STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET , METROPOLIS, Illinois, 62960

(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 Complaint Investigation: 25510142/2644802- F550, F755, 2559767/2636984- F684, F692 2559695/2634870- F600, F684, F692, F755 2559685/2634845- F755 2559575/2632916- F692 2559091/2622981- F692	S0000		12/04/2025
S9999	Final Observations Statement of Licensure Violations (1 of 5) 300.610a) 300.1210b) 300.3210t) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. 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	S9999		12/04/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

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S9999	Continued from page 1 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. These regulations were not met as evidence by: Based on interview and record review, the facility failed to treat residents with dignity and respect related to timely response to requests for assistance, valuing residents' private space, and refraining from practices that have the potential to feel demeaning or intimidating for 5 (R8, R9, R10, R33 and R37) of 5 residents reviewed for resident rights in the sample of 46. This failure resulted in R8 experiencing feeling vulnerable, belittled, and intimidated. Findings Include: 1. R8's Admission Record documented an admission date of 05/20/25 and included diagnoses of encounter for other orthopedic aftercare, muscle weakness, type 2 diabetes mellitus, sleep apnea, occlusion and stenosis or unspecified cerebral artery, seizures, diverticulitis of intestine, radiculopathy, and dizziness and giddiness. R8's MDS dated 08/21/25 documents a BIMS score of 15, indicating R8 is cognitively intact. R8's Care Plan includes a focus area related to activity preferences dated 05/28/25 with a corresponding intervention of: R8 likes doing things with groups of people dated 06/03/25. A facility grievance form dated 09/22/25 – 09/29/25 documents the following: The section for "Resident Name" has "Community Complaint (Social Media)" handwritten in and beside "Grievance From," two boxes are checked indicating the grievance was from Resident and Family. Beside "Name," R8's name is handwritten in, with "(V21) shared on social media" written to the side of R8's name. The grievance documents it was initiated by V1. Under the section where boxes can be checked to define the issue, all boxes are left blank, even though "food issue" is an option to be checked. The section for "Description" documents (Name of V21) - son of	S9999		

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S9999	Continued from page 2 (name of R8) shared on social media pictures of food that they were not happy with. The next sections indicate they are to be completed by staff. The section titled “Investigation” documents: (R8) did not address with staff - she told (V2) that she did not mean for (V21) to post on social media. The section titled “Summary/Findings” documents food was edible – she is more than welcome to something different such as an alternative. Sausage was overcooked but could have received different sausage or substitution. The section titled “Recommendations/Action Taken” documents Resident (R8) to ask for substitution if she feels food she is receiving is less desirable or does not like what is being served. The date resolved is listed as: 09/29/25 and “Person Notified of Resolution” has R8’s name written in and documents the notification was “In Person.” V1 signed the form on 9/29/25. On 09/30/25 at 2:30 PM, R8 stated she never filled out any grievance about the food or anything and she never signed any grievance. On 09/30/25 at 3:25 PM, R8 stated the food has not been good here lately and apparently V21 (Family) posted some pictures of her food (on a social media website). R8 stated she didn’t know what V21 was doing, but he can do whatever he wants. R8 said about a week ago, she initially didn’t know the reason, but “they” (staff) came and took her away from her card game and took her into a meeting with a bunch of department heads. R8 stated “I think they were trying to intimidate me.” R8 said they didn’t talk to V21, they didn’t have one of them come talk to R8 in her room, it was four of “them” and her in a meeting she didn’t know anything about, and it made her very uncomfortable and it was intimidating. On 10/17/25 at 11:10 AM, R8 stated she has talked to the staff about her food concerns and maybe some other residents. R8 said the other residents were eating the same food and saying the same things about the food not being good. R8 said the staff here had a meeting with her because of voicing her concerns and V21 posting some pictures of her food trays. R8 said she was sitting in the dining room playing cards with R29 and V84 (previous Activities Director) when V54 (Social Services Director/SSD) came and got R8 and said V1 (Administrator) wanted to have a meeting with her. R8 stated they didn’t ask her if she could meet when they were done playing cards or say they would like to meet with her at a certain time that day, they just came and got her and took her from the card game to the meeting where three more staff were waiting. R8 said she asked why there were four of them and just her and V1 stated	S9999		

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S9999	Continued from page 3 it was because they needed a witness, but R8 questioned why there were three witnesses. R8 said she felt it was intimidating, and she was very uncomfortable being brought into this meeting. R8 stated being taken from an activity and brought into a meeting where there are four staff members and you is intimidating. R8 said if they wanted to talk, why didn't V1 come out to the dining room, or just come down to R8's room? R8 stated one of the first things they brought up was the pictures V21 posted on (name of social media website). R8 stated she told them they could go get her phone from her room, she didn't even think the thing took pictures and she did not have a (name of social media website). R8 stated someone in the meeting pulled up the pictures and showed them to her and asked if V21 was related to her. R8 stated he was, and she didn't care what he did on (social media website), he can do whatever he likes. R8 stated all the pictures they showed her were pictures of some of her actual food trays she was given. R8 stated she did not tell V21 to post the pictures, but she didn't care that he did either. R8 said V21 has been at the facility several times during meals. R8 stated she asked V1 (Administrator) to come and see some of the trays they are brought without the kitchen knowing in advance and to try the food they receive. R8 stated V1 never did come see or try a tray. R8 said V1 told her she can ask for a substitution and R8 told V1 she knows, and has done that before, along with R6, and they have been told several times they can't get it, don't have it, don't have time to get it, or if they do get a substitution, it could take a couple hours to receive it. R8 said she felt like the only reason they had that meeting was because those pictures were posted, and they were upset with R8 because it made them look bad. R8 said she believed they wanted to intimidate her, stating why else would they talk to her like that? On 10/22/25 at 1:43 PM, V55 (Public Relations Coordinator) stated they did have a meeting with R8, and the meeting included herself, V1 (Administrator), V2 (Director of Nursing), and V54 (Social Service Director/SSD). V55 said she was in the meeting representing admissions. V55 stated they felt all departments needed to be represented. V55 said she does not know if any other residents had a meeting and stated the meeting was casual. V55 said she does not know who suggested having the meeting, but it was to see if R8 had any concerns. V55 stated V21's (social media) post was brought up in the meeting. On 10/22/25 at 1:58 PM, V54 (SSD) stated she attended the meeting they had with R8 as they wanted to discuss the unhappiness and concerns R8 had, so she went and	S9999		

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S9999	Continued from page 4 got R8 from the dining room where she was playing cards. V54 said R8 was a little hesitant when she went to get her for the meeting. At the beginning of the meeting, they went around and introduced everyone to R8. V54 said R8 did not have a family member there as R8's BIMS score is 15. V54 stated she was there to represent R8. V54 stated they did not have any meetings with any other residents and acknowledged there were other residents with dietary concerns. V54 said the meeting was not only because of V21's (social media) post, R8 wasn't happy with the meals, had specific concerns, and R8 was vocal. V54 said they did tell R8 they would put referrals out to other facilities for her if she chose for them to do that and R8 told them she would wait for after her doctor's appointment to decide. V54 stated she could see where that meeting could have felt intimidating to R8. V54 said R8 wondered why there was four people in the meeting and did ask about that at the beginning of the meeting. V54 stated it was brought up in the facility's morning meeting to have a meeting with R8, but there was never a specific date. V54 stated she was not sure why R8 did not have a family member with her in the meeting or why one was not invited. V54 stated she does not remember who brought up having the meeting with R8. On 10/22/25 at 2:12 PM, V2 (DON) stated they did have a meeting with R8, and herself, V1, V55, and V54 were present. V2 said V1 asked her to set up the meeting with R8 and said it was to see if there was anything they could do to make R8 happier. V2 stated originally, V2 did not realize she was intended to be part of the meeting. V2 stated she did not say much during the meeting. V2 stated R8 did say she did not like to be talked to by a lot of people at once. V2 said V21's (social media) posts were brought up in the meeting. V2 confirmed that R8 wanted V1 to come down to her room and look at one of her food trays without the kitchen staff knowing in advance. V2 stated she doesn't think the intention of the meeting was to intimidate R8, but she could see where it could be intimidating. V2 stated she is not sure why they only had a meeting with R8 and no other residents when other residents had dietary concerns at the time. V2 stated they had never discussed holding a similar meeting like a care meeting and inviting a family member to be present. On 10/22/25 at 2:28 PM, V1 (Administrator) stated the facility had a meeting with R8 because R8 had concerns with the food. They wanted to let R8 know there were other options out there for her to eat, they had substitutions R8 could ask for. V1 stated herself V55, V2, and V54 were present in the meeting with R8. V1 stated there were four department heads in the meeting	S9999		

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S9999	Continued from page 5 so R8 could address any concerns she might have had. V1 stated they did not ask R8 if she wanted a family member in the meeting due to it being a “last-minute” meeting. V1 stated she could see where it could be intimidating being brought into a meeting last minute with four of the department heads without knowing what it was about, but that was not the intention. V1 stated they did not have a meeting with any other residents. V1 said they only had the meeting with R8 as she was the one talking loudly to other residents and staff about the concerns she had. V1 stated the meeting had nothing to do with the posts on V21’s (social media) page. However, the (social media) post was part of the concern. R8 had been talking about the food, saying she was not going to eat it, and they were concerned. On 09/30/25 at 6:05 PM, V21 (Family) stated he did take pictures of R8’s food and post them to his (social media) page and doesn’t know why he would not be allowed to do that. V21 stated V1 never said anything to him about any of the pictures he posted. V21 stated R8 called him and told him about the meeting facility staff had with her. V21 stated he does not think that is right as R8 was uncomfortable and felt intimidated in that meeting. V21 said R8 was upset about it when she called him. V21 said if they had a problem with the pictures, they should have talked to him about them because he is at the facility regularly but instead, they try to intimidate R8. V21 stated, “how would that not be the intention by pulling one resident from playing cards and bringing one resident into a meeting with four of them?” The undated facility policy titled, “Resident Rights” documents: Employees shall treat all residents with kindness, respect, and dignity. Residents are entitled to exercise their rights and privileges to the fullest extent possible. Our facility will make every effort to assist each resident in exercising his or her rights to assure that the resident is always treated with respect, kindness, and dignity. The section titled, “resident rights” documents: federal code section 483.10 focuses on ways that the rights, dignity, and privacy of long-term care residents are maintained. There are many specific regulations that our facility must follow. In addition to federal requirements, there are also state regulations that we must follow. 2. R9’s Admission Record with a print date of 10/07/25 documented an admission date of 3/26/25 and included diagnoses of end stage renal disease, absence of right leg above the knee, osteomyelitis, heart failure, and muscle weakness.	S9999		

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S9999	Continued from page 6 R9's Minimum Data Set (MDS) dated 7/18/25 documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R9 is cognitively intact. This same MDS documents R9 requires substantial/maximal assistance of staff for toileting. R9's current Care Plan documents a Focus area of, "(R9) has an ADL (activities of daily living) Self Care Performance Deficit Fatigue. Date Initiated: 03/30/2025…" This Focus area includes the following intervention, "Toilet Use: the resident requires 1 staff participation to use toilet. Date Initiated: 03/30/2025…" A facility Grievance Form dated 8/6/25 documents R9 filed a grievance related to an issue of "Nursing Care." Under Description the form documents, "Call light is not getting answered in a timely manner." Under Investigation the form documents, "Call light audit done 8-4-25 - 8-8-25. Nursing met with resident and addressed concerns. Resident states he understands during certain times it takes longer to answer and he appreciates everything the staff does." Under Recommendations/Action Taken the form documents, "Staff educated to continue answering call lights as promptly as possible." On 10/23/25 at 12:30 PM, R9 stated if the regular staff is working his call light gets answered timely. R9 stated some agency staff are ok, some are not. R9 stated it has taken up to an hour and ten minutes. R9 stated two nights ago he had to sit in feces and wait for assistance. 3. R10's Admission Record with a print date of 10/22/25 documented an admission date of 5/22/25 and included diagnoses of diabetes, anemia, heart failure, muscle weakness, reduced mobility, and atrial fibrillation. R10's MDS dated 10/8/25 documents a BIMS score of 11, which indicates a moderate cognitive deficit. This same MDS documents R10 is dependent on staff for toileting. R10's current Care Plan documents a Focus area of, "(R10) has bladder incontinence. Date Initiated: 07/15/2025." This Focus area includes an intervention of, "Brief Use: the resident uses (Size) disposable briefs. Check & (and) change Q2 (every 2 hours) and prn (as needed)." On 10/15/25 at 6:20 PM, R10 stated it takes a long time for them to answer the call lights, and she's had incontinent episodes while waiting for staff to assist her.	S9999		

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S9999	Continued from page 7 4. R37's Admission Record with a print date of 10/22/25 documented an admission date of 7/7/22 and included diagnoses of osteoarthritis, hypertension, atrial fibrillation, pain, muscle weakness, and reduced mobility. R37's MDS dated 10/15/25 documents a BIMS score of 10, indicating R37 has a moderate cognitive deficit. R37's current Care Plan documents a Focus area of, "(R37) has frequent bladder incontinence. Date Initiated: 09/25/2024." This Focus area included an intervention of, "Incontinent: Check the resident Q2 (every 2 hours) and as required for incontinence…. Date Initiated: 09/25/2024…." On 10/15/25 at 6:18 PM, R37 stated they don't usually have enough staff to meet her needs timely. R37 stated it can take up to two hours for them to answer the call lights. R37 stated she's had incontinent episodes while waiting for staff to assist her. On 10/16/25 at 2:56 PM, V51 (Certified Nurse Aide/CNA) stated they sometimes have enough staff to meet the needs of the residents timely but most of the time they are really short staffed. V51 stated he works the 2-10 pm shift, and they are supposed to have two CNA's on the main halls and one CNA on the rehabilitation hall. V51 stated sometimes they only have one on each hall. V51 stated sometimes people have incontinence episodes because they can't assist them as quickly. On 10/20/25 at 11:44 AM, V62 (CNA) stated she works night shift 10 pm to 6 am. V62 stated they have 70-80 residents and work with only three CNA's on night shift. V62 stated, "I am not able to provide quality care." V62 stated on 10/19/25 she was responsible for 26 residents, seven of them required two staff to assist them and 21 required assistance with incontinence care. When asked if there was any negative outcome related to staffing, V62 stated residents have incontinence episodes because they have to wait on us, they have had to sit in urine/feces longer than they should. On 10/20/25 at 12:54 PM, V32 (Licensed Practical Nurse/LPN) stated he didn't feel like one CNA on each hall was enough to meet the needs of the residents timely. V32 stated two CNA's for each hall is more effective. V32 stated with one CNA per hall, residents have to wait a long time and have incontinent episodes. On 10/21/25 at 2:01 PM, V13 (CNA) stated they don't	S9999		

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S9999	Continued from page 8 always have enough staff to meet the needs of the residents. V13 stated when there are call in's they don't really try to get anyone to help. V13 stated residents have incontinent episodes due to how long it takes them to answer the call light. On 10/30/25 at 2:48 PM, V2 (Director of Nurses/DON) stated she expected call lights to be answered as soon as possible. The facility was unable to provide this surveyor with a policy regarding call lights. 5. R33's Admission Record dated 10/22/25 documented an admission date of 10/22/20 and included diagnoses of vascular dementia, chronic kidney disease, dysphagia, psychosis, and cognitive communication deficit. R33's Care Plan documented a focus area of R33 has impaired cognitive function/dementia or impaired thought processes dated 10/22/20. One of the interventions listed is to break tasks into small sub tasks to support short term memory deficits. Another focus area on R33's care plan documents R33 is at risk for burns from hot liquids dated 4/4/24. R33's MDS dated 9/2/25 documented a BIMS score of 11, indicating R33 is moderate cognitive impairment. On 10/20/25 at 9:35 AM, R33 stated CNA staff often put their energy drinks in his room while they are working. R33 stated he doesn't like it because he's worried the drinks will spill on his clothes. R33 named V47, and V48 (both CNA's) as staff who put their personal drinks in his room. On 10/20/25 at approximately 10:00 AM, V17 (CAN) stated other CNA staff put their personal drinks or their personal bags on the top shelf of a resident's closet. V17 stated she had witnessed V47 put personal items in a resident's room. V17 stated it was R33's room. V17 showed this surveyor the closet in R33's room where she had witnessed V47 put her personal belongings. At this time of observation there were no other belongings in R33's closet besides his own. On 10/22/25 at 11:33 AM, V48 (CNA) stated she does keep her personal drink and lunch bag in the closet of R33's room. V48 stated she has asked R33 in the past if he minds if she puts her personal things in his closet and R33 reportedly told her it was fine. V48 stated there is a break room where staff may place their personal belongings.	S9999		

