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	04/25/2024

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 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interview and record review the facility failed to refer a resident with a new mental health diagnosis for a level II PASARR assessment. This failure applies to one of three residents (R102) reviewed for PASARR assessments. Findings include: R102 is a [AGE] year-old male with a diagnoses history of Recurrent Major Depressive Disorder (as of 08/17/2023), Adjustment Disorder with Mixed Anxiety and Depressed Mood (as of 07/13/2023), who was admitted to the facility 02/19/2023. R102's medical records did not include a PASARR Level II Assessment On 04/24/24 at 01:27 PM V11 (Psychotropic/Falls Nurse) stated, she believes R102 had a stroke at a young age 32. V11 stated she has always been able to sit and talk with R102 and has not had to send him out, but at times he cannot be calmed down or deescalated. V11 stated, she gave R102 a supervised pass but that does not seem to be sufficient. V11 stated she believes R102 does not belong at the facility and maybe belongs in a different type of facility. On 04/25/24 at 02:04 PM V1 (Administrator) reported, the facility does not have a PASARR Policy. As of the exit of the annual certification survey 04/25/2024 the facility could not provide an answer to surveyors inquiry made 04/25/2024 at 12:41 PM of whether R102 should have received a PASARR Level II Assessment due to receiving new mental health diagnoses after his admission to the facility.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews the facility failed to follow their policy and procedures for comprehensive care planning by not developing and implementing person centered care plan interventions for a resident who refused ADL (Activities of Daily Living) care, a resident with a history of substance use who was observed to be under the suspicion of substance use, and a resident with a history of aggressive and maladaptive behaviors. This failure applies to three of three residents (R78, R85, and R102) reviewed for care planning. Findings include: 1. R78 is a [AGE] year-old male with a diagnoses history of Cerebral Infarction, Unspecified Symptoms and Signs Involving the Nervous System, and Aphasia following Cerebrovascular Disease who was admitted to the facility 11/10/2022. On 4/23/24 at 11:19 AM surveyor observed R78's gown, linens and body with a strong odor of urine. R78 shook his head no when asked by surveyor if he needed to be changed. R78 shook his head up and down to confirm he wanted to be dressed and get out of bed later. R78's admission Minimum Data Set, dated dated dated [DATE] documents he requires supervision and setup for transfers and walking and most activities of daily living and one-person physical assistance for locomotion on and off the unit, toilet use and personal hygiene. On 04/23/24 at 01:24 PM V28 (Family Member) stated, sometimes she comes in at three in the afternoon and R78 has an extremely strong urine smell and is still in the bed, he has not been changed and V28 will get him up. V28 stated R78 can not sit up due to medications and stroke. V28 stated her main concern is R78 getting a little more attention. V28 stated when she comes to visit R78 is in a urine-soaked bed and his gown has a urine smell. V28 stated she is assuming R78 gets changed once a day maybe later at night. V28 stated she would like to see R78 get more assistance, he needs more prompting to get up and get showered. V28 stated sometimes when R78 goes out at night they do not make sure he takes his clothes off when he returns, and he sleeps in his clothes and urinates in them. V28 stated R78 needs help. On 04/24/24 at 03:16 PM V2 (Assistant Administrator) stated, R78 has a history of refusing ADL (Activities of Daily Living) care and the facility regularly has to contact V28 for him to comply with incontinence care and bathing, V2 stated social services are involved because R78 lacks motivation to get out of bed and engage in activities of daily living. V1 (Administrator) and V2 stated these issues are included and addressed in R78's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R78's current care plan documents he is incontinent but prefers to do his own toileting; R78 has an ADL (Activities of Daily Living) Self Care Performance Deficit related to impaired ability with Dressing and Grooming such as: Putting on or take off clothing, unable to obtain or replace article of clothing, unable to fasten clothing, unable to groom self satisfactorily, unable to complete task with personal hygiene, unable to bathe and groom self independently; R78 requires assistance with ADL's (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting) with interventions including: Assist resident with shower/bathing per schedule, Encourage participation in ADL's; R78 exhibit(s) the symptoms of resisting care by refusing caregiver requests to leave the bed and refusing/resisting ADL assistance (bathing, dressing, grooming, transferring, etc.) with interventions including: Conduct an evaluation of the behavioral symptoms(s) to determine what strength or needs are communicated via the behavior (e.g., resisting care often communicates the emotion of fear and need for control). R78's current care plan does not include personalized interventions to address his refusal of ADL care and does not document the causes of his refusals. R78's Progress notes from March 01/2024 - April 24/2024 does not document refusals of attempts to provide him with ADL care of incontinence, showers, or personal hygiene. R78's Psychotropic progress notes dated 03/21/2024, and 04/04/2024 created by V25 (Psychiatric Nurse Practitioner) document Staff nurse had no complaints and did not report any behaviors. 2. R85 is a [AGE] year-old male with a diagnoses history of End Stage Renal Disease and Nicotine Dependence who was admitted to the facility 09/17/2022. On 04/22/24 from10:55 - 12:13 PM surveyor observed a strong odor of Marijuana outside and in R85's room. Observed R85 with strong Marijuana odor near him. Observed R85 walking through the facility with his eyes red and droopy. On 04/23/24 at 9:12 AM Observed strong Marijuana smell in R85's room. On 04/23/24 at 09:34 AM Observed along with fell ow surveyor hallway near R85's room and R85's room with a strong smell of marijuana. On 04/23/24 at 12:40 PM Observed R85 sleeping in bed. R85 stated he had been out of the facility earlier and is often in and out of the facility. On 04/23/24 at 01:00 PM Observed V12 (Licensed Practical Nurse) measure R85's blood pressure. V12 stated R78 blood pressure fluctuates depending on dialysis. Observed R85's eyes to be red and droopy. Observed V12 administer R85's blood pressure and Kidney medication. V12 stated at times R85 smells of marijuana and if observed with this smell social services is notified and they will talk to him. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 10:01 AM V4 (Assistant Director of Nursing/Registered Nurse) stated, she is not aware of any residents returning to the facility under the influence of substances. V4 reported that she can check the policy on contraband searches, however the facility may not necessarily search residents upon return from the community. V4 stated if nursing smell marijuana, social services is notified, and the nurse and social service staff inform the resident of the concerns brought to their attention then get permission from resident to fully search their room. V4 stated these situations have occurred at times with residents. V4 stated other signs of marijuana use include eyes blood shot, smell of marijuana on person. V4 stated concerns of marijuana use for residents include that other substances may have been within the marijuana that affect cognition, safety issues, and medication use. V4 stated the nurse would perform a full head to toe assessment including vital signs if residents show any signs they are under the influences of other illegal substances along with marijuana. R85's Progress Notes from February - April 2024 did not include observations of substance use. R85's Current care plan documents he expresses the desire to receive an outside, independent pass, he must make a commitment to behave appropriately while in the community, take medications as prescribed and remain clean and sober but does not include personalized interventions regarding substance use. On 04/24/24 at 01:01 PM V21 (Social Services) stated she has not received any reports of R85 using any substances. V21 stated if it was reported that a resident possibly used marijuana a room search would be conducted and they may possibly receive a clinical assessment or be sent out for evaluation and testing. V21 stated if the resident has an outside pass, they would be restricted if they are showing signs of intoxication. V21 stated due to receiving dialysis, if R85 was using marijuana it could affect his dialysis treatment, and there would also be concerns of bringing substances into the facility, and general safety. 3. R102 is a [AGE] year-old male with a diagnoses history of Recurrent Major Depressive Disorder (as of 08/17/2023), Adjustment Disorder with Mixed Anxiety and Depressed Mood (as of 07/13/2023), who was admitted to the facility 02/19/2023. R102's social service progress notes dated 02/27/2024 documents he attempted elopement. Writer met with R102 to counsel on the importance of making staff aware of issues before he gets too anxious and frustrated in future situations. He expressed understanding. R102 will be on 72 hour follow up. Staff will monitor for aggression and mood changes. Social services will follow up. R102's social service progress note dated 3/5/2024 documents created by V2 (Social Services Director) Day 1: Writer was made aware of resident was presenting with exit-seeking behavior. Writer approached resident and he appeared in an anxious mood at this time. R102 was re-directed and reoriented by writer back to a quiet and safe setting to discuss noted behavior. Writer encouraged R102 to vent feelings or concerns to staff. R102 expressed understanding at this time. Social Services will continue to monitor behaviors. R102 requires constant reminders to decrease in behavior, facility protocols, plan of care, his safety, and a need for daily supervision. R102 has a history of Elopement. Care Plan Updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R102's Psychiatry/Mental Health progress note created by V25 (Psychiatric Nurse Practitioner) dated 3/13/2024 documents Chief Complaint: Follow up mood. History of Present Illness: [AGE] year-old male with Opioid Use, Unspecified, Uncomplicated and Adjustment Disorder with Mixed Anxiety and Depressed Mood. There were no behavior issues to report. Staff nurse had no complaints and did not report any behaviors. R102's Psychotropic Progress note dated 3/21/2024 documents Chief Complaint: Follow up adjustment disorder. There were no behavior issues to report. Staff nurse had no complaints and did not report any behaviors. R102's Psychotropic Progress note dated 3/29/2024 documents Chief Complaint: Follow up mood.There were no behavior issues to report, and his mood has been baseline per staff. Staff nurse had no complaints and did not report any behaviors. R102's Health Status Progress Note dated 4/4/2024 created by V11 (Psychotropic Nurse) documents a Change In Condition/s reported on this change in condition evaluation are/were: Behavioral symptoms (e.g. agitation, psychosis). R102's Progress note dated 4/4/2024 documents he is being aggressive, being delusional, trying to elope out the front door, and is not able to be redirected. Writer called resident's Psych Physician and left a voice message. Writer asked the Physician. to call back to the facility concerning the resident. Writer notified Director of Nursing to make her aware of resident's behavior. Writer called Insight hospital and gave nursing report. Writer called transportation to schedule pick-up for the resident. R102's Progress note dated 04/6/2024 documents he became verbally and physically threatening to writer. Resident is not able to be redirected after several failed attempts to calm him down. Resident stormed out of the facility unescorted against writer and other staff request . Code yellow was called staff quickly responded to bring him out the courtyard back inside. Physician was notified ordered to send resident out to insight hospital for psychiatric evaluation. R102's social service progress note dated 4/8/2024 by V21 (Social Services) documents Note Text: Behavior monitoring Day 1 of 3. Writer met with (staff member) to conduct well-being check. Resident went outside with writer along with psychotherapist for about an hour. R102's social service progress note dated 4/10/2024 12:37pm documents a code yellow was called to the receptionist area and upon arrival the resident was at the front door trying to elope, being physically/verbally aggressive. Writer tried to talk to the R102, and he continued to scream/yell. R102 was not able to be redirected. The writer informed the V13 (Nurse Practitioner) and orders were to send the resident to hospital. A petition will be sent along with the resident. R102's social health status progress note dated 4/16/2024 documents writer approached resident regarding skin assessment, resident was pacing and appeared upset, writer asked R102 if he was ok, he yelled No and kept walking. Writer later saw R102 on the 2nd floor of the building attempting to get into the social services office, he appeared upset, staff was able to redirect him. Writer unable to complete an assessment on the resident due to aggressive behaviors. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R102's progress note dated 4/23/2024 at 2:16 PM documents he is showing aggressive behaviors towards staff physically and verbally. The resident is not able to be redirected. A petition to hospital has been presented to the writer for the resident. The writer has contacted ambulance service for transport to Local Hospital was given. The Director of Nursing and V13 (Nurse Practitioner) is aware of the residents petition/transport; at 3:30 PM Behavior follow up note: documents Writer was made aware by nursing staff that resident was inside of nursing office exhibiting with verbal aggressive behavior and demanding that nursing staff change his current out on pass order from supervised to independent. R102 voiced that he is capable of going out alone and wants order changed immediately. Writer approached resident and he was in an agitated mood. R102 was asked kindly to exit nursing office and go speak to social services in their office. When R102 entered office, he was asked to sit as he was standing in doorway of social services office yelling and screaming stating, I want my pass changed now! I don't understand why I can't go out by myself! R102 was reassured that he was safe and that he ok with staff. Resident was then asked again to sit and calmy express himself, resident refused. Resident was then notified of outside pass procedures, his gait imbalance, poor decision making, and safety awareness. R102 then continued to express agitation towards staff with noted verbal aggression, while resident was in the doorway of social services office another resident approached social services office to notify them of his return from Association House Skills Training. R102 then turned towards peer and yelled loudly, this is my time I'm busy leave now! Peer was immediately assisted out by social service designee to his room. R102 remained in social services office with noted uncontrollable verbal aggressive behavior. Social services continued to encourage resident to speak in a soft tone of voice resident refused. R102 was then asked to be taken on a walk down to his room to calm down. Once R102 reached first floor nursing station he refused to present in a calm manner. Social services was notified by nursing staff to petition resident out for psychiatric evaluation, noted aggression towards staff and peer and uncontrollable verbal outburst. R102 has a history exhibiting with, exit seeking behavior, aggressive/inappropriate behavior, attention seeking behavior, conflicts/altercations with others, and acting impulsively, and erratically. R102's current medical diagnoses are Aphasia Following Cerebral Infarction, Symptoms and Signs Involving Emotional State, Other Symptoms and Signs Involving Appearance and Behavior, Recurrent Major Depressive Disorder, Adjustment Disorder with Mixed Anxiety and Depressed Mood, and Opioid Use. R102 suffers from a family history of verbal abuse. R102 currently receives psychotherapy and agrees with counseling sessions at this time. Social Services will continue to follow up, intervene, and council resident as needed. R102 is currently petitioned out to hospital for assessment review. Care plan updated. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 12:45 PM V21 (Social Services Designee) stated a lot of R102's frustrations are from him wanting to go outside so sometimes staff will take him outside for a walk upon request. V21 stated R102 also visits with psychotherapist 3-4 times per week, engages in activities, and his needs are addressed by social services when expresses them. V21 stated she is not aware of any group programs for residents, but the psychotherapist or social services director may have more information. V21 stated she keeps in touch with V26 (Psychotherapist/Psychologist) often regarding R102's behaviors. V21 stated she believes V25 (Psychiatric Nurse Practitioner) works along with the V11 (Psychotropic/Fall Nurse). V21 stated she only communicates with V26. V21 stated it's pretty important to communicate behaviors to R102's psychotropic care team which is why she tries to communicate consistently with V26 so she can meet with R102. V21 stated R102 wants to be outside probably daily and even wants to go out at times after he's already been out. V21 stated on occasion R102 can be taken outside multiple times a day depending on who's available. V21 stated R102 likes to watch videos on his computers, but mainly likes sitting outside when he can. V21 stated if activities are not being offered enough or R102 isn't able to go outside frequently enough it may contribute to more behaviors. V21 stated R102 exhibits these behaviors sometimes even when offered activities and outside time. V21 stated if activities and outside time are still not adequate for R102 we'll try to work with him and she personally will invite him to her office just to vent his frustrations which can be helpful. V21 stated if none of these options are sufficient they may offer him something from the kitchen, activities, or see if there's anyone he wants to speak to. V21 stated she believes V26 can refer residents to outside services or providers for psychosocial services if needed. R102's current care plan documents he is a younger individual [AGE] years of age and presents with a Substance abuse history and difficulties expressing himself. He may present with poor motivation, lack of energy. May state he is bored or act bored. Interventions include: Assess the need for additional, formal education needs and offer referrals, as appropriate for educational opportunities; Assure the resident is in an appropriate treatment setting. R102 has a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior. R102's history includes conflicts/altercations with others, acting impulsively, and erratically by throwing chairs. R102 has been noted flipping over tables when he is stressed and refuse staff redirection/reorientation to setting. On 11/21/23 R102 was noted with aggression towards staff. Interventions include: If R102's symptoms warrant further assessment of ongoing management, Refer him to a mental health professional, including a consulting psychiatrist, for evaluation; Intervene when any inappropriate behavior is observed. Communicate assertively that he must exercise control over impulses and behavior (Social skills training); Provide supportive intervention as needed; R102 demonstrates strong activity participation, may refuse some activities at certain times, goes outside as an activity at his request, also enjoys arts and crafts. Interventions include: Escort the resident to preferred setting as requested; establish a rapport with the family. R102 demonstrate(s) movement behavior that may be interpreted as wandering, pacing or roaming. R102 attempts to leave the facility without a responsible escort (elopement) and will become agitated, oppositional and combative when redirected by staff. R102's care plan does not include personalized behavioral interventions to address causes of or prevent behaviors. The facility's Comprehensive Care Plan Policy reviewed/receive 04/25/2024 states To meet the resident's physical, psychosocial and functional needs, the facility will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and target goals. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Facility IDT will develop and implement a person-centered care plan for each resident/patient in conjunction with resident and his/her family/ or legal representative's participation in care. Care plan interventions or approaches will be based on resident or patient health records, comprehensive assessments, resident/patient preferences and reasonable requests from family/legal representative. The comprehensive, person-centered care plan will be measurable and attainable. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50519 Based on observation, interview and record review the facility failed to document medication administration in the Electronic Medical Record in accordance with acceptable clinical practice for seven (R29, R109, R17, R64, R28, R86, R25) residents reviewed for medication administration. Findings include: On 04/23/24 at 08:47 AM V8 (License Practical nurse) stated, I finished passing all my medications for all my patients. The electronic medical record screen displays a yellow color over all residents' names. V8 stated, I did not sign the medications after I passed them. I normally pass the medication first for each resident, then I will sit down and sign them out, even though the facility policy is to sign each medication after the patient takes them, I did not do it today. R29 was admitted on [DATE] with diagnosis that include and are not limited to diabetes and sacral pressure ulcer, per current physician orders dated: 4-2024 reads: 12 medications are due at 9:00am R109 was admitted on [DATE] with diagnosis that include and are not limited to: diabetes and acute kidney failure, Per current Medication administration dated; 4-2024 reads: 9 medications are due at 9:00am. R17 was admitted on [DATE] with diagnosis that include and are not limited to: atrial fibrillation and hypertension, per current Medication administration dated; 4-2024 reads: 14 medications are due at 9:00am. R64 was admitted on [DATE] with diagnosis that include and are not limited to hypertension and prosthetic heart valve, per current Medication administration dated; 4-2024 reads: 5 medications are due at 9:00am. R28 was admitted on 2-22-2020 with diagnosis that include and are not limited to chronic back pain, asthma and polycystic ovarian syndrome, per current Medication administration dated; 4-2024 reads: 14 medications are due at 9:00am. R86 was admitted on [DATE] with diagnosis that include and are not limited to chronic obstructive pulmonary disease and atrial fibrillation, per current Medication administration dated; 4-2024 reads: 14 medications are due at 9:00am. R25 was admitted on [DATE] with diagnosis that include and are not limited to: cerebral infarct and tracheostomy, per current Medication administration dated; 4-2024 reads: 11 medications are due at 9:00am. Per census report dated: 4-23-2024 reads, 14 residents currently in unit 2 north. On 04/23/24 at 08:50 AM V3 (Director of Nursing) stated, my expectation is for the nurses to sign the medications as soon as they are done giving the medication. It is not acceptable to wait and signed them out later. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4-24-2024 at 1:30pm V4 (Assistant Director of Nursing) stated, my expectation is for the nurses to complete the medication pass and signed the Electronic Medical Administration Record. It is unacceptable to wait until all medications are passed because you need to document vital signs and you can forget if any patient refused any. V4 presented, Facility Policy Title Medication administrations dated 05/18/23 reads, nurse administering medications initials/signs the resident's Electronic Medical Administration Record (EMAR) after giving medication.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on observation, interview and record review, the facility failed to ensure staff provide shower/bed bath and grooming for residents who are dependent on staff for Activities of Daily Living (ADL). This failure affected 6 residents (R3, R7, R21, R47, R78, R99) of 11 residents reviewed for ADL care. Findings include: R21 is [AGE] years old and have resided at the facility since 2021, past medical history includes multiple sclerosis, hyperlipidemia, acquired absence of left leg below the knee, history of falling, etc. On 04/22/24 at 10:55AM, R21 was observed in bed, awake and alert and stated that she is doing okay, R21 told surveyor to come closer, because she had something to show surveyor. R21 raised up her head from the pillow and showed surveyor her long hair that was clumped together and matted in the back, with a lump of hair in the middle all tangled up. R21 stated, the facility does not give her showers or bed bath, no one has ever washed or combed her hair since admission, she does not want it washed or combed at this point because it is too painful, she just wants them to cut it off. R21 further stated, her bed baths are scheduled at night while other residents get theirs during the day, and R21 must wait more than 4 hours sitting in urine before getting changed. R21 stated, she has not been changed today, she was last changed last night. R21 added, she has some redness on her bottom from sitting in urine for a long time, they gave her a cream to apply, staff does not help her with brushing her teeth and all she needs is for someone to put toothpaste on her toothbrush, she cannot do that due to a contracture in her right hand, but she can brush her own teeth. Resident's room was noted to be dirty with lots of garbage and used medicine cups and pink liquid on the floor. On 04/22/24 at 11:02AM, V6 (CNA) was observed going into the room. Surveyor asked V6 if he was going to change the resident. V6 stated, yes, he added that he has not changed the resident today, and he started his shift at 8:00AM because he was a little later