STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of the Willows	1000 Elizabeth Dr Valparaiso, IN 46383

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, record review, and interview, the facility failed to ensure a resident's dignity was maintained related to the resident's back side being exposed while in the hallway for 1 of 1 resident reviewed for dignity. (Resident 24)Finding includes:During a random observation on 1/22/26 at 2:12 p.m., Resident 24 was observed sitting in a shower chair in the doorway of his room. The resident was wearing a hospital gown that was open in the back. The resident's backside, including his buttocks were exposed and visible. CNA 1 was observed wheeling the resident out of his room and down the hallway into a shower room. There were a few other residents who were sitting in the hallway who could observe the resident being wheeled down the hallway with his buttocks visible. The CNA did not cover the resident with any other clothing or a blanket before wheeling him down the hallway.Record review for Resident 24 was completed on 1/22/26 at 2:15 p.m. Diagnoses included, but were not limited to, anemia, heart failure, and hypertension.The Quarterly Minimum Data Set (MDS) assessment, dated 12/24/25, indicated the resident was severely cognitively impaired.During an interview on 1/22/26 at 2:24 p.m., CNA 1 indicated she should have covered the resident up before transporting him down the hallway so his buttocks were not exposed.During an interview on 1/22/26 at 2:26 p.m., the Assistant Director of Nursing (ADON) indicated the CNA should have covered the resident up before transporting him down the hallway.3.1-3(t)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. Based on record review and interview, the facility failed to ensure a resident and the resident's representative were informed of a change in treatment related to psychotropic medication for 1 of 5 residents reviewed for unnecessary medications. (Resident 48) Finding includes: Record review for Resident 48 was completed on 1/22/2 at 9:38 a.m. Diagnoses included, but were not limited to, insomnia, anemia, heart failure, end stage renal disease, and respiratory failure.The admission Minimum Data Set (MDS) assessment, dated 10/29/25, indicated the resident was moderately cognitively impaired. The resident received an antidepressant medication.A Health Status Note, dated 10/25/25 at 9:02 p.m., indicated the resident was requesting a sleep aid. The physician and resident representative were informed. The physician ordered trazodone (antidepressant medication) 50 mg (milligrams), 1 tab every night.The January 2026 Physician's Order Summary (POS) indicated an order for trazodone 50 mg, give 2 tablets at bedtime for insomnia. The record lacked any documentation the resident and the resident's representative were informed when the antidepressant medication had been increased.During an interview on 1/22/26 at 3:28 p.m., the Infection Preventionist/Wound Nurse indicated the resident had been having increased problems sleeping at night. The physician had ordered to increase the trazodone. She was unaware if the resident and the resident's representative were informed of the increase in dosage of the medication.During an interview on 1/27/26 at 10:25 a.m., the Director of Nursing (DON) indicated she could not provide any documentation the resident and the resident's representative were informed the trazodone was increased. 3.1-3(n)(2)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, record review and interview, the facility failed to develop and implement a care plan related to a tracheostomy stoma site for 1 of 4 residents reviewed for respiratory care. (Resident 10) Finding includes:During an interview and observation on 1/20/26 at 11:31 a.m., Resident 10 indicated he was unable to speak and used a whiteboard for communication as he had a tracheostomy stoma site. He indicated he did the care for the stoma site himself every day. The stoma site appeared clean upon observation. Resident 10's record was reviewed on 1/21/26 at 11:29 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, respiratory failure, and history of cancer of larynx. The admission Minimum Data Set assessment, dated 11/6/25, indicated the resident was cognitively intact and received tracheostomy care while a resident. A Physician's Order, dated 10/31/25, indicated tracheostomy stoma care completed per resident daily and as needed. Monitor for signs and symptoms of infection or skin irritation every shift. Monitor for discoloration of sputum along with respiratory