STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E095	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Batavia Rehabilitation & Health Care Center	520 Fabyan Parkway Batavia, IL 60510

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303 Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medications. This applies to 3 of 5 residents (R13, R18, and R21) reviewed for unnecessary medications in the sample of 14. The findings include: 1. The EMR (Electronic Medical Record) showed R18 was admitted to the facility on [DATE], with multiple diagnoses including neurocognitive disorder with Lewy Bodies, unspecified psychosis not due to a substance or known physiological condition, major depressive disorder, anxiety disorder, paranoid personality disorder, Alzheimer's disease, and unspecified mood disorder. R18's MDS (Minimum Data Set) dated March 31, 2025, showed R18 had severely impaired cognitive skills for daily decision making. R18's Order Summary Report dated June 3, 2025, showed an active medication order dated April 18, 2025, for Haloperidol (antipsychotic medication) Lactate Oral Concentrate 2 mg (milligrams)/ mL (milliliters), give 0. 75 mL by mouth every two hours as needed for agitation/restlessness. R18's May 2025 MAR (Medication Administration Record) showed R18 received as needed Haloperidol on May 20 and May 24, 2025. The EMR showed R18 had orders for as needed Haloperidol from November 25, 2025, to June 4, 2025. The facility does not have documentation to show R18 was directly examined by the prescribing practitioner to assess R18's continued need for an as needed antipsychotic medication every 14 days. On June 4, 2025, at 2:42 PM, V2 (DON/Director of Nursing) said as needed antipsychotic medications should only be prescribed for 14 days. V2 said after 14 days, the order should be discontinued, and a new order should be obtained from the physician. V2 said a resident receiving an as needed antipsychotic medication needed to be evaluated by the physician in order for the medication to be reordered. (continued on next page)

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

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. The EMR showed R13 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, major depressive disorder, dementia, unspecified psychosis, and bipolar disorder. R13's MDS dated [DATE], showed R13 had severe cognitive impairment. R13's Order Summary Report dated June 4, 2025, showed an active medication order dated March 31, 2025, for Lorazepam (antianxiety medication) oral tablet 0.5 mg, give one tablet by mouth every eight hours as needed for anxiousness. R13's April 2025 MAR showed R13 received 15 doses of as needed Lorazepam. R13's May 2025 MAR showed R13 received 13 doses of as needed Lorazepam. The facility does not have documentation to show the prescribing practitioner documented the rationale for the extended time and indicate a specific duration for R13's as needed psychotropic medication. On June 4, 2025, at 2:42 PM, V2 said as needed psychotropic medication should only be prescribed for 14 days. V2 said after 14 days, staff should obtain a new order for the as needed psychotropic medication. 48308 3. R21's admission record showed R21 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, unspecified dementia, hypertensive heart disease, alcohol abuse with unspecified alcohol induced disorder, major depressive disorder and anxiety disorder. R21's physician order summary showed R21 had an order for Aripiprazole 1 mg (milligram, antipsychotic medication,) daily. The date of the initial order was not available due to the recent change in the EMR (Electronic Medical Record) system. The Consultant Pharmacist Recommendation to Prescriber dated April 29, 2025, for R21 showed a recommendation for GDR (Gradual Dose Reduction) of Aripiprazole 1 mg to dose every other day for 1 week and then discontinue the medication, due to no behaviors documented in the month of April. On June 4, 2025, at 12:47 PM, V2 (DON) referred to the psychotropic medication log and stated it showed the initial order date for Aripiprazole 1 mg was August 5, 2022. V9 (Social Services Director) and V2 stated R21 was not currently receiving psychiatric services. V2 stated R21's attending physician was prescribing the medication currently. V2 stated she did not give the recommendation form from the pharmacist to the prescriber. R21's behavior monitoring record for the months of April 2025, May 2025 and June 1-4, 2025, showed there were no episodes of behavior documented. On June 4th, 2025, at 12:47, V2 and V9 stated R21's behavior had been stable for months. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The GDR recommendation dated April 29, 2025, had not been presented to the prescriber for review as of June 4, 2025, despite stable behavior and R21 remains on psychoactive medication without documented indication for continued use. The facility's policy titled Psychotropic Medication Use dated February 2025, showed Policy: Residents will only receive psychotropic medications when necessary to treat specific symptoms for which they are indicated and effective.Procedure: .4. Based on assessing the resident's symptoms and overall situation, the medical practitioner will determine whether to continue, adjust, or stop existing psychotropic medication.6. The timeframe for PRN (as needed) psychotropic medications, which are antipsychotic medications is limited to 14 days without exception, unless the attending provider evaluates the resident and deems it necessary.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on interview and record review, the facility failed to develop comprehensive care plans for residents' oxygen use and need for trauma-informed care. This applies to 2 of 14 residents (R19 and R25) reviewed for care plans in a sample of 14. The findings include: On June 5, 2025, at 10:38 AM, V2 (Director of Nursing) stated R19 and R25 should have had care plans developed for their oxygen use and their post-traumatic stress disorder. 1. R25's admission record showed R25 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, history of pneumonia and bipolar disorder. R25's physician order summary showed R25 had an order for oxygen 2-3L (liters) per NC (Nasal Cannula) as needed for shortness of breath, initiated on May 31, 2025. R25's progress note dated May 22, 2025, at 3:10 PM showed R25 experienced shortness of breath and used oxygen 3L (Liter) per NC (Nasal Cannula) for oxygen saturation 80-82 % on room air. R25 was transferred to the local emergency roiagnom on [DATE], at 8:50 AM and diagnosed with pneumonia and returned to the facility at 6:05 PM. R25's care plan initiated on April 1, 2025, for asthma and shortness of breath while lying flat, did not address the use of oxygen, monitoring parameters for when to use oxygen or safety precautions for the use of oxygen. 41855 2. R19's EMR (Electronic Medical Record) showed R19 was admitted to the facility on [DATE]. 2023, with diagnoses that included dementia unspecified severity with psychotic disturbances, anxiety, depression, and PTSD. R19's MDS (Minimum Data Set) dated March 31, 2025, showed R19 had mild cognitive impairment, and her active diagnoses included anxiety, depression, psychotic disorder, and PTSD (Post-traumatic stress disorder). R19's care plan showed there was no assessment of R19's diagnosis of PTSD, identification of PTSD triggers, or interventions to assist with R19's PTSD. R19's Social Service Quarterly Assessments showed there was no documentation that R19 had PTSD. On June 2, 2025, at 2:27 PM, R19 said she has had a lot of trauma in her life and she didn't know if facility knew that or knew what her triggers were. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 4, 2025, at 12:22 PM, V7 (LCSW/Licensed Clinical Social Worker) said R19 does have a diagnosis of PTSD (Post Traumatic Stress Disorder) but said R19's PTSD is not active, meaning she has no symptoms related to her PTSD. V7 went on to say that R19 had experienced some childhood trauma that included physical abuse, mental abuse, verbal abuse, and neglect by her parents. R19 also experienced sexual assault sometime between her teenage years and adulthood. R19 also had a history of domestic abuse by her significant others. V7 said R19 does not have any triggers that she is aware but then stated R19 has nightmares about the abuse by her parents and displays anger issues with other residents. R19 also demonstrates abandonment issues when her family member leaves town by claiming she has physical ailments. For example, a couple weeks ago when R19's family member went out of town, R19 complained of breast pain. The facility provided their December 2024 policy titled Trauma Informed Care. The policy showed, It is the policy of this facility to consider residents past traumatic experiences in developing person centered care plans designed to avoid re-traumatization through the application of the principles of trauma-informed care . Procedure: Identification of trauma survivors during the admission/intake process, residents and/or residents' representatives are given the voluntary opportunity to answer questions regarding trauma and to discuss their experiences to the extent they are comfortable. At least annually, residents and/or their representatives are again given the voluntary opportunity to answer questions regarding trauma and to discuss their experiences to the extent they are comfortable. Residents/representatives may disclose information regarding trauma at