STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145070	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Zahav of Berwyn	3601 South Harlem Avenue Berwyn, IL 60402

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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, interview and record review, the facility failed to ensure that staff administer ordered pain medications to residents according to resident's needs and as outlined in their care plan and failed to ensure that resident's medications readily available. These failures affected two residents (R1 and R2) of four residents reviewed for pain management and have the potential to affect all 45 residents on the first floor of the facility. This failure resulted in R1 and R2 missed multiple doses of about 9 different pain medications while at the facility. Findings include: 1.R1's diagnosis includes, but are not limited to Malignant neoplasm of bone and articular cartilage, secondary malignant neoplasm of other parts of nervous system, anemia, benign prostatic hyperplasia without lower urinary tract symptom, wedge compression fracture of first lumbar vertebrae, osteomyelitis unspecified, etc. On 6/23/2025 at12:20PM, R1 was interviewed, and he said that his pain is not being managed because of how staff give his medications, he would like to have something in between Norco, staff always tell him that he is not due for Norco, and they cannot give him anything else. R1 said that they always run out of his lidocaine patch, he did not get any patch this morning, that is supposed to help with his neck pain. Active physician order summary for R1 showed the following: 1. Lidocaine External Patch 4 % (Lidocaine) apply to neck topically in the morning for Take off at 6PM related to acute hematogenous osteomyelitis, multiple sites, order date 6/12/2025. 2. Hydroxyzine HCl Oral Tablet 25 MG (Hydroxyzine HCl) Give 12.5 tablet by mouth every 8 hours as needed for Anxiety for 14 Days, order date 6/17/2025. 3 Gabapentin Oral Capsule (Gabapentin) Give 100 mg by mouth every 12 hours as needed for pain AND Give 200 mg by mouth every 24 hours as needed for Pain. Order date 6/12/2025. 4. Hydrocodone-Acetaminophen Tablet 5-325 MG *Controlled Drug* Give 1 tablet by mouth every 6 hours as needed for pain moderate to severe. Order date 6/18/2025. 5. Acetaminophen Oral Tablet (Acetaminophen) Give 650 mg by mouth every 6 hours as needed for Pain (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's Medication administration record (MAR) for the month of June 2025 showed the following documentations: Lidocaine patch was not signed as given on 6/14/2025, 6/20/2025 and 6/23/2025. Hydroxyzine signed out as given once, on 6/15/2025, Hydrocodone was not given on 6/12, 6/13, 6/14 and 6/17/, 6/19, 620, 6/21, 6/22 and 6/23/2025. Tylenol was given once on 6/13, 6/17 and 6/18/2025. Gabapentin was never signed out as given from the date it was ordered. On 6/23/2025 at 12:27PM, V3 (LPN) said that she did not remove any lidocaine patch from R1, the Surveyor informed V3 that R1 said he did not get his lidocaine patch this morning and does not have any on him right now. V3 then said, we have some house stock, I can go give him one now. On 6/23/2025 at 2:00PM, V2 (DON) was presented with all the days R1 did not get his pain medications and she said that R1 he was getting his pain medications, the nurses are probably documenting only in the narcotic sheet and not in the MAR, medications are supposed to signed out both in the narcotic count sheet and MAR when given. On 6/25/2025 surveyor reviewed medication supply for R1 with V10 (LPN) and noted that R1 did not have any gabapentin or hydroxyzine. V10 said that she could not find any, she will search more in the medication cart for it. At 2:18PM V10 told the surveyor that she did not find any gabapentin or hydroxyzine for R1. On 6/25/2025 at 3:11PM, V2 (DON) was presented with R1's missing gabapentin that was delivered on 6/13/2023, but never signed out as given in the MAR and she said that staff probably ran out, the medication is being re-ordered today. Surveyor asked V2 if she was aware that none of the delivered 30 tablets of gabapentin was signed out as given to R1 in his MAR and none is on hand at this time, she said yes. Facility could not provide any documentation that R1 received any gabapentin since it was ordered. 2. R2's medical diagnosis includes, but are not limited to Unilateral primary osteoarthritis, right knee, generalized muscle weakness, unspecified abnormalities of gait and mobility, lack of coordination, presence of right artificial knee joint, etc. On 6/23/2025 at 11:25AM, R2 was observed in his room, awake and alert and stated that he came to the facility after a knee surgery, the facility is not controlling his pain, he was supposed to be getting Norco for pain, but has not been getting it consistently, the last time he received his Norco was last Thursday, 6/19/2025. R2 said that he is in pain right now and rated his pain as 8 on a scale of 1 to 10. R2 have the following listed in physician order summary: 1. Hydrocodone-Acetaminophen Tablet 5-325 MG *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for pain, order date 5/30/2025. 