status and notify the physician of any significant changes. The record lacked any care plans related to the resident's tracheostomy stoma site. During an interview on 1/27/26 at 3:15 p.m., the Director of Nursing indicated the stoma site should have been included in the resident's care plan. 3.1-35(a)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. Based on observation, record review, and interview, the facility failed to obtain orders and document treatment changes for a non-pressure skin condition for 1 of 2 residents reviewed for non-pressure skin conditions. (Resident 10)Finding includes:During an interview and observation on 1/20/26 at 11:31 a.m., Resident 10 indicated he had screws coming out of his right elbow and he was awaiting surgery to correct it. He indicated the staff changed the bandage for him. Resident 10's record was reviewed on 1/21/26 at 11:29 a.m. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, respiratory failure, and history of cancer of larynx. The admission Minimum Data Set assessment, dated 11/6/25, indicated the resident was cognitively intact, had an impairment with range of motion on one side of the upper extremity. He had surgical wound(s) that required surgical wound care and application of nonsurgical dressings other than to his feet. A Care Plan, dated 10/31/25, indicated the resident had actual impairment to the right elbow with hardware showing from a surgical site. Interventions included, but were not limited to, follow facility protocols for treatment of injury and weekly treatment documentation. A Physician's Order, initiated on 10/31/25 and discontinued on 12/13/25, indicated cleanse the right posterior upper arm surgical wound with normal saline, pat dry, apply Hydrofera Blue (antimicrobial foam dressing) to fit the wound and cover with a foam dressing three times weekly and as needed for soilage or dislodgement. A Physician's Order, dated 1/20/26 at 1:33 p.m., indicated cleanse the right elbow surgical wound with normal saline, pat dry, apply Hydrofera Blue to fit the wound and cover with a foam dressing three times weekly (day shift on Monday, Wednesday, and Friday) and as needed for soilage or dislodgement. Wound Observation Tools, dated 12/8/25, 12/15/25, 12/22/25, 12/29/25, 1/5/26, and 1/20/26, indicated the resident had a right posterior upper arm surgical wound dehiscence (closed wound reopens) with no drainage measuring 1.5 centimeters (cm) long by 1.2 cm wide by 0.2 cm deep. There was 100% necrotic tissue and hardware was exposed. The treatment plan was Hydrofera blue and dry dressing. There were no physician's orders for treatment and no documented treatments on the Treatment Administration Record (TAR) for the right elbow wound from 12/13/25 to 1/20/26. During an interview on 1/23/26 at 3:20 p.m., the Wound Care Nurse/Infection Preventionist indicated the resident received wound care three times a week. The order had been discontinued in December 2025, but she was not sure why it was discontinued. She indicated that she had been providing wound treatments three times a week. During an interview on 1/27/26 at 3:15 p.m., the Director of Nursing indicated she had no further information to provide. 3.1-37(a)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, record review, and interview, the facility failed to provide treatment for limited range of motion related to a palm protector not in place for 1 of 1 resident reviewed for range of motion (ROM). (Resident 4)Finding includes:On 1/20/26 at 11:49 a.m., Resident 4 was observed lying in bed. Her left hand was in a fist and there was no palm protector in place. On 1/21/26 at 10:23 a.m., Resident 4 was observed lying in bed. Her left hand was in a fist and there was no palm protector in place. On 1/22/26 at 8:57 a.m., Resident 4 was observed lying in bed. Her left hand was in a fist and there was no palm protector in place. The resident's record was reviewed on 1/22/26 at 10:19 a.m. Diagnoses included, but were not limited to, type two diabetes mellitus, dementia with behavioral disturbance, and contracture of the left hand.The Quarterly Minimum Data Set (MDS) assessment, dated 12/24/25, indicated the resident was cognitively impaired and had impaired ROM to the upper and lower extremities on both sides.A Care Plan, updated 10/10/24, indicated the resident had left sided hemiparesis and was at risk for contractures. The interventions included, left palm protector.A Physician's Order, dated 1/7/25, indicated left palm protector as tolerated, check placement and skin under palm protector every shift.The Medication