

Illinois State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001056		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Benton Rehabilitation and Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1409 NORTH MAIN STREET PO BOX 847, BENTON, Illinois, 62812			
(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			03/31/2026	
	First Probationary Licensure Survey						
S9999	Final Observations		S9999			03/31/2026	
	Statement of Licensure Violations						
	1 of 6						
	300.610a)						
	300.686f)						
	300.1210b)						
	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 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications						
	f) Residents who use antipsychotic medications shall receive gradual dose reductions and behavior interventions, unless clinically contraindicated, in an effort to discontinue these medications in accordance with Appendix F. In compliance with subsection 2-106.1(b-3) of the Act and this Section, the facility shall obtain informed consent for each dose reduction.						
	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						

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 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. This requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were free from unnecessary psychotropic medication for 3 of 4 (R1, R2, and R34) residents reviewed for unnecessary medication in a sample of 44. Findings include: 1. R2's Admission Record documented and admission date of 02/01/24 and included diagnoses of bipolar disorder, delusional disorder, depression, anxiety, post-traumatic stress disorder, extrapyramidal and movement disorder, schizoaffective disorder, and insomnia. R2's Minimum Data Set (MDS) dated 01/14/26 documented a Brief Interview for Mental Status (BIMS) score of 7, indicating R2 has severe cognitive impairment. R2's Care Plan with a revision date of 08/09/24 includes a Focus area of the resident is known to display fluctuations in mood anger/sadness r/t (related to) bipolar, a Focus area of the resident may display s/s (signs and symptoms) depression, a Focus area of the resident has an alternation in neurological status, a Focus area of mental condition that requires level II bipolar, depression, anxiety, schizoaffective disorder, a Focus area of behavior at risk and/or potential for complications with behavior, confusion, dementia, psych diagnosis, and a Focus area of Psychotropic drug use: at risk for complications r/t use of antidepressant-daily use, antipsychotic- daily use/PRN (as needed) Use. R2's Order summary report includes an order for Seroquel XR oral tablet extended release 24-hour 150mg give 150mg by mouth at bedtime with an order date of 02/26/25 no end date. A "Note to Attending Physician/Prescriber" from the pharmacist with a MMR (Medication Regimen Review) date of 02/11/26 documented R2 receives the following medication used for psychiatric condition: Quetiapine (Seroquel) ER (Extended Release) 150mg (milligrams) at bedtime. The Center for Medicare and Medicaid Services	S9999					

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S9999	Continued from page 2 (CMS) requires attempts at dosage reductions on medications used for psychiatric symptoms twice a year, in two separate quarters (with at least one month between attempts), within the first year of admission or initiation unless clinically contraindicated. After the first year, dosage reduction attempts are required annually unless clinically contraindicated. This form documents "Resident is due for an evaluation. Please complete one of the following sections." Under this are three options including "1. Further dose reduction is clinically contraindicated due to:" with two selections underneath and space to document a rationale explaining the contraindication. The second option documents "2. Pharmacist recommended dose reduction to: Quetiapine ER 50mg; Take 2 tablets (100mg) at bedtime" and the third option documenting "3. Gradual dose reduction (other)" with an area to specify a different reduction plan. This portion of the form is all blank with no options selected. At the bottom of the form is a space for the Physician/Prescriber response to select boxes to "Agree" or "Disagree" and a signature/date area below that. These areas are also blank with nothing selected and no physician/prescriber signature or date. R2's psychiatric visit notes for 02/25/25, 04/22/25, 06/20/25, 10/24/25, and 12/19/25 included no acknowledgement or documentation of consideration for the gradual dose reduction (GDR) recommendation for the quetiapine (Seroquel). On 03/12/26 at 9:36AM, R2 who was alert and orientated stated that she doesn't know of any time they tried to reduce her antipsychotic medication since she has been at the facility. R2 said before she came to the facility, they did try to take her off the Seroquel and that she went "crazy" without it. R2 said staff do try different interventions when she is anxious, depressed, or having problems with her mood. R2 said they do a really good job of "trying to keep me calm and happy and make sure I see my psychiatrist around every 2-3 months." On 03/12/26 at 12:52PM, V2 (Director of Nursing/DON) stated that she talked to R2's Psychiatrist office, and they do not have documentation of any gradual dose reductions done at the office. V2 stated that she is unable to find any record of GDR's attempted on R2 since she was admitted for any of her medication that she currently has. V2 stated she does have a GDR that was recommended by the pharmacy on 02/11/26 and she will send that to R2's psychiatrist now. V2 said she couldn't find any other documentation of a GDR in her records other than the one she got from the pharmacy on 02/11/26.	S9999					

