall follow up assessments were completed after R36's fall. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R36's Nursing Notes from 5/12/25 to 5/20/25 were reviewed. There were no nursing assessments documented. R36's Nursing Note dated 5/21/25 shows, Patient returned from therapy c/o (complains of) increased pain in right ankle. Patient states it started last night and is worse now after therapy Ankle is swollen and looks abnormal, but that is the patient's baseline. Ankle elevated with pillow and ice pack placed by nurse to decrease swelling. Physician contacted and X-ray ordered R36's right ankle X-ray results from 5/21/25 shows, There is an acute fracture of the distal fibula and of the medial malleolus with subluxation of the tibia on the talus medially There is soft tissue swelling diffusely. R36's Fall Care Plan shows, Monitor/Document/Report PRN (as needed) x 72h (hours) for MD (Physician) for s/sx (signs and symptoms): Pain, bruises, change in mental status, new onset: confusion, sleepiness, inability to maintain posture, agitation. The facility's Assessing Falls and Their Causes Policy revised 3/2018 shows, If a resident has just fallen, or is found on the floor without a witness to the event, evaluate for possible injuries to the head, neck, spine, and extremities If an assessment rules out significant injury, help the resident to a comfortable sitting, lying or standing position and then document relevant details Observe for delayed complications of a fall for approximately forty-eight (48) hours after an observed or suspected fall, and document findings in the medical record. Document any observed signs or symptoms of pain, swelling, bruising, deformity and/or decreased mobility; and any changes in level of responsiveness/consciousness and overall function. Note the presence or absence of significant findings. 2. R52's Podiatry Note dated 6/3/25 shows, Edema Control- Ace Wrap BLE (Bilateral Lower Extremities) On 6/9/25 at 11:50 AM, R52 was sitting in his wheelchair in his room. R52's lower extremities were swollen and reddened. R52 had socks on. R52 had ace wraps located on his windowsill. R52 said that he sees a podiatrist due to wounds on his legs. R52 said that the podiatrist is concerned about the swelling in his legs. R52 said that he used to wear support stockings on his legs, but they were too tight. R52 said that the last time that he went to the podiatrist, they put ace wraps on his legs, and it felt a lot better than the support stockings. R52 said that when the nursing staff at the facility changed his dressing, they did not re-apply the ace wraps. R52 said, I am not sure why they do not put them back on, maybe they think that I don't need them. On 6/10/25 at 10:00 AM, R52 was sitting in his wheelchair. R52's legs were swollen, and he did not have ace wraps applied to them. R52's June Medication Administration Record (MAR) shows an order for Tubigrip (elasticated tubular bandage) on right and left lower extremities in the morning every Monday, Wednesday, and Friday. These were signed out as applied on 6/9/25 at 9:00 AM. There was no order for ace wraps to be applied on R52's MAR. R52's Physician's Order Sheet printed on 6/9/25 does not show an order for ace wraps. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/25 at 10:35 AM, V14 (Wound Care Nurse) said that when R52 returned from his podiatry appointment, the ace wrap orders should have been entered into the computer by the nurse. V14 said that if a resident comes back to the facility with new wound orders, they should either put the orders into the system or notify the wound nurse. V14 said that she did speak to the nurse regarding the order, and it was a communication issue. V14 said that the nurse did see the order but never put it into the computer. On 6/10/25 at 11:02 AM, V4 (Director of Nursing) said that if a resident goes out to a doctor's appointment, it is the floor nurse's responsibility to enter any new orders into the computer system. 