Administration Record and the Treatment Administration Record, dated 1/2026, indicated the left-hand palm protector had been in place as ordered. There were no documented refusals.During an interview on 1/22/26 at 4:15 p.m., the Director of Nursing and the Administrator were made aware the palm protector had not been in place as ordered. No further information was provided.3.1-42(a)(2)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure safety was maintained related to smoking safety interventions, a smoking assessment, and fall interventions not in place for 3 of 7 residents reviewed for accidents (Residents 6, 38, and 3)Findings include:1. On 1/20/26 at 3:56 p.m. Resident 6 was observed outside smoking with staff supervision. The resident was not wearing a smoking apron. On 1/21/26 at 9:06 a.m. Resident 6 was observed outside smoking with staff supervision. The resident was not wearing a smoking apron. Record review for Resident 6 was completed on 1/22/26 at 9:21 a.m. Diagnoses included, but were not limited to, type two diabetes mellitus, vascular dementia, and major depressive disorder. The Quarterly Minimum Data Set (MDS) assessment, dated 12/18/25, indicated the resident was cognitively impaired. A Care Plan, updated 10/23/25, indicated the resident was a smoker and had a smoking incident that caused an injury on 10/20/25. An intervention, dated 10/20/25, indicated to ensure the resident had a smoking apron on at all times during smoking time. A Behavior Note, dated 10/20/25 at 4:17 p.m., indicated staff had taken the resident outside to smoke. The resident went to light her cigarette and caught a pom pom on fire. The item was on the resident briefly before she was able to toss it off of her. A singed area was noted to the top of the resident's left hand and a small area of red irritation was noted to left ring finger. A Progress Note, dated 10/20/25 at 7:25 p.m., indicated staff had taken the resident outside to smoke. As the resident went to light her cigarette, a tissue paper origami pom pom caught on fire. The resident began to swat herself and the inflamed item fell to the ground and fire was put out. Some hair was singed off the resident's left hand and a small red area to the left ring finger was noted. The resident's responsible party, the Nurse Practitioner, and Director of Nursing were made aware. A Smoking Safety Evaluation, dated 11/8/25, indicated the resident exhibited poor safety awareness when smoking and interventions must be put in place to promote smoking safety. During an interview on 1/22/26 at 4:15 p.m., the Director of Nursing and the Administrator were made aware the resident had not been using a smoking apron. No further information was provided. A facility policy, titled Smoking Use Protocol, indicated, .Residents who desire to use tobacco and or e-cigarettes will only be permitted to do so based on clinical assessment and are deemed safe to do so.Residents desiring to smoke must utilize safety equipment as deemed necessary by smoking assessment such as smoking aprons, etc. Failure to comply with the utilization of safety equipment, as necessary, will be deemed a violation of this protocol . 2. During an interview on 1/20/26 at 4:11 p.m., Resident 38 indicated he was a smoker, but was trying to quit. He had just returned inside from going out to smoke. During an interview on 1/21/26 at 9:30 a.m., Resident 38 indicated he had just returned to his room (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	from being outside smoking. Resident 38's record was reviewed on 1/23/26 at 9:03 a.m. Diagnoses included, but were not limited to, cognitive communication deficit and personal history of mental and behavioral disorders. The resident admitted to the facility on [DATE]. The admission Minimum Data Set (MDS) assessment, dated 1/8/26, indicated the resident was moderately cognitively impaired. A Communication Note, dated 1/8/26 at 12:31 p.m., indicated the smoking policy had been discussed with the resident and the resident signed the policy form. A Care Plan, dated 1/6/26, indicated the resident was at risk for respiratory illness related to being an active smoker. There was no Smoking Safety Evaluation completed for the resident. During an interview on 1/27/26 at 3:15 p.m., the Director of Nursing indicated a smoking assessment had not been completed yet as they were not currently going out to smoke due to the cold weather, so they could not assess him while he was out smoking. It was missed upon admission. 