

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000384		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/03/2026	
NAME OF PROVIDER OR SUPPLIER Arcadia Care Toulon				STREET ADDRESS, CITY, STATE, ZIP CODE 700 E MAIN ST , TOULON, Illinois, 61483			
(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		S0000				
	Annual Licensure Survey						
S9999	Final Observations		S9999				
	Statement of Licensure Violations:						
	1 of 3						
	300.610a)						
	300.1210b)						
	300.1210d)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.						
	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						

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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S9999	Continued from page 1 shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one of 21 residents (R10) was free from involuntary seclusion, failed to ensure criteria was met for admission to the Secured Dementia Unit and failed to follow physician's guidance for resident's wellbeing to prevent a change in condition reviewed in a sample of 41. These failures resulted in R10, a cognitively intact resident with admitting diagnoses of Post-Traumatic Stress Disorder and Generalized Anxiety, to be admitted to the Secured Dementia Unit on 1/30/26 and remained in the unit until 2/26/26. The Dementia Unit Admission/Discharge Criteria Program policy, revised 10/2017, documents The Secured Dementia Unit exist to provide residents with cognitive or Alzheimer's/Dementia related diagnoses a safe and comfortable environment where staff has been trained to care for their special needs, Residents may be admitted based on the following guidelines: 1. Resident does not display disruptive behaviors such as repetitive yelling or calling out. 8. Does not display wandering that is not easily directed or poses a risk to the resident or others. May include but not limited to excessive attempts to exit the unit or facility. The Facility's 671 dated 2/24/26 documents they have a Dedicated Special care Unit labeled as Alzheimer's Disease and has 53 beds. R10 was admitted on 1/29/26 with diagnoses of Post-Traumatic Stress Disorder and Generalized Anxiety Disorder. R10 was transferred to the Secured Dementia Unit on 1/30/26. R10's record did not include an admitting diagnosis of Dementia/Alzheimer's Disease. The Brief Interview for Mental Status (BIMS) documents on 1/29/26 R10's cognition was moderately impaired and from 2/3/26 to present has been cognitively intact.			S9999			

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S9999	Continued from page 2 The Preadmission Screening and Resident Review Level 1 dated 1/27/26, documents R10 did not have a Dementia or Alzheimer's Disease Diagnosis, and Level 2 was not required. V56's (R10's Family Physician) visit notes dated 12/30/25,10/31/25 and 8/22/25 documents R10 had been evaluated for Dementia and passed the given test. No diagnosis of Dementia or Alzheimer's Disease were identified on the visit notes. R10's Elopement/Unauthorized Leave Risk review dated 1/29/26, documents R10 has a "... history of or verbalizes a strong desire to leave-yes. Is there a history of dementia? No". A Progress Note dated 1/30/26 documents to move resident to Secured Dementia Unit for high elopement risk. On 2/3/26, V54's (Psychiatric Family Nurse Practitioner) Progress Note documents R10 would benefit from and resident requests to be out of the unit. V54 stated R10 has taken on a role as a caretaker for the residents in the Dementia unit. On 2/24/26 and 2/25/26, R10 was observed in bed with the lights out and stated "I told them (facility staff) I didn't want to be here (facility), so they put me back here (Secured Dementia Unit). I don't feel like it's right. I shouldn't be locked in here." R10 stated she had passed all her cognitive tests and was not going to leave the facility (elope). R10 did not participate in activities because "I don't want to be with old people, and I can't stand to see them (cognitively impaired residents) like that. I'd rather be alone." On 2/25/26 at 2:50 PM, R10 stated she had not slept the previous night because another resident was crying, and staff did not help the resident. "I was worried she was going to die, so I kept checking on her. " On 2/24/26 at 11:18 AM, V55 (R10's family member and Healthcare Power of Attorney) stated "My mom does not have Dementia or Alzheimer's. She lived independently until (Financial Power of Attorney) stole her house and sent her to the nursing home." On 2/25/26 at 9:45 AM, V12 (CNA/Certified Nursing Assistant) stated she has cared for R10 since she was transferred to the Secured Dementia Unit) on 1/30/26. V12 stated R10 does not appear to be confused, has expressed wanting to leave the locked unit and go back		S9999				