any time they feel comfortable in doing so. Care Planning for Trauma Survivors- Interdisciplinary staff work together with the resident/resident's representatives to assess the resident's needs and to identify triggers that may cause the survivor to remember the traumatic event and induce a reaction similar to when the resident was originally traumatized. Care plan should describe the resident's cultural preferences, values, and practices and include approaches to meet the resident's cultural needs. Care plan should describe interventions which consider the resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization and psychosocial harm. Care plans are reviewed and revised as needed on at least a quarterly basis . Facility provided their December 2024 policy, titled Care Planning. The policy showed, Purpose: 1. To assess each resident's strengths, weaknesses, and care needs 2. To use this assessment data to develop a comprehensive Plan of Care (POC) for each resident that will assist a resident in achieving and maintaining the highest practical level of mental functioning, physical functioning, and wellbeing as possible .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48308 Based on observation, interview, and record reviewed the facility failed to date and contain resident's oxygen equipment for a resident with oxygen concentrator in their room. This applies to 1 of 1 resident (R25) reviewed for oxygen use in the sample of 14. The findings include: R25's admission record showed R25 was admitted to the facility on [DATE], with multiple diagnoses including chronic obstructive pulmonary disease, type 2 diabetes, history of pneumonia and bipolar disorder. R25's physician order summary showed R25 had an order for oxygen 2-3L (liters) per NC (Nasal Cannula) as needed for shortness of breath, initiated on May 31, 2025. On June 2, 2025, at 12:51 PM, R25's room had an oxygen concentrator in the room with tubing and nasal cannula that was undated and stored draped over the concentrator and touching the floor. There was no oxygen in use sign on the door to the room. R25's progress note dated May 22, 2025, at 3:10 PM showed R25 experienced shortness of breath and used oxygen 3L per NC for oxygen saturation 80-82 % on room air. R25 was transferred to the local emergency roiagnom on [DATE], at 8:50 AM and diagnosed with pneumonia and returned to the facility at 6:05 PM. On June 4, 2025, at 1:00 PM, R25's oxygen concentrator remained in the room with the tubing draped over the concentrator and touching the floor, there was no date on the tubing of the last tubing change. There was no oxygen in use sign on the door to the room. On June 4, 2025, at 1:10 PM, V2 (Director of Nursing) stated there should always be an oxygen in use sign on the door when there is oxygen in the room. V2 stated R25 still had an active order for oxygen use and the tubing should be labeled with the date of last change and the tubing should be changed weekly. The facility's policy titled Oxygen Administration, undated, showed Preparation 1. Verify that there is a physician order for oxygen administration and .Steps in the Procedure .3. Place an Oxygen in use sign on the outside of the room entrance door. Close the door.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on observation, interview, and record review, the facility failed to assess a resident with PTSD (Post-Traumatic Stress Disorder) and identify triggers. This applies to 1 of 1 resident (R19) reviewed for trauma informed care in a sample of 14. The findings include: R19's EMR (Electronic Medical Record) showed R19 was admitted to the facility on [DATE]. 2023, with diagnoses that included dementia unspecified severity with psychotic disturbances, anxiety, depression, and PTSD. R19's MDS (Minimum Data Set) dated March 31, 2025, showed R19 had mild cognitive impairment, and her active diagnoses included anxiety, depression, psychotic disorder, and PTSD. R19's Social Service Quarterly Assessments showed there was no documentation that R19 had PTSD. R19's POS (Physician Order Set) showed there were no orders to monitor for triggers or behaviors related to R19's diagnosis of PTSD. On June 2, 2025, at 2:27 PM, R19 said she has had a lot of trauma in her life and she didn't know if facility knew that or knew what her triggers were. On June 4, 2025, at 12:22 PM, V7 (LCSW/Licensed Clinical Social Worker) said R19 does have a diagnosis of PTSD (Post Traumatic Stress Disorder) V7 said R19's PTSD is not active, meaning she has no symptoms related to her PTSD. V7 went on to say that R19 had experienced some childhood trauma that included physical abuse, mental abuse, verbal abuse, and neglect by her parents. R19 also experienced sexual assault sometime between her teenage years and adulthood. R19 