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S9999	Continued from page 9 On 10/22/25 at 11:45 AM, V47 (CNA) stated she does store her personal drink and lunch box in the top of R33's closet in his room. V47 stated the staff do have a break room where they can store their personal belongings but stated if a staff leaves it in there someone will "mess with your lunch or even eat it." V47 referenced R33's room as where she usually keeps her drink and lunch bag stored while on shift. V47 stated she has asked R33 in the past if he minds if she stores her personal items in his room, and he had reportedly told her he doesn't mind. On 10/22/25 at 12:07 PM, R33 stated he did not remember giving permission to any staff member to store their personal items in his room or closet. R33 stated he does not want them to because he is worried it will spill on his clothes. On 10/22/25 at 12:13 PM, V2 (DON) stated the staff have lockers in the break room they can put their drinks and lunch bags in. They are welcome to bring their own locks to use if they are concerned about theft. V2 stated the facility also has a refrigerator in the lunchroom for lunch boxes. V2 stated she would not expect staff members to store their personal items in a resident's closet. V2 stated she did not consider it appropriate for staff to store their personal items in resident's closets or rooms. On 10/22/25 at 12:29 PM, V1 (Administrator) stated she would expect staff members to store their personal belongings in the locker rooms or in the break room. V1 stated she would not expect for staff to store their personal items in a resident's closet. V1 stated she does not believe it is right for staff members to store their personal items in a resident's room. On 10/22/25 at 12:45 PM, the men's and women's locker rooms were observed to have lockers for use by staff members that could be locked. The facility's undated Residents' Rights policy documents a resident has the right to make personal decisions, right to privacy, and the right to be treated with consideration, respect, and dignity. The Ombudsman's Residents' Rights pamphlet with a revised date of 11/18 documents the resident has a general right to privacy and confidentiality. The pamphlet states a resident has a right to keep and use their own property. (B) (2 of 5)	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	**2299 METROPOLIS STREET , METROPOLIS, Illinois, 62960**

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S9999	Continued from page 10 300.610a) 300.1210b) 300.3210t) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. 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. Section 300.3210 General t) The facility shall ensure that residents are not subjected to physical, verbal, sexual or psychological abuse, neglect, exploitation, or misappropriation of property. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations were not met as evidence by: Based on observation, interview, and record review the facility failed to ensure residents were free from staff abuse for 2 of 3 residents (R6 and R19) reviewed for abuse in the sample of 46. This failure resulted in R19 being spat in the face by a staff member which	S9999		

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S9999	Continued from page 11 would cause a reasonable person to experience feelings of humiliation, anger and fear and resulted in staff verbally abusing R6 causing R6 to be visibility upset and fearful. Findings Include: 1. The facility Final Reportable for R19 dated 10/02/25 documents under Complete Description of Occurrence: Initial Report: Initial: Abuse Coordinator was notified on 10/2/2025 at around 10:30pm about an alleged incident that took place between a staff member and resident, (R19). Staff were immediately suspended. Police, Family Representative and Physician were notified. Immediate investigation was initiated. Final: A thorough investigation was conducted between October 2, 2025, and October 8, 2025. Interview Statements: Resident, (R19) was unable to state what happened: (R19) has a BIM score of 7. (V65), C.N.A. (Certified Nursing Assistant) – (R19) was at the nurse's station on front hall where she was reaching and feeling for things (d/t (due to) her blindness and hard of hearing) She proceeded to grab (V56), LPN's (Licensed Practical Nurse) lunch bag. (V56) told (R19) to stop reaching for things and to stop yelling because she was disturbing other residents. (R19) continued behavior, (V56) then grabbed her hands and told her to Stop! (R19) then grabbed (V56) hands and started to pull and bend her fingers. (V56) claimed that (R19) hurt her left thumb. (R19) started shouting, "stop touching me, leave me alone." (R19) was near (V56) face during the shouting." (V56) then leaned into (R19) face and yelled, "How do you like it?" (R19) then said she needed to go to the sink and spit. (V56) told her, "Swallow it." (R19) replied, "I'll spit on you." (V56) replied, "if you spit on me, I will spit on you." (R19) replied, "no you won't." (R19), spit on (V56)! (V56) in turn spit on (R19). (V56) placed (R19) in the large dining room to roam around. I then brought (R19) to the T.V. (television) room o 200 halls. (V56) asked if I would vouch for her, if she were to deny the claims made against her. I replied to (V56), "You did spit on her, we saw you." (V56) became upset and went outside to smoke…." Incident Analysis: Based on the consistent accounts of the staff interview statements, the incident of resident abuse was substantiated. Correction actions and Prevention Plan: Based on the investigation, the following actions have been implemented to protect (R19) and all other residents. No change in Psychosocial baseline since incident occurred. Employee, (V56), LPN was immediately suspended at time of incident. Employee, (V56), LPN will be terminated with a Do Not Rehire. Employee, (V56), LPN, all information will be sent to IDFPR	S9999		

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S9999	Continued from page 12 (Illinois Department of Professional Regulation). Updated findings will be sent to (name of local police department) …. Resolution and Conclusion: the investigation concluded that (V56), LPN, was upset that (R19) spit on her, which in turn she then spit on (R19). All necessary medical and physical assessments were completed. Corrective measures and care plan updates have been put in place. Inservice: Abuse and neglect training provided…" R19's Admission Record with a print date of 10/22/25 documents R19 was admitted to the facility on 5/12/22 with diagnoses that include cerebral infarction, encephalopathy, diabetes, legal blindness, lack of coordination, muscle weakness, difficulty in walking, major depressive disorder, and anxiety disorder. R19's MDS (Minimum Data Set) dated 9/2/25 documents a BIMS (Brief Interview for Mental Status) score of 07, indicating a severe cognitive deficit. This surveyor attempted to speak with R19 several times throughout the survey process. R19 did not respond to questions. R19's current Care Plan includes the Focus area, "(R19) has a behavior problem 1. (R19) startles easily due to blindness & (and) will strike out at others in response." The interventions for this Focus area include, "Behavior #1 Physical aggression: Hitting/yelling at staff and roommate. 1. Offer activities to (R19). 2. Offer to call (R19's) sister…3. Offer to take (R19) to a different area to calm down. Date Initiated: 07/09/2025…. Intervene as necessary to protect the rights and safety of others. Approach/Speak in a calm manner. Divert attention. Remove from situation and take to alternate location as needed. Date Initiated: 12/19/2024. Minimize potential for the resident's disruptive behaviors by helping (R19) out of areas that are crowded with a lot of people such as hallways and the dining room. Date Initiated: 12/19/2024…" R19's Progress Notes dated 10/03/25 documents the following Telehealth note, "Per RN (Registered Nurse), allegedly the patient was yelling at a (sic) one of the nurses, grabbed her hand and threatened to spit on her but the nurse told her not to and then the nurse ing (sic) staff spit on the patient. No other physical altercation happened. Admin (administrator) notified and nursing staff responsible was sent home." There is no other documentation in R19's progress notes related to the incident. On 10/15/25 at 6:24 PM, V40 (CNA/Certified Nursing Assistant) stated she was working the night the	S9999		

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S9999	Continued from page 13 incident occurred between V56 and R19. V40 stated she had just given report to the next shift, so it was around 10:00 PM or a little after. V40 stated she was walking down the hall when she heard, V56 say to R19, “how would you like it if someone spit on you.” V40 stated then she heard the spit sound and saw R19 wiping her face off. V40 stated, R19 then said to V56, “You b**ch.” V40 stated, V2 (Director of Nurses) was called immediately who told staff to call V1 (Administrator), which they did. V40 stated, V1 asked her what happened and had her write a statement. V40 stated she left the facility shortly after. V40 stated she knows V56 was suspended and hadn’t been back to work since the incident occurred. On 10/20/25 at 11:44 AM, V62 (CNA) stated she was working on the night of 10/02/25 and was walking down the hall when she heard V56 say, “How would you like it if someone spit in your face.” V62 stated then she heard the spitting sound and heard R19 say, “you bi**h.” V62 stated she called, V1 (Administrator) and reported it. V62 stated, V65 (CNA) removed R19 from the area while V62 called V1. On 10/20/25 at 2:21 PM, V65 (CNA) stated she was working on 10/02/25 when the incident with V56 and R19 occurred. V65 stated R19 was having behaviors, shouting down the hallways and V56 took her to the nurse’s station and told her she couldn’t be shouting because she would wake other residents up. V65 stated R19 told V56 they could fall back asleep if they woke up. V65 stated R19 is blind and was feeling around the nurse’s desk and kept touching V56’s lunch bag. V65 stated V56 told R19 to stop moving her stuff around and grabbed R19’s hands. V65 stated when V56 grabbed R19’s hands, R19 bent V56’s thumb back. V65 stated she started to remove R19 from the nurse’s station and V56 told her she could stay. V65 stated R19 told them she needed a sink to spit in and V56 told her to just swallow it. V65 stated R19 shouted in V56’s ear and V56 shouted back, “How do you like it?” V65 stated R19 told V56 she would spit on her and V56 told R19 if she did, she would spit back on her. V65 stated R19 told V56 she wouldn’t spit on her and V56 spit in R19’s face. V65 stated R19 wiped her face and said, “you bi**h.” V65 stated she moved R19 to another room and V62 (CNA) called V1 (Administrator). This surveyor attempted to contact V56 via telephone with no success. On 10/21/25 at 11:35 AM, V1 (Administrator) stated she was notified V56 had spit on R19 on 10/02/25. V1 stated V56 went outside the facility, called V1, and told her	S9999		

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S9999	Continued from page 14 she spit but it was just while she was talking to R19, not an intentional spit. V1 stated while she was on the phone with V56 other calls were beeping in. V1 stated she told V56 to stay outside and fill out her statement. V1 stated she spoke with the other staff working with V56, and V56 was suspended immediately. V1 stated after the investigation was completed V56 was terminated and reported to the professional regulation. 2. R6's Admission Record with a print date of 10/01/2025 documents R6 was admitted to the facility 2/6/25 with diagnoses that include acute respiratory failure, heart failure, chronic obstructive pulmonary disease, aortic valve stenosis, dementia, anxiety disorder, major depressive disorder, and cognitive communication deficit. R6's MDS (Minimum Data Set) dated 8/15/25 documents R6 is independent with making consistent/reasonable decisions, with no cognitive impairment documented. R6's current Care Plan was reviewed with no Focus area related to abuse and/or behaviors documented. On 10/16/25 at 10:16 AM, R6 was interviewed and was alert and oriented to person, place, and time at the time of the interview. R6 stated she had issues with V56. R6 stated she was short of breath and scared and V56 didn't help her. R6 stated she wrote down the things V56 said to her during that time. R6 showed this surveyor a piece of paper on her bedside table, and it listed these items with no times or dates listed next to them, "choke on that, it's all in your head, you can breathe if you try, you are crazy." R6 stated it happened on a couple of different dates and she reported it to unknown staff. R6 was visibly upset when speaking to this surveyor regarding V56. On 10/15/25 at 10:31 PM, V59 (CNA/Certified Nursing Assistant) stated R6 reported V56 told R6 she was ridiculous and yelled in her face. V59 stated R6 was really upset and crying when she reported it to her. V59 stated she told R6 she needed to tell V1 (Administrator) when she came to work the next day. V59 stated she did not report the allegation to V1 since she didn't witness it. On 10/16/25 at 2:56 PM, V51 (CNA) stated R6 reported to her "quite a few times (unknown dates)," V56 (LPN/Licensed Practical Nurse) had told her she was crazy. V51 stated R6 reported V56 was verbally mean to her, and she was afraid of V56. V51 stated she reported the allegation to V1 (Administrator) and V2 (Director of Nurses).	S9999		

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S9999	Continued from page 15 On 10/16/25 at 3:13 PM, V10 (CNA) stated V56 isn't a very nice nurse. V10 states she was afraid of repercussions if she reported allegations against V56. V10 stated R6 reported (unknown date) V56 was rude to her and got mad when she asked for anything. V10 stated she reported it to an unknown day shift nurse. On 10/20/25 at 12:09 PM, V2 (Director of Nurses) stated she was unaware of any allegations of verbal abuse regarding V56 and R6. On 10/21/25 at 11:35 AM, V1 (Administrator) stated she wasn't aware of any reports of allegations of V56 being verbally abusive towards R6. V1 stated it should have been reported immediately. V2 (Director of Nurses) who was in this same interview stated she did have staff report R6 was upset with a staff member but when she talked to R6 she told V2 she didn't want anyone to get in trouble. On 10/21/25 at 1:01 PM, V31 (CNA) stated R6 and R8 (roommates) had reported allegations of "inappropriate staff behavior" to her. V31 stated R6 was crying and told her a nurse was being mean to her, calling her names, and saying awful things. V31 stated she told R6 she could speak with V2 (Director of Nurses). V31 stated she reported the allegations to V2 (Director of Nurses). V31 stated V2 spoke with R6 and R8 and after speaking with them, V2 told V31 since the residents would not give her the name of facility staff member, she could not do anything more about it. V31 stated the residents told me it was V56, and it was reported to V2, but because they wouldn't tell V2 who it was she was unable to investigate it further. On 10/24/25 at 10:11 AM, R8 stated, a nurse whose name sounded like V56's was mean to R6. R8 stated V56 would tell R6 she was crazy and ridiculous. R8 stated V56 would tell R6 she was watching her when R6 wasn't aware, and she could breathe "just fine." R8 stated she reported this to V32 (LPN/Licensed Practical Nurse) who she thought reported it to administration. On 10/27/25 at 5:10 PM, V32 (LPN) stated he did not remember R6 and/or R8 reporting any allegations to him. On 10/21/25 at 2:38 PM, V2 (Director of Nurses) was asked to tell this surveyor about the time R6 reported a staff member was mean to her. V2 stated she wasn't sure which staff member reported it to her. V2 stated they told her R6 was upset after morning meeting and V1 (Administrator) told her and the Social Services Director (SSD) (V27) to talk with R6. V2 stated the CNA	S9999		

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S9999	Continued from page 16 (who reported it) told her something was wrong but reported not knowing why R6 was upset. This surveyor reviewed with V2, V31's interview where she stated she reported the allegation and the name of the alleged perpetrator (V56) to V2. V2 stated that was not accurate. V2 stated she was not told who R6 was upset with or what she was upset about. V2 stated R6 didn't want anyone to get in trouble. On 10/22/25 at 1:23 PM, V27 (LPN/SSD) stated she did write a grievance for R6, but she couldn't remember what the details were. When asked if R6 ever reported anything concerning V56, V27 stated that was probably what the grievance was about but R6 would not tell her who the staff member was. V27 stated R6 would never say who it was and didn't report it as abuse just that someone wasn't very nice to her. V27 wasn't sure about a CNA reporting the allegation. The facility Grievance Form dated 7/28/25 documents R6 filed a grievance which included a check mark next to "Staff Concern." This same form documents under Description: (R6) feels as though staff member had poor customer service with her…" There are no specific details documented on what the poor customer service includes. The form documents under Recommendations/Action Taken: "SSD/ Social Services Director) to meet with (R6) once a week x (times) 4 weeks to ensure customer service has improved." There are no SSD meetings/audits attached to this form. Documentation regarding the SSD meeting/audits were requested from V1 (Administrator) via email on 10/27/25. V1 provided this surveyor with R6's SSD progress notes dated 8/5/25 that documents, "This writer met with resident at this time to follow up with her regarding recent grievance. Resident states she is doing well, and she is happy with her care in the facility. This writer provided support to resident at this time." There were no other progress notes provided to this surveyor that documented follow up regarding the grievance that was filed by R6. V1 (Administrator) stated in the email that she was unable to locate any other documentation of meetings once a week for four weeks. On 10/22/25 at 3:23 PM, this surveyor reviewed the allegation of abuse regarding V56 and R6 with V1 (Administrator) and she stated she had started an investigation and spoke with R6's power of attorney who reported to her R6 had an issue with a nurse telling her she was ridiculous. The facility Abuse Prevention and Prohibition Policy	S9999		

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S9999	Continued from page 17 dated 03/2025 documents, "…Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends or other individuals…. Prevention: The resident has the right to be free from verbal, mental, sexual, exploitation, or physical abuse; corporal punishment and involuntary seclusion. The owner, licensee, Administrator, employee, or agent of the facility shall not abuse or neglect a resident and must prohibit the misappropriation of resident property. Resident behaviors will be monitored for changes, which trigger abusive behaviors…. (B)" (3 of 5) 300.610a) 300.1210b) 300.1210c) 300.1220b)2)3) 300.3220f) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. 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.	S9999		

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S9999	Continued from page 18 c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3220 Medical Care f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the facility's director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These regulations were not met as evidence by: Based on observation, interview and record review, the facility failed to ensure physician orders were accurate and implemented for recommended changes in treatment after a hospitalization and a fall and failed to assess and treat lymphedema/wounds per physician's orders for 3 of 3 residents (R6, R7, R20) reviewed for quality of care/treatment in a sample of 46. This failure resulted in R6 struggling to breathe, causing anxiety, sleep disturbance, and significant discomfort due to recommended medications changes not being	S9999		