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S9999	Continued from page 3 to the general non-secured unit with the general population, although R10 has not attempted to elope from the unit or has not displayed exit-seeking behavior. V12 stated the only behavior R10 has exhibited was "Anxiety. She doesn't need to be down here (Secured Dementia Unit)." On 2/25/26 at 9:40 AM, R10 was observed to ask if anyone could take her outside to smoke. V23 (LPN/ Licensed Practical Nurse) stated "It's past time. The scheduled mid-morning smoking time is 9:30 AM." On 2/25/26 at 10:55 AM, V23 (LPN/Licensed Practical Nurse) stated the residents smoking times were at 7:00 AM, 9:30 AM, 1:30 PM, 5:00 PM and 7:00 PM. V23 stated R10 is the only smoker on the unit and "Down here (Secured Memory Care Unit) we try to stick to the times. We have to have some kind of schedule." On 2/25/26 at approximately 10:05 AM, V12 (anonymous staff member) stated V23 did not allow R10 to smoke this morning because she didn't ask to smoke until 9:40 AM, 10 minutes after smoking time. Staff deny R10 of her smoking privileges if she is late for the scheduled smoking time. On 2/26/26 at 10:52 AM, V54 (Psychiatric Family Nurse Practitioner) stated she had voiced and emailed her concerns to V1 (Administrator), V2 (Director of Nursing) and V20 (Social Worker) on 2/3/26 and 2/17/26 regarding R10's overall well-being, increased anxiety, as well as acting as being a caregiver to the other cognitively impaired residents by being in the Secured Dementia Unit and did not meet the criteria or benefit from being housed there. V54 stated she was told "no" that R10 was not being moved because she was an elopement risk. On 2/26/26 at 10:21 AM, V54 (Physician's Certified Medical Assistant) stated their office did not refer R10 to the facility. On 1/20/26, the facility called the physician's office and requested R10's records. V54 stated R10 did not have a Dementia diagnosis and the facility had called two times today (2/26/26) and requested the doctor to add a Dementia diagnosis code to R10's diagnosis lists. On 2/26/26 at 10:40 AM, V39 (Medical Director/R10's Physician) stated many residents experience delirium the first 24-72 hours of admission. They get confused from taking them out of their environment. If the referring physician says R10 does not have a dementia diagnosis, R10 doesn't have a dementia diagnosis. R10		S9999				

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S9999	Continued from page 4 did not have a Dementia diagnosis and did not meet the criteria to be admitted to the Secured Dementia Unit. (B) 2 of 3 300.610a) 300.1010h) 300.1210b) 300.1210d)2) 300.1210d)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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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 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	S9999					

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S9999	Continued from page 5 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: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to assess a resident's change in condition and ensure diagnostic tests were completed as ordered for one of two residents (R1) with a change in condition, in a sample of 41. This failure resulted in R1 being transferred to the hospital with a diagnosis of RSV (Respiratory Syncytial Virus), Findings include: The Licensed Practical Nurse (LPN) and Registered Nurse (RN) job descriptions, dated 7/2023, documents to chart nurse's notes in an informative and descriptive manner that reflects the care provided to the residents, as well as the resident's response to the care. The nurse must be knowledgeable of nursing and medical practices and procedures. The Assessment of Resident policy documents to document the resident's comments, complaints as appropriate and assessment findings in the nurse's progress notes and initiate nursing interventions. R1 was admitted on 9/12/25 with diagnoses of Orthopedic Aftercare, Fracture of Femur Shaft, Morbid Obesity, Chronic Respiratory Failure, Type 2 Diabetes and Major Depressive Disorder. The Minimum data Set dated 2/6/26 section C documents R1 had a Brief Interview for Mental Status score of 15,			S9999			