4. R299's admission Record showed R299 was admitted to the facility on [DATE] with a diagnosis of a cervical vertebral fracture of his neck due to a fall. R299's physician order dated 6/8/25 showed R299 was to wear a soft cervical collar around his neck, at all times, as treatment for his vertebrae fracture. On 6/9/25 at 9:06 AM, R299 was in bed, lying on his back. A soft, cervical neck collar was noted in R299's bed, however the collar was not secured around R299's neck. The collar laid loosely on R299's pillow. On 6/9/25 at 9:33 AM, V6 Certified Nursing Assistant (CNA) began providing incontinence care to R299. R299's neck collar laid loosely on his bed; not secured in place around R299's neck at any point. When V6 repositioned R299 on his right side in bed, R299 complained of neck pain as his head fell back towards the pillow, during the repositioning. After completing incontinence care on R299 and as V6 repositioned him on his back in bed. R299 again complained of neck pain with repositioning. On 6/10/25 at 10:34 AM, V5 Director of Nursing (DON) stated R299 should have a cervical collar in place around his neck at all times especially when doing cares and repositioning him to support his neck. V5 stated, I believe he has the collar because he fell and fractured his neck. The collar should be secured in place around his neck. 3. R47's face sheet shows he was admitted to the facility on [DATE] from a local community hospital. R47's After Visit Summary from the hospital provided to the facility on admission shows he had an order for mirtazapine (Remeron) 15 milligrams (mg.) to be given every night at bedtime for 30 days. R47's Order Summary Report shows an order for mirtazapine 15 mg. to be started on 4/6/25 and ended on 5/6/25. On 6/9/25 at 9:22 AM, V13 (R1's daughter and Power of Attorney) said she had a concern at the facility because R47 had been taking Remeron at home for an appetite stimulant and to help him sleep and the facility just stopped the medication for a couple of weeks. V13 said she is not sure why the medication was stopped no one could tell her but he is taking the medication again now. A physician note completed on 4/7/25 by V17 (R47's Primary Care Physician) shows he was aware that R47 was taking mirtazapine 15 mg at bedtime and documented the medication should be reviewed for an indication for use. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A physician note completed on 4/14/25 by V11 (Psychiatrist) shows she spoke with V13 who had told her that R47 had been taking mirtazapine (Remeron) for 4 years for insomnia and for a weight stimulant. V11's note states, Continue Remeron 15 mg QHS, which he has been on for 4 years and tolerated well for insomnia and help with appetite. V11's note does not specify a stop date. R47's 5/1/25-5/31/25 Medication Administration Summary (MAR) shows his mirtazapine was stopped on 5/5/25 and restarted on 5/25/25. A provider note completed on 5/22/25 by V12 (Psychiatric Nurse Practitioner) shows V12 documented for R47's mirtazapine to be restarted at 7.5 mg. every night for appetite and depression. On 6/10/25 at 10:09 AM, V5 (Director of Nursing) said what happened with R47's mirtazapine was that he came in with a hospital order for it to only be for 30 days and that nurse who admitted him was new and did not know they shouldn't enter admission orders for only 30 days. V5 said facility nurses should also clarify with a physician the duration the medication should be given. V5 said V17 is out of the country and not reachable by phone but V4 (Medical Director) is available to speak with. On 6/10/25 at 12:53 PM, V4 said in his opinion this is a provider and hospital issue that the medication was only initially ordered for 30 days. The physician who assessed and documented the medication should have continued it and also should have specified how long they wanted the medication for. V4 said a verbal order for the medication should have been given. On 6/11/25 at 8:46 AM, V11 (Psychiatrist) said she could not recall if she gave a verbal order to continue the medication to any nurses when she saw R47 on 4/14/25, and typically when she sees residents at the facility she will go back and document the note in the residents Medical Record. V11 said she was not able to comment for the facility about why the medication was discontinued. On 06/10/25 at 1:45 PM, V30 (Registered Nurse) said when residents are admitted orders need to be clarified and if a medication is suddenly stopped, they have to contact the physician to clarify if the medication should be stopped especially for psychotropic medications. The facility provided Medication and Treatment Orders policy last revised on July 2016 shows that medication orders should include start and stop dates and if an order does not contain those and a stop order becomes effective due to the medication not having a stop dated the supervisor on duty must contact the prescriber or attending physician to determine if the medication should be continued.