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S9999	Continued from page 19 administered/implemented to treat newly diagnosed congestive heart failure. This failure also resulted in R7's developing redness, increased swelling, tenderness, and altered mental status and R7's subsequent hospitalization with a diagnosis of cellulitis and septic shock. Findings include: 1. R6's Admission Record documented an admission date of 02/06/25 and included diagnoses of acute respiratory failure with hypercapnia, chronic obstructive pulmonary disease (COPD) with acute exacerbation, heart failure, dementia, anxiety disorder, major depressive disorder, dysphagia, type 2 diabetes mellitus with diabetic nephropathy, and acute kidney failure. R6's Minimum Data Set (MDS) dated 08/12/25 documents a BIMS score of 15, indicating cognitively intact. R6's Care Plan documented a focus area of oxygen therapy dated 05/20/25, with interventions including: give medications as ordered by physician, monitor/document side effects and effectiveness; monitor for signs or symptoms of respiratory distress and report to medical doctor PRN (as needed): respirations, pulse oximetry, increased heart rate (tachycardia), restlessness, diaphoresis, headaches, lethargy, confusion, atelectasis, hemoptysis, cough, pleuritic pain, accessory muscle usage, and skin color; position resident to facilitate ventilation/perfusion matching, use upright high Fowlers position whenever possible to allow for optimal diaphragm, when on side the good side should be down (e.g., damaged lung should be up) all dated 02/06/25 and oxygen settings; the resident has O2 (oxygen) via nasal prongs dated 02/11/25. R6's care plan documents a focus area of R6 has SOB (shortness of breath) while lying flat r/t (related to) respiratory failure dated 02/11/25 with interventions listed of: administer PRN medications as ordered dated 02/06/25 and elevate HOB (head of bed) dated 02/06/25. R6's June 2025 Medication Administration Record (MAR) documents an order for albuterol sulfate nebulization solution (2.5 mg/3ml) 0.083%, 3 ml inhale orally via nebulizer every 4 hours as needed for shortness of breath with a start date of 04/02/25 at 10:44 AM and a D/C (discontinue) date of 08/20/25 at 9:15 AM and an order for furosemide oral tablet 40 mg, give one tablet by mouth every 24 hours as needed for edema/swelling with a start date of 02/06/25 at 2:30 PM and a D/C date of 08/20/25 at 9:15 AM.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

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S9999	Continued from page 20 R6's hospital records with an admission date of 08/15/25 document: history of present illness: 95 year old female with past medical history of hypertension, COPD (Chronic Obstructive Pulmonary Disease), on 2-3 liters (oxygen) per NC (nasal cannula) anxiety, and depression presented to the ER (emergency room) from (facility name) with respiratory distress. Nursing staff at (facility name) noticed her in respiratory distress sometime yesterday evening. No mention of cough, fever, or other symptoms. On EMS (emergency medical service) arrival, O2 (oxygen) saturation was 70%. Her oxygen was increased, and albuterol nebulizer was given en route. Chest x-ray showed bilateral pleural effusions BNP (B-type natriuretic peptide) 10,000, pH 7.27, pCO2 (partial pressure of carbon dioxide) 83. She was given DuoNeb, Lasix, and placed on BIPAP (bilevel positive airway pressure), ABG (arterial blood gas) improved after 1 hour on BIPAP. Admitted to med/surg inpatient. The section titled, "patient visit information; activity restrictions or additional instructions: discharge to skilled nursing facility; follow up with PCP (primary care physician) in 3 days, recommend repeat blood work to monitor HGB/BUN (hemoglobin/blood urea nitrogen), continue good bowel regimen, DX (diagnosis): ileus, EKG (electrocardiogram) changes, CHF (congestive heart failure); prescriptions (in part): furosemide (Lasix) 40 mg (milligrams) oral daily #30 tablet. Additional documents given: patient health summary and home medications list. The home medication list includes furosemide (Lasix) 40 mg tablet, stop taking: 40 mg oral daily as needed, start taking: 40 mg oral daily. The section titled problems documents active problems: acute exacerbation of CHF. Under the section titled, "discharge plan" documents in part: dx: ileus, EKG changes, CHF. Prescriptions: changed: furosemide (Lasix) 40 mg tablet, 40 mg PO (per oral) daily. Under the continued medications listed: albuterol sulfate 2.5mg/3ml (milliliters) solution for nebulization, 2.5 mg inhalation Q (every) 4 hours PRN (reason: shortness of breath or wheezing). R6's hospital discharge records dated 08/21/25 documented to follow up with primary care physician in 3 days, recommend repeat blood work to monitor hemoglobin and blood urea nitrogen. R6's Dietary Progress Note dated 08/25/25 documented in part, Dietitian chart review for RA (recent admission). August weight: 143.7# (pounds) 08/12/25 weight recorded (prior to hospitalization)…some varied history but overall stable. Sent to hospital 08/15/25 with diagnosis: acute respiratory failure, BLE (bilateral lower extremities) increased swelling. Diagnosis: new onset of CHF (congestive heart failure) use of Lasix 20mg (milligrams) Q (every) 8 hours and 1800 ml fluid	S9999		

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S9999	Continued from page 21 restriction with hospital weight recorded: 131.34 pounds RA (recent admission) here 08/21…Continue diet order of NAS (no added salt) as least restrictive therapeutic intervention. Monitor weight, lab and consumption with new order for Lasix 40mg QD (every day) may see fluid shifts affecting weight patterns. Record weekly weight or 4 weeks, follow up as needed with new concerns. R6's Medication Review Report documents an active order with a start date of 8/21/25 documenting furosemide oral tablet 40 mg, give 1 tablet by mouth every 24 hours "as needed" for edema/swelling. This document does not show the order change implemented at the hospital from furosemide 40mg tablet daily "as needed" to furosemide 40mg tablet daily. This report also documented an active order with a start date of 8/21/25 documenting albuterol sulfate inhalation nebulization solution 2.5mg/0.5ml (milliliter); 1 vial inhale orally every 4 hours as needed for COPD. This order does not match the hospital record's continued medications of albuterol sulfate 2.5mg/3ml solution for nebulization. R6's Progress Note dated 10/15/25 at 1:16 AM documented R6 complained of shortness of breath and O2 (oxygen) sats (saturation) at 94% on 3L (liters)/NC (nasal cannula). PRN (as needed) medications administered per MD (Medical Doctor) orders. R6's October 2025 MAR documented an albuterol sulfate inhalation nebulization solution 2.5mg/0.5ml treatment was given on 10/15/25 at 1:15 AM. R6's Progress Note dated 10/15/25 at 2:20 AM by V53 (Licensed Practical Nurse/LPN) documented: "resident continues to c/o (complain of) SOB (shortness of breath) and unable to breath. Nurse explained to resident that she needed to go to ER (emergency room) and get checked out. Resident refused and said she would make it. This nurse requested (V78/Registered Nurse-RN) to come and evaluate resident. Resident also told V78 that she was not going to the hospital, and she would just wait. X-ray ordered and (x-ray company) called to schedule. R6's Progress Note dated 10/15/25 at 7:00 AM by V77 (Nurse Practitioner/NP) documented, Visit Type: Telehealth: the nurse reported dyspnea accompanied by low oxygen saturation and abnormal lung sounds with crackles. A chest x-ray was requested, along with adjustments to the respiratory treatment plan. Ordered chest x-ray and a one-time PRN dose of 2 ml albuterol sulfate neb (nebulizer) treatment. Rounding to follow up.	S9999		

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S9999	Continued from page 22 R6's October 2025 MAR showed no administration of a one-time dose of 2ml albuterol sulfate neb treatment ordered by V77 as documented in the progress note above for the corresponding time of 7:00AM. On 10/15/25 at 10:29 AM, R6 was sitting on her bed with an anxious facial expression. R6 appeared to be struggling to breathe with loud crackles heard. At this time, R6 was alert and oriented and stated she was having a hard time breathing. R6 said she would make it if she could have a breathing treatment and would not have to go to the hospital. R6 stated she had not had one since about 1:00 AM this morning. R6 stated she asked the nurse for a breathing treatment earlier but was not given a treatment. R6 said the nurse was not nice to her and told her just to "spit it out." R6 stated, she can't, and her breathing is getting worse. On 10/15/25 at 10:34 AM, V27 (Licensed Practical Nurse/LPN) was at the nurse's station when surveyor requested V27 to go check on R6. V27 stated R6's SPO2 (saturation of peripheral oxygen) was fine, R6 has an x-ray ordered, and she is fine. V27 did not go assess R6 at this time. On 10/15/25 at 10:35 AM, another surveyor entered R6's room and immediately noticed R6 displaying symptoms of anxiety due to respiratory difficulty including trying to sit up straight, use of accessory muscles, and gasping and anxious/fearful facial expression. There were noted audible crackles that could be heard without a stethoscope while standing next to R6. On 10/15/25 at 10:36 AM, V2 (Director of Nursing/DON) stated R6 is having trouble breathing, R6 definitely should get a breathing treatment. V2 stated V27 (LPN) should have come down to visually assess R6. V2 stated there could be more going on than what SPO2 percentages can show. V2 stated R6 should have received a breathing treatment when she had asked for one earlier, it is not appropriate for the nurse just to tell her to "spit it out." V2 stated R6 knows when she needs a breathing treatment and should be given one when she asks. R6's Progress Note dated 10/15/25 at 10:54 AM by V27 (LPN) documented: "reported to this nurse that resident had an acute change in condition. This nurse entered resident's room and resident was noted to be sitting on edge of bed. No new onset shortness of breath noted, resident did not appear to be in distress, cognition continues to be baseline. No complaints of pain, No audible wheezing present. VS (Vital Signs) as follows: BP (blood pressure) 112/56, P (pulse) 81, R	S9999		

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S9999	Continued from page 23 (respirations) 20, O2 (oxygen) 99% via NC (nasal cannula). Temperature 98.0. Resident has received scheduled nebulizer treatments this AM, this nurse asked resident if she felt as if she needed to go to the hospital and she refuses at this time stating she would like to wait and have her in house chest x-ray. I informed resident that chest x-ray has been scheduled but she can still go to hospital if she feels she needs to. Resident verbalized understanding at this time." On 10/15/25 at 10:55 AM, V2 (DON) administered a breathing treatment of albuterol sulfate nebulization solution 2.5mg/0.5ml to R6. At this time, R6 asked why there was barely any medication in there anymore (while shaking the nebulizing chamber in her hand). R6 took a couple breaths and stated, "look it is gone already." R6's Progress Note dated 10/15/25 at 11:27 AM by V2 documented: "after PRN breathing treatment resident stated she was still SOB. Lung sounds audible and crackles could be heard. Residents current O2 sat is 99% on 2 L NC. Resident wanted another treatment and denied going to hospital for evaluation. This nurse called on call NP, (V77) and obtained order for a one-time PRN dose of 2ml albuterol sulfate neb treatment. Treatment given at this time." On 10/15/25 at 11:45 AM, V2 administered the one-time dose of 2ml albuterol sulfate neb treatment ordered by V77. R6's October MAR documents administration of albuterol sulfate inhalation nebulization solution 2.5mg/0.5ml at 10:59AM and a subsequent administration of albuterol sulfate inhalation nebulization solution 0.63mg/3ml (Albuterol Sulfate), give 2ml inhale orally via nebulizer one time only for SOB for 1 day at 11:45 AM. R6's MAR shows no administration of albuterol sulfate inhalation nebulization treatment after the 10/15/25 1:15 AM administration until the 10:59 AM and 11:45 AM administrations. On 10/16/25 at 9:19 AM, V2 (DON) was questioned about R6's Progress Note entry dated 10/15/25 by V27 and why it did not match observations of R6's condition on that date and time. V2 stated V27 put in the change in condition progress note because V2 asked her to. V2 stated what V27 documented was not an accurate assessment of R6 at the time. R6's Progress Note dated 10/16/25 at 7:00 AM by V82 (Physician Assistant) documents: visit type: telehealth: "resident chest x-ray showed signs of pulmonary edema and the patient complains of dyspnea	S9999		

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S9999	Continued from page 24 and cough, no fevers. She is Lasix 40mg prn, will change to Lasix 40mg daily for 5 days and then add potassium 10mEq (milliequivalents) daily for 5 days as well. Rounding to assess." On 10/16/25 at 10:15 AM, R6 was again struggling to breathe, was tearful and anxious. At this time, R6 stated she is still having trouble breathing. R6 stated she did not get a breathing treatment last night or this morning and she asked for one. R6 stated she is just so tired because she could not sleep because she couldn't breathe. R6's October MAR documents no further administrations of albuterol sulfate inhalation nebulization treatments after 10/15/25. R6's October MAR documents an order for furosemide oral tablet 40 mg, give 1 tablet by mouth one time a day for CHF for 5 days with a start date of 10/17/25 at 8:00 AM. R6's MAR documents furosemide 40 mg given on 10/17/25 at 8:00 AM. On 10/16/25 at 11:01 AM, V2 (DON) stated R6 is still having trouble breathing, she should have received a breathing treatment last night and/or early this morning. V2 stated R6 knows when she needs a breathing treatment. R6's Progress Note dated 10/17/25 at 5:53 AM by V74 (Nurse Practitioner) documented in SOAP (Subjective, Objective, Assessment, and Plan) format included: note text: "S-dyspnea with anxiety; O-review of CXR (chest X-Ray): initial was incomplete not viewing lung bases. Repeat on 10/16 showed worsening of bilateral opacities with edema, possible pneumonia, COPD-end stage on supplemental oxygen. Currently on multiple medications for this. Newly diagnosed CHF (congestive heart failure) in August 2025 with PRN Lasix. See new orders from on-call (V78). A-COPD exacerbation. Community acquired pneumonia. CHF exacerbation." P-1. See plan for Lasix/KCL (potassium chloride), recommend new facility draw BMP Monday, 2 augmentin, 3 prednisone, 4 check if (brand name) inhaler will be covered by insurance to replace current ICS/LABA (inhaled corticosteroid/long-acting beta-agonist), 5 recommend referral to pulmonologist. R6's October 2025 MAR documents furosemide oral tablet 40mg; give one tablet by mouth every 24 hours "as needed" for edema and swelling with documentation noting it was administered on 10/08/25 at 7:38 AM and 10/16/25 at 7:38 PM. These are the only two administrations of furosemide documented for the whole	S9999		

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S9999	Continued from page 25 month of October. R6's Discharge Summary documents discharge from the facility on 10/17/25 to another nursing facility in a neighboring town. R6's Progress Notes dated 10/17/25 at 10:43 AM documented receiving facility here to transport resident. On 10/22/25 at 7:40 AM, R6 was observed in her new facility. R6 stated she still has some problems breathing but it is some better. R6 said after she returned from the hospital last time at the end of August, she kept telling the nurses she was supposed to have another medication that she was given in the hospital but the nurses either said she was crazy, or they said they did not have any new orders for medication for her. R6 still appeared to have some difficulty with breathing but did not appear to be in respiratory distress, was not anxious during this observation and no crackling sounds were heard during the visit. On 10/22/25 at 1:32 PM, V2 (DON) stated she does not see a physician follow up appointment that was set up for R6, but she will provide one if she can find one. V2 said she does not know why the diagnosis of CHF was not added to R6's diagnosis list after her hospital visit. V2 said she does not know why the order for the furosemide was not changed to daily for R6. V2 stated she can see in the hospital paperwork where R6 was given a diagnosis for CHF and R6's order for Lasix was changed to daily from as needed. V2 said she does not see where there have been any notes from any doctors for the furosemide not to be changed to daily. V2 also stated she does not see where or why R6's order was changed from the albuterol sulfate 2.5mg/3ml to the 0.5ml dosage after she returned from the hospital. On 10/23/25 R6's electronic health record (EHR) did not contain any documentation of a follow up visit with a physician after R6's hospital visit. On 10/23/25 at 9:40 AM, V2 stated she had not found any other documentation for R6 from after her hospital visit. On 10/24/25 at 10:11 AM, R8 (R6's previous roommate) stated when R6 returned from the hospital in August, R6 kept telling the nurses she was supposed to have another medication from the hospital, but some nurses told her she was crazy and some just stated R6 did not have any new medications. On 10/28/25 at 1:05 PM, V74 (Nurse Practitioner) stated	S9999		

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S9999	Continued from page 26 she was not aware of the medication changes of the Lasix or the albuterol nebulizer treatment after 08/21/25 when R6 was discharged from the hospital. V74 said she was unaware of the updated diagnosis of congestive heart failure for R6. V74 said she has told the facility several times she can only see the records in (EHR company name), therefore when residents return from the hospital with new medications or diagnoses she either needs to be sent the hospital records or the resident's medical record needs to be updated so she can be notified and be aware of what is going on with the resident. V74 stated a diagnosis of CHF and medications changed to Lasix daily could make a significant difference to a resident. V74 stated she was not notified of any of the information and if it was not put into (name of EHR company) she would not know. On 10/29/25 at 2:22 PM, V75 (Nurse Practitioner) stated, he has seen R6 for her anxiety. V75 stated R6 does get more anxious when she cannot breathe. On 10/29/25 at 2:48 PM, V79 (Hospital Nurse Practitioner) stated R6 was given a diagnosis of CHF while in the hospital from 08/15 – 08/21/25 and upon discharge from the hospital, R6's Lasix was changed from as needed to daily. V79 stated would have expected R6 to have CHF added to her diagnoses and the Lasix to be given daily as prescribed at the hospital, upon discharge to the facility. V79 stated she can see on R6's discharge paperwork from the hospital they did not change her albuterol nebulizer dosage. V79 stated R6 should have had a follow up appointment with her primary care physician as in her discharge paperwork from the hospital. The facility's Medication Administration Policy documents "Adherence to this Medication Administration Policy is essential to ensure the well-being and safety of our residents. All staff members are expected to follow these guidelines strictly and to report any issues or deviations from the policy. Continuous improvement and open communication are encouraged to uphold best practices in medication administration." The policy further documents that it applies to all staff members involved in the administration of medication, including nurses. Under Guidelines, Medication Orders and Documentation: 1. All medication orders must be prescribed by a licensed healthcare professional and documented accurately in the resident's medical records. 2. Written, verbal, or telephone orders may only be received and transcribed by an LPN or RN. 3. Any changes in medication orders must be documented in the resident's medical record. 4.	S9999		