also had a history of domestic abuse by her significant others. V7 said R19 does not have any triggers that she is aware of but then stated R19 has nightmares about the abuse by her parents and has anger issues with other residents. R19 demonstrates abandonment issues like claiming to have physical ailments when her family member leaves town. For example, a couple weeks ago when R19's family member went out of town, R19 complained of breast pain. On June 4, 2025, at 10:47 AM, V6 (MDS Nurse) provided copies of hospital records she reviewed and used to obtain R19's medical diagnoses. The hospital records showed R19 has PTSD. V6 said she talked to V9 (Social Services) and was told R19 had no issues. V6 said she does not know what R19's trauma is or what the triggers are. (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided their December 2024 policy titled Trauma Informed Care. The policy showed, It is the policy of this facility to consider residents past traumatic experiences in developing person-centered care plans designed to avoid re-traumatization through the application of the principals of trauma-informed care. Definitions: Trauma: Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being. The individual's experience of the event(s) determines whether it is a traumatic event. An event may be traumatic for one individual & not for another. The individual's interpretation will determine whether it is experienced as traumatic. Trauma: Informed Care: An approach to delivering care that involves understanding, recognizing and responding to the effects of all types of trauma; recognizing the widespread impact and signs and symptoms of trauma; and avoiding re-traumatization . Trigger: Something that causes the survivor to remember the traumatic event and induces a reaction like when they were originally traumatized. Triggers can re-traumatize survivors .Procedure: Identification of trauma survivors during the admission/intake process, residents and/or residents' representatives are given the voluntary opportunity to answer questions regarding trauma and to discuss their experiences to the extent they are comfortable. At least annually, residents and/or their representatives are again given the voluntary opportunity to answer questions regarding trauma and to discuss their experiences to the extent they are comfortable. Residents/representatives may disclose information regarding trauma at any time they feel comfortable in doing so.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 48308 Based on interview and record review, the facility failed to provide 8 hours of RN (Registered Nurse) coverage on 20 days during the past 6 months. This applies to all 37 residents who reside in the facility. The findings include: The PBJ (Payroll Based Journal) report for quarter 4 2024, showed dates in December when there was no RN on duty. V2 (Director of Nursing) provided documentation to show she was the RN on some of those December dates. Review of the staffing schedule with V2 showed that December 7, 8, 22, 25, and 29, 2024 did not have any hours of RN coverage working in the facility. V2 stated on June 3, 2025, at 11:12 AM, that the facility does use agency staff. V2 stated she had to work out a system with payroll to report V2 hours as RN coverage for PBJ. V2 stated she works Monday through Friday and provides the RN coverage on those days. Review of January, February, March, April, and May 2025, staffing schedules with V2, showed there was no RN coverage for 8 hours, and V2 did not work on the following days: January 1, 4, 5, 18 and 19, 2025, February 13, 2025, March 1, 16, 24, 25, 29, 30, 31, 2025, April 26, 2025, and May 26, 2025. V6 (LPN Licensed Practical Nurse/ MDS nurse) stated on June 2, 2025, at 2:28 PM there were only LPNs that worked on some days because we did not have RNs who could work. On June 2, 2025, at 2:10 PM, V1 (Administrator) stated the facility had five stars but last year the facility began reducing nurse staffing which caused occasional shortages in RNs. V1 stated if an RN had last minute call off and the facility was unable to find an RN to fill in and cover the call off that would also cause an RN shortage. DON is an RN and works full time.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. 