STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057042	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/04/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BELLA TERRA ELMHURST	420 WEST BUTTERFIELD ROAD , ELMHURST, Illinois, 60126

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
S0000	Initial Comments Annual Licensure and Certification	S0000		
S9999	Final Observations Statement of Licensure Violations 1 of 8: 300.615f) Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information. f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to check for the resident's name on the Department of Corrections sex registrant website as part of the new admission criminal background checks. This applies to 10 of 10 residents (R6, R7, R18, R19, R20, R21, R23, R24, R25, R26, and R27) reviewed for criminal background checks. The findings include: 1. R6's EMR (Electronic Medical Record) showed R22 was admitted to the facility August 14, 2025. 2. R7's EMR showed R7 was admitted to the facility on August 1, 2025 3. R18's EMR showed R18 was admitted to the facility on August 18, 2025. 4. R19's EMR showed R19 was admitted to the facility on August 22, 2025. 5. R20's EMR showed R20 was admitted to the facility on	S9999		

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

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S9999	Continued from page 1 August 22, 2025 6. R21's EMR showed R21 was admitted to the facility on August 25, 2025 7. R23's EMR showed R23 was admitted to the facility on August 20, 2025 8. R25's EMR showed R25 was admitted to the facility on July 31, 2025 9. R26's EMR showed R26 was admitted to the facility on August 5, 2025 10. R27's EMR showed R27 was admitted to the facility on August 10, 2025 On September 04, 2025, at 9:24 AM, V18 stated that background checks for residents are run within 24 hours of admit to facility. V18 stated that she manages a team of eighteen employees who are responsible for running background checks for all residents in their Illinois facilities. V18 stated that residents' names should be checked on the following sites: IL State Police sex Registry, Illinois Department of Corrections (IDOC) inmate search, and the National Sex Offender Registry. On September 04, 2025, 9:30 AM, the facility failed to provide documentation to show that R6, R7, R18, R19, R20, R21, R23, R25, R26, and R27 were searched on the Illinois Department of Corrections Sex Registrant. The facilities policy entitled "Resident Background Check" Revised on July 03, 2025, states "The Facility shall check for individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a sex registered offender. (C) Statement of Licensure Violations 2 of 8: 300.1210a) 300.1210b)4) 300.1210d)1)2)6) Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued from page 2 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act). b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of	S9999		

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S9999	Continued from page 3 accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement was not met as evidenced by: Based on observations, interviews, and record reviews the facility failed provide assistance with meals as per the plan of care. The facility also failed to serve meals to residents in a timely and dignified manner. This failure applies to 7 of 8 residents (R8, R12, R13, R14, R15, R16, and R17) reviewed for meal service from a total sample of 29. Findings include: 1. R12 is a is an 89-year-old female with diagnoses of history of Dementia, Major Depressive Disorder, Partial Paralysis due to Stroke, Dysphagia, Anemia, Seizures, and COPD who was admitted to the facility 01/19/2020. R12's Current Physician Orders include one-to-one feeding assistance during all meals to ensure safety during oral intake and for one-to-one feeding assistance with strict adherence to precautions. R12's current nutritional and dietary care plans document that R12 requires a puree texture diet due to dysphagia; she is at risk for compromised nutritional status and unintended weight loss. Interventions include to monitor the resident, assess for signs of choking and/or aspiration; and an intervention implemented 09/24/2024 of recommendation for 1:1 feeding assistance during all meals to ensure safety during oral intake per most recent treatment course. R13 is a 76-year-old female with diagnoses of history of Dementia and Encephalopathy (Impaired Brain Function) who was admitted to the facility 08/18/2025. R14 is an 86-year-old female with diagnoses of history of Malignant Cancer of the Breast, and Protein Calorie Malnutrition who was admitted to the facility 08/12/2025. R15 is a 94-year-old male with diagnoses history of Alzheimer's Disease, Cognitive Communication Deficit and Age-Related Physical Debility who was admitted to the facility 08/12/2025. R16 is an 83-year-old female with diagnoses of history of Alzheimer's Disease, Depression, Age Related	S9999		