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S9999	Continued from page 27 Medication administration records (MARs) should be maintained for each resident and must be up-to-date and easily accessible. On 11/06/25 at 10:31 AM, V2 (Director of Nurses) stated she was unable to locate a significant change in condition policy. 2. R7's face sheet dated 10/7/25 documents an admission date of 7/10/24. R7's face sheet documents the following diagnoses including but not limited to lymphedema, reduced mobility, localized edema, and congestive heart failure. R7's minimum data set (MDS) dated 10/2/25 documents R7 has a brief interview for mental status score of 15 indicating R7 is cognitively intact. R7's MDS documents R7 is a substantial/maximum assist for all mobility needs including repositioning in bed and is at risk for pressure ulcers/injuries. R7's care plan dated 10/7/25 documents R7 has a focus area for potential/actual impairment to skin integrity related to decreased mobility and lymphedema to left lower leg dated revised on 4/23/24. R7's care plan documents interventions for the above focus area includes but is not limited to administer treatments as ordered and monitor for effectiveness dated 7/10/24; float heels while in bed as tolerated dated 7/10/24; for dry and flaky skin use high quality moisturizers to rehydrate skin dated 7/10/24; monitor pressure areas for changes in color, sensation, temperature and report any change to nurse dated 7/10/24. R7's physician's orders sheet dated 10/7/25 documents physician's orders including but not limited to ace wrap for compression to bilateral lower extremities related to edema. Change daily. Wrap leg with ace wrap from foot to knee everyday shift with a start date of 6/8/25. R7's physician's order from same physician's order sheet documents cleanse left lower extremity with wound cleanser, apply puracol cut to fit open areas and wrap with kerlix (gauze wrap) every day and night shift for wound care with a start date of 6/27/25. R7's physician's order from same form documents another order for a low air loss mattress with a start date of 5/1/25. R7's physician's order documents an order for lymphedema pump to be used three times weekly times three weeks with a start date of 6/26/25. R7 has skin/wound assessments for dates 6/3, 6/10, 6/17, 6/25, 7/2, 7/8, 7/16, 8/18, 8/25, 9/1, 10/14, and 10/16. There were no skin/wound assessments for the weeks of 7/20-7/26, 7/27-8/2, 8/3-8/9, 8/10-8/16,	S9999		

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S9999	Continued from page 28 9/7-9/13, 9/14-9/20, 9/21-9/27, 9/28-10/4, 10/5-10/1, and 10/19-10/25. R7's skin/wound assessments fail to document the circumference of R7's legs indicating the amount of lymphedema being monitored. R7's skin/wound assessments fail to document on the dates completed what type of wounds R7 has, where the wounds are located on the left lower extremity, size of the wounds, how many wounds, and/or if any exudate from wounds. There is also no mention of monitoring of R7's weights to aid in monitoring R7's lymphedema. The most descriptive assessment dated 7/2/25 given for any of the dates skin/wound assessments were completed documents R7's left lower leg has lymphedema present with wounds, and treatments are in place. R7's progress notes from June – October 2025 including dieticians, nurse practitioners, medical doctors, and all nursing staff progress notes do not document R7's lymphedema was being measured/monitored for increase/decrease in size/amount, that medical doctor was being notified of R7's frequent refusals of dressing changes, or that R7 wanted a different treatment to left lower extremity wounds. R7's progress note dated 10/28/25 at 9:19 A.M., documents R7 was sent to local hospital for left lower extremity being red, warm to touch, having altered mental status, and increased left sided facial drooping. R7's hospital records dated 11/5/25 documents R7 was admitted to local hospital from 10/28/25 – 11/3/25. R7's hospital records documents on page 8, R7 was started on broad spectrum antibiotics intravenously to treat her diagnosis of septic shock and cellulitis of left lower extremity. R7's hospital records documented no treatment of left lower extremity regarding how and what type of dressing was being done, except left lower extremity was not being wrapped for compression due to severe swelling. R7's same hospital records documents R7 went to local hospital emergency room on 10/28/25 for altered mental status, fever, leg pain and swelling. Page 17 of same hospital records documents R7's admitting diagnosis was septic shock secondary to lower extremity cellulitis. Page 18 documents from medical doctor's notes R7 is at high risk of recurrence due to underlying lymphedema and poor wound care. On 10/15/25 at 10:35 A.M., R7, who was alert and oriented, stated the nurses frequently do not do her dressing changes or at least all her dressing change. R7 stated her legs are to be wrapped with ace wraps every day, but frequently the staff tell her they do not have ace wraps, or they simply don't do the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

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S9999	Continued from page 29 dressing change. R7 stated she doesn't know and/or has not asked why they weren't done. R7 stated she feels concern for her legs because the cracked, open, bleeding, and weeping skin on her legs could cause infections. At this time, R7's legs were not currently wrapped in ace wraps. There was noted gauze wrap to left lower leg with some light-yellow staining of the gauze in multiple areas from what appears to be weeping and/or serosanguineous drainage from wounds. R7's left leg was extremely swollen with edema. Unable to visualize skin due to gauze wrap. R7's right leg also had severe edema noted but is less than the left leg. There were also no lymphedema pumps noted at R7's bedside. On 10/16/25 at 1:29 P.M., observed the dressing change and treatment of R7's wounds and lymphedema of both lower extremities. V30, (Licensed Practical Nurse/LPN) was the nurse performing the treatment with V2, (Director of Nursing/DON) and V31, (Certified Nursing Assistant/CNA) assisting. Upon entering room the V30 brought the treatment cart into R7's room to perform dressing. V30, V2, and V31 were all wearing gloves, but no one had donned a disposable gown before beginning wound care. V30 performed hand hygiene and then donned gloves. V30 removed the old dressing which was only the gauze wrap using scissors. Upon removal of R7's old dressing R7's left leg skin was cracked and peeling with numerous open cracks that were not actively weeping but appeared to be moist with serosanguineous fluid and/or blood. The skin was very tight in appearance also. There were also what appeared to be blister like formations near the posterior region of the left knee above and below the knee joint. The lesions were intact and not currently open or draining. R7's right leg was also severely swollen with edema, but the skin had not started to crack, peel and open like the left leg. Skin to right leg was intact and appeared healthier than the left leg's skin condition overall. V30 then performed hand hygiene and donned new set of gloves. V30 washed both legs with soap and water changing gloves and performing hand hygiene according to current standards of practice. R7's left leg was rinsed with water and washcloths. Left leg was dried, then lotion applied. There was no medicated creams or ointments applied to R7's open areas on her left leg. Then gauze wrap was applied from toes to knee on the left foot and then two four-inch ace wraps applied to left leg. Right leg was then completed with lotion being applied and two four-inch ace wraps applied. On 10/16/25 at 11:01 A.M., V32, LPN stated as far as treatment/dressing supplies the facility is frequently out of ace wraps. V32 stated the trouble with obtaining	S9999		

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S9999	Continued from page 30 wound supplies has been ongoing for about the last two months periodically. On 11/6/25 at 12:12 P.M., V32, LPN stated when he realized on the incidents, he was out of ace wraps to do R7's dressing changes with he would notify V2. V32 couldn't say how frequently he was out of ace wraps, but did mention it was more than once. V32 stated he would notify V2 the same day because he worked day shift, and she was usually in the building. V2 stated as far as he is aware administration did not go to a local store and pick any ace wraps up that same day. V32 stated administration would tell him the ace wraps were on back order or delayed. V32 stated he did not notify the medical doctor when R7 would frequently refuse her dressing changes. V32 stated R7 frequently refused her dressing changes because he would not do it the way she wanted but only do it according to doctor's orders, or R7 would state she was too tired or wanted to sleep at that particular time. V32 stated because he would only do the dressing according to doctor's orders she would refuse it. V32 stated he thought notifying the wound care nurse V30, LPN and V2 would be sufficient. On 11/5/25 at 1:32P.M., V32, LPN stated R7 frequently wanted him to put Nystatin powder in her open wounds because she said that was what healed them. V32 stated on 9/9/25 when it was documented in R7's treatment administration records that she refused the treatment that day it was because he refused to do the dressing like R7 wanted it done versus how the dressing and treatment were ordered. V32 stated he did notify the nurse practitioner of R7's refusal that day on 9/9/25. V32 stated when he notified V74, nurse practitioner that day, he stated he received no new orders from V74 regarding R7's treatments to wounds or lymphedema. R7's only progress note dated 9/9/25 documents there was no notification to V74 of R7's refusal of dressing change. On 11/5/25 at 1:36 P.M. V29, LPN stated R7 would frequently refuse her dressing changes to her left lower leg because the nursing staff wouldn't put Nystatin powder on the open wounds and/or sometimes R7 would tell the nursing staff she was just too tired or hurting. V29 stated she would notify V2, DON of her refusal of dressing changes, but does not remember notifying the medical doctor or nurse practitioner. V29 stated R7 would refuse the entire treatment including wrapping her legs with the ace wraps when V29 refused to put the nystatin powder on them when it wasn't what the doctor ordered. V29 stated looking back on R7's refusals she should have notified the doctor or nurse practitioner if and/or when R7 refused her treatments.	S9999		

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S9999	Continued from page 31 On 11/5/25 at 5:30 P.M. V53, LPN stated she could not remember the exact dates or date R7 had refused her dressing changes to her legs including application of the ace wraps, but remembered it was frequently R7 did refuse. V53 stated the reason given from R7 for frequently refusing her dressing changes was because she wanted the nursing staff to do it a certain way including rubbing nystatin powder or cream into her open wounds on her legs and then dressing them. V53 stated she explained to R7 couldn't do that because it wasn't the doctor's orders. V53 stated when she would explain this to R7 she would then refuse the dressing all together. V53 stated she did not notify the medical doctor when R7 would refuse her dressing changes because it was in the evening and R7 refused frequently. V53 stated there were shifts she was working when there were no ace wraps in the building she knew of. V53 stated she would not notify V2, DON or the wound nurse immediately, but would leave a note on the shift report in the electronic health record system and let them know that way. V53 stated she would expect them to find the notification the next morning when they reported to work. V53 stated when she would be out of ace wraps for R7's dressings she simply wouldn't do them. V53 stated she did notify the medical doctor at the time of being out of ace wraps completely or the correct size of ace wrap that the dressings were not completed as ordered. On 11/6/25 at 9:04 A.M., V53, LPN stated the facility was only out of ace wraps once or twice completely. V53 stated when the facility was out of ace wraps it wasn't out of all sizes but only the size needed for wrapping R7's legs which was the six-inch width. V53 stated the facility would often only have the three-inch ace wraps when the nursing staff would need the six inch for someone like R7 who had lymphedema in the legs. V53 stated when the nursing staff was out of the correct size of ace wraps or didn't have any the nursing staff would do the treatment for the open wounds as ordered and wrap with gauze but would leave the ace wraps off and notify the administration via shift report in the electronic health record system they needed more ace wraps of the correct width. V53 stated she did not notify the medical doctor when she would not have the ace wraps to do the dressing changes as ordered. V53 stated looking back she probably should have notified the medical doctor but just didn't think of it. On 11/6/25 at 10:32A.M. V2, DON stated she would expect nursing staff to notify her immediately of being out of any supplies including ace wraps. V2 stated if they would notify her immediately the facility has a nurse	S9999		

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S9999	Continued from page 32 living close by that could go pick up those supplies immediately from a local store. V2 stated she would expect nursing staff to document refusals of dressing changes and expect them to notify the nurse practitioner/medical doctor in charge of the resident's care of R7's frequent refusal of dressing changes. V2 stated regarding monitoring of R7's lymphedema she would expect R7 to be weighed at least weekly. V2 stated however due to R7's frequent refusals of being weighed the facility was fortunate to get one weight per month much less weekly. V2 stated she would expect the nursing staff to continue to offer weekly weights to monitor and then document R7's refusals. V2 stated she did not know how often or if there was even an order for R7's legs to be measured to monitor R7's lymphedema. When asked if she had to have a physician order to measure circumference of R7's legs, V2 stated she didn't know. V2 stated she expected the floor nurses to monitor any areas, document new areas with a description of what they look like and notify her and the physician with changes for R7's lymphedema and wounds. When this surveyor notified V2 that R7's skin assessments were not done weekly and there was no description and/or measurements of R7's lower extremities on the skin assessments V2 could not explain why. V2 stated to monitor the progress of wounds and lymphedema the facility's wound nurse would assess the areas weekly. V2 stated the wound nurse no longer works at the facility and V2 had been doing the weekly assessments for the last couple of weeks. V2 stated they take weekly pictures of the areas, and R7's legs are measured. When this surveyor asked about R7's wounds, V2 stated she would have to look at the wound care report the wound nurse left for her. V2 stated she would expect the nursing staff to document daily on any changes to R7's left lower extremity when they document her dressing changes. On 11/10/25 at 12:24 P.M., V2, DON stated R7 never actually started the lymphedema pumps. V2 stated when the facility received the order for the lymphedema pumps, they scheduled R7 an appointment at a local hospital to start the pumps. V2 stated the facility transported R7 to her first appointment for the lymphedema pumps and the hospital sent her back with only measurements of her legs for the pumps. V2 stated it was a miscommunication between the facility and the local hospital. V2 stated the local hospital only does the measurements to determine the size of the pumps, then the pumps are shipped to the facility where they are used there. V2 stated the facility then sent the order into R7's insurance to get the lymphedema pumps and insurance denied them. V2 stated facility administration notified R7 if she wanted to do the	S9999		

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S9999	Continued from page 33 lymphedema pumps, she must pay for them out of pocket. V2 stated R7 instructed the facility she wasn't going to pay for the pumps out of pocket because she had tried them in the past and didn't tolerate them well, so she didn't want to spend her own money on something that didn't work for her in the past. On 11/5/25 at 10:35 A.M. V74, Nurse Practitioner (NP) stated she was aware of R7's lymphedema in both her legs and had ordered treatments for the lymphedema and associated open wounds in the past. V74 stated to treat the lymphedema she had asked about sending R7 to a lymphedema clinic for treatment and was told no by the facility. V74 stated she does not remember who from facility shut down the idea of the lymphedema clinic. V74 stated she also asked for lymphedema pumps to treat R7's lymphedema. V74 stated the lymphedema pump helps to promote the lymph fluid to move out of the legs and decrease swelling. V74 stated as far as she was aware the facility did get them in, but it took some time. V74 stated she is unsure how long the period was from when she ordered the lymphedema pumps until the facility got them in, but knew it was longer than she expected. V74 stated the order for the lymphedema pump should be current and they should be currently in use. V74 stated if the facility does not use the lymphedema pumps, then R7's lymphedema will not get better. V74 stated in the meantime facility nursing staff were supposed to be wrapping her legs from toes to thighs with double layer of ace wraps. V74 stated she had also asked the physical therapists if they could do lymphatic massage, but they all stated they were not trained in lymphatic massage. V74 reported R7 has had open wounds to her left lower extremity behind the left knee for some time but cannot remember how long the wounds have been present. V74 stated she did have concerns with the facility having a lack of ace wraps. V74 stated it has been too frequent that the facility staff telling her they don't know how to do the treatment, or they are not doing it correctly. V74 stated the last time she saw R7 was last week, and she had to send R7 out to the local hospital emergency room. V74 stated when she saw R7's legs upon her last visit upon sending her to the local emergency room R7's legs were more swollen than the last time V74 had saw them, her legs were not wrapped, left leg was red and weeping, and R7 was shaky, confused, and weak. V74 stated she can't say for sure that the facility's failure to do the treatments as ordered or not applying the ace wraps as ordered lead to R7's most recent hospitalization for certain, but the fact the ace wraps were not being applied as ordered would have caused R7's lymphedema to possibly worsen causing the skin to weep, bleed, crack and possibly become infected. V74	S9999		