35267 Based on interview and record review, the facility failed to ensure a resident did not receive an unnecessary medication. This applies to 1 of 5 residents (R4) reviewed for unnecessary medications in a sample of 14. The findings include: Face sheet, dated June 4, 2025, shows R4's diagnoses included urinary tract infection. Hospital records, printed December 14, 2024, show R4's diagnoses included complicated UTIs (Urinary Tract Infections). POS (Physician Order Sheets), printed June 4, 2025, shows the following physician orders: Bactrim 400-80 mg (milligrams) one tablet daily every Monday, Wednesday and Friday- start date April 1, 2025, and to be given indefinitely. Nursing progress note, dated April 13, 2025, shows R4 was sent to the hospital after experiencing weakness and lack of responsiveness. Review of R4's hospital discharge record, printed April 13, 2025, shows no orders for Keflex or Bactrim on the after visit summary medication list. The discharge record shows R4's diagnoses included UTIs (Urinary Tract Infection). Nursing progress notes, dated April 13, 2025, shows R4 returned to the facility from the hospital. The progress notes shows R4 had a new order for Keflex 500 mg twice daily for seven days. POS (Physician Order Sheets), printed June 4, 2025, R4 received a physician order on April 13, 2025, for Keflex 500 mg two capsules twice daily for UTI. The order shows no stop date was provided when the order was entered into the clinical record. The POS shows the antibiotic was discontinued on May 8, 2025. The POS shows R4 continued to receive the Bactrim as ordered on April 1, 2025, while receiving the Keflex. POS, printed June 4, 2025, shows R4 received another physician order on May 8, 2025, extending R4's order for Keflex 500 mg two capsules twice daily for UTI. The POS shows the Keflex was discontinued May 13, 2025. The POS shows R4 continued to receive the Bactrim as ordered on April 1, 2025. Review of the clinical record shows no documentation that supported the use of Keflex and Bactrim concurrently or that the Keflex to be continued for more than 7 days. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 4, 2025, at 10:18 AM, V2 (Director of Nursing) reviewed the hospital records that were sent with R4 on readmission and no antibiotic order for Bactrim or Keflex were identified. V2 stated the nurse on duty placed an order in R4's clinical record for Keflex when R4 was readmitted to the facility. V2 stated she was unable to locate any clinical documentation by R4's nurse as to where the nurse received R4's order for Keflex. V2 stated she was not sure if the original order for Keflex was given for 7 days or more because the order was entered into the system differently than what was written on the progress note indicating the Keflex was to be given for 7 days. V2 stated it appeared the Keflex order was placed in the clinical record system to be given for 30 days however the nurse documented in the progress notes R4 was only supposed to only get the Keflex for a total of 7 days. V2 stated R4's order for prophylactic Bactrim should have been on hold while R4 was receiving Keflex so R4 did not receive Keflex and Bactrim at the same time. V2 stated she was behind on tracking the facility antibiotic use during April 2025 because she was working as a floor nurse often and was not keeping up with her work. Resident Infection Control and Antimicrobial Log, dated April 2025, shows R4 received Keflex 100 mg (milligrams) twice daily for 30 days from April 13, 2025, to May 13, 2025. The log indicated that there was clinical documentation to support the antibiotic use. The log also shows R4 was receiving Bactrim on Mondays, Wednesdays and Fridays, beginning on April 1, 2025, for UTI (Urinary Tract Infection) prophylaxis. The log indicated that clinical documentation was available to support the antibiotic use.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 41855 Based on observation, interview, and record review, the facility failed to puree food items to a smooth consistency per their facility policy. This applies to 3 of 3 residents (R2, R18, R22) reviewed for pureed diets in the sample of 14. The findings include: On June 3, 2025, at 11:25 AM, V4 (Cook) was preparing pureed diets. He said there are three residents with pureed diet orders in the facility. V4 was preparing pureed spaghetti with meat sauce and pureed green beans. V4 used tongs and placed three servings of noodles into the food processor and then he used the four-ounce scoop per the recipe and placed three scoops of meat sauce into the food processor with the noodles. Per the recipe, he also added three ounces of water and blended it. Visually, there were small pieces of unblended noodles and meat. When tasted, there were small pieces of noodles and meat that needed to be chewed. V4 pureed fresh green beans by taking the four-ounce scoop and placing three servings into the food processor with 1/4 tsp chicken base, three ounces of water, 2 3/4 tsp of thickener. After he pureed the green beans, the consistency was not smooth and when tasted there were pieces of skin in the pureed green beans. V3 (FSM/Food Service Manager) tasted both the spaghetti with meat sauce and the green beans and said they both needed to be pureed more to a smooth, pudding like consistency. V4 was asked to puree the spaghetti and green beans again. V4 was not able to get the green beans to a smooth pudding like consistency and was told he could not serve the green beans. The facility provided a list of residents in the facility that required a pureed diet which included R2, R18 and R22. The facility provided their undated policy titled, Pureed Foods. The policy showed . measure and add commercial thickener, stabilizer or shaping/enhancing product as directed in the recipe and process until blended. Scrape down the sides and reprocess until very smooth like pudding .