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S9999	Continued from page 4 Physical Debility, and Skin Cancer who was admitted to the facility 02/14/2024. R17 is an 87-year-old female with a diagnoses history of Partial Paralysis related to Vascular Disease, Vascular Dementia, and Malignant Lung Cancer who was admitted to the facility 01/17/2023. On September 02, 2025, at 12:35 PM R13 was observed waiting to receive her lunch meal while sitting at a table with R12, R16, and R17 who were already served and eating. R14 waiting to receive her lunch while sitting at a table with R29 who was served and already eating. On September 02, 2025, at 12:51 PM, R13 was waiting to receive her lunch meal while sitting at a table with R12, R16, and R17 and watching as they were already eating their meals. R12 eating her pureed food with her bare hands. On September 02, 2025, at 12:53 PM R13 was observed sitting in the dining area at a table still waiting to receive her meal while R12, R16, and R17 were eating; R14 was observed sitting in the dining area still waiting for her meal while R29 who was sitting at the table with her was already eating. R14 stated that at times R14 must wait for the meal while others are eating. R12 was eating her pureed meal with her hands with no staff assisting her; V7 (Certified Nursing Assistant) stated usually if multiple residents are dining at the same table all their meal trays are delivered at the same time and R13's tray should have been delivered along with the other three residents sitting at the table with her. On September 02, 2025, at 12:58 PM, R14 was observed receiving her meal tray. At 12:59 PM, R13 was observed still waiting to receive her lunch, R13 stated that it happens when asked she's had to wait for meals while others are eating, she replied this happens. On September 02, 2025, at 1:00 PM, V19 (Agency Certified Nursing Assistant) stated R13's meal tray should have been delivered along with all the other residents sitting at the dining table with her and she shouldn't still be waiting for her tray. On September 02, 2025, at 1:01 PM, R12 was observed coughing heavily multiple times. On September 02, 2025, at 1:04 PM, R13 was observed receiving her meal tray.	S9999		

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S9999	Continued from page 5 On September 03, 2025, at 7:58 AM, Ten residents were observed sitting in the dining area during breakfast, and all other residents served their breakfast meal except R13 and R15. On September 03, 2025, at 8:09 AM R17 was observed request more cold cereal, and R16 ask for more pancake syrup. On September 03, 2025 at 8:10 AM V20 (Certified Nursing Assistance) stated R13's meal tray comes up on the last cart delivered to the floor, R13's aide usually has her up in the dining area and ready for meals so there should be some communication from nursing to dietary to let them know that her tray needs to be delivered sooner, V20 stated R15's meal tray may not have arrived to the dining room yet likely because he consistently fluctuates between eating in the dining area or in his room based on his behaviors. On September 03, 2025, at 8:19 AM, R13 had a look of frustration while waiting for breakfast, R15 was observed to turn his wheelchair around and watch the other residents eat their food, at 8:23 AM, R15's breakfast was delivered. On September 03, 2025, at 8:32 AM, R13's breakfast tray was observed being delivered. V21 stated trays are delivered to the dining area first then to residents' rooms in room order, R13 typically eats in her room, and as soon as the staff realized that R13 and R15 had not received their trays while others in the dining area had received theirs, staff should have notified the kitchen. On September 03, 2025 at 3:04 PM V2 (Director of Nursing) stated residents in the dining area should be eating at the same time and if some residents are waiting for a period of time while others are eating this can be a dignity issue, R12 requires one to one feeding assistance due to possible aspiration or choking while eating. 2. R8 was admitted to the facility on July 30, 2025 with diagnoses including Epidural abscess, Sepsis, Gout, Spinal hardware infection, Anemia, Seizure, disorder, depression, cerebral vascular attack, and bilateral primary osteoarthritis of the knee. R8's Minimum Data Set (MDS) dated August 3, 2025, showed R8 was dependent on staff for all activities of daily living and care. R8 had the following care plan documents that R8 is on	S9999		