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. R299's admission Record showed R299 was admitted to the facility on [DATE]. R299's Wound Assessment Details Report dated 6/8/25 showed R299 was admitted to the facility with a, DTI (deep tissue injury) to left buttock and blanchable redness to coccyx and right buttock. Patient noted in bed, very bony. NPO (eats nothing by mouth)- has G-tube (gastrostomy tube) feeding. Low air loss mattress ordered. The report showed R299's left buttock DTI measured 3.0 cm (centimeters) x 3.0 cm x 0.0. R299's Skin/Wound progress note dated 6/8/25 showed R299 was also admitted to the facility with blanchable redness to both of his heels. The note showed, Heel boots applied, educated on wearing them in bed to offload heels . A physician order for R299, dated 6/8/25, showed an order for R299 to have a low air loss mattress. A facility invoice receipt showed a low air loss mattress, for R299, was delivered to the facility on 6/8/25. On 6/9/25 at 9:33 AM, R299 was in bed, lying on a standard mattress. The mattress on R299's bed was not a low air loss mattress. On 6/10/25 at 8:14 AM, R299 was in bed, lying on a standard mattress. No heel boots were noted to R299's heels. R299's heels rested directly on the mattress. R299's heel boots noted on a chair next to the bed. On 6/10/25 at 10:56 AM, R299 was in bed, lying on a standard mattress. No heel boots were noted to R299's heels. R299's heels rested directly on the mattress. On 6/10/25 at 10:34 AM, V5 Director of Nursing (DON) stated residents that have wounds, are mostly bed-bound, and/or are failure to thrive require a low air loss mattress to help prevent skin breakdown. V5 stated heel boots are to be worn by residents, while in bed, to prevent skin breakdown to the heel area. V5 stated, Our low air loss mattresses are connected to a machine that regulates the air pressure of the mattress based on the resident's weight. Our wound nurses assess the resident and make the determination if the resident needs a low air loss mattress. The wound nurse orders the mattress from an outside company. It is usually delivered to the facility within 24 hours. On 6/10/25 at 1:09 PM, R299 was asleep in bed on a low air loss mattress. V9 (Family of R299) was in R299's room. V9 stated, He just got this new mattress today. V9 was asked about R299's heel boots, V9 stated, I visit him everyday. I have never heard him refuse to wear those boots. The facility's Pressure Ulcers/Skin Breakdown-Clinical Protocol dated April 2018 showed, Treatment/Management 1. The physician will order pertinent wound treatments, including pressure reductions surfaces, wound cleansing and debridement approaches, dressings (occlusive, absorptive, etc.), and application of topical agents . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview and record review the facility failed to ensure a resident had a dressing on a pressure injury and failed to ensure pressure prevention interventions were in place for 2 of 6 residents (R47, R299) reviewed for pressure injuries in the sample of 20. The findings include: 1. R47's Wound Assessment Details Report completed on 6/7/25 shows he has a stage 4 pressure injury to his left heel. The report shows his wound measures 1.00 centimeter (cm.) length x 1.00 cm. width x .20 cm. depth with a light amount of drainage. R47's Physician Order Summary shows he has treatment orders for medi-honey and a dry dressing over the wound bed. On 6/9/25 at 9:50 AM, V14 (Wound Care Nurse) and V15 (Wound Care Nurse Practitioner) were completing a wound assessment on R47's left heel wound. When V14 pulled off R47's sock there was no dressing on his left heel. V14 said R47 should have a dressing on his wound and he has orders for dressing changes 3 times a week and as needed. V14 said any nurse can reapply the dressing to R47. The facility provided Pressure Ulcers/ Skin Breakdown policy last revised April 2018 shows the facility will identify and implement treatment interventions for pressure injuries/ulcers with the wound care physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to have fall interventions in place for a resident at risk for fall and failed to ensure a resident was transferred safely for 2 of 20 residents (R33 and R36) reviewed for safety and supervision in the sample of 20. This failure resulted in R36 falling and sustaining a right ankle fracture that required surgical repair. The finding include: 1. R36's Face Sheet shows that she admitted to the facility on [DATE] with diagnoses of: cellulitis of right and left lower limbs, unsteadiness of feet, abnormalities of gait, reduced mobility and morbid obesity. R36's Functional Status Note dated 4/29/25 shows that R36 requires partial/moderate