2.Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 5 mg by mouth one time only for severe pain for 1 Day. Order date 6/5/2025. 3.Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug*Give 1 tablet by mouth every 12 hours as needed for Pain, order date 6/23/2025. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for neuropathic pain, order date 5/30/2025 discontinued 6/3/2025. Gabapentin Tablet 600 MG Give 1 tablet by mouth as needed for Pain related to presence of right artificial knee joint, three times a day. Order date 6/3/2025. On 6/23/2025 at 12:03PM, surveyor informed V2 (DON) that R2 has been waiting for pain medication and the other nurse on the floor said that his assigned nurse is on break. V2 said that she will follow up on that, the nurse should be returning from break shortly. On 6/23/2025 at 12:35PM, surveyor followed up with R2 who stated that he still did not receive any medication, no one has been to his room. Surveyor spoke to a staff who was sitting at the nursing station V4 LPN) she said that she is the assigned nurse for R2, she was told that resident needed pain medication, she just spoke to the nurse practitioner who said that she will fax a new prescription to pharmacy. V4 added that she will go and pull a dose for the resident from the emergency box. Review of June MAR for R2 showed that his Norco was last given on 6/19/2025 as the resident said, there is no documentation that R2 was medicated for pain on 6/23/2025. R2's gabapentin 600mg was recorded as given once or twice some days, but not given at all on 6/3/2025, 6/4/3035, 6/6/2025, 6/8/2025. 6/9/2025, 6/15/2025, 6/18/2025 and 6/19/2028. There was no entry for tramadol in R2's MAR, or any documentation that R2 was receiving tramadol. On 6/23/2025 at 2:00PM, V2 (DON) said that R2 likes his pain medication, and he runs out, resident's pain medication is supposed to be reordered. 6/23/2025 at 3:30PM, V2 said that the nurse practitioner gave the nurse an order to give R2 tramadol until his Norco is refilled. The NP faxed a new order to pharmacy on the 19th, not sure why it was not delivered. On 6/25/2025 at 11:35AM, surveyor presented R2's MAR to V2 (DON) that did not list any tramadol, and did not have any documentation that R2 was receiving any tramadol and she said, The nurse received an order to give resident tramadol when he ran out of Norco, she just forgot to put the order in or document it in the MAR. V2 added that all medications residents receive are supposed to be documented in the MAR, and signed out when given, the nurse just forgot to do that. On 6/25/2025 at 12:29PM V15 (Nurse Practitioner) said that R2 came to the facility from the hospital post right knee arthroplasty, V15 did a script for his Norco to be refilled on 6/20/2025 and faxed it to pharmacy, not sure why the medication was not delivered. V15 gave an order to give resident tramadol until the Norco comes. Surveyor informed V15 that there is no documentation that R2 was receiving any tramadol in the medication administration record. She said, that part will be for the DON, I am just the NP, all resident medications are supposed to be documented in the medication administration record and signed out when given. Medication administration policy revised 4/2024 states in part: All medications are administered safely and appropriately to aid residents to overcome illness, relive and prevent symptoms and help in diagnosis. Licensed staff will administer medications as ordered by the physician. Under guideline, the policy states, #18 document as each medication is prepared in the medication administration record (MAR). #24, Document reason and response for any PRN medications. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Job description for registered nurse and licensed practical nurse (undated) states in part: Under the direction of the physician, is responsible for total nursing care to all residents on assigned unit during the assigned shift including responsibility for delegation of duties, ----------, and adherence by staff members to facility policies and procedures. Essential duties #3, Administer prescribed medications and treatments according to policy and procedure, evaluate treatment effectiveness on a continuous basis. #10. Document nursing care rendered, resident response, and all other pertinent and necessary data as outlined in facility's policies and procedures.