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S9999	Continued from page 6 a mechanically altered diet related to dysphagia. The care plan documents on September 2, 2025 to serve the diet as ordered, mechanical soft with one to one feeding assistance. . On September 2, 2025, at 11:15 AM, R8 was screaming for help in her room. R8 stated she wanted to get out of the bed. R8 stated she is blind and can only see shadows. R8's breakfast tray was untouched and on the bedside table. R8 cried "I haven't eaten. I want to get up. Please help me." R8 stated "I want to eat. I need some liquid and some food." On September 2, 2025, at 11:23 AM, V6 (Registered Nurse/RN) came to the room and stated she will feed R8 and V6 looked and saw food had not been touched (scrambled eggs, orange juice toast, minced sausage, 2% milk. On September 2, 2025, at 11:28, V22 (Certified Nursing Assistant/CNA) came to R8's room and stated that she was assigned to care for R8 today. V22 stated that R8 required 1:1 feeding assistance, and she had not had time to feed R8 breakfast because she was helping another staff with R28. V22 stated she is going to finish helping get R28 up out of bed then she will come get R8 up and feed R8. At 11:31 AM V6 came back to R8's room to feed here. On September 4, 2025, at 10:00 PM, V2 (Director of Nursing) stated that residents who require 1:1 feeding assistance should be fed within 15 minutes of their food tray being delivered. The facility's General Care Policy states: "It is the facility's policy to provide care for every resident to meet their needs." "Upon admission or readmission, the facility will evaluate the resident for physical needs. Physical needs would include but are not limited to ADL (Activities of Daily Living). " "The facility will assist the resident to meet these needs." (B) Statement of Licensure Violations 3 of 8: 300.1210b) 300.1210d) 6)	S9999		

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S9999	Continued from page 7 Section 300.1210 General Requirements for Nursing and Personal Care. b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement was not met as evidenced by: Based on observation, interview and record review, the facility failed to provide a safe environment and ensure a resident at risk for fall was adequately supervised. This applies to 1 of 1 (R22) resident reviewed for safety hazards and supervision in the sample of 29. The findings include: R22's EMR (Electronic Medical Record) showed R22 has multiple diagnoses including Parkinson's disease, unspecified ataxia, primary osteoarthritis, and aftercare following status post right total knee arthroscopy (joint replacement surgery). R22's MDS dated September 3, 2025, showed R22 had mild cognitive impairment. R22's Fall Risk Assessment dated September 3, 2025, showed that R22 was a high risk for fall. R22's Fall Care Plan dated August 30, 2025, documented that R22 was at risk for falls due to weakness related to Parkinson's disease and right knee surgical replacement requiring weight bearing as tolerated. R22's Care Plan also included interventions that staff should provide R22 a safe environment, including that floors should be free from spills and/ or clutter. R22's (ADL) Activities of Daily Living Care Plan showed R22 had self-care deficit, impaired mobility, and interventions included that R22 required 2 staff assist	S9999		