3. Resident 3 was observed on 1/20/26 at 2:37 p.m., 1/22/26 at 10:12 a.m., and 1/23/26 at 10:12 a.m., sitting up in a Broda chair. She had a large discoloration noted to her forehead. Resident 3's record was reviewed on 1/23/26 at 10:18 a.m. Diagnoses included, but were not limited to, non-traumatic brain dysfunction, senile degeneration of brain, stroke, and non-Alzheimer's dementia. The Quarterly Minimum Data Set (MDS) assessment, dated 1/2/26, indicated the resident was severely cognitively impaired and was on hospice care. She was dependent on staff for toileting hygiene, shower/bathe, and transfers and required substantial/maximal assistance for bed mobility and eating. She had two or more falls with no major injuries. A Care Plan, dated 7/12/24, indicated the resident was at risk for falls related to dependence for activities of daily living (ADL) care, diagnoses of dementia, psychotics, depression, and anxiety, and antianxiety and antidepressant medication use. Interventions included, but were not limited to, (updated 8/26/25), Resident to be removed from the dining room when meals are not going on and placed in common areas such as nurses station or TV room. A Care Plan, dated 9/22/25, indicated the resident had actual falls with no injury on 9/21/25, 9/28/25, 10/2/25, 11/3/25, 11/25/25, 12/13/25, 1/15/26, and 1/19/26. The fall on 1/19/26 resulted in hematoma/laceration (head trauma) to the left side forehead. Interventions included, but were not limited to, assess resident's needs and meet in a timely manner, increase monitoring while in wheelchair and reposition as needed, and increase assistance during at high-risk times (dinner, early morning, and sundowners). An Event Note, dated 1/19/26 at 8:00 p.m., indicated the resident was in the dining room and the CNA was making her way back to the dining room from down the hall and found the resident in the dining room on the floor at 7:15 p.m. The CNA called another staff member into the dining room, where the (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	resident was found lying on the floor in front of the wheelchair. One other resident was in the dining room but did not notice the resident's fall. No other people were in the room. The CNA stated she had just walked out to answer the call light, and upon return found the resident on the floor. The resident was not fidgeting in the wheelchair prior to the CNA leaving the room, but the resident did have a witnessed fall earlier in the day from her wheelchair. The resident had a laceration to the left side of her forehead with moderate amount of blood on the floor. A head-to-toe assessment was completed and there was a 3.0 centimeter by 0.2 centimeter laceration to her left side forehead. A pressure dressing was applied to stop the bleeding, which was successful. Neurochecks were initiated. 911 was called. Hospice was notified as well as the resident's family, Physician, the Director of Nursing and the Executive Director. An Event Note, dated 1/19/26 at 10:05 p.m., indicated the resident arrived back to the facility at 9:50 p.m. The resident had glue placed on the laceration and the hematoma was drained. New orders were received to keep the laceration clean and open to air. During an interview on 1/23/26 at 3:54 p.m., the Director of Nursing indicated the resident was not supposed to be left unattended in the dining room. 3.1-45(a)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, record review, and interview, the facility failed to ensure a resident with a gastrostomy tube (g-tube, the surgical insertion of a feeding tube) received the appropriate treatment related to administration of the tube feeding for 1 of 1 resident reviewed for tube feedings. (Resident 4)Finding includes: On 1/21/26 at 10:23 a.m., Resident 4 was observed lying in her bed. The tube feeding was not connected to the resident's g-tube and the pump was off.On 1/22/26 at 8:57 a.m., Resident 4 was observed lying in her bed. The tube feeding was not connected to the resident's g-tube and the pump was off.The resident's record was reviewed on 1/22/26 at 10:19 a.m. Diagnoses included, but were not limited to, type two diabetes mellitus, dementia with behavioral disturbance, and contracture of the left hand.The Quarterly Minimum Data Set (MDS) assessment, dated 12/24/25, indicated the resident was cognitively impaired and received the majority of their nutrition by tube feeding.A Care Plan, updated 4/3/25, indicated the resident had dysphagia and a g-tube was in place to ensure adequate nutrition and hydration were received. The interventions included, nutrition and hydration via g-tube as ordered.A Physician's Order, dated 