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S9999	Continued from page 34 stated she was never notified that R7 didn't like the orders for the treatment of her leg wounds or that she was refusing the orders to wrap her legs because she didn't like them or agree with them. V74 stated to monitor R7's lymphedema and leg wounds she would expect measurements of the wounds and circumference of the legs be done on a weekly basis. 3. R20's Admission Record with a print date of 10/22/25 documents R20 was admitted to the facility on 8/3/25 with diagnoses that include muscle weakness, cognitive communication deficit, and reduced mobility. R20's MDS dated 8/10/25 documents a BIMS score of 15, indicating R20 is cognitively intact. R20's current Care Plan does not document a Focus area of falls. On 11/5/25 at 10:35 AM, V74 (Nurse Practitioner/NP) stated R20 had a fall at the facility on 10/28/25. V74 stated she was told R20 was in the beauty shop with family when she attempted to transfer herself without assistance and fell. V74 stated the facility got x-rays including one of R20's right hip. V74 stated she assessed R20 on 10/30/25 and ordered a CT (computed tomography) scan of her right hip since the x-ray results were inconclusive. V74 stated as far as she could tell the CT scan still hadn't been completed and she would have had them send R20 to the hospital for evaluation if she had known the facility was not going to get the CT scan done timely. V74 stated she was concerned because the x-ray results were inconclusive and R20 had shortening of that limb. R20's Progress Note dated 10/28/25 documents, "This nurse was called to the beauty shop d/t (due to) resident being on the floor. Resident and hairdresser states her legs began to give out and she lowered herself to the floor using her left hand but falling to the right. She bumped her right cheek on the counter and landed on her right knee. Resident c/o (complained of) right hip and right knee pain at this time. DON (Director of Nurses) and son (name of son) and NP (V74) were notified of incident. A portable right hip and right knee xray has been ordered. R20's Patient Report dated 10/29/25 documents a right hip x-ray and documents under, Findings…. Hip: 2 views of the right hip submitted. No prior studies. No acute fracture or dislocation. Femoral head is anatomically situated within the acetabulum with moderate osteoarthritic changes. Mineralization is decreased. Scattered vascular calcifications. Impression: 1. No	S9999		

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S9999	Continued from page 35 acute fracture or dislocation by plain radiography. 2. Moderate osteoarthritis involving the hips. If there remains clinical concern for occult hip fracture in this osteopenic patient, recommend nonweightbearing (sic) and repeat Multiview radiographs in 2-3 days to evaluate for interval change." R20's Progress Note dated 10/30/25 documents, "As of right now pt (patient) non weight bearing to right hip. No walking or standing pt." On 11/5/25 at 12:00 PM, R20 was sitting in a wheelchair in the therapy room. R20 stated she had a fall and her hip hurt at the time, but it was better now. R20 stated she had physical therapy this morning and had walked the length of the gym (meaning the therapy room). On 11/5/25 at 12:03 PM, V87 (Physical Therapy Assistant) stated R20 had Occupational (OT) and Physical therapy (PT) today, had walked with OT and did some standing exercises with PT. This surveyor reviewed R20's x-ray results dated 10/29/25 that documents a recommendation for resident to be non-weight bearing. V87 stated R20's therapy was paused until they got the CT (computed tomography) results back on Monday 11/3/25 and V34 (Registered Nurse/RN) told them R20 could be weight bearing. On 11/5/25 at 12:13 PM, V74 (Nurse Practitioner) stated they did do a CT scan on Friday 10/31/25 but they didn't call her with the results. V74 stated the facility just printed the results out for her prior to this interview. V74 stated the results of the CT are still inconclusive and R20 should remain non-weight bearing until she sees the orthopedist. On 11/05/25 at 12:41 PM, V34 (Registered Nurse/RN) stated they received the results of R20's CT on 11/03/25 and she and V2 (Director Nurses) read them. V34 stated she discussed them with therapy, and they determined R20 could be weight bearing. V34 stated she did not call the physician and/or V74 (Nurse Practitioner) with the results and did not get a physician's input on whether R20 could be weight bearing. R20's CT Report dated 10/31/25 documents under Findings, "There is diffuse demineralization which limits sensitivity for detection of an acute nondisplaced fracture. No acute fracture identified…. Soft tissue swelling most pronounced posterolaterally. 5.5 x 4.8 x 2.1 cm (centimeter) collection within the posterolateral subcutaneous tissues overlying the band at the greater trochanter suggesting suggesting (sic)	S9999		

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S9999	Continued from page 36 hematoma in the setting of direct trauma…Impression: Demineralization limits sensitivity for detection of acute nondisplaced fracture, with no acute fracture identified…. Further assessment with MRI of the hip can be considered as clinically warranted. R20's Progress Note dated 11/5/25 documents, "(V74), NP in the building today and has reviewed this resident's x-rays and CT post fall. She has stated she would like this resident to go back to ortho (orthopedist) with the new CT results. This nurse attempted to contact (name of orthopedist) where this resident is already established and was seen there after her fall (for unrelated previous injury) On 11/06/25 at 10:31 AM, V2 (Director of Nurses) stated she would expect facility staff to notify the physician of results and to not change recommendations such as weight bearing status without talking with the physician/Nurse Practitioner first. (A) (4 of 5) 300.610a) 300.1010h) 300.1210b) 300.1210c) 300.1210d)4)A) 300.1220b)3) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited	S9999		

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S9999	Continued from page 37 to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification. 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. 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: 4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following: A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. These regulations were not met as evidence by:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

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S9999	Continued from page 38 Based on observation, interview, and record review the facility failed to provide the prescribed diets, nutritional supplements and the appropriate portion sizes according to the approved menus for 7 of 7 residents (R2, R3, R13, R15, R18, R19 and R42) reviewed for weight loss in a sample of 46. This failure further contributes to continued harm to R3 and R18, who are currently considered severely thin and underweight. Findings include: 1. R3's admission record documents an admission date of 05/14/24 with diagnoses including: Alzheimer's disease with late onset, dementia, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, pleural effusion, abnormal posture, and body mass index 19.9 or less. R3's minimum data set (MDS) dated 09/03/25 documents a dash for the question, "should brief interview for mental status be conducted?" and a dash for the "BIMS summary score." R3's MDS section L documents none of the above were present with the boxes included B. no natural teeth or tooth fragments and F. mouth or facial pain, discomfort or difficulty with chewing. R3's MDS section GG documents R3's eating ability requires supervision or touching assistance indicating helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. R3's order summary report documents a dietary order for a regular diet with regular consistency and minced meats for nutrition with an order date of 01/28/25 and an order status of active. R3's order summary report documents a dietary supplement order of fortified foods with an order date of 07/15/24 with an order status of active. R3's care plan documents a focus area of R3 has a nutritional problem or potential nutritional problem dated 07/01/25 and interventions listed as: provide and serve diet as ordered and registered dietician to evaluate and make diet change recommendations as needed with a date initiated 05/30/24. R3's care plan documents a focus area of R3 has an ADL (Activities of Daily Living) self care performance deficit related to dementia dated 05/14/24 with an intervention listed as: eating: the resident requires 1 staff participation to eat dated 05/14/24.	S9999		

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S9999	Continued from page 39 R3's weight summary documents weights as follows: 08/02/25 as 69.7 pounds, 09/01/25 as 69.5 pounds, 10/02/25 as 68.9 pounds. R3's weight summary documents that R3 is 62 inches tall, has a BMI (Body Mass Index) of 12.6 and her IBW (Ideal Body Weight) Range is 131.0-159.0 pounds. On 11/13/25 at 10:04 AM, R3 was in the dining room in her wheelchair, she appeared thin, R3 was assisted to stand on scale by V35 (Certified Nurse Aide/CNA), R3's weight was 68.0 pounds. According to the Adult BMI Calculator on the CDC (Centers for Disease Control) website at https://www.cdc.gov/bmi/adult-calculator/index.html, R3 has a BMI of 12.4 and is considered underweight. According to the World Health Organization at https://apps.who.int/nutrition/landscape/help.aspx?menu=0&helpid=420#:~:text=Moderate%20and%20severe%20thinness%20%E2%80%93%20A,population%20has%20a%20BMI%20%3C18.5, a BMI of less than 17.0 indicates moderate and severe thinness. According to the WHO the consequences and implications of moderate and severe thinness: A BMI < 17.0 indicates moderate and severe thinness in adult populations. It has been linked to clear-cut increases in illness in adults studied in three continents and is therefore a further reasonable value to choose as a cut-off point for moderate risk. A BMI < 16.0 is known to be associated with a markedly increased risk for ill health, poor physical performance, lethargy and even death; this cut-off point is therefore a valid extreme limit. R3's dietician nutrition assessment dated 08/29/25 at 2:46 PM documents: R3 has a regular diet with fortified foods, nutritional drink at 120 ml (milliliters) two times a day with varied intakes at review of available records since 08/16/25. R3's height is 62 inches dated 05/16/24 at 6:21 PM by method of standing with a weight on 08/02/25 at 1:51 PM of 69.7 pounds with a BMI of 12.7 %. R3's usual body weight is listed as 69.5 pounds. R3's goal weight is listed as 110 pounds and the comment section documents: R3 is at base weight and stable, her weight is low with low BMI but usual. R3's most current dietary note dated 04/09/25 at 1:36 PM documents: dietitian weight review for loss at 3 months. April weight is 69.2 pounds with a body mass index of 12.7%, R3 has a weight loss of 8.7 % over the last 3 months. R3 appears to have fluid related/CHF (Congestive Heart Failure) family wanted no further evaluation, use of Lasix noted. R3 has no wounds and has wound preventative in place. May give R3's	S9999		

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S9999	Continued from page 40 medications in pudding if accepted. R3's lab review on 04/05 notes R3 is nutritionally stable except BUN (blood urea nitrogen) which is elevated at 33. R3's diet order is regular diet with regular texture with fortified food, boost 120 ml (milliliters) twice a day on 01/28/25. Meal consumption at review of available records since 03/27/25 is 26-100% with no refusals which is baseline. Although low body weight is stable with interventions. Continue per orders and follow up as needed with new concerns. R3's dietary ticket dated 09/29/25 documents for lunch: supplement: 1 #8 scoop FB (fortified blended) vanilla pudding – supplement. On 09/29/25 at 12:55 PM, R3 did not receive any fortified pudding at lunch. R3 received: 1 each ground cheeseburger, ½ cup French fries, 4 ounces seasoned green beans, 2 each chocolate chip cookies. R3's dietary ticket 09/30/25 documents for breakfast: supplement: 1 #8 scoop FB vanilla pudding – supplement. On 09/30/25 at 8:19 AM, R3 was eating in the dining room and did not receive any fortified pudding at breakfast. Staff were noted in the dining room, no one was sitting with R3. Facility menu: Summer menu 2025 – week 1, Tuesday, lunch, general/regular documents: 2 each hard taco shells, 3 ounces ground taco chicken filling, 2 fluid ounces salsa fresh, 4 ounces Spanish rice, 4 ounces refried beans, 1 each churro, 8 fluid ounces 2% milk, 6 fluid ounces coffee, 1 each butter, 1 each sugar, and 6 fluid ounces hot tea. (9/30/25) R3's dietary ticket 09/30/25 documents for lunch: supplement: 1 #8 scoop FB vanilla pudding – supplement. On 09/30/25 at 1:18 PM, R3 received 2 hard taco shells and a churro with her lunch. At that time R3 put the churro in her mouth, took it out, and hit it on her plate. R3 was observed not to have any teeth. R3 did not receive any fortified pudding with her lunch tray. V16 (Family) was noted sitting at the table with R3. On 09/30/25 at 2:25 PM, V16 stated R3 did not get her pudding today. V16 stated, the churro R3 received with lunch was hard and R3 could not bite it. The taco shells were too hard for her to bite because R3 does not have any teeth, so she took the meat out of the shells and gave her that. On 09/30/25 at 3:10 PM, V16 stated, R3 does not have	S9999		

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S9999	Continued from page 41 any teeth and has ground meat on her order that she gets most of the time, however there are times they will still give her hard crunchy foods such as the hard shell taco shells and the churro that they know she cannot eat. On 10/15/25 at 1:12 PM, R3 did not receive any fortified pudding at lunch. On 10/16/25 at 1:35 PM, R3 was sitting in the dining room eating lunch with no staff present in the dining room until 1:46 PM. On 10/22/25 at 12:34 PM, R3 was noted sitting in the dining room, there were staff on the other side of the dining room. At that time R3 was noted to be attempting to eat her rice with her knife. R3 continued until 12:46 PM when surveyor encouraged her to use her spoon, R3 then looked at the spoon for a few seconds and then picked it up and started using it to eat her rice. On 10/27/25 at 5:21 PM, V16 (Family) stated she never requested for V72 (Registered Dietician) to not evaluate R3. V16 stated, she only requested before R3 was sent to the hospital or had x-rays she would like to be contacted. V16 stated, her mother is small and she needs the extra nutrition. V16 stated, she unfortunately does not always get the fortified pudding she is supposed to receive. V16 stated she has gone to the kitchen to get it for R3 before and the staff would not give it to her and sometimes they would state they did not have any. On 11/13/25 at 11:17 AM, V72 stated, R3's weight has been fairly consistent over the past year. R3 will have some peaks and valleys, that will happen. V72 stated, she did her last assessment on R3 on 08/29/25, she has not looked at her closer since then because she has been fairly consistent. V72 stated, she does have the expectation that R3 would receive the supplements she has recommended for her. 2. R18's admission record documents an admission date of 06/03/23 with diagnoses including: Huntington's disease, chorea, severe protein calorie malnutrition, body mass index 19.9 or less, adult failure to thrive, depression, dysphagia, abnormal posture, feeding difficulties, speech and language deficits following other cerebrovascular disease, extrapyramidal and movement disorder, chronic obstructive pulmonary disease, muscle weakness, lack of coordination, muscle wasting and atrophy, altered mental status, and ataxia following cerebral infarction.	S9999		

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S9999	Continued from page 42 R18's order summary report documents a dietary order of regular diet with mechanical soft texture dated 03/19/25 with no end date listed and a dietary supplements order of fortified foods two times a day for weight loss dated 03/19/25 with no end date listed. R18's MDS dated 07/16/25 documents no BIMS was conducted due to resident is rarely to never understood. Section GG documents R18's eating abilities require supervision or touching assistance indicating helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity. Assistance may be provided throughout the activity or intermittently. R18's care plan documents a focus area of R18 has nutritional problem or potential nutritional problem, thickened liquids dated 05/08/25 with interventions including: explain and reinforce to the resident the importance of maintaining the diet ordered, encourage the resident to comply, explain consequences of refusal, and obesity/malnutrition risk factors dated 05/08/25. Monitor/document/report to physician as needed for signs or symptoms of dysphagia: pocketing, choking, coughing, drooling, holding food in mouth, several attempts at swallowing, refusing to eat and appearing concerned during meals dated 05/08/25. Provide and serve diet as ordered dated 05/08/25. R18's weight summary documents weights of: 08/28/25 as 100.6 pounds, 09/03/25 as 99.0 pounds, 09/11/25 as 95.2 pounds, 10/02/25 as 95.0 pounds, 10/10/25 of 91.8 pounds, and 10/16/25 of 91.6 pounds. R18's weight summary documents that R18 is 70 inches tall, has a BMI of 14.1 and her IBW Range is 167-202 pounds. On 11/13/25 at 10:22 AM, V17 (CNA) weighed R18 who was sitting in a wheelchair in the dining room and appeared tall and very thin. R18 was smiling and talking but confused. R18's weight was 139.8 pounds, her wheelchair weight was documented on back of her wheelchair as 41.6 pounds which indicates R18's weight was 98.2 pounds. According to the Adult BMI Calculator on the CDC (Centers for Disease Control) website at https://www.cdc.gov/bmi/adult-calculator/index.html, R18 has a BMI of 14.1 and is considered underweight. According to the World Health Organization at https://apps.who.int/nutrition/landscape/help.aspx?menu=0&helpid=420#:~:text=Moderate%20and%20severe%20thinness%20%E2%80%93%20A,population%20has%20a%20BMI%20%3C18.5, a BMI of less than 17.0 indicates moderate and severe thinness. According to the WHO the consequences and	S9999		

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S9999	Continued from page 43 implications of moderate and severe thinness: A BMI < 17.0 indicates moderate and severe thinness in adult populations. It has been linked to clear-cut increases in illness in adults studied in three continents and is therefore a further reasonable value to choose as a cut-off point for moderate risk. A BMI < 16.0 is known to be associated with a markedly increased risk for ill health, poor physical performance, lethargy and even death; this cut-off point is therefore a valid extreme limit. R18's dietician nutrition assessment dated 10/09/25 at 10:11 AM documents: most recent height is 70 inches dated 06/03/23 at 6:34 PM with a method of standing and R18's most recent weight of 95 pounds dated 10/02/2025 at 8:43 AM with a BMI of 13.6 % and a usual body weight of 100 pounds. The comment section notes: R18's usual body weight since last November 2024 a review of records is 95-104 pounds, R18 has low body weight/varied patterns with chronic diseases. R18's most current dietary note date 07/18/25 at 12:02 PM documents: chart review weight shifts up and down trends. July weight recorded: 7/8 at 102.8 pounds, 7/6 at 102.8 pounds, 07/17 at 96.2 pounds, R18's BMI is 13.8 percent. Patterns since 03/06/25: 95.4 – 104.4 pounds, trends very likely affected by chronic disease, declined swallow ability with Huntington's waiver signed for oral po (per oral) diet. By history of use of alternative feeding but when tube became dislodged 01/08/25 resident and POA (power of attorney) decided against replacing and po (per oral) diet for pleasure. No wounds noted. Recent fall. Diet order: regular with mechanical soft texture and honey thick liquids. 3 fortified foods daily (pudding twice a day and mashed potatoes every day per 06/06/25 recommendation), meal consumption is varied since 07/05 – 0-100% more 26-100%. Is not always adequate for needs however facility is honoring choice and preference that has been agreed to by POA as well. Continue all interventions and follow trends. Facility menu: Summer menu 2025, Monday, week 1, lunch, general/mechanical soft documents: 1 each ground cheeseburger, ½ cup French fries, 4 ounces seasoned green beans, 2 each chocolate chip cookies, 1 each sugar, 0.5 coffee creamer, 1 each butter, 8 fluid ounces 2% milk, 6 fluid ounces coffee, and 6 fluid ounces hot tea. (9/29/25) On 09/29/25 at 1:18 PM, R18 was sitting in her wheelchair in the dining room. R18's bones were prominently visible under her skin, and she was very thin.	S9999		