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S9999	Continued from page 3 On 03/12/26 at 2:08AM, V1 (Administrator) stated that the facility does not have a policy on GDR's. 2. R1's Admission Record dated 3/12/26 documented an admission date of 2/1/24 and included diagnoses of dementia, generalized anxiety disorder, paranoid schizophrenia, and agoraphobia with panic disorder. R1's MDS assessment dated 2/17/26 documented a BIMS score of 14, indicating R1 is cognitively intact. This same MDS documented R1 is on an anti-anxiety medication. R1's Physician's Order Sheet dated 3/12/26 documents orders including but not limited to diazepam 2 milligram tablet – take two tablets by mouth twice daily with a revision date of 1/24/25. R1's most recent Care Plan documents R1 uses anti-anxiety medications related to a diagnosis of anxiety. A corresponding intervention for this focus area documents to monitor for adverse effects of the medication. R1's "Note to Attending Physician/Prescriber" with a MRR date of 11/10/25 documents the following: Resident receives the following long-acting benzodiazepine: diazepam 4mg q12 hours. Due to its increased risk of cognitive impairment, delirium, falls and fractures this medication is not recommended in the elderly population. The recommendation: avoid; strength of evidence: moderate; strength of recommendation is strong. Please consider discontinuing this medication and initiating _____. If this medication is to be continued, please add a benefit/risk statement. This document is also blank with no Physician/Prescriber response of "Agree" or "Disagree" selected and no physician/prescriber signature or date. R1's "Note to Attending Physician/Prescriber" with a MRR date of 2/9/26 documents resident receives the following medication used for anxiety: Diazepam 4 mg every 12 hours ***Last GDR performed was in January 2025.*** This form documents "Resident is due for an evaluation. Please complete one of the following sections." Under this are three options, with the first being "1. Further dose reduction is clinically contraindicated due to:" with two selections underneath and space to document a rationale explaining the contraindication. The second option documents "2. Pharmacist recommended dose reduction to: Diazepam 4 mg in the morning and 2 mg at bedtime" and the third option documenting "3. Gradual dose reduction (other)"		S9999				

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S9999	Continued from page 4 with an area to specify a different reduction plan. This portion of the form is all blank with no options selected. At the bottom of the form is a space for the Physician/Prescriber response to select boxes to "Agree" or "Disagree" and a signature/date area below that. These areas are also blank with nothing selected and no physician/prescriber signature or date. R1's psychiatric visit notes dated 2/10/26, 1/27/26, 11/25/25, 10/28/25, 8/12/25, 7/31/25, 6/23/25, 5/1/25, and 3/12/25 contained no acknowledgement or documentation of consideration for the gradual dose reduction recommendation for diazepam. On 3/12/26 at 9:46 AM, R1 stated he is not sure what medications he is currently on, but stated Valium sounded familiar. R1 stated, "It's like an antidepressant, isn't it?" This surveyor clarified the medication was an anti-anxiety. R1 stated he does feel like the medication he is currently taking helps his anxiety. R1 stated, "It helps to calm me down." R1 stated as far as side effects it does make him feel sleepy after taking his meds. 3. R34's Admission Record documented an admission date of 2/2/24 and included diagnoses of generalized anxiety disorder and anxiety disorder unspecified. R34's Physician Order Sheet dated 3/12/26 documents an order for clonazepam 0.5mg tablet – take one tablet two times per day for anxiety. R34's most recent Care Plan documents a Focus area of being at risk for complications related to use of anxiety medications and antipsychotic medications (revised 11/12/24). Corresponding interventions for this focus area included to monitor for medication effectiveness dated 11/7/24; review medication potential side effects with resident and/or person in charge of health care decisions for informed consents dated 11/7/24; and reviewing for possible medication reductions dated 11/7/24. R34's MDS assessment dated 1/27/26 documents a BIMS score of 5, indicating R34 has severe cognitive impairment. This same MDS documents R34 is on an anxiety medication. R34's "Note to Attending Physician/Prescriber" with a MRR date of 11/10/25 documents resident receives the following medication used for anxiety: Clonazepam 0.5 mg two times daily. This form documents "Resident is due for an evaluation.	S9999					