today. V6 was observed changing resident's incontinence brief that was visibly soiled with urine and brown in color. On 04/23/24 at 9:45AM, R21 was observed in bed, awake and alert and stated she was in pain. The CNA just changed her and moved her around, but the nurse just gave her medications. R21 added that the last time she was changed was last night, and she is still waiting for someone to cut her hair. On 04/24/24 at 10:36AM, surveyor went to R21's room with V4 (ADON) who examined resident's clumped and matted hair, V4 stated, this is unacceptable, she will get someone to take care of it. Resident stated, she does not want her hair to combed at this point because it is very painful, she just wants someone to cut it out. MDS assessment dated [DATE] scores resident with a BIMs score of 14 out of 15, section GG of the same assessment coded resident as being totally dependent on staff for most ADL care needs except for eating and oral hygiene. ADL care plan initiated 4/12/2024 stated that R21 has an ADL care self-care performance deficit related to impaired ability with dressing and grooming and requires total assistance x 1 staff for ADLs. (continued on next page)

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	145070	A. Building B. Wing	04/25/2024

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

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R21 was scheduled for showers on Monday and Saturday on 3PM to 11PM shift. Review of shower sheets for the month of April 2024 showed R21 received 2 bed baths, on 4/13/2024 and 4/15/2024. R3 is a [AGE] year-old female who have resided at the facility since 2009, past medical history includes, but not limited to chronic obstructive pulmonary disease, chest pain, essential primary hypertension, unspecified osteoarthritis, respiratory failure, etc. On 04/22/24 at 11:36AM, R3 was observed in her room, awake and alert. Staff was at the bedside and stated she is about to change resident but is waiting for another staff. R3 stated, she is usually changed after lunch, but she has not been changed today. R3 stated, she was last changed last night. R3 added, she does not get showers and cannot remember the last time she had a bed bath. V22 (CNA) who was in the room at with resident stated, she has not changed resident because they are short staffed, they should have 4 CNAs but they only have 3 and they still have to do breakfast and assist with feeding. V22 further stated, they have 15 residents each and some of them are 2-person assist so it takes a while to get to everyone on time. On 04/23/24 at 9:50AM, R3 was observed again in her room, awake and alert and stated, she is still waiting to be changed, she was last changed early morning around 3:00AM. On 04/24/24 at 10:10AM, R3 was observed in bed and stated, she is still waiting to be changed. V24 (CNA) was in the room and stated, she is about to change resident, she started her shift at 7:00AM, and she is not sure how many residents she has right now. V24 stated, they have 3 CNAs on the third floor, they sometimes have 4 CNAs and it is better when they work with 4. V24 proceeded to give resident a bed bath, when she removed resident's brief, it was visibly soiled with urine and brown in color. Minimum Data Set (MDS) assessment dated [DATE] section C (cognitive) scored R3 as 12 for brief interview for mental status (BIMS) Section GG (functional abilities) of the same assessment documented that R3 requires substantial/maximal to total dependence on staff for all ADL care. Care plan initiated 12/06/2023 stated that R3 has ADL self-care performance deficit and requires extensive assist x 1 staff for all ADL care needs. Per shower schedule on the third floor, R3 is scheduled for shower two times a week on Wednesday and Friday, review of shower sheets for the month of April 2024 showed R3 received a bed bath two times on 4/17/2024 and 4/20/2024. R47 is an [AGE] year-old male who have resided at the facility since 2019, with past medical history including, but not limited to unspecified sequelae of cerebral infarction, hyperlipidemia, chronic kidney disease stage 2, presence of cardiac pacemaker, essential primary hypertension, heart failure, etc. 04/22/24 10:55AM, R47 was observed in his room reading a book and stated he is doing okay. R47 asked surveyor to speak to his wife whom is in bed B. Resident was noted with long hair and beard. R47 stated, they do not have enough staff to help residents, and he has not been washed and cannot remember the last time he had a shower or bed bath. R47 further stated, there is no one to help him with trimming his beard or cutting his hair. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/23/24 at 10:58 AM, 9:45AM, R47 said that he has not been washed up yet, he has a wound on his bottom, but it will not be changed today, they changed it yesterday, resident still noted with lots of overgrown hair and beard, lying down in a hospital gown. R47 has a BIMs score of 13 and is coded as requiring substantial/maximal assist to total dependence on staff for most ADL care. Care plan dated 1/02/2020 stated that resident has an ADL care performance deficit and impaired mobility related to CVA, COPD and Dementia and requires assistance of 1 staff for ADL cares, bed mobility, transfers, and toileting. R47 is scheduled for showers on Tuesdays and Thursdays, review of shower sheets for April 2024 showed that R47 received a bed bath once on 4/2/2024. On 04/24/24 at 11:10AM, during wound care observation for R47, surveyor asked V18 (LPN) if resident ever refused wound care. V18 stated, :No. R47 was asked in the presence of the wound team if he refuses shower or bed bath and he said that he can never refuse a bed bath. R7 is a [AGE] year-old-male who have resided at the facility since 2020, past medical history includes, but not limited to colostomy status, acquired absence of other specified parts of the digestive tract, gout, rhabdomyolysis, type 2 diabetes, etc. On 04/22/24 at 11:50AM, R7 was observed in his room, alert and oriented and stated that he has been at the facility for a long time, everything is going well except that call light sometimes takes 30 to 40 minutes to be answered. R7 stated, the facility need more staff, sometimes they get agency which helps, he does not get a shower or bed bath, sometimes they help him wash his face, he was asked if he would like to be shaved and he said yes, a staff used to help him trim his beard and hair but he lost his scissors, not sure what happened to it. On 04/23/24 at 10:03AM, R7 was observed again in his room, awake and alert and stated that he got washed up but did not get a shave or haircut. Review of shower schedule showed that R7 is scheduled for