12/23/25, indicated the resident was to receive Glucerna 1.5 at 50 cubic centimeters (cc) per hour for 18 hours, on at 6 p.m. and off at 12 p.m. daily.The Medication Administration Record (MAR), dated 1/2026, indicated the tube feeding had been administered as ordered.During an interview on 1/22/26 at 4:15 p.m., the Director of Nursing and the Administrator were made aware the tube feeding had not been administered as ordered. No further information was provided.3.1-44(a)(2)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, record review and interview, the facility failed to ensure residents received the necessary care and treatment related to oxygen administration for 2 of 4 residents reviewed for respiratory care. (Residents 51 and 74) Findings include:1.On 1/21/26 at 9:23 a.m., Resident 51 was observed in bed. She had a nasal cannula sitting next to her head. She had indicated she was not feeling well at the time and was coughing. The concentrator was set to 4 liters per minute. On 1/21/26 at 2:50 p.m., Resident 51 was observed in bed with no nasal cannula in place. On 1/22/26 at 9:53 a.m., Resident 51 was observed sitting in bed with no nasal cannula in place. On 1/23/26 at 10:12 a.m., Resident 51 was observed in bed with no nasal cannula in place. Resident 51's record was reviewed on 1/22/26 at 2:25 p.m. Diagnoses included, but were not limited to, heart failure, dementia, and respiratory failure. The Quarterly Minimum Data Set (MDS) assessment, dated 12/24/25, indicated the resident was cognitively intact. A Physician's Order, dated 1/17/26, indicated oxygen at 4 liters per minute continuously per nasal cannula. During an interview on 1/27/26 at 3:15 p.m., the Director of Nursing indicated she had no further information to provide. 2. On 1/22/26 at 2:29 p.m. and 1/23/26 at 10:12 a.m., Resident 74 was observed in bed. He had oxygen via nasal cannula at 2.5 liters per minute. Resident 74's record was reviewed on 1/27/26 at 1:19 p.m. Diagnoses included, but were not limited to, neurocognitive disorder with Lewy Bodies, schizophrenia, and chronic obstructive pulmonary disease. The admission Minimum Data Set (MDS) assessment, dated 1/21/26, indicated the resident was severely cognitively impaired and he received oxygen. The current January 2026 Physician Order Summary indicated oxygen at 3 liters per minute continuously via nasal cannula. A Care Plan, dated 1/16/26, indicated the resident had oxygen therapy related to ineffective gas exchange. Interventions included, but were not limited to, give medications as ordered by the physician, oxygen via nasal cannula at 3 liters per minute continuously with humidity as needed. During an interview on 1/27/26 at 3:15 p.m., the Director of Nursing indicated the family had been problematic with care and would change settings on the oxygen concentrator. She would provide the family with further education. 3.1-47(a)(6)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on record review and interview, the facility failed to ensure weights were being checked and monitored for a resident who received medications for heart failure and failed to ensure medication was not administered in an excessive dose for 1 of 5 residents reviewed for unnecessary medications and 1 of 1 resident reviewed for pain. (Residents 48 and 75)Findings include:1. Record review for Resident 48 was completed on 1/22/2 at 9:38 a.m. Diagnoses included, but were not limited to, insomnia, anemia, heart failure, end stage renal disease, and respiratory failure. The admission Minimum Data Set (MDS) assessment, dated 10/29/25, indicated the resident was moderately cognitively impaired. The resident received diuretic medication. A Care Plan, dated 10/29/25, indicated the resident had fluid overload or potential fluid volume overload related to chronic heart failure. Interventions included administer medications as ordered, observe and report sudden weight gain, and to weigh at the same time of day as ordered by the physician. The January 2026 Physician's Order Summary (POS) indicated the following orders:- Lasix (diuretic medication) 20 mg (milligrams), give 1 table every day related to heart failure- potassium chloride extended release (to lower potassium) 10 meq (milliequivalents), give 2 tablets every day related to heart failure- weights every Monday, Wednesday, and Friday related to heart failure. Call the physician for a greater than 3 pound weight gain. The January 2026 Medication Administration Record (MAR) indicated the weights were not recorded on the following dates:- 1/8, 1/12, 1/14, 1/16, 1/19, and 