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E095	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Batavia Rehabilitation & Health Care Center	520 Fabyan Parkway Batavia, IL 60510

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. 35267 Based on interview and record review, the facility failed to develop and present a facility QAPI (Quality assurance Performance Improvement) plan. This applies to all 37 residents residing in the facility. The findings include: Long Term Care Facility Application for Medicare and Medicaid, dated June 2, 2025, shows the facility census was 37. On June 3, 2025, V1 (Administrator) provided a document QAPI Policy, dated January 2024, and stated the document was the facility's QAPI plan. The document shows, The QAPI Program takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality while involving all caregivers in practical and creative problem solving. The community QAPI Program achieves the following: monitor quality/performance, find opportunities for improvement, improve performance, achieve resident/family desired outcomes, meet regulatory requirements, understand the CMS (Centers for Medicare & Medicaid Services) survey process and regulations, provide a QAPI path to correcting issues. The QAPI Program consists of monthly/quarterly meetings, daily quality assurance activities, 'QAPI tasks' and Performance Improvement Plans. The document fails to show how the committee will identify and correct quality deficiencies, failed to reflect specific aspects unique to the facility population and programs, track and measure performance, how goals and thresholds for performance would be established, systems of analyzing root causes of quality concerns, and monitoring/evaluating the effectiveness of corrective actions. On June 3, 2025, at 10:34 AM, V1 (Administrator) stated he confirmed with corporate that the QAPI Policy he provided was the facility QAPI plan.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 45303 Based on interview and record review, the facility failed to have a water management plan for Legionella which included ways to intervene when control limits are not met and to document control measures for the prevention of Legionella growth. The facility also failed to follow their Infection Prevention and Control Program for surveillance of infections. This applies to all 37 residents residing in the facility. The findings include: The facility's Long-term Care Application for Medicare and Medicaid dated June 2, 2025, showed the facility's census was 37 residents. 1. On June 4, 2025, at 2:19 PM, V10 (Maintenance Director) said for the facility's water management plan for Legionella, V10 empties the hot water heaters about once a month but does not empty the kitchen's hot water heater because there is a water softener. V10 said the only thing he does with the shower heads is replace them when they break which is about three times a year. On June 4, 2025, at 2:26 PM, V1 (Administrator) said V10 should be following the facility's water management plan for Legionella. V1 said he completed a Legionella environmental assessment form for the facility last year but did not do anything with assessment when it was completed. The facility's water management plan for Legionella dated December 13, 2019, showed Control Measures: Water Heaters are maintained at appropriate temperatures 60 degrees Celsius and above; Annual cleaning of water heaters and thermostatic mixing valves; Quarterly dissemble shower heads to be cleaned and disinfected; Quarterly clean and/or replace faucet aerators; Weekly randomly check hot and cold water temperatures, (let run for one minute before); Weekly flush toilets, taps, and shower heads not in use; Continuous Positive Airway Pressure machines use distilled water and are changed daily; Humidifiers for oxygen concentrators use humidified water and are changed every three days . The facility does not have documentation to show the control measures were being monitored. The facility's water management plan for Legionella does not include interventions if control measures cannot be met. On June 3, 2025, at 3:40 PM, V1 said he provided the facility's new water management plan for Legionella. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V1 provided a one-page facility document titled Water Management Program, Facility Legionella Base Line/Annual Testing dated May 23, 2019. The document showed Instruction: Each Senior Health Care Facility will purchase through [medical equipment company] the following kit: .Kit will be ordered, and four base line tests will be administered at each facility (one test for reserve). Listed below are the locations for testing to be recorded for base line . Once the test kits arrive, ensure all Water Management Program check list and logs have been active and proceed with the testing. Utilize the Legionella test log to record the initial base line results for validation. If failed test identify area test is pulled from and start with immediate actions to secure and flush system, inspect for any impedance to the system, check system integrity for leaks or deterioration, compare to other test locations and validate if any other tests have similar results . On June 4, 2025, at 2:26 PM, V1 confirmed the document was instructions for performing Legionella testing in the facility. 2. On June 3, 2025, at 1:54 PM, V2 (DON/Director of Nursing) said she has been the facility's Infection Preventionist since 2020. V2 said she used to perform McGeer's Criteria for infections but stopped some time last year. V2 said she does not use a standardized tool for data collection of resident infections to identify if a resident has an infection. V2 said the facility had a COVID-19 outbreak in April 2025, and 10 residents tested positive for COVID-19. The facility's April 2025 Resident Infection Control and Antimicrobial Log does not show the residents who were positive with COVID-19 infection. The facility's policy titled Infection Prevention and Control Program Manual- Surveillance dated 2019, showed Infection Surveillance- Overview: Purpose: Infection prevention begins with routine and ongoing surveillance to identify possible communicable diseases or infections before they can spread to other persons in the facility or have the potential to cause an outbreak. The facility closely monitors all residents who exhibit signs/symptoms of infection through ongoing surveillance and has a systemic method for collecting, consolidating, analyzing, and interpretation of data concerning the frequency and cause of a given disease or event, followed by dissemination of that information to those who can improve the outcomes. The intent of surveillance is to identify possible communicable diseases or infections before they can spread to other persons in the facility. In addition, surveillance is crucial in the identification of possible clusters, changes in prevalent organisms, or increases in the rate of infection promptly. The results should be used to plan infection control activities, direct in-service education, and identify individual resident problems in need of intervention.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. 45303 Based on interview and record review, the facility failed to develop an Antibiotic Stewardship Program with a standardized tool and criteria to assess residents for infections. This applies to all 37 residents residing in the facility. The findings include: The facility's Long-term Care Application for Medicare and Medicaid dated June 2, 2025, showed the facility's census was 37 residents. On June 3, 2025, at 1:54 PM, V2 (DON/Director of Nursing) said she has been the facility's Infection Preventionist since 2020. V2 said she used to perform McGeer's Criteria for infections but stopped some time last year. V2 said she does not use a standardized tool for data collection of resident infections to identify if a resident has an infection. V2 said the facility does not have a current Antibiotic Stewardship Program policy. On June 4, 2025, at 10:18 AM, V2 said she had been behind on tracking resident antibiotic use in April 2025 because V2 had to work on the floor as a nurse. V2 said she was unable to keep up with her work. The facility's policy titled Infection Prevention and Control Program dated 2019, showed Mission of Program: The primary mission is to establish an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Policy: It is the policy that this facility's Infection Prevention and Control Program (IPCP), is based upon information from the Facility Assessment and follows national standards and guidelines to prevent, recognize and control the onset and spread of infection whenever possible. The Infection Prevention and Control Program includes: .3. An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use . Elements of the Program Include: . Antibiotic Stewardship and review including