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S9999	Continued from page 5 Please complete one of the following sections." Under this are three options, with the first being "1. Further dose reduction is clinically contraindicated due to:" with two selections underneath and space to document a rationale explaining the contraindication. The second option documents "2. Pharmacist recommended dose reduction to: Clonazepam 0.5 mg in the morning and 0.25 mg at bedtime" and the third option documenting "3. Gradual dose reduction (other)" with an area to specify a different reduction plan. This portion of the form is all blank with no options selected. At the bottom of the form is a space for the Physician/Prescriber response to select boxes to "Agree" or "Disagree" and a signature/date area below that. These areas are also blank with nothing selected and no physician/prescriber signature or date. R34's Psychiatry notes dated 1/13/26, 11/25/25, 10/28/25, 9/2/25, 7/31/25, 6/23/25, 5/1/25, 3/27/25 contained no acknowledgement or documentation of consideration for the gradual dose reduction recommendation for clonazepam. On 3/12/26 at 12:49 PM, V2 (Director of Nurses/DON) stated she could not find any documentation where the pharmacist's recommendations for R1's diazepam to have a gradual dose reduction were addressed in the comprehensive behavioral health service notes over the past year. V2 also stated she could not find where the pharmacist's recommendations for R34's clonazepam to have a gradual dose reduction were addressed in the comprehensive behavioral health service notes in the past year. V2 stated the recommendations for these GDR's should have been addressed by the psychiatric practitioner upon receiving the recommendation from the pharmacist. V2 stated she could give no explanation as to why the GDR's were not addressed by the psychiatric practitioner. The facility policy titled "Psychotropic Medication Use" with an approval date 02/2025 documents under the policy: Residents will only receive psychotropic medications when necessary to treat specific conditions for which that are indicated and effective. A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to antipsychotics, antidepressants, antianxiety, and hypnotics. Procedure: 1. Staff will complete the Psychoactive Medication Review assessment on admission, when any new psychotropic medication is ordered, with a change of condition, and quarterly. This assessment will be completed for any medication prescribed to manage behaviors... 3. Residents who are admitted from		S9999				

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S9999	Continued from page 6 the community or transferred from a hospital and who are already receiving psychotropic medications will be evaluated for the appropriateness and indications for use. The interdisciplinary team will:... 2. Re-evaluate the use of the psychotropic medication at the time of admission to consider whether the medication can be reduced, tapered, or discontinued per regulation. 3. Complete the Psychotropic Medication Review assessment in the EHR (electronic health record). 4. Based on assessing the resident's symptoms and overall situation, the medical practitioner will determine whether to continue, adjust, or stop existing psychotropiD ÖVF-6 F-öäà (B) 2 of 6 300.610a) 300.696b) 300.1210b) 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 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed. 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				