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S9999	Continued from page 6 cognitively intact. The Active Physician Orders on 2/20/26 at 3:10 PM included an order for a chest x-ray. On 2/24/26 at 10:30 AM, R1 stated she did not feel well. Complained that her chest felt heavy and it was hard to breathe. When asked if she had sputum, she said "Yes. I've been bringing up (coughing up) yellow and greenish junk." R1 stated she had not had a chest x-ray because "They (contracted x-ray staff) never came." On 2/24/26 at 11:00 AM, V3 (Assisting Director of Nursing/Infection Preventionist) was unaware R1's chest x-ray had not been completed. V3 stated the x-ray staff come whenever they have the staff to do the x-ray. V3 stated R1 had not been tested for Influenza, RSV (Respiratory Virus) or COVID-19 because testing is not done unless ordered by the Physician. On 2/25/26 at 9:15 AM, R1 stated she felt even worse than yesterday, appeared to have difficulty breathing and stated "No one pays attention to me. I'm going to die." On 2/25/26 at 9:20 AM, V3 (Assisting Director of Nursing/Infection Preventionist) was notified by this surveyor of R1's complaints of her difficulty breathing, comments about staff not paying attention to her and feeling like she was going to die. R1's Progress Note documents on 2/20/26, R1 was weak and had a cough which was productive at times with yellowish/greenish mucus, wheezing throughout lung fields and received a new order for a chest x-ray; on 2/21/26, awaiting chest x-ray, still wheezing; on 2/23/26 and on 2/24/26, still wheezing. The progress notes do not document that vital signs or oxygen saturations were monitored between 2/20/26 and the morning of 2/25/26 (after V3 was notified of R1's complaints by surveyor); on 2/25/26 at 10:00 AM, documents R1 was confused, lethargic, responds to verbal stimuli but falls right back to sleep, shallow respirations, lung sounds diminished with "Rhonci (rattling lung sound cause by obstructions or secretions in the large airway)", oxygen saturation of 53% (normal limits are 90-100%), oxygen was applied at 2 L (liters) and oxygen saturations went up to 72%,		S9999				

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S9999	Continued from page 7 oxygen increased to 4 L and oxygen saturations went up to 76%-78%, V39 (Medical Director) was notified of altered level of consciousness and hypoxia (low oxygen saturation) and received orders to send R1 to hospital. R1 remains hospitalized as of 3/3/36. The Emergency Department Physician Notes dated 2/25/26 documents upon admission, R1 was lethargic, had a cough, was short of breath, wheezing, confused and tested positive for RSV (Respiratory Syncytial Virus), Acute Bronchiolitis due to RSV, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) and Acute Hypoxia Respiratory Failure and was ultimately transferred to another hospital for a higher level of care. R1's Hospital Inpatient Progress Notes dated 2/25/26, documents R1's Primary Diagnoses are Acute Metabolic Encephalopathy due to Hypercarbia, Acute and Chronic Hypoxemia and Hypercarbic Respiratory Failure, Acute Chronic Obstructive Pulmonary Disease (COPD) Exacerbation secondary to RSV Bronchiolitis and Acute Kidney Injury. On 2/20/26 an Infection Screening Evaluation documents R1 had no active infection, had a new onset of functional decline, new/unchanged lung exam abnormality, new/increased cough, productive/purulent sputum and Loeb's Criteria was triggered as suspected Lower Respiratory Tract Infection and McGreer's Criteria triggered suspected Bronchitis or Tracheobronchitis. On 3/3/26 at 12:00 PM, V39 (Medical Director) stated the facility's county was currently at a very high activity level for RSV and that RSV in the facility's resident population can be fatal. On 2/27/26 at 2:30 PM, V32 (Regional Nurse Consultant) stated the facility initiates an Infection Screening Evaluation if a resident is suspected of having an infection. Loeb's and/or McGreer's Criteria are utilized to determine if there is an infection. V32 reviewed R1's record and stated an Infection Screening Evaluation had been started on 2/20/26 although had not been completed until V32 closed the evaluation during the interview. V32 agreed R1's record did not include documentation that ongoing assessments were conducted, and her condition was monitored after the change in condition was identified nor was an x-ray was completed as ordered and should have been. (A)		S9999				

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S9999	Continued from page 8 3 of 3 300.510a) 300.510e) 300.610a) 300.1010h) 300.1210b) 300.1210d)1) 300.1210d)2) 300.1210d)3) 300.2210b)1) Section 300.510 Administrator a) There shall be an administrator licensed under the Nursing Home Administrators Licensing and Disciplinary Act (Ill. Rev. Stat. 1987, ch. 111, par. 3651 et seq.) full-time for each licensed facility. The licensee will report any change in administrator to the Department, within five days. e) The licensee and the administrator shall be familiar with this Part. They shall be responsible for seeing that the applicable regulations are met in the facility and that employees are familiar with those regulations according to the level of their responsibilities. 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 and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.			S9999			

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S9999	Continued from page 9 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 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. 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. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.2210 Maintenance b) Each facility shall: 1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards.			S9999			