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S9999	Continued from page 8 using a gait belt. On September 3, 2025, at 1:50 PM, several residents were in the dining room with V8, (Certified Nursing Assistant/CNA) present. A loud sound was heard and R22 was observed sitting up on the wet hard wood floor with his wheelchair right behind him. A large area, including where R22 was sitting was entirely wet with some spots with trickle of fluids, and a yellow "Wet Floor" sign was also positioned next to R22's table. R22 was wearing a non-skid sock and had no shoes on. V9, (Registered Nurse/RN) and other staff came into the dining room to attend to R22. The hard wood floor was visibly wet while V5, R22's assigned RN assessed R22. On September 3, 2025, at 2:06 PM, V8 stated that today is her first day of work at the facility and she is on orientation. She also stated that she came into the dining around 1:30 PM to supervise the residents. She added that she saw the hard wood floor was wet where R22 was sitting and there was a yellow "Wet Floor" sign positioned close to him. On September 3, 2025, at 2:09 PM, V11(Activity Aide) was in the dining room moving the tables and stated, "I see, the floor is wet." and she did not know why it was wet. On September 3, 2025, at 2:11 PM, V12, (Housekeeper) stated he mopped the floor area where R22 had fallen at 1:30 PM and V8 was present in the dining room while he was mopping the floor. He also stated that a few of the residents were still eating and one of the residents dropped some food on the floor. V12 also added that there were 2 residents sitting at the table where some foods were spilled on the floor, he mopped the floor while the residents were sitting there and placed the yellow "Wet Floor" sign close to the table. He also added that it was possible the floor was not completely dry because some of the spill was under R22's wheelchair. On September 3, 2025, at 2:24 PM, V13, CNA stated that R22 had a non-skid sock on, and he requires 2 staff assistance with a gait belt. On September 3, 2025, at 2:28 PM, R22 was in bed, with V14 (family member) at the bedside. R22 stated that he tried to scoot up and his wheelchair slid backwards from underneath him, and he fell on his buttocks. V14 stated that R22 had history of falls at home due to weakness from his Parkinson's disease. On September 3, 2025, at 2:35 PM, V5, RN stated that	S9999		

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S9999	Continued from page 9 she was notified that R22 had fallen in the dining room. V5 stated that when she entered the dining room, the floor was wet in the area where R22 had fallen. V5 also added that R22 informed her that he was trying to scoot up in his wheelchair when the chair slid backwards, and he fell and landed on his buttocks. On September 4, 2025, at 9:19 AM, V2 (Director of Nursing/DON) stated that the staff should have removed the residents from the wet areas and ensure that the floor was completely dry to prevent falls and sliding from the wet floor. (B) Statement of Licensure Violations 4 of 8: 300.1210d)1)2) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. This requirement was NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to follow physician orders during medication administration. There were 28 medication opportunities with 3 errors resulting to 10.7% error rate. This applies to 3 of the 4 residents (R7, R8, R24) reviewed during medication pass in the sample of 29. The findings include: 1. On September 2, 2025, at 11:49 AM, V6 (Nurse) administered Acetaminophen liquid solution via gastric tube to R8 who was complaining of pain. V6 did not administer the full amount of the medication, she only administered 2/3 of the Acetaminophen. R8's Medication Administration Audit Report dated September 2, 2025, at 11:46 AM, shows that V6	S9999		

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S9999	Continued from page 10 administered 20.3 mg(milligram)/ml (milliliter) via g-tube. 2. On September 3, 2025, at 9:59 AM, V4 administered multiple medications to R7. However, Zoloft was not available. Medication Administration Record (MAR) dated September 2025 shows: Zoloft was ordered on August 28, 2025. The Zoloft oral tablet 25 mg is to be given via gastric tube once a day (in the morning) for depression. This same MAR shows that it was not given on September 2, because it was not available. There was no documentation about following up with pharmacy to ensure that the medication is given on September 2 and be available for the following scheduled time or days. 3. On September 3, 2025, at 10:28 AM, V6 administered multiple medications to R24. However, Diltiazem was not available. R24's blood pressure was 160/88. Upon follow up with V6 at around 11:15 AM, the Diltiazem remained unavailable. Blood Pressure was rechecked which showed result of 175/68. V6 called R24's physician after the inquiry. R24's Medication Administration Record dated September 2025, showed that initially Diltiazem was ordered on September 2, 2025, to administer 120 mg once in the morning for HTN (Hypertension). On September 4, 2025, at 9:54 AM, V2 (Director of Nursing/DON) stated the expectation is for staff to follow physician order and follow the 5 rights when administering medications which is the right patient, right dose, right time, right medication, and right route. When the medication is running out or not available the staff must call pharmacy to reorder to ensure the medication is available upon administration. (B) Statement of Licensure Violations 5 of 8: 300.696b) 300.696d)1)2) Section 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation	S9999		