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S9999	Continued from page 7 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. This requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure infection control was maintained that was consistent with current standards of practice to prevent infection/cross contamination for 2 of 3 residents (R3 and R34) reviewed for infection control in the sample of 44. Findings Include: 1. R3's Admission Record dated 3/12/26 documents an admission date of 2/1/24 and included diagnoses of obstructive and reflex uropathy, urinary tract infection, and chronic kidney disease stage 3. R3's Physician Order Sheet dated 3/12/26 documents orders including but not limited to change (urinary catheter) every Sunday night dated 2/11/26; change (urinary catheter) monthly dated 2/11/26. R3's Minimum Data Set (MDS) assessment dated 2/14/26 documented a Brief Interview for Mental Status (BIMS) score of 4, indicating R3 has severe cognitive impairment. R3's MDS documents R3 is dependent for all activities of daily living (ADL's). R3's MDS documents R3 has a urinary catheter placed and R3 is always incontinent of bowel. On 3/10/2026 at 10:33 AM, foley catheter care was provided to R3 by V7 (Certified Nurse Aide/CAN) and assisted by V6 (CNA). V7 and V6 applied personal protective equipment according to Enhanced Barrier Precautions. Privacy was provided for R3. V7 explained the procedure to R3. V7 then cleansed the perineal area using wet wash cloths and no rinse wash. V7 then performed a glove change but did not perform hand hygiene between glove changes. V7 then cleansed Foley catheter itself in the same fashion as the perineal area beginning closest to the body and moving away. V7 then performed another glove change but there was no hand hygiene performed between glove changes. V7 then patted dry R3 with a towel. On 3/10/2026 at 10:41 AM, when questioned, V7 stated yes, she should have performed hand hygiene between glove changes using an alcohol-based hand sanitizer to help prevent infections. 2. R34's Admission Record dated 3/12/26 documented an	S9999					

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S9999	Continued from page 8 admission date of 2/2/24 and included diagnoses of neuroleptic induced Parkinsonism, schizoaffective disorder, and generalized anxiety disorder. R34's most recent Care Plan documented a Focus area for bowel and bladder, indicating she is at risk for complications with bowel and bladder related to current medical/physical status dated 12/11/24. Interventions for this focus area included incontinence care to be provided with each incontinence episode dated 12/11/24. R34's most recent MDS assessment dated 1/27/26 documents R34 has a BIMS score of 5, indicating severe cognitive impairment. This same MDS documents R34 is dependent for all her ADLs including toileting hygiene and R34 is always incontinent of bowel and bladder. On 3/10/2026 at 10:05 AM, V8 (CNA) provided incontinence care to R34. V8 assisted R34 into the restroom, providing privacy by closing the door. V8 donned gloves as appropriate and assisted R34 with getting her pants down and sitting down on the toilet. V8 removed R34's soiled pants and placed them directly on the floor. V8 then removed R34's soiled brief and placed it directly on the floor. V8 then provided incontinence care to R34 using appropriate hand hygiene and glove changes, but V8 then placed dirty wash cloths used to clean R34's perineum directly on the floor. After care was provided and R34 was reclothed, V8 placed R34's soiled clothing and wash cloths in one bag and the soiled brief in the trash. On 3/10/2026 at 10:47 AM, V8, stated she should have placed the dirty clothing, washcloths, and brief directly into bags versus on the bare floor of the restroom. On 3/12/2026 at 12:49 PM, V2 (Director of Nurses/DON), who is also the Infection Preventionist, stated hand hygiene with an alcohol-based hand sanitizer should be used between glove changes when performing (urinary catheter) care. When asked about where soiled clothing and incontinence briefs should go immediately upon being removed from the resident's' person, V2 stated they should be placed in a plastic bag for transportation to either laundry or the trash. V2 stated soiled clothing or incontinence briefs should not be placed directly on the floor of the resident's room or bathroom. The facility's Infection Control Policy dated 2019 documents Standard Precautions should be utilized during any manipulation of the foley catheter or the collection system. Same policy documents, "Hand hygiene	S9999					