assistance to stand from sitting and transfer from bed to chair. On 6/9/25 at 11:35 AM, R36 was lying in bed. R36 had a cast on her right lower leg. R36 said that she fell in the bathroom and broke her leg. On 6/10/25 at 10:20 AM, V34 (R36's Spouse) said that he came in on 5/11/25 and R36 was sitting on the bathroom floor and had fallen. V34 said that a couple days later, R36's right leg was bruised, and her foot was pointed in an abnormal position. V34 said that eventually R36 had an X-ray and it showed that she had a fracture in two areas, and she had surgery. On 6/10/25 at 12:19 PM, V22, Certified Nursing Assistant (CNA) said that on 5/11/25, R36 had a fall in the bathroom. V22 said that he brought R36 into the bathroom to transfer to the toilet. V22 said that he instructed R36 to hold the grab bar and stand. V22 said that as R36 stood up, she lost her balance and started to fall. V22 said that he tried to place the wheelchair under her before she fell but was unable to. V22 said that when R36 fell, her right knee hit the floor, but she was still holding onto the grab bar and standing on her left leg. V22 said that he guided her to a sitting position on the floor. V22 said that when she was in the sitting position on the floor, her left leg was extended in front of her, and her right leg was under her weight, so he moved her right leg from under her and placed it in front of her. V22 said that he did not have a gait belt on R36 when the fall occurred because he did not have one but one was put on her when V32 came to help get her up off of the floor. On 6/11/25 at 12:51 PM, V32 said that V22 had requested her assistance to help with R36. V32 said that she entered R36's room and R36 was on the floor in the bathroom. V32 said that they applied a gait belt and lifted her up off the floor and into her wheelchair. On 6/11/25 at 12:52 PM, V22 was re-interviewed at the request of V4 (Director of Nursing) V22 stated, I do believe I did have a gait belt on before the fall. V22 explained the fall again in detail. V22 was then notified that this surveyor had spoken to V32 and V32 said that they applied the gait belt to R36 before they lifted her to her wheelchair. V22 stated, To be honest, I don't remember the scenario whatsoever. I do not remember exactly when the gait belt was put on. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 6/11/25 at 10:38 AM, V4 (Director of Nursing) said that R36 was a one person assist with a gait belt for transfers. V4 said that staff should always use a gait belt for the resident's safety. V4 said that it is likely that R36 received a small fracture during her fall on 5/11/25 but it worsened due to participation with therapy. V4 said that R36 had no other incident that had happened between R36's fall and the finding of the fracture. R36's right ankle X-ray results from 5/21/25 shows, There is an acute fracture of the distal fibula and of the medial malleolus with subluxation of the tibia on the talus medially There is soft tissue swelling diffusely. R36's Orthopedic Surgery Consult Note dated 5/22/25 shows, Patient is a 69 y.o. female who presents with right ankle fracture. She presented to my clinic today for this issue. The patient fell at her rehab on Mother's Day (5/11). She states that she had pain and swelling to the ankle over the past week and then they eventually got x-rays after she was in too much pain to ambulate with PT (Physical Therapy) there is moderate swelling to the ankle diffusely. There is tenderness medial and laterally Assessment: Right ankle bimalleolar fracture subluxation .Plan for ORIF (Open Reduction Internal Fixation) right ankle 5/23. The facility's Final Investigation Summary dated 5/23/25 shows, Resident Injury-Confirmed Fracture Post-Fall Based on the clinical record and timeline, no localized symptoms or signs of ankle injury were evident immediately following the assisted fall on 5/11/25 or in the days afterward However, the subsequent right ankle fracture confirmed on 5/21/25 may reflect an initially minor or hairline fracture caused by the assisted fall. Factors supporting this possibility include: The resident's high pain threshold and non-localized chronic lower extremity pain masking early injury. Morbid obesity contributes to mechanical stress and potential progression of injury. The facility's Gait Belt Policy revised on 1/2025 shows, Staff will use a gait/transfer belt on residents who need limited to total assistance with transfer or walking. 