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S9999	Continued from page 10 These requirements are not met as evidenced by: Based on observation, interview and record review, the facility failed to provide adequate administrative oversight to ensure the facility implemented their policies for protecting resident's dignity, be free of involuntary seclusion and restraints, accurately assessed residents and provided quality of care based on those assessments, services were provided to meet professional standards, ADL (Activities of Daily Living) cares were provided for dependent residents, medications were safely administered, infection prevention measures were implemented and appropriately utilized, staff were qualified and competent and maintained a safe/ clean/comfortable environment. These failures resulted in a facility-wide lack of supervision and care leading to residents experiencing a lack of dignity by being exposed to other residents, visitors and other staff members not involved in the residents care, lack of nursing assessments which led to a residents decline and resulted in hospitalization, involuntarily seclusion which caused psychosocial harm, residents received unnecessary medications and amounts of medications without a diagnosis or behaviors to indicate the need for those medications, untimely assistance with showers resulting in residents being left disheveled and a sense of being dirty, lack of assurance the right resident received the right medication, right dose, right route at the right time, and not providing a competent and trained staff to provide resident cares. These failures have the potential to affect all 67 residents residing in the facility. Findings include: The facility's Daily Census Report, dated 2/24/26, documents 67 residents reside in the facility. The Facility Assessment dated 11/1/25-11/1/26, documents in Part 4 Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies Staff type include Administrator, Staff Development, Quality Assurance Performance Improvement, Infection and Control and Prevention, Environmental Services, Social Services, Discharge Planning, Human Resources and Compliance and Ethics.			S9999			

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S9999	Continued from page 11 On 2/24/26 at 9:15 AM, V1 (Interim Regional Administrator) stated the facility has not had an Administrator for "probably a year, year and a half." V1 stated Regional Interims have filled in during this time. R5 was not provided dignity by staff by not utilizing a privacy curtain prior to pulling down his pants and incontinent brief before performing catheter care. R27 was not provided dignity by closing the door to the hallway for wound care. V29 (Certified Nurse Aide/CNA) was standing while feeding R76 and repetitively called R76 "honey" and "sweetie." R51 was not accommodated with her toileting preferences to get her up in a chair to toilet to prevent constipation due to staff time constraints. The facility was not maintained, safe, clean and comfortable due to leaves being in piles in the hallway and dirty floors on multiple occasions. R58 was observed in his room, wearing a heavy winter coat and complained of his room being cold because his heater had not worked in "awhile." R58 stated it had been reported multiple times and staff say maintenance will come fix it. V6 (Maintenance) stated he was not informed of the broken heater in R58's room. R48 and R1 stated their joining bathroom sink had been clogged for six months and were unable to wash hands after toileting or brush their teeth at the sink. This has been reported to the Resident Council as well. R48 and R1's sink were observed half full of water which was not draining. The Dementia Care Unit had two floor drainage metal caps which were not secured, and one had a screw sticking upward approximately one inch causing a tripping hazard. The ceiling tile in the common areas had water stains on ceiling tiles and dust hanging from ceiling vents. V6 stated the water damaged ceiling tile was from a roof leak a year ago. Staff can submit electronic work orders although V6 did not have access to a computer from a water leak in his office. R10 was admitted on 1/29/26, was alert and reported she wanted to leave the facility. On 1/30/26, facility staff transferred R10 to the Secured Dementia Unit to prevent elopement. During this time, R10 did not meet admission criteria to the Secured Dementia Unit, had no diagnosis of Dementia, took on a role as a caretaker to Dementia residents, wound not participate in activities because "I can't stand to see them (cognitively			S9999			