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S9999	Continued from page 44 R18's dietary ticket dated 09/29/25 lunch, documents at the bottom ice cream for lunch and dinner and grilled cheese with meal. On 09/29/25 at 1:18 PM, R18 did not receive ice cream, pudding, a grilled cheese, or fortified mashed potatoes for lunch. R18 received a ground cheeseburger, ½ cup French fries, 4 ounces green beans, and two chocolate chip cookies. Facility menu: Facility menu: Summer menu 2025 – week 1, Tuesday, lunch, general/mechanical soft documents: 2 each corn tortillas, 3 ounces ground taco chicken filling, 2 fluid ounces salsa fresh, 4 ounces Spanish rice, 4 ounces refried beans, ½ cup butterscotch pudding, 8 fluid ounces 2% milk, 6 fluid ounces coffee, 1 each butter, 1 each sugar, and 6 fluid ounces hot tea. (9/30/25) R18's dietary ticket dated 09/30/25 lunch, documents at the bottom ice cream for lunch and dinner and grilled cheese with meal. On 09/30/25 at 1:35 PM, R18 did not receive ice cream, fortified mashed potatoes, a grilled cheese or butterscotch pudding for lunch. R18 received 3 ounces ground taco chicken filling, 4 ounces Spanish rice, and 4 ounces refried beans. R18 did not receive corn tortillas either with her lunch meal. Facility menu: Facility menu: Summer menu 2025 – week 3, Wednesday, lunch, general/mechanical soft documents:1 #6 scoop ground sweet and sour pork, 4 ounces rice white, 4 ounces roasted Italian vegetables, 1 (2x2) assorted dessert, 1 each sugar, 1 each butter, 8 fluid ounces 2% milk, 6 fluid ounces hot tea, and 6 fluid ounces coffee. (10/15/25) On 10/15/25 at 1:17 PM, R18 did not receive ice cream, fortified mashed potatoes, or pudding for lunch. R18 received 1 #6 scoop ground sweet and sour pork, 4 ounces rice white, 4 ounces roasted Italian vegetables, and one brownie. On 11/13/25 at 11:17 AM, V72 (Registered Dietician) stated R18 is underweight but with her diagnosis of Huntington's disease she is a pleasure eater. R18's weight will fluctuate also, she believes her weight is up today. 3. R42's admission record documents an admission date of 02/25/22 with diagnoses including: spinal stenosis, weakness, osteoarthritis, pure hypercholesterolemia,	S9999		

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S9999	Continued from page 45 long term (current) use of antithrombotics/antiplatelets, chronic obstructive pulmonary disease, dysphagia, vascular dementia, and anxiety disorder. R42's order summary report documents a dietary order for a regular diet with a pureed texture and double portions with an order date of 11/07/25 and an order status of active. R42's MDS dated 08/08/25 documents a BIMS score of 05 indicating severe impaired cognition. R42's eating assistance is listed as setup or clean up assistance required. R42's height is listed as 72 inches. R42's care plan documents a focus area noting R42 has potential nutrition problem relating to being below IBW (Ideal body weight) of 177-214 pounds dated 08/14/24 with interventions listed as: double portions at meals dated 04/14/2021, provide and serve supplements as ordered dated 11/16/22, provide, serve regular, ground meat diet as ordered. Monitor intake and record every meal dated 04/26/21, and monitor/record/report to medical doctor as needed signs and symptoms of malnutrition: emaciation (cachexia), muscle wasting, significant weight loss: 3lbs in 1 week, >5% in 1 month, >7.5% in 3 months, and >10% in 6 months dated 08/18/20. R42's weight summary documents weights as follows: 08/05/2025 as 163.2 pounds, on 09/06/25 as 159.8 pounds, and on 10/07/25 as 154.2 pounds. On 11/13/25 at 10:27 AM, R42 was weighed by V15 (Licensed Practical Nurse/LPN) R42 was weighed in his wheelchair with a weight of 200.0 pounds. The wheelchair had a weight of 42.2 pounds, indicating he weighs 157.8 pounds. According to the Adult BMI Calculator on the CDC (Centers for Disease Control) website at https://www.cdc.gov/bmi/adult-calculator/index.html, R42 has a BMI of 21.4 and is considered to be at a healthy weight. R42's dietary note dated 10/10/25 at 7:33 PM documents: dietitian chart review for weight trends, October weight 154.2 pounds with a BMI of 20.9%. At review history of gain and is currently trended down but remains with in usual body weight range. Trends may be reflective of cognition. R42 has no pressure wounds and recent lab review noted as stable. R42's diet order is regular with pureed texture and regular liquids with one fortified food twice a day, double portions at	S9999		

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S9999	Continued from page 46 meals with meal consumption at review of records since 09/27 is 0(2) – 100%. R42 receives nutritional drink noted as well. Continue diet order with extra calorie and protein monitor intake, labs and weight for stability. Facility menu: Facility menu: Summer menu 2025 – week 1, Monday, lunch, general/puree documents: 8 ounce puree cheeseburger 3 ounce meat, 1 ounce sauce, 4 ounce bread, 4 ounce pureed French fries, 4 ounce seasoned green beans, puree cookie chocolate chip, 1 each butter, 1 each sugar, 8 fluid ounce 2 % milk, 6 fluid ounce coffee, 6 fluid ounce hot tea. (9/29/25) R42's dietary ticket dated 09/29/25 documents: supplement: FB vanilla pudding – supplement-fortified food. The bottom of the ticket notes: double portions and fortified pudding – ½ cup. On 09/29/25 at 1:18 PM, R42 did not received double portions or any fortified pudding with his lunch meal. R42 received a single portion, 8-ounce puree cheeseburger, 4 ounces of pureed French fries, 4 ounces of pureed green beans, and puree chocolate chip cookies. Facility menu: Summer menu 2025, Tuesday, week 1, breakfast, general/puree documents: 3 ounces puree western scramble, 6 fluid ounces puree oatmeal, 1 each sugar, 1 each butter, 0.5 fluid ounce coffee creamer, 1 each jelly, 6 fluid ounces orange juice, 8 fluid ounce 2% milk, and 6 fluid ounce coffee. On 09/30/25 at 8:11 AM, R42 did not receive double portions with his breakfast. R42 received 3 ounces puree western scramble and 6 fluid ounces pureed oatmeal. Facility menu: Summer menu 2025, Tuesday, week 1, lunch, general/puree documents: 2 each pureed corn tortillas, 3 ounces pureed taco chicken filling, 2 fluid ounces salsa fresh, 4 ounces pureed Spanish rice, 4 ounces pureed refried beans, ½ cup butterscotch pudding, 8 fluid ounces 2% milk, 6 fluid ounces coffee, 1 each butter, 1 each sugar, and 6 fluid ounces hot tea. (9/30/25) On 09/30/25 at 1:25 PM, R42 did not receive double portions, any fortified pudding, any butterscotch pudding, or any pureed corn tortillas with his lunch meal. R42 received 4 ounces pureed taco chicken filling, 4 ounces pureed Spanish rice, and 4 ounces pureed refried beans.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	2299 METROPOLIS STREET , METROPOLIS, Illinois, 62960

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S9999	Continued from page 47 Facility menu: Summer menu 2025, Wednesday, week 3, lunch, general/puree documents: 6 ounces puree sweet and sour chicken, 4 ounces pureed white rice, 4 ounces pureed vegetable roasted Italian, 4 ounces pureed brownie, 1 each sugar, 1 each butter, 8 fluid ounces 2% milk, 6 fluid ounces hot tea and 6 fluid ounces coffee. (10/15/25) On 10/15/25 at 1:02 PM, R42 did not receive double portions, pureed brownie or any fortified pudding with his lunch meal. R42 received 6 ounces pureed sweet and sour chicken, 4 ounces pureed white rice, 4 ounces pureed vegetable roasted Italian. 4. R2's Admission Record documents an admission date of 02/23/24 with diagnoses including: dementia, hypertension, anxiety disorder, major depressive disorder, dysphagia, feeding difficulties, gastro-esophageal reflux disease, cognitive communication deficit. R2's order summary sheet documents a dietary order of regular diet with pureed texture with an order date of 04/29/25 and no end date listed. The dietary supplements order documents: fortified foods in the afternoon for ice cream at lunch with an order date of 05/29/25 and no end date listed. The order summary documents an order for fortified pudding for dinner in the evening for nutrition with an order date of 11/14/24 and no end date listed. R2's minimum data set (MDS) dated 07/03/25 documents a brief interview of mental status (BIMS) of 03, indicating severely cognitively compromised. R2's eating assistance is listed as: partial to moderate assistance. R2's care plan documents a focus area of: dietary with interventions listed as: foods R2 dislikes are rice and mashed potatoes are not my favorite and R2 likes fruit cups and ice cream with a date initiated of 07/21/23. R2's care plan documents a focus area of: R2 has nutritional problem or potential nutritional problem dated 05/09/25 with interventions listed as: provide and serve supplements as ordered dated 05/27/25 and provide and serve diet as ordered dated 05/09/25. R2's most current dietary note dated 05/28/25 at 2:58 PM documents: dietitian review for weight change at 1 month. May weight: 124.4 pounds, up 6.1 % at one month post loss last month with a BMI (body mass index) of 22.0 %. R2's dietary order is regular diet with pureed texture and regular liquids, fortified food at dinner, ice cream every day, boost 120 ml (milliliters) two	S9999		

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S9999	Continued from page 48 times a day. R2's meal consumption at review of available records since 05/15 with 26-100%. Continue diet order and monitor for texture tolerance, continue interventions and follow up as needed with new concerns. R2's Dietary ticket dated 09/29/25 lunch documents: supplement 4 ounces vanilla ice cream and at the bottom: 4 ounces assorted ice cream. On 09/29/25 at 12:55 PM, R2 did not receive ice cream with her lunch. Facility menu: Summer menu 2025, Tuesday, week 1, lunch, general/puree documents: 2 each pureed corn tortillas, 3 ounces pureed taco chicken filling, 2 fluid ounces salsa fresh, 4 ounces pureed Spanish rice, 4 ounces pureed refried beans, ½ cup butterscotch pudding, 8 fluid ounces 2% milk, 6 fluid ounces coffee, 1 each butter, 1 each sugar, and 6 fluid ounces hot tea. (9/30/25) R2's dining ticket documents 09/30/25 lunch: adaptive equipment of 2 handled cup with lid, Spanish rice, butterscotch pudding, and supplement: 4 ounce vanilla ice cream. On 09/30/25 at 1:23 PM, R2 did not receive ice cream, butterscotch pudding, or pureed corn tortillas with her lunch meal. R2 received 4 ounces pureed taco chicken filling, 4 ounces pureed Spanish rice, and 4 ounces pureed refried beans. Facility menu: Summer menu 2025, Wednesday, week 3, lunch, general/puree documents: 6 ounces pureed sweet and sour pork, 4 ounces pureed white rice, 4 ounces pureed vegetable roasted Italian, 4 ounces pureed brownie, 1 each sugar, 1 each butter, 8 fluid ounces 2% milk, 6 ounces hot tea, and 6 ounces coffee. (10/15/25) On 10/15/25 at 1:05 PM, R2 did not receive pureed brownie or any ice cream with her lunch meal. R2 received 6 ounces pureed sweet and sour chicken, 4 ounces pureed white rice, 4 ounces pureed vegetable roasted Italian. 5. R13's admission record documents an admission date of 09/09/25 with diagnoses including: cerebral palsy, type 2 diabetes mellitus with hypoglycemia, epilepsy, dysphagia, disorder of urea cycle metabolism, major depressive disorder, poisoning by other antiepileptic and sedative hypnotic drugs accidental, dysphagia, metabolic encephalopathy, anemia, iron deficiency,	S9999		

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S9999	Continued from page 49 intellectual disabilities, atrial fibrillation, and adult failure to thrive. R13's MDS dated 08/26/25 documented a BIMS score of 00. R13's eating assistance is documented as partial/moderate assistance – helper does less than half the effort, helper lifts or holds trunk or limbs and provides less than half the effort. R13's physician order sheet documents a dietary order of consistent carbohydrate diet of mechanical soft texture with add ice cream at lunch and supper for nutrition with an order date of 07/21/25 and no end date listed. R13's care plan documents a focus area of R13 has a potential nutritional problem PEG (percutaneous endoscopic gastrostomy) tube is in place due to history of poor intake and weight loss prior to admission dated 06/25/24 with an intervention of provide and serve diet as ordered dated 06/25/24. R13's dietary note dated 09/24/25 at 6:09 PM documents: dietitian review for weight change. September weight: 109.6#, 9/12: 110.4#, 9/19: 110 stable currently since 7/22/25 BMI: 20.8 Loss of 8.7% 3 months/loss of 10% 6 months. H/O hospitalization, seizure and medication adjustment. No wounds, no new labs, use of megace noted. Diet order: CCD, (Consistent carbohydrate diet) mechanical soft with regular liquids, use of scoop plate, ice cream BID (twice a day). Use of prostat BID (twice daily). Meal consumption is varied at review but usual for meals 25-75% plus snacks po (by mouth) fluids that she request. Long history of diet noncompliance which is her choice. Family is aware. Continue diet order as weight patterns are now stable. F/U (follow up) as needed with new concerns. R13's dietary ticket dated 09/29/25 lunch documents at the bottom: ice cream. On 09/29/25 at 12:53 PM, R13 did not receive any ice cream with her lunch. Facility menu: Summer menu 2025, Tuesday, week 1, lunch, general/mechanical soft documents: 2 each corn tortillas, 3 ounces ground taco chicken filling, 2 fluid ounces salsa fresh, 4 ounces Spanish rice, 4 ounces refried beans, ½ cup butterscotch pudding, 8 fluid ounces 2% milk, 6 fluid ounces coffee, 1 each butter, 1 each sugar, and 6 fluid ounces hot tea. (9/30/25) On 09/30/25 at 1:10 PM, R13 did not receive any corn	S9999		

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S9999	Continued from page 50 tortillas, butterscotch pudding or ice cream with her lunch. On 10/15/25 at 1:12 PM, R13 did not receive any ice cream with her lunch. On 10/23/25 at 1:40 PM, V15 (Licensed Practical Nurse) stated, R13 does not have a PEG tube anymore. 6. R15's admission record documents an admission date of 04/11/25 with diagnoses including: chronic kidney disease, dementia, major depressive disorder, atrial fibrillation, disease of intestine, and hyperglycemia. R15's minimum data set (MDS) dated 07/11/25 documents a brief interview of mental status (BIMS) of 03, indicating severely cognitively compromised. R15's eating assistance is listed as: setup or clean up assistance. R15's order summary sheet documents a dietary order of mechanical soft texture and add one fortified food with all meals with an order date of 04/18/25 and no end date listed. The dietary supplements order documents: fortified foods two times a day for breakfast and lunch with an order date of 05/28/25 and no end date listed. R15's care plan documents a focus area of: R15 has nutritional problem or potential nutritional problem dated 07/29/25 with an intervention listed as provide and serve diet as ordered dated 05/09/25. R15's dietary note dated 09/24/25 at 2:39 PM documents: dietitian chart review for weight change. R15's September weight 151.6 pounds (August weekly had dropped but now rebounded). R15's BMI is 27.2%. Noted insidious changes. R15's diet order is regular diet with mechanical soft texture and regular liquids with fortified foods two times a day and nutritional drink 90ml. R15's meal consumption had been varied but since 09/11 is more stable 0-100% more often 51-75%. From review with ADON (Assistant Director of Nursing) there had been a history of medication refusal. Recently adjusted to liquid and tolerating better. Is also noted to accept the supplement. Based on current trends with extra nutrition opportunities in place continue all orders and follow up with new concerns. R15's dietary card documents 09/29/25, lunch, fortified pudding. On 09/29/25 at 1:32 PM, R15 did not receive any fortified pudding with lunch.	S9999		