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S9999	Continued from page 9 is performed immediately after any manipulation of or contact with the catheter site, catheter, tubing, drainage bag, or emptying container, even when gloves were worn." (B) 3 of 6 300.3060a)1) Section 300.3060 Nursing Unit a) General Requirements for Bedrooms 1) Single resident bedrooms shall contain at least 100 square feet of usable floor area. Multiple resident bedrooms shall contain at least 80 square feet per bed of usable floor area. This requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide at least 80 square feet of living space for 4 (R21, R31, R34 and R45) of 4 residents reviewed for room size in a sample of 44. Findings include: On 3/10/2026 at 3:15pm, V11 (Maintenance Director) accompanied by this surveyor, measured R21 and R45's room with a measuring tape. The room measured 11 feet 9 inches by 12 feet 7 inches, total square feet=151.13 (75.57 square feet per resident bed). The room contained 2 beds, 2 nightstands, personal items, a recliner and an inset dresser. The measurements did not include the inset dresser area. On 3/10/2026 at 3:45pm, R21 said her room size was ok and had no complaints about her room size. R45 is not reliably interviewable and when asked did not offer any complaints concerning her room size. On 3/10/2026 at 3:20pm, V11 accompanied by this surveyor measured R31 and R34's room with a measuring tape. The room measured 12 feet 3 inches by 11 feet 9 inches, total square feet = 146.37 (73.19 square feet per resident bed). The room contained 2 beds, 2 nightstands, personal items, 1 inset dresser and 1 additional dresser. The measurement did not include the inset dresser area. On 3/10/2026 at 4:00pm, R31 said she was pleased with	S9999					

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S9999	Continued from page 10 her room and had no complaints about her room size. R34 is not reliably interviewable and when asked did not offer any complaints about her room size. On 3/11/2026 at 9:30am, V1 (Administrator) said rooms 1-18, 20-25 and rooms 30-33 were all waived rooms. V1 said these rooms were all dually certified and double occupancy rooms and did not meet the 80 square feet per resident bed requirements. A facility matrix provided by the facility on 3/9/2026 documents R21, R31, R34 and R45 reside in the rooms observed and measured by V11. Inquiries made regarding the size of the waived rooms during the survey from 3/9/26 to 3/12/26 found no concerns or negative interviews from residents or families of residents who reside in the waived rooms. Review of 6 months of Resident Council meeting minutes indicated no concerns related to the size of the waived rooms. (C) 4 of 6 300.610a) 300.3300e) 300.3300g) 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 300.3300 Transfer or Discharge e) For transfer or discharge made under subsection (d), the notice of transfer or discharge shall be made as soon as practicable before the transfer or discharge.	S9999					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 3001056		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/12/2026	
NAME OF PROVIDER OR SUPPLIER Benton Rehabilitation and Health Care Center				STREET ADDRESS, CITY, STATE, ZIP CODE 1409 NORTH MAIN STREET PO BOX 847, BENTON, Illinois, 62812			
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S9999	Continued from page 11 The notice required by subsection (d) shall be on a form prescribed by the Department and shall contain all of the following: 1) The stated reason for the proposed transfer or discharge; (Section 3-403(a) of the Act) 2) The effective date of the proposed transfer or discharge; (Section 3-403(b) of the Act) g) A copy of the notice required by subsection (d)(1) of this Section and Section 3-402 of the Act shall be placed in the resident's clinical record and a copy shall be transmitted to the Department, the State Long-Term Care Ombudsman, the resident, and the resident's representative. (Section 3-405 of the Act) This requirement is not met as evidenced by: Based on interview and record review, the facility failed to send a bed hold notification with residents upon transfer and failed to send a bed hold notification to family/representative for 3 (R5, R17 and R25) of 3 residents reviewed for discharge process in the sample of 44. The findings include: 1. R25's Admission Record documents an admission date of 05/09/25 and included diagnoses of COPD (Chronic obstructive pulmonary disease) and hemiplegia and hemiparesis following cerebral infarction. R25's Minimum Data Set (MDS) dated 02/12/26 documents a Brief Interview for Mental Status (BIMS) score of 15, indicating R25 is cognitively intact. R25's Care Plan with a date initiated of 05/21/25 documents a focus area of Respiratory: dx (Diagnosis) COPD and ADL (Activities of Daily Living) actual/at risk and/or potential for complications with deficit's with ADL's r/t (related to) current medical/physical status has meds/dx that can/may affect ADL's hemiplegia/hemiparesis. R25's Progress Note dated 12/13/25 at 10:58AM by V16 (Licensed Practical Nurse/LPN) documents "Resident complaining of being short of breath, requesting to go to emergency room. Lung sounds wheezing and crackles in bilateral lungs. Having a difficult time walking, stumbling more than usual. Using accessory muscles to breathe. EMS (Emergency Medical Services) called and left with resident at this time. Report called to (local hospital). Resident is own POA (power of attorney) and has no emergency contacts." There is no documentation in R5's record to indicate a bed hold notification was provided for the 12/13/25		S9999				