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to follow the physician ordered to ensure as needed pain medications (Norco, Tramadol, Gabapentin, and Tylenol) were administered to residents as prescribed. This affected two of three (R1, R2) residents reviewed pain management. This failure resulted in R1 suffering a psychosocial harm and stated that R1 endured excruciating pain due to not getting his pain medications. R2 said R2 needed pain medication, rated his pain as 8 on a scale of 1 to 10, but his medication was not available. Findings include: 1. R1 is [AGE] years old, admitted to the facility on [DATE], medical diagnosis includes, but not limited to Malignant neoplasm of bone and articular cartilage, secondary malignant neoplasm of other parts of nervous system, anemia, benign prostatic hyperplasia without lower urinary tract symptoms, low back pain, wedge compression fracture of first lumbar vertebrae, osteomyelitis unspecified, etc. On 6/23/2025 at12:20PM, R1 was observed in his room, awake, alert and oriented and stated that he is doing okay, he is managing to survive, but it could be better. R1 said that his pain is not being managed well because of how staff gives him his medicine, he would like to have something in between his Norco, staff always tells him that he is not due for Norco, and he cannot get anything else. They always run out of his lidocaine patch, he did not get any patch this morning, R1 said that the first week he was at the facility was hell, they took forever getting his medications and when they did, he was still not getting his medicine as he should, and he had to deal with excruciating pain. R1 said, imagine my medical condition and not having pain medications, the staff just don't understand, they think I was just asking for pain medicine for the heck of it. On 6/24/2025 at 9:40AM, R1 said that that he never received any anxiety medication or something for muscle pain, just the Norco. Active physician order summary for R1 showed the following: 1. Lidocaine External Patch 4 % (Lidocaine) apply to neck topically in the morning for Take off at 6p related to acute hematogenous osteomyelitis, multiple sites, order date 6/12/2025. 2.Hydroxyzine HCl Oral Tablet 25 MG (Hydroxyzine HCl) Give 12.5 tablet by mouth every 8 hours as needed for Anxiety for 14 Days, order date 6/17/2025. 3.Gabapentin Oral Capsule (Gabapentin) Give 100 mg by mouth every 12 hours as needed for pain AND Give 200 mg by mouth every 24 hours as needed for Pain. Order date 6/12/2025. 4.Hydrocodone-Acetaminophen Tablet 5-325 MG *Controlled Drug* Give 1 tablet by mouth every 6 hours as needed for pain moderate to severe. Order date 6/12/2025, discontinue on 6/17/2025. Hydrocodone-Acetaminophen Tablet 5-325 MG *Controlled Drug* Give 1 tablet by mouth every 6 hours as needed for pain moderate to severe. Order date 6/12/2025. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	5.Acetaminophen Oral Tablet (Acetaminophen) give 650 mg by mouth every 6 hours as needed for Pain, order date 6/12/2025. Care plan initiated 6/13/2025 states the following: PAIN: Resident has an alteration in comfort r/t Advanced Disease process. Goal: Resident will not experience a decline in overall function r/t pain through next review. Interventions: Administer pain meds and treatments as ordered, assess effectiveness of pain medication, encourage to report any pain, Educate on non-pharmacological interventions such as heat, ice, massage, relaxation, and distraction techniques, etc. R1's Medication administration record (MAR) for the month of June 2025 showed the following documentations: Lidocaine patch was not signed as given on 6/14/2025, 6/20/2025 and 6/23/2025. Hydroxyzine signed out as given once, on 6/15/2025, Hydrocodone was signed as given on 6/15/2025, 6/16/2025, 6/18/2025, and 6/24/2025.Tylenol was signed as given on 6/13/2025, 6/17/2025 and 6/18/2025. Gabapentin was never signed out as given from the date it was ordered. On 6/23/2025 at 12:27PM, V3 (LPN) said that she is the assigned nurse for R1, he gets lidocaine patch for pain but not on her shift, it is usually given by the PM shift and removed in the morning by the AM shift nurse. V3 was asked if she removed any lidocaine patch from the resident this morning and she said no. V3 then said, we have some house stock, I can go give him one now. On 6/24/2025 at 2:47PM, V10 (LPN) said that R1 thought that he was supposed to be getting Norco and oxycodone at the same time, he wants pain medication all the time every hour. V10 said that she has not given R1 any other medication other than Norco for pain. She added that they are supposed to sign the narcotic sheet, document the pain scale, and sign