showers on Monday and Fridays, shower sheets for the month od April 2024 indicated R7 received a bed bath two times, on 4/4/2024 and 4/10/2024. MDS assessment dated [DATE] scored R7 with a BIMs score of 14, section GG of the same assessment that R7 requires substantial/maximal assistance to total dependence on staff foe all ADL care needs. Care plan initiated 9/27/2022 stated that R7 has ADL self- care deficit related to chronic diastolic congestive heart failure, gout, obesity, type 2 diabetes, etc. On 04/24/24 at 10:01AM, V4 (ADON) stated, she started working at the facility November of 2023 as an ADON. The CNAs are supposed to follow the shower schedule, if a resident refuses shower, a bed bath is offered and if they still refuse bed bath, the CNA should notify the nurse, and sometimes the family or guardian will be contacted. Showers can be done as needed, not just on shower days, the CNAs are supposed to help residents with all ADL needs including dressing, brushing their teeth, nail care and any other help they may need. V4 added, the facility does not have anyone that comes in to give residents haircut, CNAs are supposed to wash resident's hair on shower days and shave the male residents. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ADL care policy dated 01/01/2021, revised 7/22/2023 states in part that the facility ensures that residents receive ADL care assistance and maintains resident's comfort, safety, and dignity. The goal is to maximize the residents and staff safety, confidence, independence, and ability to handle everyday activities. Under procedures, the policy states in part: Facility will identify ADL needs of the residents and assess performance and capabilities to complete task on admission, quarterly and as needed. 3. Care plan will be developed to enhance completion of ADLs. 6. Assist the resident to be clean, neat, and well-groomed including nail care and having finger and toenails cut on shower days and as needed. 40718 R78 is a [AGE] year-old male with a diagnoses history of Cerebral Infarction, Unspecified Symptoms and Signs Involving the Nervous System, and Aphasia following Cerebrovascular Disease who was admitted to the facility 11/10/2022. On 4/23/24 at 11:19 AM Observed R78 with a strong urine body odor, along with his gown and linens. R78 shook his head no when asked by surveyor if he needed to be changed. R78 shook his head up and down to confirm he wants to get up later when asked by surveyor if he wanted to be dressed and raised out of bed. R78's admission Minimum Data Set, dated dated dated [DATE] documents he requires supervision and setup for transfers and walking and most activities of daily living and one-person physical assistance for locomotion on and off the unit, toilet use and personal hygiene. On 04/23/24 at 01:24 PM V28 (Family Member) stated sometimes she comes in at three in the afternoon and R78 has an extremely strong urine smell and still in a bed that has not been changed and she'll get him up. V28 stated R78 can't sit up due to medications and stroke. V28 stated her main concern is R78 getting a little more attention. V28 stated when she comes to visit R78 is in a urine-soaked bed and his gown has a urine smell. V28 stated she's assuming R78 gets changed once a day maybe later at night. V28 stated she would like to see R78 get more assistance, he needs more prompting to get up, get showered. V28 stated sometimes when R78 goes out at night they don't make sure he takes his clothes off when he returns, and he sleeps in his clothes and urinates in them. V28 stated R78 needs help. On 04/24/24 at 03:16 PM V2 (Assistant Administrator) stated R78 has a history of refusing ADL (Activities of Daily Living) care and the facility regularly has to contact V28 for him to comply with incontinence care and bathing, V2 stated social services are also involved because R78 lacks motivation to get out of bed and engage in activities of daily living. V1 (Administrator) and V2 stated these issues are included and addressed in R78's care plan. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R78's current care plan documents he is incontinent but prefers to do his own toileting; R78 has an ADL (Activities of Daily Living) Self Care Performance Deficit related to impaired ability with Dressing and Grooming such as: Putting on or take off clothing, unable to obtain or replace article of clothing, unable to fasten clothing, unable to groom self satisfactorily, unable to complete task with personal hygiene, unable to bathe and groom self independently; R78 requires assistance with ADL's (bed mobility, transfers, dressing, walking, personal hygiene, eating and toileting) with interventions including: Assist resident with shower/bathing per schedule, Encourage participation in ADL's; R78 exhibit(s) the symptoms of resisting care by refusing caregiver requests to leave the bed and refusing/resisting ADL assistance (bathing, dressing, grooming, transferring, etc.) with interventions including: Conduct an evaluation of the behavioral symptoms(s) to determine what strength or needs are communicated via the behavior (e.g., resisting care often communicates the emotion of fear and need for control). R78's current care plan does not include personalized interventions to address his refusal of ADL care and does not document the causes of his refusals. R78's Progress notes from March 01/2024 - April 24/2024 do not document refusals of attempts to provide him with ADL care of incontinence, showers, or personal hygiene. R78's Psychotropic progress notes dated 03/21/2024, and 04/04/2024 created by V25 (Psychiatric Nurse Practitioner) document Staff nurse had no complaints and did not report any behaviors. R99 is a [AGE] year-old female with a diagnoses history of Type 2 Diabetes Mellitus, Morbid Obesity, Contracture of Right Knee and Ankle, On 04/23/24 10:25 AM surveyor observed R99 lying in her bed. R99 stated her assigned certified nursing assistant was supposed to bring ice approximately 9:30 AM but never came back. R99 stated call light response times are between 45 minutes to an hour and a half and she just wants to be changed. R99 stated she is supposed to have showers twice week on Mondays and Thursdays from 3-11. R99 stated she typically has to want for 11-7 shift to receive showers and receives bed baths because she requires multiple staff for assistance. R99's current care plan documents she has an ADL (Activities of Daily Living) Self Care Performance Deficit and Impaired Mobility related to Type 2 Diabetes Mellitus, Disorders of tendon of right ankle and foot, Depression, Pruritus, Obesity, Asthma, Rash Skin Eruption, Dislocation of Patella, and Contracture of Right Ankle and Right