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3000384		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/03/2026	
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S9999	Continued from page 12 impaired residents) like that and V58 (Psychiatric Family Nurse Practitioner) addressed verbally and via email with the Interdisciplinary Team that R10 needed to be in the general population, had not stated she was going to leave and didn't meet requirements to be in a locked unit against her will, although the Interdisciplinary Team denied the transfer because of the elopement risk. R10 resided in the Secured Unit until 2/26/26 when Immediate Jeopardy for Involuntary Seclusion was identified. R9 had a Physician's Order and Care Plan documents to use a self-releasing seat belt while in motorized wheelchair, although R9 was unable to release the seatbelt when prompted. R6 was prescribed and administered an antipsychotic, although no behaviors were exhibited to account for the use of the medication. R7 was prescribed and administered three antidepressant medications for a diagnosis of Depression, although R7 had no behaviors to account for the use of the medication. The resident nor staff could verbalize why R7 was on three antidepressant medications. R11 was prescribed and administered an antidepressant and a medication for Bipolar Mania. R11's guardian stated R11 had been nonverbal, frail and did nothing except lie in her chair. R71's medical record documented R71 was sent to the Emergency Department for evaluation of wounds. The medical record did not document any further information including whether R71 was admitted, expired or went home from the hospital. R7 sustained a fall at the facility and new interventions were not implemented on the care plan. R10 was admitted on 1/29/26 with diagnoses of Post Traumatic Stress Disorder and Generalized Anxiety and was alert and oriented and. R10 stated she wanted to leave and was deemed to be a high risk for elopement therefore was transferred to the Secured Dementia Unit on 1/30/26. A Dementia diagnosis was added to R10's diagnosis list although there was no Physician's Order or supporting documentation to support the Dementia diagnosis. During an interview with R10's family physician, it was stated that R10 was tested prior to admission to the facility and passed testing and did		S9999				

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S9999	Continued from page 13 not have a diagnosis of Dementia. R11 was admitted with diagnoses of Alzheimer's, Conversion Disorder with Seizures and Hypothyroidism. A new physician order documents a new diagnosis of schizoaffective disorder. The Psychiatric physician's note did not mention a new diagnosis of schizoaffective disorder. V26, R11's Guardian stated R11 had no history of mental illness. R6 was sitting in his recliner, hair appeared disheveled, was in just shorts, fingernails were long and jagged, and he had facial hair. R6 stated he has been at the facility for "approximately a year" and has only had 5 showers. R6 had no documented showers given. R43 stated she had not received showers twice weekly as scheduled and felt dirty. R48 stated she had not been showering twice weekly and felt "sticky" all over from being sweaty and lying in bed. R43 and R48's shower sheets dated December 2025, January 2026 and February 2026 lacked documentation showers were received twice weekly. The facility did not assess, develop and/or implement a care plan, or provide an ongoing program of activities based on residents' assessments and preferences for R51 and R11. The facility did not assess or address R1's change in condition and ensure diagnostic tests were completed as ordered which resulted in hospitalization on 2/25/26. The hospital records documented R1 was lethargic, had a cough, was short of breath, wheezing, confused and tested positive for RSV (Respiratory Syncytial Virus), Acute Bronchiolitis due to RSV, Acute Exacerbation of Chronic Obstructive Pulmonary Disease (COPD) and Acute Hypoxia Respiratory Failure. R1 was ultimately transferred to another hospital for a higher level of care. R1 was still hospitalized upon exit on 3/3/26. R8 had a physician's order to remove an indwelling catheter and implement voiding trial. Staff denied knowledge of a voiding trial or that urinary output should have been monitored and recorded. R55 was observed to have oxygen at 2 liter per nasal cannula. R55's oxygen tubing had not been changed weekly as ordered and the prefilled humidification		S9999				

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S9999	Continued from page 14 bottle was empty. R55 stated he had requested it to be refilled for 2 days and now had a dry nose. V1/Administrator stated she did not have documentation demonstrating staff employed at the facility received education and competencies related to the facility's standards, policies, and procedures. R48 was observed resting in bed with the light out. Two medications were in a medicine cup sitting on her bedside table. R48 woke up, turned her light on and took her medications. R48 did not have a physician's order or was it care planned to self-administer medications. The facility did not ensure medications were safely administered. The facility did not dispose of food which was not safe for consumption. The facility failed to properly contain garbage and refuse in the facility's dumpsters. The facility failed to ensure residents and staff were monitored and tracked for communicable diseases, ensured a process to prevent the spread of diseases to other residents and staff, wear masks properly while in close proximity to residents, to wear appropriate PPE (Personal Protective Equipment) for Enhanced Barrier Precautions and failed to perform hand hygiene. The facility failed to provide a Pneumococcal Immunization to 2 residents (R1, R60) that requested to receive it and failed to offer a Pneumococcal Immunization to 3 (R13, R52, R55) residents. The facility did not maintain the facility by repairing holes in the wall, torn wallpaper and exposed dry wall. V1/Administrator stated she did not have documentation demonstrating staff employed at the facility received the required staff training/education and competencies for Infection Prevention and Control, Compliance and Ethics. In addition, there is no documentation Certified Nurse Aides were provided and completed a minimum of 12 hours of in-service training per year. (B)		S9999				

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