the MAR whenever pain medication is given to a resident. On 6/24/2025 at 12:39PM, V6 (C.N.A) said that she is familiar with R1, he lets staff know when he needs anything. V6 said that R1 never complained of anything to her except one time he was asking V6 about getting more medication, stating that he is not getting all his pain medications. On 6/25/2025 at 11:15AM, V14 (pharmacy technician) said that they delivered 15 tablets of Norco for R1 on 6/13/2025, and then 30 tablets on 6/21/2025. V14 said that they also delivered 30 tablets of Gabapentin and 15 tablets of hydroxyzine for R1 on 6/13/2025.V14 added that that they did not supply any lidocaine patch for R1 because it is considered a house stock, they normally don't send it for individual residents, the facility uses their own supply. Review of manifest sheet from pharmacy confirmed that the above medications were delivered to the facility 6/13/2025 as stated by V14. On 6/25/2025 surveyor reviewed medication supply for R1 with V10 (LPN). There is 1 bingo card of Norco (30 tablets) delivered on 6/10/2025, resident have 15 tablets remaining. V10 was asked about resident's gabapentin and hydroxyzine, and she said that she could not find any, she will search more in the medication cart for it. At 2:18PM V10 told the surveyor that she did not find any gabapentin or hydroxyzine for R1. On 6/23/2025 at 2:00PM, V2 (DON) said that R1 he was getting his pain medications, the nurses are probably documenting only in the narcotic sheet and not in the medication administration record (MAR), medications are supposed to be signed out both in the narcotic count sheet and MAR when given. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 6/25/2025 at 3:11PM, V2 (DON) was presented with R1's missing gabapentin that was delivered but never signed out and she said that staff used all the gabapentin, and it is being reordered today. Surveyor asked V2 if she was aware that none of the medication was signed out as given to R1 in his MAR and she said yes. 2. R2 is [AGE] years old admitted to the facility on [DATE], medical diagnosis includes, but not limited to Unilateral primary osteoarthritis, right knee, generalized muscle weakness, unspecified abnormalities of gait and mobility, lack of coordination, essential primary hypertension, atherosclerotic heart disease of native coronary artery without angina pectoris, anemia, presence of right artificial knee joint, etc. On 6/23/2025 at 11:25AM, R2 was observed in his room, awake and alert and stated that he came to the facility after a knee surgery, the facility is not controlling his pain, he was supposed to be getting Norco for pain, but has not been getting it consistently, the last time he received his Norco was last Thursday, 6/19/2025. R2 was observed holding his right leg and grimacing, R2 said that he needs his pain medicine right now, have not received any today and rated his pain as 8 on a scale of 1 to 10. On 6/23/2025 at 11:30AM, surveyor inquired about the assigned nurse for R2 from V3 who was working on the same floor but was told that the nurse for R2 is on break. Surveyor asked V3 if she can give pain medication to R2, but she said that she does not have the narcotic key for the other cart and cannot tell if resident have had his pain medication today, she has to look in the narcotic book. On 6/23/2025 at 12:03PM, surveyor informed V2 (DON) that R2 has been waiting for pain medication and the other nurse on the floor said that his assigned nurse is on break. V2 said that she will follow up on that, the nurse should be returning from break shortly. On 6/23/2025 at 12:35PM, surveyor followed up with R2 who stated that he still did not receive any medication, no one has been to his room. Surveyor spoke to a staff who was sitting at the nursing station V4 (LPN), she said that she is the assigned nurse for R2, she was told that resident needed pain medication, she just spoke to the nurse practitioner who said that she will fax a new prescription for his Norco to pharmacy. V4 added that she will go and pull a dose for the resident from the emergency box. R2 has the following listed in physician order summary: 1. Hydrocodone-Acetaminophen Tablet 5-325 MG *Controlled Drug* Give 1 tablet by mouth every 4 hours as needed for pain, order date 5/30/2025. 2.Oxycodone HCl Oral Tablet 5 MG (Oxycodone HCl) *Controlled Drug* Give 5 mg by mouth one time only for severe pain for 1 Day. Order date 6/5/2025. 3.Tramadol HCl Oral Tablet 50 MG (Tramadol HCl) *Controlled Drug*Give 1 tablet by mouth every 12 hours as needed for Pain, order date 6/23/2025. 