2. R33's facility assessment dated [DATE] showed R33 is a [AGE] year-old female with impaired cognition and was admitted to the facility on [DATE] with diagnosis which include dementia and unspecified disorientation. On 6/9/25 at 9:05 AM, R33's door was closed at this time. Upon entering R33's room, R33 was lying in bed diagonally across the mattress with her right foot off the edge of the bed and her head near the upper left bed mobility rail. Several fall mats were across the room leaning against the opposite wall from the bed. R33's bed was approximately two and a half to three feet above the ground which is not the bed's lowest position. On 6/10/25 at 1:20 PM and at 6/11/25 at 9:00 AM, R 33 was in bed with the fall mats stacked against the opposing wall from the headboard. On 6/10/25 at 1:25 PM, V26 CNA stated R33's fall mats should be next to the bed. On 6/11/25 at 9:44 AM, V35 CNA stated we are usually notified by the nurse or during morning report if a resident is a fall risk. V35 stated R33 does have fall mats, and they should be next to her bed when R33 is in it. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Healthbridge of Arlington Hts	1200 N Arlington Heights Rd Arlington Heights, IL 60004

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R33's medical records showed R33's last Fall Assessment was completed on 9/11/24. R33 is listed as having a moderate risk for falls. R33's Care Plan showed R33 has a risk for falls with an intervention of having fall mats landing pads in position while in bed and have the bed in the lowest position. R33's Physician Orders has an order for floor mats and low bed position with a start date of 10/3/24. On 6/11/25 at 11:35 AM, V2 Director of Nursing stated a residents fall interventions should be in place when a resident is in bed (fall mats, bed in low position, door open etc.).

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview and record review the facility failed to ensure indwelling urinary catheter bags were kept below the level of the bladder and off of the floor to prevent infections for 2 of 3 residents (R148 and R47) reviewed for indwelling urinary catheters in the sample of 20. The findings include: 1. On 6/9/25 at 9:08 AM, R148 was being transferred from her bed to a shower chair with a mechanical lift. R148 had an indwelling urinary catheter in place with cloudy yellow urine present in the tubing. V19 and V20 (Certified Nursing Assistants) placed a mechanical lift sling under R148. V19 and V20 attached the sling to the mechanical lift and then hung R148's catheter bag on the sling strap which was above R148's bladder. R148's urine in her catheter tubing was seen backflowing into R148's bladder. On 6/10/25 at 11:02 AM, V5 (Director of Nursing) said that urinary catheter bags should always be kept below the level of the bladder. V5 said that hanging the bag from the straps of the mechanical lift sling is not appropriate. R148's Care Plan shows, Position catheter bag and tubing below the level of the bladder and away from entrance room door. The facility's Urinary Catheter Care Policy revised on 8/22 shows, Position the drainage bag lower than the bladder at all times to prevent urine from flowing back into the urinary bladder. 2. On 6/9/25 at 9:30 AM, R47's was lying in bed his indwelling urinary catheter bag was lying on the floor on the right side next to his bed. At 9:50 AM, V14 (Wound Care Nurse) and V15 (Wound Care Nurse Practitioner) came into R47's room to do a dressing change. V15 raised up R47's bed did the wound care measurements and when the wound care was completed, he lowered the bed. R47's catheter bag remained on the floor. On 6/9/25 at 11:57 AM, R47's catheter bag was still laying on the floor on the right side of his bed. On 6/10/25 at 11:03 AM, V5 (Director of Nursing) said catheter bags should not be on the floor. The facility provided Catheter Care policy revised August 2022 says catheter bags should be kept off the floor.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 observation, interview, and record review the facility failed to monitor residents to ensure medications were administered completely which applies to 2 of 2 residents (R1, R4) reviewed for medication administration in a sample of 20. The findings include. 