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S9999	Continued from page 11 Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections 2) Guideline for Hand Hygiene in Health-Care Settings. This requirement was NOT MET as evidenced by: Based on observation, interview, and record review, the facility failed to follow standard infection control practices with regards to hand hygiene and gloving during provisions of care. In addition, the facility also failed to ensure that staff wear complete Personal Protective Equipment (PPE) when providing care for residents who are on Enhance Barrier Precaution (EBP). This applies to 4 of 4 (R2, R3, R6, R8) residents reviewed for infection control in the sample of 29. The findings include: 1. On September 2, 2025, at 12:29 PM, V16 and V17 (Both Certified Nursing Assistants/CNA) rendered incontinence care to R3. V16 cleansed R3 from front to back of his perineum using a wipes and cleansing spray. After completing the care, V16 returned the cleansing bottle spray to R3's bedside table without cleaning or sanitizing the bottle. V16 changed her gloves without hand hygiene and continued to assist R3 by changing bed linens, incontinence pad, and incontinence brief. While V17 helped placed the soiled linen into a bag, then continued to help R3 removed his shirt, held R3's Oxygen tubing when removing his soiled shirt, she changed her gloves without hand hygiene, placed new linen, incontinence pad, and brief. 2. R2 is on EBP due to presence of Intravenous (IV) line for Antibiotic Therapy and presence of indwelling urinary catheter. R2's physician order summary dated	S9999		

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S9999	Continued from page 12 August 31, 2025, shows Enhance Barrier Precaution related to ESBL. On September 3, 2025, at 1:12 PM, V5 (Nurse) administered IV antibiotic to R2. V5 did not wear a gown and only wore a pair of gloves during medication administration. 3. R6's EMR (Electronic Medical Record) showed R6 had multiple diagnoses including Parkinson's Disease, retention of urine, urinary tract infection, infection and inflammatory reaction due to indwelling urethral catheter, and unspecified dementia. R6's Care Plan dated August 8, 2025, showed R6 was on Antibiotic Therapy due to having urinary tract infection. On September 3, 2025, at 3:06 PM, V9, (Registered Nurse/RN) was changed R6's indwelling urinary catheter. When V9 removed R6's old indwelling urinary catheter she removed her gloves and without hand hygiene donned sterile gloves and proceeded to clean R6's penile area with the iodine and inserted the new indwelling urinary catheter. 4. Physician Order Summary (POS) dated August 13, 2025, shows R8 was placed on EBP related to presence of gastrostomy tubing and wound. On September 2, 2025, at 11:49 AM, V6 (Nurse) administered Acetaminophen to R8 via g-tube. V6 did not wear a gown, and she only wore a pair of gloves during medication administration. On September 4, 2025, at 9:58 AM, V2 (Director of Nursing/DON) stated that staff must change gloves and perform hand hygiene in between tasks dirty to clean during provisions of incontinence care, medication administration, to prevent spread of infection. For residents who are on Enhance Barrier Precaution, the expectation is to wear complete such as gown and gloves and mask (if mask is indicated) to prevent spread of infection. Hand Hygiene Policy dated June 30, 2025, shows: Policy States:" Hand Hygiene is important in controlling infections. Hand Hygiene consists of either hand washing or the use of alcohol gel. The facility will comply with the CDC Guidelines regarding hand hygiene. " According to policy Hand Hygiene using alcohol-based	S9999		