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S9999	Continued from page 51 On 09/30/25 at 8:32 AM, R15 did not receive any fortified food with her breakfast. The oatmeal on R15's tray was regular oatmeal. At that time, R15 who was alert and oriented stated, the oatmeal did not taste sweet or any different than plain oatmeal. R15's oatmeal was light in color and did not appear any different than the other oatmeal given. On 10/22/25 at 1:50 PM, V88 (Dietary Manager) stated, fortified cereal or oatmeal will be darker and sweater then regular oatmeal or hot cereal. Facility menu: Facility menu: Summer menu 2025 – week 1, Tuesday, lunch, general/mechanical soft documents: 2 each corn tortillas, 3 ounces ground taco chicken filling, 2 fluid ounces salsa fresh, 4 ounces Spanish rice, 4 ounces refried beans, ½ cup butterscotch pudding, 8 fluid ounces 2% milk, 6 fluid ounces coffee, 1 each butter, 1 each sugar, and 6 fluid ounces hot tea. (9/30/25) On 09/30/25 at 1:38 PM, R15 did not receive any corn tortillas or butterscotch pudding with the lunch meal. R15 did not receive any fortified pudding with lunch. R15's dietary ticket dated 10/15/25 lunch documents fortified pudding. On 10/15/25 at 12:52 PM, R15 did not receive any fortified pudding with her lunch. 7. R19's admission record documents an admission date of 12/22/23 with diagnoses including: end stage renal disease, dementia, dependence on renal dialysis, gastro-esophageal reflux disease without esophagitis, combined systolic and diastolic heart failure, dysphagia, and cognitive communication deficit. R19's MDS dated 08/27/25 documents a BIMS score of 06, indicating severe cognitive impairment. Section GG documents R19's eating ability as set up or clean up assistance needed. R19's order summary report documents a dietary order of no added salt diet with mechanical soft texture with an order date of 04/18/25 and no end date listed. R19's order summary report documents a dietary supplement order of fortified foods every day and evening shift with an order date of 03/31/25 and no end date listed. R19's care plan documents a focus area of R19 has a swallowing problem dated 02/03/25 with interventions including: diet to be followed as prescribed dated 10/01/24, monitor for shortness of breath, choking,	S9999		

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S9999	Continued from page 52 labored respiration, lung congestion dated 10/01/24, and monitor/document/report to nurse/dietitian and physician as needed for difficulty swallowing, holding food in his mouth, prolonged swallowing time, repeated swallows per bite, coughing, throat clearing, drooling, and pocketing food in mouth dated 10/01/24. R19's care plan does not include a focus area of nutrition. R19's dietary note dated 10/18/25 at 11:56 AM documents: dietitian chart review for weight trends. October weight was 127.2 pounds and BMI 24.8 % weight is 127.2 – 136.4 pounds since 2/2025. At review overall trends within UBW (usual body weight) range since admission. No pressure wounds and lab review on 09/19 notes glucose 181.5 which is elevated. Diet order has been individualized based on intake trends. Regular with regular texture, sugar free condiments, fortified hot chocolate every day, ice cream twice a day (per her preference). Meal consumption at review of available records since 10/5: R-100%. Intake patterns appear at least in part related to cognition and sleep patterns. Based on cognition use of individualized diet order remains appropriate with extra nutrition sources present and noted per her preference. Continue to follow trends for weight, intake, and lab. See back with new concerns. R19's dietary note dated 07/25/2025 at 11:03 AM documents: dietitian review for weight change. July weight 134.2 pounds with a BMI of 26.2 %. Usual weight trends over 6 months 127.8 – 136.4 pounds. No wounds are noted. R19's H/O (history of) AMS (altered mental status) with positive UA/UTI (urine analysis/urinary tract infection) with antibiotic that may have contributed to altered intake and some behaviors. R19 chronically has dementia as well. R19's diet order is regular diet with regular texture and liquids, interventions include: ice cream two times a day, fortified food every day (5/29). Meal consumption at review since 7/12: R(2)-100% trends currently a little better. R19's fluid needs are 1830 ml/d diet order offers 100% of estimated needs and with extra calorie and protein in place remains appropriate. Continue to encourage fluids at meals and med pass to support needs with recent UTI. Follow up as needed with new concerns. R19's weight summary documents R19's weight on 08/08/25 as 130.8 pounds, 09/05/25 as 130 pounds, 10/09/25 as 127.2 pounds. On 11/13/25 at 3:18 PM, R19 was weighed with V2 present, R19's weight was 161.6 pounds while in wheelchair, the weight of the wheelchair was 36.4 pounds indicating R19's weight was 125.2 pounds.	S9999		

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S9999	Continued from page 53 R19's dietary ticket dated 09/29/25 lunch documents: supplement: 1 #8 scoop (1/2 cup) FB (fortified blended) vanilla pudding-supplement-fortified. On 09/29/25 at 1:22 PM R19 did not receive any fortified food (fortified vanilla pudding) with lunch. Facility menu: Summer menu 2025 – week 1, Tuesday, lunch, general/mechanical soft documents: 2 each corn tortillas, 3 ounces ground taco chicken filling, 2 fluid ounces salsa fresh, 4 ounces Spanish rice, 4 ounces refried beans, ½ cup butterscotch pudding, 8 fluid ounces 2% milk, 6 fluid ounces coffee, 1 each butter, 1 each sugar, and 6 fluid ounces hot tea. (9/30/25) R19's dietary ticket dated 09/30/25 lunch documents: supplement: 1 #8 scoop (1/2 cup) FB vanilla pudding – supplement – fortified food. On 09/30/25 at 1:13 PM, R19 did not receive any fortified food (fortified vanilla pudding) with lunch. R19 did not receive the 2 corn tortillas or the ½ cup butterscotch pudding. R19 received 3 ounces ground taco chicken filling, 4 ounces Spanish rice, 4 ounces refried beans. On 09/30/25 at 3:20 PM, V20 (Family) stated, the residents have not been getting ice cream and pudding as directed by their dietary cards. V20 stated, she goes to the facility almost every day and helps some of the residents she knows because the staff are busy. There are some residents that always received those items and lately they have not, and it is on their dietary ticket they should receive it. V20 stated she has tried to go to the kitchen and ask for those items for the residents and the kitchen would not give them to her. On 09/30/25 at 11:40 AM, V10 (Certified Nurse Aide/CNA) stated, sometimes the residents receive the supplements and other items they are supposed to receive and sometimes they do not. V10 stated, sometimes she has asked for them and sometimes they will give them to her and sometimes they will not. On 09/30/25 at 1:46 PM, V15 (Licensed Practical Nurse) stated the kitchen has been missing supplements and not reading the tickets carefully. On 09/30/25 at 3:18 PM, V10 (CNA) went to the kitchen door and asked for a fortified pudding and an ice cream and V18 (Dietary) and V19 (Dietary) shook their heads	S9999		

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S9999	Continued from page 54 no and shut the door on her while she was still talking. On 09/30/25 at 3:20 PM, V18 stated if they have the item such as pudding, they give it, if they do not they don't. On 09/30/25 at 3:21 PM, V19 stated, they did not have any pudding to give. On 10/27/25 at 12:45 PM, V72 (Registered Dietician) stated, she would expect the residents would receive all supplements and fortified foods as she has recommended, especially the residents that have weight loss or are underweight. The fortified foods that she typically recommends are fortified cereal/oatmeal, fortified mashed potatoes, fortified hot chocolate, or fortified pudding. On 11/13/25 at 1:34 PM, V76 (Medical Director) stated, the underweight residents with low BMIs should get the supplements recommended for them to keep them healthy. Their weight can go up and down some. Facility policy dated 12/24 titled, "Nutrition Impaired/Unplanned Weight Loss" documents: Nutritional needs: the dietitian and physician consult to determine the appropriate diet for the resident based on the resident's degree of nutritional impairment, expressed wishes, and underlying causes and conditions. Order for appropriate diet will be obtained from the physician. c. supplementation: strategies to increase a resident's intake of nutrients and calories may include fortification of foods, increasing portion sizes at mealtimes, and providing between meal snacks and/or nutritional supplementation. (B) (5 of 5) 300.610a) 300.1210b) 300.1210d)1)2) 300.1220b)3) 300.1630d) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the	S9999		

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S9999	Continued from page 55 facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. 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) 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. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. Section 300.1630 Administration of Medication d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed prescriber shall be notified as soon as is reasonable,	S9999		

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S9999	Continued from page 56 depending upon the situation, and a notation made in the resident's record. These regulations were not met as evidence by: Based on observation, interview, and record review the facility failed to 1. ensure medications were available to be administered as ordered, 2. ensure medications were administered timely, and 3. ensure medications were stored in a secure area for 6 of 6 residents (R4, R5, R19, R31, R35, and R45) reviewed for pharmacy services in the sample of 46. This failure resulted in R4 and R31 not receiving their pain medication and R4 and R31 crying with uncontrolled pain. Findings Include 1(a). R4's Admission Record with a print date of 10/01/25 documents R4 was admitted to the facility on 7/14/21 with diagnoses that includes polyneuropathy. R4's MDS (Minimum Data Set) dated 8/29/25 documents a BIMS (Brief Interview for Mental Status) score of 03, indicating R4 has a severe cognitive deficit. R4's current Care Plan documents a Focus area of "(R4) has pain. Date Initiated: 01/22/2025…" This Focus area includes the intervention of, "Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. Date Initiated 01/22/2025…" R4's Order Summary Report dated 10/01/2025 documents physician orders for Hydrocodone-Acetaminophen Oral Tablet 5-325 MG (milligrams) give 1 tablet by mouth every 6 hours as needed for pain with an order date of 7/30/25 and Acetaminophen 650 mg by mouth every 4 hours as needed for pain/fever with an order date of 4/18/25. R4's Medication Administration Record (MAR) dated 9/1/25 to 9/30/25 documents a physician order for Hydrocodone-acetaminophen 5-325 mg give one tablet every 6 hours as needed for pain. This same MAR documents R4 is routinely administered the hydrocodone from 9/1/25 until 9/20/25. There is no documentation R4 was administered hydrocodone from 9/21/25 through 9/30/25. This MAR documents the following pain scale assessments for R4: 9/22- night shift-2, 9/23-night shift-4, 9/24- night shift- 4, 9/26- evening shift- 4, 9/29/25 – night shit- 5. This MAR documents the	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

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S9999	Continued from page 57 physician order for acetaminophen 650 mg every four hours as needed was administered on 9/25 at 2:20 PM, 9/26 at 657 PM, 9/27 at 7:28 PM, and 9/28/25 at 6:46 PM. This indicates R4's pain was not treated with the physician ordered hydrocodone from 9/21 to 9/30/25 and was not treated with any pain-relieving medication on 9/23, 9/24, and 9/29 when she was assessed with pain scales of 4 and 5. R4's MAR dated 10/01/25 to 10/31/25 documents a physician order for hydrocodone-acetaminophen 5-325 mg give one tablet every 6 hours as needed for pain. This same MAR documents R4 is routinely administered hydrocodone from 10/09/25 until 10/31/25. There is no documentation of the hydrocodone and/or acetaminophen being administered from 10/01 through 10/8/25. This MAR documents the following pain scale assessments: 10/01 – night shift- 5, 10/02 – night shift- 3, 10/03 – day shift – 3, 10/05 – night shift – 4, 10/6 – night shift – 3, 10/07 – night shift – 3, 10/08- night shift- 4. This indicates R4's pain was not treated with pain relieving medications from 10/01 to 10/8/25 when she was assessed as having pain at a scale of 3-5. On 10/20/25 at 12:28 PM, V7 (Caregiver) stated R4 currently had pain medications but she was out of them the end of September, and it took about a week and a half to get it in. V7 stated R4 would cry in pain after her lunch time nap. V7 stated the facility staff offered her Tylenol but it didn't relieve the pain. V7 stated she didn't know why the medications weren't available. On 10/20/25 at 12:54 PM, V32 (LPN/Licensed Practical Nurse) stated they run out of controlled substances (pain medications) at times. When asked why, V32 stated "the NP (Nurse Practitioner), it's hard." V32 stated when a resident needs a new prescription, they let the physician know and then the facility staff call the pharmacy to get it and the pharmacy reports they don't have the prescription. V32 stated R4 was out of her pain medications about three weeks ago for four to five days. V32 stated R4 had an increase in pain, they tried Tylenol to control it, but it didn't work. 1(b). R31's Admission Record with a print date of 10/22/25 documents R31 was admitted to the facility on 7/19/17 with diagnoses that include multiple sclerosis, stiffness, and polyosteoarthritis. R31's current Care Plan documents a Focus area of, "(R31) has potential for pain. Date Initiated: 10/15/2019…" This Focus area includes the intervention of, "Administer analgesia as per ordered. Date	S9999		

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S9999	Continued from page 58 Initiated: 08/17/2020…" R31's Order Summary Report dated 10/22/2025 documents a physician order for Gabapentin Oral Capsule 900 mg by mouth at bedtime for Multiple Sclerosis with an order date of 09/28/2025. R31's Medication Administration Record dated 10/01/25 to 10/31/25 documents a 6 for the dates of 10/07/25-10/13/25. Under the Chart Codes the MAR documents "6=Other-See Progress Notes." This same MAR documents R31's pain level, using a 0-10 pain scale, at 0 (indicating no pain) each shift from 10/1/25 to 10/22/25 except for the following dates: 10/09- and 10/17-night shift and 10/20/25 day shift, R31's pain is assessed as a 1. On 10/7 and 10/13/25, R1's pain level is assessed at a 3. On 10/15/25 at 7:01 PM, V53 (LPN) stated R31 had been without her gabapentin for about a week. V53 stated R31 would cry at night because she was in pain and didn't have the medication needed to treat it. V53 stated the physician wasn't ordering the medication and she wasn't sure why. 1(c). R5's Admission Record with a print date of 10/01/25 documents R5 was admitted to the facility on 5/31/22 with diagnoses that include polyneuropathy. R5's Minimum Data Set dated 7/17/25 documents R5 has a BIMS score of 15, indicating she is cognitively intact. R5's current Care Plan documents a Focus area of, "(R5) has pain r/t (related to) polyneuropathy. Date Initiated: 05/31/2022…" This Focus area includes the following interventions, "Monitor/record/report to Nurse resident complaints of pain or requests for pain treatment. Date Initiated: 05/31/2022…." R5's Order Summary Report dated 10/01/2025 documents a physician order of Lyrica Oral Capsule 50 mg give 1 capsule by mouth every morning and at bedtime for Anticonvulsants with an order date of 6/11/2025. R5's MAR dated 9/1/25 to 9/30/25 documents a physician order for Lyrica 50 mg to be administered every morning and at bedtime. This same MAR documents a 6 at bedtime on 9/28, 9/29, 9/30/25 and at 8 am on 9/29 and 9/30/25." Under the Chart Codes the MAR documents "6=Other-See Progress Notes." R5's MAR dated 10/1/25 to 10/31/25 documents a physician order of Lyrica 50 mg to be administered every morning and at bedtime. There is a 6 documented	S9999		

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S9999	Continued from page 59 at 8 am on 10/1, 10/2, 10/4, 10/10-10/19, 10/22, 10/23 and at 8 pm on 10/1-10/4, 10/11-10/17, and 10/19-10/22. On 11/3/25 at 1:32 PM, V2 (Director of Nurses) stated there should be a progress note written each time a 6 is documented for medication administration on the MAR. This surveyor asked for the progress notes to review and V2 stated she checked and there is not a progress note written for each time there is a 6 documented. V2 stated she spoke with the nurses, and they reported to her they document the 6 when the medication is not available from the pharmacy, but they don't write a progress note each time. R5's Weights and Vitals Summary documents a Pain Level Summary of 0 (indicating no pain) on 9/28, 9/29, 9/30, 10/01, 10/4, 10/14, 10/15, 10/16, and 10/19-10/21. This same summary documents the following pain levels 10/2- 2, 10/10- 4, 10/11- 3, 10/13- 2, and 10/17/25- 1. This indicates on these dates R5 was experiencing pain that was not treated by her routine order of Lyrica. On 10/20/25 at 11:34 AM, R5 stated she doesn't remember not getting her medications as ordered. R5 stated her feet hurt from her diagnosis of diabetes. R5 stated she wasn't aware she didn't have all her medications as ordered. On 10/15/25 at 7:01 PM, V53 (LPN) stated R5 hadn't had her Lyrica for about a week. V53 stated she heard the physician wasn't ordering them, but she wasn't sure why. On 10/20/25 at 12:54 PM, V32 (LPN) stated R5 had been out of her Lyrica for about a week. V32 denied any negative impact on R5. On 10/21/25 at 12:44 PM, V34 (Registered Nurse/RN) stated she had issues with pain medications being available to administer to the residents as ordered by the physician. V34 stated she is an agency nurse and does not have access to the emergency medication kit. On 10/22/25 at 1:13 PM, V70 (RN) stated she had issues with medications not being available to administer to the residents. V70 was not able to recall the specific resident and/or medications. On 10/16/25 at 11:11 AM, V2 (Director of Nurses/DON) stated the facility pharmacy is in a different regional state and Gabapentin is considered a controlled substance in that state. V2 stated the physician (Medical Director) wasn't submitting the prescriptions to the pharmacy and that is why the residents went	S9999		