1. R1's Facility assessment dated [DATE] showed R1 to be a [AGE] year-old female resident with severe cognitive impairment admitted with diagnoses which included dementia. On 6/9/25 at 10:55 AM, R1 was resting in their wheelchair in the common area near the nurse's station. When R1 went to speak 2 partially dissolved pills fell out of R1's mouth. R1 was appeared very tired and had some confusion when asked when they had taken their pills. On 6/9/25 at 11:00 AM, V29 Registered Nurse stated R1 had received their medications with the morning medication pass around 9 AM. V29 stated they thought R1 had swallowed all their pills. V29 stated they did not check for pocketing after the medications were given. On 6/10/25 at 10:00 AM, V16 Licensed Practical Nurse (LPN) stated when giving medications to a resident the nurse should make sure the resident has swallowed the pills. On 6/10/25 at 1:00 PM, V2 VP of Operations stated nurses should make sure residents swallows their pills as part of the medication administration. The facility's Medication Administration Policy dated 4/2019 showed medications should be administered in a safe and timely manner, and as prescribed. 2. On 6/9/25 at 9:00 AM, R4 was asleep in her room. On her overbed table and nightstand were multiple bottles of medications including 2 bottles of Naso Gel spray for dry noses, a Fluticasone nasal spray and Systane eye drops. On 6/10/25 at 8:45 AM, R4 had the same bottles of medications at her bedside. V16 (Licensed Practical Nurse/LPN) said residents have to have an order to be able to self- administer medications and R4 is not able to administer her own medications. On 6/10/25 at 10:38 AM, V5 (Director of Nursing) said that residents have to be assessed for the ability to self-administer medications and have medications at the bedside. V5 said she does not believe anyone on the second floor has orders to be able to self-administer medications and nurses monitor this and there should not be medications left in resident rooms, they should be taken out. On 6/10/25 at 1:31 PM, The same medications were still at R4's bedside and R4 said that she takes these medications nasal sprays and eye drops by herself when she wants too usually one time a day. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R4's Physician Order Summary (POS) does not show an order for medications to be stored at her bedside and self-administered. R4's POS shows an order for both Fluticasone 50 micrograms (mcg) spray in both nostrils every 6 hours as needed for nasal congestion and for Saliene Nasal Gel 1 spray in both nostrils 4 times a day for soothing and moisturizing. There was no order for Systane eye drops. On 6/11/25 at 10:10 AM, V5 said R4 did not have any order for her to self-administer the medications or have them at her bedside prior to the evening of 6/10/25. The facility provided Administering Medications policy last revised April 2019 shows that residents can only self- administer medications if it has been approved and assessed by the attending physician and treatment team.

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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. On 6/9/25 at 1:41 PM the refrigerator in the kitchenette of the 2nd floor north bistro area, contained an opened box of thickened prune juice dated 5/2/25. At 1:42 PM, the refrigerator in the kitchenette of the 1st floor north bistro area, contained 2 opened boxes of thickened water dated 4/25/25, and a box of thickened apple juice dated 5/30/25. The boxes of water and apple juice said, after opening discard after 7 days. On 6/10/25 at 9:10 AM, the opened prune juice dated 5/2/25 remained in the refrigerator in the 2nd floor north bistro area kitchenette. There was no other date or opened date. At 9:15 AM, the opened boxes of thickened water dated 4/25/25 and the box of apple juice dated 5/30/25 remained in the refrigerator in the 1st floor north bistro area kitchenette. There was no other date or opened date. On 6/10/25 at 10:00 AM, V28 Dietary Manager said the boxes of thickened liquids are dated when they are received. V28 said when the staff opens the box, they should label the box with opened and the date the box was opened. V28 said once the boxes area opened, they should be discarded after 6 days. V28 said there is no policy for this, this is just the recommendation from the manufacturer. V28 said if the boxes of liquid are not labeled with an open date they should be discarded because there is no way to know how long they have been opened. The facility's Diet Type Report for Nectar thick liquids dated 6/10/25 shows R65, R298, R199, and R80 are on thickened liquids. Based on observations, interviews, and record reviews the facility failed to ensure resident refrigerators were monitored and maintained, and failed to ensure perishable foods were dated which applies to 7 of 7 residents (R33, R55, R67, R65, R298, R199, R80) reviewed for safe food handling in a sample of 