1/21/26. During an interview on 1/27/26 at 10:25 a.m., the Director of Nursing (DON) indicated the resident was under isolation during some of the missing dates. The staff should have checked the resident's weight but did not. 2. During an interview on 1/20/26 at 9:35 a.m., Resident 75 indicated that her pain was controlled as long as she received her scheduled pain medicine. Resident 75's record was reviewed on 01/21/2026 1:30 p.m. Diagnoses include, but were not limited to heart disease, fracture of left ischium, hypertension, osteoarthritis. The Physician's Order Summary, dated 1/2026, indicated the following pain medication order:- acetaminophen tablet 325 milligrams give 2 tablets by mouth every 4 hours for pain, not to exceed 3 grams in 24 hrs. The Medication Administration Record, dated 1/2026, indicated the resident received the scheduled pain medications six times on 1/16, 1/18, and 1/19/2026. The total dose of acetaminophen the resident received on those days was 3,900 milligrams (mg), which was greater than the 3 grams/3000 mg daily limit. On 1/20 and 1/21/2026, the resident received five doses of the scheduled pain medicine, which equalled 3,250 milligrams of acetaminophen and was greater than the 3gm/3000 mg daily limit. During an interview on 1/22/2026 at 9:58 a.m., LPN 1 indicated she would call the doctor to clarify order for pain medication. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155158	A. Building B. Wing	01/27/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Life Care Center of the Willows	1000 Elizabeth Dr Valparaiso, IN 46383

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During interview on 1/22/2026 at 11:23 a.m., the Director of Nursing (DON) indicated she would review the pain medication order with the nurse and have her contact the doctor for clarification. 3.1-48(a)(1)3.1-48 (a)(3)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview, the facility failed to serve food under sanitary conditions related to staff touching food directly with gloved hands after touching non-food items for 1 of 1 meal service observed in the main kitchen. (Cook 1) Finding includes: On 1/22/26 at 11:52 a.m., [NAME] 1 was observed placing items on plates to prepare a lunch meal. She had on clean gloves. She turned to the prep area to prepare a grilled cheese sandwich. She opened a bag of bread using her gloved hands, reached into the bag and grabbed a piece of bread and placed it on a pan on the stove top. She proceeded to open a package of cheese, with the same gloved hands, picked up a piece of the cheese and placed it onto the bread in the pan, and then retrieved another piece of bread with the same gloved hands and placed it on top of the cheese. She prepared another tray with Super Soup and then had to prepare another grilled cheese sandwich. She repeated the above steps using the same gloved hands throughout the process. During an interview on 1/22/26 at 12:00 p.m., the Dietary Manager indicated the cooks were not supposed to touch food items directly with gloved hands after touching non-food items. 3.1-(i)(3)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation and interview, the facility failed to ensure infection control practices were in place and implemented related to lack of glove changes and performing hand hygiene during wound care for 1 of 3 wound care treatments observed. (Resident 64) Finding includes:On 1/23/26 at 11:30 a.m., the Wound Nurse was observed performing dressing changes for Resident 64. The resident had a pressure ulcer to the medial side and lateral side of the left foot. The Wound Nurse washed her hands and then donned a gown and gloves. She removed the dressing to the lateral side of the foot. There was a small pressure area that she cleaned with saline and applied skin prep (provides protective film over skin). She then removed the old dressing to the medial foot, without changing gloves or performing hand hygiene. She cleansed the area with saline and applied skin prep. She removed her gloves and donned new gloves, without performing hand hygiene. She removed a dressing from the coccyx. There was a small open wound with slough observed. She washed the wound with saline, removed her gloves and donned new gloves. She did not perform hand hygiene before donning new gloves. She applied Santyl (debriding ointment) and covered the wound with a dry dressing. She removed her gown and gloves and performed hand hygiene. During an interview at the time, the Wound Nurse indicated she should have performed hand hygiene with each glove change, and she should have changed her gloves between the treatment of different wounds. 