knee. Interventions include: requiring total assistance with transfer and preferring staff to provide prompt pericare each shift and as needed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/24/24 at 1:44 PM V27 (Restorative Aide) stated, she works with R99 at varying times depending on the week but she is sometimes pulled to the floor to work as a CNA (Certified Nursing Assistant). V27 stated, she is pulled to the floor about 2-3 times per week which is approximately half the time she works during the week. V27 stated R99 has expressed concerns regarding call light response time and receiving assistance or services as requested. V27 stated sometimes she will educate the CNA's on R99's needs and if she observes her call light on will sometimes step in and assist. V27 stated she has not observed R99's call light on for a long period of time but if she sees the light on and observes her to be frustrated, she'll offer her assistance. V27 stated R99 complains about these issues often and has even stated she will call the state. V27 stated she is not sure if these concerns would be considered grievances. V27 stated she is not sure and can not recall being trained on how to handle grievance concerns. On 04/25/2024 at 3:22 PM V1 (Administrator) stated, if a resident feels issues with call light response time and receiving assistance with activities of daily living continues for an extended period or they want to escalate it, a grievance form can be completed. Grievances/Concerns from January - April 2024 were reviewed and did not include concerns from R99 regarding call light response time or receiving assistance with activities of daily living. The facility's Grievance Policy received/reviewed 04/25/2024 states: It is the policy of the facility to allow and encourage residents and their families to express grievances and concerns they may have regarding the facility, services and staff. Responsible Parties Include: All facility staff. Guidelines Include: 2. Any staff member in the facility may receive a grievance or complaint from a resident or family member. 3. All grievances will be overseen by the facility grievance official. 4. If possible, upon receiving the grievance, attempt to resolve the grievance or direct the resident or family member to the appropriate department head or the Administrator. 6. The staff member will submit the grievance form to the appropriate department head/designee for resolution.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. 46344 Based on observation, interview, and record review, the facility failed to ensure sufficient nursing coverage to adequately meet the residents care needs. This failure has the potential to affect all 45 residents who are currently residing on the third floor. Findings Include: Per daily census report dated 4/22/24 shows that 45 total residents reside on the third floor. On 4/22/24 at 11:36AM, R3 stated, she is usually changed after lunch but she has not been changed at all today. R3 stated, the last time she was changed was last night (4/21/24). R3 stated, the staff get upset when I use my call light. V22 (CNA) stated, R3 has not been changed today because they are short staffed. V22 stated, they need to have four CNA's but they only have three CNA's. V22 stated, a lot of the resident's on the third floor need two person assistance and assistance with meals. This requires a lot of care and takes a while to get all the resident's up out of bed. On 4/23/23 at 10:10AM, V1 (Administrator) was interviewed regarding new facility interventions put into place to help prevent abuse. V1 stated, since 4/16/24, we have implemented a new intervention where male certified nursing assistants (CNA's) are required to have a female CNA present when performing incontinence care. This surveyor asked V1 if she feels as if they have enough staff to perform this intervention. V1 stated, she does not feel as if it is a problem. On 4/24/24 at 9:30AM, V6 (CNA) was interviewed regarding staffing. V6 stated, I do not feel as if we have enough staff to implement this 'care in pairs' intervention. We typically have only three CNA's on the third floor and a lot of resident's need assistance with ADL care. One CNA is responsible to be in the dining room at all times to watch residents who require supervision. Therefore, the two CNA's who are left are responsible to perform incontinence care in pairs. V6 stated, on 4/22/24, we were stretched thin with care and did not have enough staff. I had to perform incontinence care without a female CNA because there were none available. I was late arriving to my shift. R21 was saying she was very soiled and wanted me to provide incontinence care as soon as possible. On 4/24/24 at 10:10AM, R3 said she has been waiting to be changed and has not been changed since the previous shift started before 7:00AM. V23 (CNA) said they have three CNA's assigned to the third floor but it is so much better when they have four CNA's. R3's incontinence brief was observed to be heavily soiled with urine and brown in color. On 4/24/24 at 1:45PM, V27 (Restorative Aide) said she is pulled off the floor 2-3 times a week to work as a CNA because they are constantly short staffed. V27 said she has to work as a CNA on the floor and will not be able to perform her restorative duties when this happens. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/24/24 at 3:07PM, V1 (Administrator) was interviewed regarding staffing. V2 said on the third floor, adequate staffing would include 4 CNA's providing each side of the third floor with two CNA's. The residents on the third floor are more dependent and have increased ADL needs. It is not feasible to have three CNA's on the third floor. On 4/24/24 at 3:25PM, R21 was interviewed regarding staffing within the facility. It is to be noted that R21 resides on the third floor. R21 said this new 'care in pairs' procedure they put in place does not make sense since they do not have enough staff as is. R21 said there are times that I work with V29 (Male CNA) and he refuses to change me when there is not a female CNA available. I will have to sit in my urine or feces for over four hours since there is not an available female CNA. R21 was observed to get visibly upset and start crying during interview. R21 was observed to be unkempt, wearing gown, with dreaded hair at time of interview. Facility Assessment Tool states in part but not limited to the following: General staffing plan shows that 1 LPN/RN to 22 residents for all shifts and 1 CNA to 14 residents for all shifts. Per staffing schedules from 3/27/24-4/25/24 and interview with V23 (Nursing Scheduler) on 4/24/24, It is to be noted that on the 11PM-7AM shift, one nurse is scheduled for 45 residents.