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S9999	Continued from page 13 hand rub is recommended in the following situations: "Before and after performing aseptic task such as insertion of indwelling catheter or before handling invasive medical devices such as during insertion of peripheral IV catheter, fingerstick blood sampling, etc. Before moving from work on soiled body site to a clean body site on the same resident. After contact with blood, body fluids, or surfaces contaminated with blood or body fluids and after removing gloves including during wound dressing change. Enhanced Barrier Precaution Signage states that everyone must clean their hands, including before entering and when leaving rooms. Providers and staff must also wear gloves and gown for high contact resident care activities: Dressing, bathing/showering, transferring, changing linens, providing hygiene, and changing briefs and assisting with toileting. Gown and gloves are also needed for device care or use i.e. central line, urinary catheter, feeding tube, tracheostomy, and wound care that includes any skin opening requiring a dressing. According to enhanced barrier precaution "Do not wear the same gown and gloves for the care of more than one person." (B) Statement of Licensure Violations 6 of 8: 300.1210b) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: The REQUIREMENT was not met as evidenced by: Based on observation, interview and record review, the facility to ensure that residents call lights were within reach of the residents. This applies to 3 of 3 residents (R8, R9, and R10) reviewed for call lights in the sample of 29.	S9999		

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S9999	Continued from page 14 The findings include: 1. R8 was admitted to the facility on July 30, 2025, with diagnoses including Epidural abscess, Sepsis, Gout, Spinal hardware infection, Anemia, Seizure, disorder, depression, cerebral vascular attack, and bilateral primary osteoarthritis of the knee. R8's Minimum Data Set (MDS) dated August 3, 2025, showed R8 was dependent on staff for all activities of daily living and care. R8 ADL care plan showed the following: R8's Activity of daily living (ADL) care plan has the following intervention: Keep call lights within reach when in bedroom or bathroom dated 07/31/2025. On September 2, 2025, at 11:15 AM, R8's call light (a round device about the size of a silver dollar and grey) was in on the right side of her bed tied to the bottom of the right side of her bedrail. On September 2, 2025, at 12:00 PM V22 (Certified Nursing Assistant) left R8's room and did not place R8's call light within reach. The call light remained in the same position at the bottom of R8's right bedrail. On September 2, 2025, at 12:28 PM, R8's call light in the same position wrapped around the bottom of her right-side bedrail and not in reach of R8. On September 2, 2025, at 12:48 PM V22 was done feeding R8. V22 left R8's room without putting R8's call light within reach. On September 2, 2025, at 1:12 PM, R8's call light is still in the same position wrapped around the bottom of her bedrail and not within reach. ADL Self Care Performance Deficit and Impaired Mobility related to diagnosis. Intervention: keep call light within reach. 2 R9's diagnoses include: hypoxemia, obesity, unspecified, dehydration type 2 diabetes mellitus without complications, acute kidney failure, acute pulmonary edema, urinary tract infection, site not specified, pain in unspecified knee, autoimmune thyroiditis, localized edema, peripheral vascular disease, personal history of other venous thrombosis and embolism, and weakness. R9's ADL care plan showed the following: R9 requires assistance with ADL's (bed mobility, transfers,	S9999		

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S9999	Continued from page 15 dressing, walking, personal hygiene, eating and toileting) r/t Colitis, Peripheral vascular disease, Obesity, Anemia, Pulmonary edema, Hypothyroidism, HTN, AKI, Dehydration dated 08/28/2025 with the following intervention: Keep call lights within reach when in bedroom or bathroom dated 08/28/2025. On September 2, 2025, at 12:59 R9 is Spanish speaking sitting in a wheelchair on the right side of her bed closet to the door and her call light was on the left side of the bed and out of reach. 3.R10's diagnoses include generalized edema, acute pulmonary edema, malignant ascites, malignant neoplasm of abdomen, anemia, unspecified, dysthymic disorder, insomnia, unspecified, generalized anxiety disorder. acute respiratory failure with hypoxia, and unspecified severe protein-calorie malnutrition R10's ADL care plan showed the following: R10 requires assistance with ADL's (activities of daily living). On September 2, 2025, at 1:03 PM R10 was calling from behind the curtain and stating she needs help. R10's call light was not within reach. R10's call light was on the right side of her bed closest to the door and wrapped around the bottom of the left railing almost touching the floor. . V20 stated both residents call lights were not in reach and should have been in reach of the residents. On September 4, 2025, at 10:00 AM, V2 (Director of Nursing) stated that V2 stated call lights should be within reach of the resident. V2 stated staff should make sure the resident's call lights are within reach before leaving the resident's room. The facility's policy revised June 30, 25 showed the following: Be sure call lights are placed within reach of residents who are able to use it. (B) Statement of Licensure Violations 7 of 8: 300.1210b)4) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's	S9999		