3.1-18(b)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on record review and interview, the facility failed to promote antibiotic stewardship by ensuring appropriate use of antibiotic therapy to reduce antibiotic resistance related to ordering an antibiotic for prophylactic (preventative) use in a resident with COPD (Chronic Obstructive Pulmonary Disease) for 1 of 1 resident reviewed for antibiotic use. (Resident 5)Finding includes:During interview on 1/20/26 at 2:46 p.m., Resident 5 indicated that he had been taking an antibiotic three times per week to keep his Chronic Obstructive Pulmonary Disease (COPD) from getting bad. Resident 5 record was reviewed on 1/23/2026 at 9:27 a.m. Diagnoses included, but were not limited to, Atherosclerotic Heart Disease, automatic implantable cardiac defibrillator, Chronic Obstructive Pulmonary Disease (COPD), peripheral vascular disease (PVD), hypertension, Diabetes Mellitus type 2, and paroxysmal atrial fibrillation. The Quarterly Minimum Data Set assessment, dated 12/24/25, indicated the resident was moderately cognitively impaired. The Physician's Order Summary, dated 1/2026, indicated Azithromycin Oral Tablet 250 mg (milligrams), give one tablet by mouth one time a day every Monday, Wednesday and Friday for COPD exacerbation prophylaxis. There was no documentation that the resident met criteria for a true infection for antibiotic use.During an interview on 1/27/26 at 3:50 p.m., the Infection Preventionist/Wound Nurse indicated it did not meet McGeer criteria for antibiotic use. The doctor had ordered the antibiotic because of the resident's history. She could not provide any documentation whether the medication use met criteria for a true infection or why the doctor had ordered the antibiotic.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain comfortable water temperatures. This had the potential to affect all 67 residents who resided in the facility. Finding includes:On 1/21/26 at 11:43 a.m., Resident 9 was observed sitting on the bed in her room. The resident indicated the sink water did not get hot in her room. Her roommate was on Hospice Services and Hospice would have to heat water up in a basin in the microwave to give her roommate a bed bath. The sink water was turned on at this time and let it run for approximately a minute. The water was only slightly warm to touch.During an interview on 1/27/26 at 11:50 a.m., Hospice CNA 1 indicated the water at the facility did not get hot. When she would have to complete bed baths on the residents, she would put the water in a basin and heat it up in the microwave. She would then stir it up with her hand to test to make sure it wasn't too hot.Confidential Staff Interviews during the survey indicated the water in the residents' rooms and shower rooms did not get hot. They informed management about it a while ago and it had not been fixed.An environmental tour was completed on 1/27/26 at 1:24 p.m. with the Administrator to check water temperatures. The following water temperatures were collected. 1. [NAME] Unita. room [ROOM NUMBER]'s water temperature was 86.1 F (Fahrenheit). There were 2 residents who resided in the room.b. room [ROOM NUMBER]'s water temperature was 82.9 F. There were 2 residents who resided in the room.c. Center [NAME] Shower Room's water temperature was 84.7 F. 2. East Unita. room [ROOM NUMBER]'s water temperature was 82.2 F. There was 1 resident who resided in the room.b. room [ROOM NUMBER]'s water temperature was 80.2 F. There was 1 resident who resided in the room.c. Center East Shower Room's water temperature was 82.7 F. The water temperatures logged by Maintenance Assistant 1 were reviewed and documented as the following temperatures:1/22/26-room [ROOM NUMBER] was 91.3 F-room [ROOM NUMBER] was 93 F-room [ROOM NUMBER] was 92 F-room [ROOM NUMBER] was 91.7 F1/26/26-room [ROOM NUMBER] was 90.3 F-room [ROOM NUMBER] was 91.4 F-room [ROOM NUMBER] was 93.6 F-room [ROOM NUMBER] was 91.4 F-room [ROOM NUMBER] was 91.2 FDuring an interview on 1/27/26 at 2:05 p.m., the Administrator and Maintenance Director indicated the local water company called the facility on 1/19/26 and indicated the facility may have a water leak. The water company was supposed to have someone come out to check but they had not done it yet. Assistant Maintenance 1 did not let them know the water temperatures were below 100 F. None of the facility staff or Hospice staff had informed them the water was not getting hot. The water temperatures should be between 100 F to 120 F. 3.1-19(h)