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S9999	Continued from page 60 without their medications. V2 stated she called the physician, and he was coming to the facility in 2-3 days to see the residents. V2 stated the physician told them to call the on-call doctors who told the facility they could only write the prescriptions for 2-3 days since they didn't see the residents routinely. V2 stated she also contacted the physician services company, and they told the physician to write the prescriptions. V2 stated V74 (Nurse Practitioner) who sees the residents at least weekly, did not have a controlled substance license so was unable to write those prescriptions. V2 stated the pharmacy was attempting to come up with a solution to the problem and had made her an authorized signer for the narcotics prescriptions. V2 stated if the medication is in the emergency kit they can get them from there. V2 stated the agency nurses don't have access to them but if they needed something the on-call nurse could come get it for them. On 10/22/25 at 3:23 PM, V1 (Administrator) stated she had talked about getting a local pharmacy to have as a backup for medications that needed to be filled immediately. On 10/28/25 at 12:27 PM, V74 (Nurse Practitioner/NP) stated she was aware the facility was having issues keeping controlled substance/pain medications available for the residents. V74 stated she didn't have a Controlled Substance License and the Medical Director was supposed to be filling all controlled substances. V74 stated Gabapentin is not a medication you can stop without tapering it down. V74 stated it is approved to be used to treat pain, but it also has other intended uses that can cause sodium imbalances which can cause increased confusion. V74 stated she had brought this to the facilities attention during meetings she had with them. V74 stated it had been an issue since she started seeing residents at the facility (several months). V74 stated Lyrica is like Gabapentin. V74 stated if someone who is taking an opioid routinely doesn't get it that can trigger opioid withdrawal symptoms. V74 stated the facility has always had the option to call the on-call physician and get three day's worth of medications anytime a resident is out. V74 stated they can call every three days until they are able to get a full supply of the medications in. On 11/03/2025 at 3:43 PM, V86 (Pharmacist) stated she wasn't familiar with any resident missing medications. V86 stated the facility faxes the prescriptions to the pharmacy and then they fill them. V86 stated they deliver to the facility twice daily Monday through Friday and once daily on Saturday, Sunday, and	S9999		

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S9999	Continued from page 61 holidays. V86 stated they also have a cubex at the facility that has medications they can access, and they utilize a local back up pharmacy if they need to. This surveyor shared with V86 the interviews and record reviews documenting residents not getting Gabapentin, Lyrica, and opioids as ordered for up to a week at a time. V86 stated all the facility has to do is let them know they need a refill, and they will reach out to the provider and get the prescription. V86 stated they can even get an emergency supply if they can't get the prescription timely. V86 stated she couldn't say if there would be a negative impact to the residents that would be something the Nurse Practitioner would have to answer. The (name of regional pharmacy) Policy and Procedure Manual 2024 (dated July 2024) documents in section 2.15 Out of Stock Medication documents "Procedure: In the event the facility orders a medication that the pharmacy does not currently stock: 1. Alternative suppliers will be contacted to check availability and expected date and time of delivery to (name of regional pharmacy). 2. (name of regional pharmacy) will contact the e facility to inform that the medication order is currently not in stock, along with an expected date from the supplier if stock will not be obtained by the following day. 3. The facility and the pharmacy will determine medical necessity. An agreement will be reached as to the time of delivery of the ordered medication that meets the resident's need. a. The facility should call the patient's physician to let him/her know that the ordered medication is not available. The physician can then decide whether to hold the medication until it is available or change the medication to one that is readily available in emergency dispensing kit. The original medication that was ordered will be sent as soon as it becomes available. 4. If the resident requires the medication sooner than (name of regional pharmacy) is able to obtain it, other area pharmacy sources will be contacted to supply the item. 5. If it is determined that medications can be started when (name of regional pharmacy) is able to receive the product, the facility will receive the medication on the following delivery once (name of regional pharmacy) received the medication." 2(a). R5's Admission Record with a print date of 10/01/25 documents R5 was admitted to the facility on 5/31/22 with diagnoses that include cerebral infarct, heart failure, anemia, chronic obstructive pulmonary disease, adult failure to thrive, diabetes, and	S9999		

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S9999	Continued from page 62 neuropathy. R5's Minimum Data Set (MDS) dated 7/17/25 documents R5 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R5 is cognitively intact. R5's current Care Plan documents a Focus area of, "(R5) has Diabetes Mellitus. (R5) is non-compliant with her diet. Date Initiated: 05/31/2022…" This Focus area includes the intervention of, "Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Date Initiated: 05/31/2022…." R5's Order Summary Report dated 10/01/2025 documents the following physician orders: Furosemide 20 mg (milligrams) Give 1 tablet by mouth one time a day for diuretics, Glyburide 5 mg Give 1 tablet by mouth one time a day for antidiabetics, Jardiance 25 mg Give 1 tablet by mouth one time a day for antidiabetics, Lantus 100 unit/ml (milliliter) Inject 10 unit subcutaneously at bedtime for antidiabetics, Levothyroxine 50 mcg (micrograms) Give 1 tablet by mouth one time a day for thyroid agents, Lyrica 50 mg Give 1 capsule by mouth every morning and at bedtime for Anticonvulsants, Metformin 500 mg Give 2 tablet by mouth one time a day for Antidiabetics, Potassium Chloride ER (extended release) 20 mEq (milliequivalents) Give 1 tablet by mouth every morning and at bedtime for Minerals and electrolytes, and Tradjenta 5 mg Give 1 tablet by mouth one time a day for Antidiabetics. R5's Medication Admin Audit Report dated 10/01/2025 to 10/20/2025 documents the following medications were administered late: 10/03/25 – Lyrica 50 mg, Potassium Chloride 20 meq, and Lantus 100 unit/ml (10 units) ordered to be administered at 8:00 pm, documented as administered at 10:16 PM. 10/07/25- Lyrica 50 mg, Potassium Chloride 20 meq, Glyburide 5 mg, Jardiance 25 mg, Tradjenta 5 mg, Metformin 500 mg, Levothyroxine 50 mcg, and Furosemide 20 mg ordered to be administered at 8:00 AM documented as administered at 10:48 AM. 10/10/25- Lantus 100 unit/ml (10 units) ordered to be administered at 8:00 PM, documented as administered at 10:37 PM. 10/15/25 – Lantus 100 unit/ml (10 units) ordered to be administered at 8:00 PM, documented as administered at 9:44 PM. Lyrica 50 mg ordered to be administered at	S9999		

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S9999	Continued from page 63 8:00 PM, documented as administered at 11:57 PM. 10/18/25- Lyrica 50 mg ordered to be administered at 8:00 AM documented as administered at 10:54 AM. 10/19/25- Potassium Chloride 20 meq, glyburide 5 mg, metformin 500 mg, tradjenta 5 mg, Jardiance 25 mg, levothyroxine 50 mcg, and furosemide 20 mg ordered to be administered at 8:00 AM, documented as administered at 9:21 AM. Potassium Chloride 20 meq, Lyrica 50 mg, and Lantus 100 unit/ml (10 units) ordered to be administered at 8:00 PM, documented as administered at 10:35 PM. On 10/20/25 at 11:34 AM, R5 stated she is a diabetic and takes insulin. When asked if her medications were ever administered late, R5 stated, “Yes, all medications are late when the “agency nurse” is working. R5 stated she sometimes doesn’t get her medications that are due at 8:00 PM until 11:00 PM, including her insulin. 2(b). R19’s Admission Record with a print date of 10/22/25 documents R19 was admitted to the facility on 5/12/22 with diagnoses that include cerebral infarction, diabetes, dementia, and hypertension. R19’s MDS dated 9/2/25 documents a BIMS score of 07, indicating a severe cognitive deficit. R19’s current Care Plan documents a Focus area of, “(R19) has Diabetes Mellitus Date Initiated: 05/17/2022…” This Focus area includes the following intervention, “Diabetes medication as ordered by doctor. Monitor/document for side effects and effectiveness. Date Initiated: 05/17/2022…” R19’s Order Summary Report dated 10/01/2025 includes the following physician orders: Humalog Inject 10 unit subcutaneously with meals for Hyperglycemia and Lantus Inject 12 unit subcutaneously at bedtime for elevated blood glucose. R19’s Medication Admin Audit Report dated 9/1/25 to 10/23/25 documents the following medications were administered late: 9/11/25-Humalog 10 units ordered to be administered at 8 AM, documented as administered at 9:25 AM. 9/26/25 – Humalog 10 units ordered to be administered at 12:00 PM, documented as administered at 1:45 PM. 10/04/25 Humalog 10 units ordered to be administered at	S9999		

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S9999	Continued from page 64 8:00 AM, documented as administered at 9:37 AM. 10/18/25 – Humalog 10 units ordered to be administered at 8:00 AM, documented as administered at 11:08 AM. 10/18/25 – Lantus 12 units ordered to be administered at 8:00 PM, documented as administered at 9:30 PM. 2(c). R35's Admission Record with a print date of 10/22/25 documents R35 was admitted to the facility on 9/17/25 with diagnoses that include repeated falls, chronic obstructive pulmonary disease, chronic kidney disease, and obstructive sleep apnea. R35's MDS dated 9/24/25 documents a BIMS score of 14, indicating R35 is cognitively intact. R35's current Care Plan does not document a Focus area with interventions that include medication administration. R35's Order Summary Report dated 10/22/25 includes the following physician orders: Gabapentin Oral Capsule Give 1 capsule by mouth two times a day for nerve pain with an order date of 9/17/2025 and Quetiapine Fumarate Tablet 25 mg (Seroquel) give 1 tablet by mouth at bedtime for Insomnia with an order date of 09/17/2025. R35's Medication Admin Audit Report dated 10/1/25 to 10/20/25 documents the following medications were administered late. 10/04/25 – gabapentin 100 mg ordered to be administered at 8:00 AM, documented as administered at 11:19 AM. 10/06/25 - gabapentin 100 mg ordered to be administered at 8:00 AM, documented as administered at 10:19 AM. 10/07/25 - gabapentin 100 mg ordered to be administered at 8:00 AM, documented as administered at 10:59 AM. 10/12/25 – gabapentin 100 mg ordered to be administered at 8:00 AM, documented as administered at 11:32 AM. 10/15/25 – gabapentin 100 mg and Seroquel 25 mg ordered to be administered at 8:00 PM, documented as administered at 9:34 PM. On 10/22/25 at 12:28 PM, V33 (RN/Registered Nurse) stated she is late administering medications at times because she will pause her medication pass to feed residents. On 10/22/25 at 12:23 PM, when asked why she	S9999		

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S9999	Continued from page 65 administered medications late to the residents at times, V49 (RN) stated she was an agency nurse and she had to make sure she was administering the correct medication to the correct resident, and she also had to stop her medication pass at times and provide care to the residents. On 10/20/25 at 12:54 PM, V32 (LPN/Licensed Practical Nurse) stated he can administer his medications timely. On 10/22/25 at 1:13 PM, V70 (RN) stated medications were administered late at times in part due to the workload. V70 stated when you have so many medications to give including patches, eye drops, and nasal sprays, it gets delayed. V70 stated when you have 35 residents to administer medications to and multiple things that need to be done and you give the residents the attention they need, medication administration is late. On 10/22/25 at 2:01 PM, V71 (RN) stated she is very late administering medications at times. V71 stated it has happened more than once but not every time she administers medications. V71 stated unusual weather causes the computer to shut down and that impacts medication administration times. V71 stated she also spends a lot of time trying to locate missing items including medications and that causes her medication administration to be late. V71 stated the residents on the hall she usually works on are a higher level of care and that causes her medication administration to be late. V71 stated she only worked at the facility as needed and that could also be part of the reason the medications were administered late. On 10/22/25 at 4:56 PM, V53 (LPN) stated she was able to pass her medications timely if everything went ok but if something happened the medications would be administered late. V53 stated she administers medications to approximately 40 residents each shift. On 10/21/25 at 2:38 PM, V2 (Director of Nurses) stated she didn't know why medications were administered late. V2 stated she administers medications at the facility, and she can administer them timely unless there was another issue. V2 stated if a resident falls or she had to send someone to the hospital then timely medication administration would be an issue. On 10/22/25 at 3:23 PM, V1 (Administrator) stated she would expect medications to be administered according to the current guidelines. V1 stated medications should be administered within one of before or after the times the medications were ordered.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0046276	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
METROPOLIS REHAB & HCC	**2299 METROPOLIS STREET , METROPOLIS, Illinois, 62960**

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S9999	Continued from page 66 On 10/28/25 at 12:27 PM, when asked about medications being administered late, V74 (Nurse Practitioner) she had talked with staff about administering insulin as ordered. V74 stated she is at the facility every week. V74 stated every morning blood sugar tells her what the nighttime dose of insulin is doing. V74 stated giving that insulin late really affects things. When asked about the effect late administration has on a resident, V74 stated, as a prescriber, I don't know that it is given late. V74 stated she then adjusts the dosage of their insulins, so the worst-case scenario is hypoglycemia. V74 stated the residents blood sugar is going to bottom out. V74 stated she was very frustrated with the facility and wasn't sure why they weren't prioritizing resident care. This surveyor reviewed with V74 other medications that were administered late and V74 stated if a diuretic isn't administered until noon the onset of action would be 4-5 pm. That is when someone with Sundowner's would start exhibiting symptoms and could fall attempting to take themselves to the bathroom. The (name of regional pharmacy) Policy and Procedure Manual 2024 (dated July 2024) documents in section 5.1: Drug Administration--General Guidelines procedure step 8 "Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered precisely as ordered. Unless otherwise specified by the physician, routine medications are administered according to the established medication administration schedule for the facility." 3(a). R35's Admission Record with a print date of 10/22/25 documents R35 was admitted to the facility on 9/17/25 with diagnoses that include fractures, repeated falls, and muscle weakness. R35's MDS dated 9/24/25 documents a BIMS score of 14, indicating R35 is cognitively intact. R35's current Care Plan does not document a Focus area related to self-administration of medication. On 10/15/25 at 10:42 AM, R35 stated she hadn't seen nursing staff leave medications on the medication cart unattended, but they did at times leave them in her room on her table for her to take them independently. R35 stated she didn't think they were supposed to do that. 3(b). R45's Admission Record with a print date of 11/5/25 documents R45 was admitted to the facility on	S9999		

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S9999	Continued from page 67 10/10/25 with diagnoses that include metabolic encephalopathy, muscle weakness, cognitive communication deficit, hypertension, atrial fibrillation, weakness, and adult failure to thrive. R45's MDS dated 10/17/25 documents a BIMS score of 13, indicating R45 is cognitively intact. On 10/20/25 at 1:04 PM, V66 (Agency LPN) gave R45 her sodium chloride 1000mg tablet in the dining room, V66 set the cup down on the table and told R45 it was her medication. R45 was in the middle of eating her cookie, R45 said "ok" and started setting her cookie down, V66 told R45, go ahead and finish your cookie and take it after then V66 left the medication cup sitting on the dining room table in front of R45 and walked out of the dining room. On 10/20/25 at 2:51 PM, V66 (Agency LPN) stated she didn't remember sitting medications down on a table and walking away during the noon medication pass. V66 stated if she did, she didn't mean to. On 10/15/25 at 7:24 PM, V47 (CNA) stated she reported meds being prepped in advance and left on the top of the med cart unattended. V47 stated it was V85 (Registered Nurse/Agency) who left them out. On 10/15/25 at 10:44 PM, V61 (CNA) stated he hadn't seen nursing staff leave medications unattended on top of the medication cart, but they leave them unattended in residents rooms. V61 stated when he sees them, he always takes them to a nurse because he doesn't want another resident to take them. On 10/16/25 at 2:56 PM, V51 (CNA) stated he didn't know V85 (Agency RN) but V56 (LPN) and V53 (LPN) leave medications unattended on top of the medication cart and in resident rooms. On 10/20/25 at 11:44 AM, V62 (CNA) stated nursing staff leave medication on resident's bedside tables for the resident to take. V62 stated the pills just sit unattended on the table. On 10/21/25 at 2:38 PM, V2 (Director of Nurses) stated it was not acceptable for medications to be left unattended. The (name of regional pharmacy) Policy and Procedure Manual 2024 (dated July 2024) documents in section 5.1: Drug Administration--General Guidelines procedure step 14 "During routine administration of medications, the medication cart is kept in the doorway of the	S9999		

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S9999	Continued from page 68 resident's room, with open drawers facing inward and all other sides closed. No medications are kept on the top of the cart. The cart must be clearly visible to the personnel administering medications, and all outward sides must be inaccessible to residents or others passing by." Under "Tips for Safe Medication Administration" documents "1. Maintain security of provided medications. 2. Cart must always be visible to nurse administering medications. 3. Never leave a medication in a resident's room without orders to do so." The facility undated Medication Administration Policy for Senior Living documents, "Adherence to this Medication Administration Policy is essential to ensure the well-being and safety of our residents. All staff members are expected to follow these guidelines strictly and to report any issues or deviations from the policy…S. Residents who self-administer must have a profile only MAR which lists their medications & indicates that they self-administer…1. Medications should be stored in a secure, locked area with restricted access to authorized personnel only…3. Medications should be administered according to the "five rights" of medication use: right resident, right drug, right time, right dose, and the right route. 4. Staff members must ensure that residents have swallowed or otherwise received the medication properly. 5. Self-administration of medications will be supported for those through a self-administration evaluation upon admission, every 6 months, and as needed. "Who have written orders from an authorized healthcare provider and can demonstrate that they are capable of safely administering their medications through a self-administration evaluation upon admission, every 6 months, and as needed." (B)	S9999		