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S9999	Continued from page 16 comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. These requirements are not met as evidenced by: Based on observation, interview, and record review the facility failed to assist residents identified as needing assistance with showers based on their assessment and plan of care. This applies to 1 of 7 residents (R4) reviewed for shower tasks in a sample of 29. The findings include: Census shows R4 was admitted on 07/29/2025. R4 went out for hospital stay on 08/20/2025 and returned to the facility on 08/25/2025. On September 2, 2025, at 11:10AM R4 stated she had not had a shower since return from hospital. R4 stated her father spoke with staff earlier in the day regarding missed showers. According to R4 she had not been showered in t wo weeks. Review of First Floor Resident Shower Schedule shows R4 was to receive showers on Mondays and Thursdays from August 25,2025 to September 04, 2025, and on Wednesday and Saturday from August 1, 2025, to August 20, 2025. According to documentation and Resident Shower Sheets R4 has missed showers on the following dates: August 2, 9, 13, 25, 28 and September 1 of 2025. R4‘s Plan of care dated July 30, 2025, shows R4 requires assistance from staff for showers. MDS dated August 29, 2025, shows R4 requires Partial Moderate assist from staff with bathing. The helper does less than half of the effort. This includes helping with lifts, holds, trunk and limb support. On September 2, 2025, V2 Director of Nursing (DON)	S9999		

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S9999	Continued from page 17 stated that resident showers are documented in point click care and that staff also complete shower sheets. V2 stated that she is the recipient of shower sheets and refusals are documented on shower sheets and in Point Click Care. V2 stated on 09/04/2025 that each resident is to receive two showers per week and as needed. (B) Statement of Licensure Violations 8 of 8: 300.1210d)2) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: (2) All treatments and procedures shall be administered as ordered by the physician. The requirement is not as evidenced by: Based on interview and record review the facility failed to provide wound care treatments as ordered. This applies to 1 of 7 residents (R4) reviewed for treatments in the sample of 29. On 09/02/2025 at 11:10AM R4 stated that wound care treatments on the evening shift have often been missed. R4 stated that during that time there was an increase in drainage from her wound. Treatment Administration Record for August 2025 shows the following wound care orders for R4 were not carried out: Right Breast Wound: Right Breast: Cleanse with normal saline solution, pat dry, and apply wet-to-dry dressing, cover with ABD pads and secure with tape. Every dayshift for treatment was missed on 08/03/2025, 08/05/2025. Wound care order of Right Breast: Cleanse with normal saline solution, pat dry, and apply Adaptic calcium alginate, cover with ABD pads and secure with tape two times a day for Treatment was not completed at 0900 on 08/11/2025 and was not completed at 2100 on 08/08/2025, 08/15/2025.	S9999		

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S9999	Continued from page 18 V2 stated that 09/04/2025 9:20 AM V2 stated it is expected that residents receive two showers per week and as needed. V2 stated that it is the expectation that her staff follow all physicians' orders. It is the expectation that care is signed off when rendered. V2 stated that sometimes she will go back to check and see if Medical Administration Record/Treatment Administration Records have been completed. V2 stated that an empty space on the Medical Administration Record may mean that staff may have forgotten to sign out the medication or treatment. V2 stated she cannot say for certain if medication or treatment was or was not given. (B)	S9999		