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S9999	Continued from page 12 hospitalization. On 03/11/26 at 1:53PM, R25 stated that he didn't receive a bed hold notification on 12/13/25 when he was sent out to the hospital. R25 stated that the nurses "didn't give him s**t" when he was sent out to the hospital. 2. R5's most recent Admission Record documented an admission date of 12/12/25 and included diagnoses of cerebral infarction, primary hypertension and muscle wasting and atrophy. R5's most recent physician order sheet dated 3/12/26 documents an order to send R5 to the local emergency room for evaluation and treatment dated 12/13/25. R5's most recent MDS assessment dated 1/8/26 documents R5 has a BIMS score of 15, indicating R5 is cognitively intact. R5's Progress Notes dated 12/13/25, 12/16/25 and 12/29/25 all document instances in which R5 was sent out to the hospital. The 12/13/25 and 12/29/26 progress notes were documented by V16 (Licensed Practical Nurse/LPN) and the 12/16/25 progress note was documented by V13 (Registered Nurse/RN). None of these progress notes document a bed hold policy was given to R5 before transferring out of the facility. On 3/11/26 at 1:48 PM, R5 stated she could not remember if she had received a bed hold policy form on the dates she went to the emergency room for treatment. On 03/12/26 at 11:46 AM, V16 stated she did not remember sending the bed hold policy copy with R5 when she was sent to the hospital on the dates of 12/13/25 and 12/29/25, nor for R25 when he was sent to the hospital on 12/13/25. V16 stated the reason she did not send one with the residents on those dates was because she had either forgotten she was supposed to do it upon transfer or had never been instructed to do it to begin with. V16 stated she knows to do it going forward because V1 (Administrator) had sent out a group text to all the nurses and done an in-service yesterday, 3/11/26 instructing all nurses going forward to send a bed hold policy with residents, and a copy is to be made for the chart. On 03/12/26 at 11:04AM, V13 (Registered Nurse/RN) stated normally they do a bed hold when they send a resident to the hospital if they have time. V13 said it also depends on if they have bed hold notifications available at the nurse's station to send out with the		S9999				

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S9999	Continued from page 13 resident when they go to the hospital. V13 stated she doesn't make a copy of the bed hold policy she sends when they do send a bed hold notification with the resident. V13 stated when she sent R5 out, she did not send a bed hold out with R5 because it was an emergency. V13 said sometimes you just don't have time to get a bed hold notification done to be able to send out with the resident especially when you have an emergency. 3. R17's most recent Admission Record dated 3/12/26 documented an initial admission date of 2/1/24 and included diagnoses of chronic obstructive pulmonary disease and type II diabetes. R17's most recent MDS assessment dated 2/7/26 documents R17 has a BIMS score of 10, indicating moderate cognitive impairment. R17's Progress Note dated 11/18/25 by V15 (LPN) documented R17 was sent to the local emergency room via emergency medical services for treatment. There is no documentation to indicate a bed hold notification was provided to R17 upon transfer. On 3/12/26 at 8:58 AM, R17 stated she could not remember whether she received a bed hold notification form on 11/18/25 before being transferred to the local emergency room. On 03/12/26 at 11:38 AM, V15 (LPN) stated she does remember sending R17 to the local hospital in November 2025 but none of the details as to why. V15 stated she knows she didn't send a bed hold policy with R17 because ever since the facility has switched to electronic charting, the nursing staff have not had any copies of the bed hold policy at the nurses' desk to send with the residents. V15 stated when she did have them to send, she gave the bed hold policy to emergency medical services personnel instead of the resident to take with the resident to the hospital but did not give it directly to the resident. On 03/12/26 at 11:06AM, V14 (RN) stated she always tried to send a bed hold notification every time she sent a resident to the hospital. V14 said she doesn't think she has missed any of the bed holds when she has sent out a resident. V14 said most of the time she isn't the one sending out the residents, she is the one getting the paperwork ready. V14 said they usually have the bed hold notifications available at the nurse's station to send out with the resident. V14 stated they never made any copies of the bed holds they sent with EMS when they sent the residents out. V14 said she		S9999				