4.Gabapentin Capsule 300 MG Give 1 capsule by mouth three times a day for neuropathic pain, order date 5/30/2025 discontinued 6/3/2025. Gabapentin Tablet 600 MG Give 1 tablet by mouth as needed for Pain related to presence of right artificial knee joint, three times a day. Order date 6/3/2025. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Review of June MAR for R2 showed that his Norco was last given on 6/19/2025 as the resident said, there is no documentation that R2 was medicated for pain on 6/23/2025 for the pain scale of 8. R2's gabapentin 600mg was recorded as given once or twice some days, but not given at all on 6/3/2025, 6/4/3035, 6/6/2025, 6/8/2025. 6/9/2025, 6/15/2025, 6/18/2025 and 6/19/2028. There was no entry for tramadol in R2's MAR, or any documentation that R2 was receiving tramadol. On 6/23/2025 at 2:00PM, V2 (DON) said that R2 likes his pain medication, and he runs out, resident's pain medication is supposed to be reordered by the nurses. 6/23/2025 at 3:30PM, V2 said that the nurse practitioner gave the nurse an order to give R2 tramadol until his Norco is refilled. The NP faxed a new order to pharmacy on the 19th, not sure why it was not delivered. On 6/25/2025 at 11:35AM, surveyor presented R2's MAR to V2 (DON) that did not list any tramadol, and did not have any documentation that R2 was receiving any tramadol and she said, The nurse received an order to give resident tramadol when he ran out of Norco, she just forgot to put the order in or document it in the MAR. V2 was asked if the tramadol was delivered from the pharmacy and she said, no, it came from an outside source and we do not have any documentation of when it was received. V2 added that all medications residents receive are supposed to be documented in the MAR, and signed out when given, the nurse just forgot to do that. On 6/25/2025 at 12:29 PM V15 (Nurse Practitioner) said that R2 came to the facility from the hospital post right knee arthroplasty, he came with his own supply of Norco, Flexeril, gabapentin and tramadol, all to be taken a needed for pain. V15 did a script for his Norco to be refilled on 6/20/2025 and faxed it to pharmacy, not sure why the medication was not delivered. V15 gave an order to give resident tramadol until the Norco comes. Surveyor informed V15 that there is no documentation that R2 was receiving any tramadol in the medication administration record. She said, that part will be for the DON, I am just the NP, all resident medications are supposed to be documented in the medication administration record and signed out when given. Pain care plan for R2 initiated 6/2/2025 states: PAIN: Resident has an alteration in comfort r/t Advanced Disease process, Goal: Resident will not experience a decline in overall function r/t pain through next review. Interventions: Administer pain meds and treatments as ordered, assess effectiveness of pain medication, Educate on non-pharmacological interventions such as heat, ice, massage, relaxation, and distraction techniques, etc. Pain management policy revised 10/2024 states in part, to facilitate and provide guidance on pain observations and management, to facilitate resident independence, promote resident comfort and preserve resident dignity. This will be accomplished through an effective pain management program, ----------and enhance dignity and life involvement. Under guideline, the policy states as follows: The pain management program is based on a facility-wide commitment to resident comfort. Pain is defined as whatever the experiencing person says it is and exits whenever he or she says it does. Medication administration policy revised 4/2024 states in part: All medications are administered safely and appropriately to aid residents to overcome illness, relive and prevent symptoms and help in diagnosis. Licensed staff will administer medications as ordered by the physician. Under guideline, the policy states, #18 document as each medication is prepared in the medication administration record (MAR). #24, Document reason and response for any PRN medications. (continued on next page)

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Job description for registered nurse and licensed practical nurse (undated) states in part: Under the direction of the physician, is responsible for total nursing care to all residents on assigned unit during the assigned shift including responsibility for delegation of duties, ----------, and adherence by staff members to facility policies and procedures. Essential duties #3, Administer prescribed medications and treatments according to policy and procedure, evaluate treatment effectiveness on a continuous basis. #10. Document nursing care rendered, resident response, and all other pertinent and necessary data as outlined in facility's policies and procedures.