20. The findings include: On 6/9/25 at 9:00 AM, R33's room refrigerator thermometer read 55 degrees Fahrenheit (F). The refrigerator had yogurt and other personal food products in it. R33 was eating a yogurt of the same brand at that time. On 6/10/25 at 1:20 PM, R33's refrigerator thermometer read 50 degrees F. V26 Certified Nursing Assistant (CNA) was present at that time and verified the temperature reading on the thermometer. V26 stated they were pretty sure that was too high. On 6/9/25 at 9:15 AM, R55's room refrigerator had no thermometer in it. The refrigerator had 10 small foam food containers with no dates on them. R55 stated their daughter brought food from home for him all the time. R55 did not know how long the different items had been in the refrigerator. On 6/9/25 at 10:15 AM, R67's refrigerator had no thermometer in it. The refrigerator had opened packages (no open date) of hot dogs and lunch meat in it. R67 stated they had to have staff help get the food out of the refrigerator since they could not get it themselves (stroke). R67 stated he was not sure the last time anyone came in and checked the refrigerator. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/10/25 at 1:35 PM, V27 Environmental Services Director stated he uses the thermometers in the residents' refrigerators to check the temperatures. V27 stated the refrigerators should be kept between 33-41 degrees Fahrenheit. The rules for food in residents' refrigerators is the same as the kitchen. Open items should have some type of date on it. V27 stated opened and prepared food containers should be discarded between 5-7 days depending on the food type. On 6/11/25 at 9:30 AM, V36 (R55's Daughter) stated she has brought food from home. V36 stated she had not been asked to check in the food with the staff or put a date on it when it was made. The facility's Brought in Food Policy dated 2/2014 showed perishable foods need to be in containers and in the refrigerator. The food containers should be labeled with the resident's name and dated (use by date). This policy showed staff are responsible for discarding perishable foods on or before the use by date and if a package is past due expiration dates.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. On 6/9/25 at 11:35 AM, R36 was lying in bed. R36 said that she is getting treatment for the wounds on her buttock. R36's room door did not have a sign on it saying she was on EBP (Enhanced Barrier Precautions) nor was there PPE (Personal Protective Equipment) outside of R36's room. On 6/9/25 at 11:37 AM, V7 (Infection Preventionist) put an EBP sign on R36's door and a cart of PPE outside of the door. On 6/9/25 at 2:25 PM, V7 said that she did just put R36's EBP sign on her door that day. V7 said that she was reviewing charts and noticed that R36 came back from the hospital with multiple wounds and should have been placed on EBP upon her re-admission. R36's Physician's Order Sheet printed on 6/9/25 shows that she re-admitted to the facility on [DATE] and an order for EBP for wounds was placed on 6/9/25. R36's Wound assessment dated [DATE] shows that she has an unstageable pressure injury on her left hip, right hip and buttock and a stage 3 pressure injury on her left lower buttock. The facility's Enhanced Barrier Precautions Policy shows, EBPs are indicated (when contact precautions do not otherwise apply) for residents with wounds EBPs remain in place for the duration of the resident's stay or until resolution of the wound signs are posted in the door or wall outside the resident room indicating the type of precautions and PPE required. Based on observation, interview and record review the facility failed to implement Enhanced Barrier Precautions (EBP) for a resident with a gastrostomy tube (G-tube) and a resident with a wound. The facility failed to inform a resident's private caregiver the resident was on Contact Isolation for an infection and failed to educate the caregiver on wearing PPE (personal protection equipment) in the resident's room. The facility failed to ensure staff changed their gloves and washed their hands to prevent cross contamination. These failures apply to 4 of 20 residents (R299, R301, R300, R36) reviewed for infection control in the sample of 20. The findings include: 1. R299's admission Record showed R299 was admitted to the facility on [DATE]. R299's admission care plan showed R299 required Enhanced Barrier Precautions due to R299 being admitted to the facility with a gastrostomy tube (G-tube) in place for nutrition/enteral feedings. On 6/9/25 at 9:06 AM, no EBP isolation sign hung on or around the door/doorframe to R299's room. Upon entrance to R299's room, V10 Licensed Practical Nurse (LPN) was holding R299's G-tube in her hand. V10 wore gloves but no gown. V10 LPN stated she had just finished giving R299 his morning medications via his G-tube. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/9/25 at 9:33 AM, V6 Certified Nursing Assistant (CNA) donned gloves and began to provide incontinence care to R299 as he was incontinent of urine. V6 CNA wiped R299's perineal area and repositioned him on his right side. V6 CNA wiped R299's buttocks and removed his soiled incontinence brief. Without changing her soiled gloves, V6 CNA then picked up R299's personal cell phone, that was lying next to R299 on the bed, and placed the phone on the bedside table. Without changing her soiled gloves, V6 CNA proceeded to place R299 in a clean incontinence brief and gown. Upon completion of these cares, V6 CNA removed her gloves. On 6/10/25 at 10:34 AM, V5 Director of Nursing (DON) stated residents that require Enhanced Barrier Precautions are residents with wounds, urinary catheters, G-tubes, and drains. V5 stated staff are to wear PPE, which includes a gown and gloves, when providing high-contact cares to a resident's G-tube. The facility Enhanced Barrier Precautions policy dated August 2022 showed, Enhanced barrier precautions (EBPs) are utilized to prevent the spread of multi-drug resistant organisms to residents . EBP's employ targeted gown and glove use during high contact resident care activities when contact precautions do not otherwise apply . Examples of high-contact resident care activities requiring the use of gown and gloves for EBP's include: device care or use (central line, urinary catheter, feeding tube, tracheotomy/ventilator, etc.) . 2. R301's admission Record dated 6/7/25 showed R301 was admitted to the facility with a diagnosis of colitis due to a Clostridium Difficile (c-diff) infection of her stool. R301's physician order dated 6/7/25 showed R301 required Contact Isolation Precautions due to her c-diff infection. On 6/9/25 at 9:35 AM, a Contact Isolation sign hung on the doorway of R301's room. V8 (Private Caregiver for R301) was seated in a chair in R301's room. R301 was asleep in bed. V8 wore no PPE, no gown or gloves. On 6/9/25 at 10:13 AM, V8 (Private Caregiver for R301) stood beside R301's bed. V8 held a cup to R301's mouth as she drank from the cup. V8 wore no PPE, no gown or gloves. On 6/9/25 at 11:40 AM, V7 Infection Control Nurse educated V8 (Private Caregiver for R301) on the importance of wearing PPE while in R301's room, while she was on Contact Isolation. On 6/9/25 at 2:20 PM, V8 (Private Caregiver for R301) stated, No one told me I had to wear a gown and gloves or that (R301) was on isolation until (V7 Infection Control Nurse) told me this morning. On 6/10/25 at 10:34 AM, V5 DON stated all staff are to don PPE, including a gown and gloves, prior to entering the room of a resident on Contact Isolation. V5 stated private caregivers and any visitors are to don and wear PPE while in the room of a resident on Contact Isolation. V5 stated when staff observe a visitor and/or caregiver not wearing the required PPE in an isolation room, staff are to immediately educate and ask them to don the required PPE to attempt to stop the spread of an infection. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Isolation-Categories of Transmission-Based Precautions policy dated September 2022 showed, Contact precautions are implemented for residents known or suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the resident's environment . The policy showed staff and visitors must wear a PPE gown and gloves when in the room of a resident on Contact Isolation. 3. On 6/9/25 at 9:14 AM, R300 was in bed, R300 was on supplemental oxygen via a nasal cannula attached to his nose. On 6/9/25 at 9:15 AM, V6 CNA donned gloves and began providing incontinence care to R300 as he was incontinent of urine. V6 cleansed R300's groin and buttocks and removed R300's soiled incontinence brief. Without changing her soiled gloves, V6 removed the nasal cannula from R300's nose and placed the cannula on the bedside table. V6 CNA proceeded to place R300 in a clean incontinence brief, shirt, and shorts without changing her soiled gloves. V6 CNA then transferred R300 from his bed to the wheelchair. Upon completion of these cares, V6 CNA removed her soiled gloves. On 6/10/25 at 10:34 AM, V5 DON stated staff must change their gloves anytime gloves are soiled and prior to touching anything clean.