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S9999	Continued from page 14 doesn't give the resident the bed hold she just puts it in the paperwork that they send with EMS. On 03/11/26 at 1:03PM, V1 (Administrator) stated when a resident is sent out to the hospital, they should be sending a bed hold notification form with them. V1 said she doesn't have any proof they sent a bed hold notification form out with the residents they have sent to the hospital. V1 said the nurses should be making a copy of the bed hold notification form they send with the resident to the hospital. V1 said they haven't sent any copies of the bed hold notification forms to the family/representatives because they don't have the copies to send since the nurse never made one at the time of discharge to the hospital. V1 said the nurses should be contacting the family/representative about the bed hold policy if the resident wasn't cognitively intact. V1 said they should be letting every resident know about the bed hold policy even if they aren't cognitively intact. V1 said they should be charting if/when they sent the bed hold policy with the resident as well as notifying the family/representative about the bed hold and of the resident being sent out to the hospital. V1 said with the new company, the bed hold policy is different then what they previously had. V1 said that the new policy is more detailed. V1 said she is already doing in-services with the nurses, and she sent out a mass message notifying the nurses of the new bed hold policy and already put the new form and policy up at the nurses station. V1 said she also gave the nurses copies of the forms. V1 said the nurses were not doing the previous bed hold policy correctly because she never found any copies of any of the bed holds, they sent out with the resident or to the family/representative. The policy titled "Bed Hold Policy and Agreement Form" with a revised date of 2/2014 documents under purpose: To establish policy and procedure for facility to notify the resident/responsible party of the Bed Hold Policy and Agreement to pay charges for bed hold. The facility is to execute an acknowledgement stating whether or not such resident desires to exercise his or her right to a bed hold. The policy should meet applicable regulatory, federal and state program guidelines. (C) 5 of 6 300.610a) 300.1210d)6)	S9999					

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S9999	Continued from page 15 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 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: 6) All necessary precautions shall be taken to ensure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. This requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to complete an assessment for smoking safety for 1 (R8) of 1 resident reviewed for accidents in a sample of 44. Findings Include: 1. R8's Admission Record documented an admission date of 02/01/24 and included diagnoses of personal history of TIA (Transient Ischemic Attack) , Alcohol abuse, chronic obstructive pulmonary disease, vascular disease, and other chronic pain. R8's Minimum Data Set (MDS) assessment dated 01/12/26 documented Brief Interview for Mental Status (BIMS) score of 12, indicating R8 has moderate cognitive impairment. R8's Care Plan with a date initiated of 2/18/25 documents a focus area of: Smoking at risk for complication/injuries r/t (related to) smoking/tobacco/nicotine use with interventions of	S9999					

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S9999	Continued from page 16 assess for safe smoking/tobacco/nicotine use practices upon Admission, Quarterly, SCC (Significant Condition Change) and PRN (as needed) as indicated. R8's electronic medical records document a Safe Smoking Screening assessment completed on 01/17/25. No other Safe Smoking Screening Assessments were found in R8's record until one was completed on 03/10/26. On 03/09/26 at 10:08AM, R8 stated he is a smoker. R8 stated he has never burned himself while smoking and said staff always goes out with him when he goes out to smoke. R8 said staff keep his cigarettes and lighter locked up and give them to him when he goes out to smoke. On 03/10/26 at 9:30AM, V1 (Administrator) stated according to their smoking policy a smoking assessment should be done quarterly. V1 said she was going to let V9 (Activity Director) know that smoking assessments are to be done quarterly and ensure they have the assessments done quarterly on all residents. V1 said they will make sure R8 has another assessment done other than the one that was completed on 01/17/25. V1 stated she was not able to find any other assessments on safe smoking for R8 other than the one completed on 01/17/25. On 03/10/26 at 9:32AM, V1 (Administrator) handed V9 (Activity Director) the smoking policy and told V9 today when she takes the resident to smoke, to take her laptop out with her and do a smoking assessment on all the residents that smoke, including R8. On 03/10/26 at 9:34AM, V9 (Activity Director) stated she thought she had done a smoking assessment recently on R8. V9 stated when she looked through the assessments, she couldn't find any other safe smoking assessment on R8 other than the one that was done on 01/17/25. V9 said she didn't remember if the safe smoking assessments needed to be done quarterly or annually. V9 said she did do a smoking assessment on R8 recently but doesn't know where the assessment went to. V9 said she is going to do a new safe smoking assessment "today" on R8 and on all the residents just to make sure they are all up to date and in the electronic health record. V9 said she hasn't had any problems with R8 not being a safe smoker and she takes the residents out often to smoke. V9 said she observes all the residents when they smoke and hands out their cigarettes and lighters. On 03/10/26 at 10:33AM, R8 was outside smoking. R8 was able to hold and light his cigarette without any		S9999				

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S9999	Continued from page 17 problem. R8 kept his cigarette over the ashtray when he wasn't smoking the cigarette. R8 appeared to be able to smoke safely without any problem. The facility's "Smoking Policy Residents" documents policy: any resident that expresses an interest to smoke will be assessed at the time of admission and at least quarterly or with any significant change to determine the level of assistance and supervision that will be needed to ensure the resident's safety. Based on the assessment findings, the resident's plan of care will be revised to reflect the level of assistance and any assistive devices that will be needed by the resident to enable the resident's safety. Residents or their representative must provide all smoking materials (Cigarettes, pipes, cigars, lighters, etc.) Smoking materials must be secured at the nurses' station when not in use. All residents will be supervised when they smoke. Residents must smoke in designated smoking area. Residents may not use vaping devices or e cigarettes at any time. (C) 6 of 6 300.1210a) 300.1210b)3) 300.1210c) Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable	S9999					

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S9999	Continued from page 18 physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. This requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop a plan of care for indwelling urinary catheter use for 1 (R3) of 16 residents reviewed for care plan development in the sample of 44. Findings include: R3's Admission Record dated 3/12/26 documented an admission date of 2/1/24 and included diagnoses of obstructive and reflex uropathy, urinary tract infection, and chronic kidney disease stage 3. R3's Physician Order Sheet dated 3/12/26 documents the following orders: change (urinary catheter) every Sunday night dated 2/11/26; change (urinary catheter) monthly dated 2/11/26. R3's Minimum Data Set (MDS) assessment dated 2/14/26 documented a Brief Interview for Mental Status (BIMS) score of 4, indicating R3 has severe cognitive impairment. The same MDS documents R3 is dependent for all Activities of Daily Living (ADL's), has a urinary catheter placed, and is always incontinent of bowel. R3's Care Plan with most recent revision date of 3/2/26 does not mention a focus area for care or maintenance of a urinary catheter.		S9999				

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S9999	Continued from page 19 On 3/10/2026 at 10:33 AM, this surveyor observed R3 had a urinary catheter in place. On 3/10/2026 at 11:18 AM, V5 (MDS and Care Plan Coordinator) stated (urinary catheters) and their care should be care planned. V5 reviewed R3's care plan with this surveyor present and verified there was no care plan focus area for urinary catheter care. V5 stated if urinary catheters are not care planned it could be a liability in case a new Certified Nurse Aide or nurse had questions as to what interventions were needed or expected for catheter care. V5 stated the care plan tells the entire story of the resident's care needed, including what appliances they are using and care needed for them. V5 stated she could not provide a reason R3's urinary catheter was not care planned except she splits her work time between two different facilities making it difficult to keep up with care plan and MDS updates for all the residents at both facilities. On 3/12/2026 at 12:49 PM, V2 (Director of Nurses/DON), stated yes, urinary catheters and their care should be care planned so all staff members know what kind of care to provide for the resident affected. (B)		S9999				