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident must receive and the facility must provide necessary behavioral health care and services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on interviews and record reviews the facility failed to follow their policy and procedure for ensuring residents are provided necessary behavioral health care and services to maintain their highest practicable mental and psychosocial wellbeing consistent with a comprehensive assessment and plan of care and for the prevention and treatment of substance use disorders by not developing comprehensive person-centered care plans, and not reporting signs of resident substance use to social services,. This failure applies to two of three residents (R85, and R102) reviewed for behaviors. Findings include: 1. R85 is a [AGE] year-old male with a diagnoses history of End Stage Renal Disease and Nicotine Dependence who was admitted to the facility 09/17/2022. On 04/22/24 from 10:55 - 12:13 PM surveyor observed a strong odor of Marijuana outside of and in R85's room. Observed R85 with strong Marijuana odor near him. Observed R85 walking through the facility with his eyes appearing red and droopy. On 04/23/24 at 9:12 AM surveyor observed strong Marijuana smell in R85's room. On 04/23/24 at 09:34 AM surveyor observed along with fell ow surveyor hallway near R85's room and R85's room with a strong smell of marijuana. On 04/23/24 at 12:40 PM surveyor observed R85 sleeping in his bed. R85 stated he had been out of the facility earlier and is often in and out of the facility. On 04/23/24 at 01:00 PM surveyor observed V12 (Licensed Practical Nurse) measure R85's blood pressure. V12 stated R78 blood pressure fluctuates depending on dialysis. Surveyor observed R85's eyes to be red and droopy. Surveyor observed V12 administer R85's blood pressure and Kidney medication. V12 stated at times R85 smells of marijuana and if observed with this smell social services is notified and they will talk to him. On 04/24/24 at 10:01 AM V4 (Assistant Director of Nursing/Registered Nurse) stated, she is not aware of any residents returning to the facility under the influence of substances. V4 reported that she can check the policy on contraband searches, however the facility may not necessarily search residents upon return from the community. V4 stated, if nursing smell marijuana, social services is notified and the nurse and social service staff inform the resident of the concerns brought to their attention then get permission from resident to fully search their room. V4 stated, these situations have occurred at times with residents. V4 stated other signs of marijuana use include eyes blood shot, smell of marijuana on person. V4 stated concerns of marijuana use for residents include that other substances may have been within the marijuana that affect cognition, safety issues, and medication use. V4 stated the nurse would perform a full head to toe assessment including vital signs if residents show any signs that they are under the influences of other illegal substances along with marijuana. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R85's Current care plan documents he expresses the desire to receive an outside, independent pass, he must make a commitment to behave appropriately while in the community, take medications as prescribed and remain clean and does not include personalized interventions regarding substance use. R85's Progress Notes from February - April 2024 did not include observations of substance use. On 04/24/24 at 01:01 PM V21 (Social Services) stated, she has not received any reports of R85 using any substances. V21 stated, if it was reported that a resident possibly used Marijuana a room search would be conducted and they may possibly receive a clinical assessment or be sent out for evaluation and testing. V21 stated, if the resident has an outside pass, they would be restricted if they are showing signs of intoxication. V21 stated, due to receiving dialysis, if R85 was using marijuana it could affect his dialysis treatment, and there would also be concerns of bringing substances into the facility, and general safety. 2. R102 is a [AGE] year-old male with a diagnoses history of Recurrent Major Depressive Disorder (as of 08/17/2023), Adjustment Disorder with Mixed Anxiety and Depressed Mood (as of 07/13/2023), who was admitted to the facility 02/19/2023. R102's social service progress notes dated 02/27/2024 documents he attempted elopement. Writer met with R102 to counsel on the importance of making staff aware of issues before he gets too anxious and frustrated in future situations. He expressed understanding. R102 will be on 72 hour follow up. Staff will monitor for aggression and mood changes. Social services will follow up. R102's social service progress note dated 3/5/2024 documents created by V2 (Social Services Director) Day 1: Writer was made aware of resident was presenting with exit-seeking behavior. Writer approached resident and he appeared in an anxious mood at this time. R102 was re-directed and reoriented by writer back to a quiet and safe setting to discuss noted behavior. Writer encouraged R102 to vent feelings or concerns to staff. R102 expressed understanding at this time. Social Services will continue to monitor behaviors. R102 requires constant reminders to decrease in behavior, facility protocols, plan of care, his safety, and a need for daily supervision. R102 has a history of Elopement. Care Plan Updated. R102's Psychiatry/Mental Health progress note created by V25 (Psychiatric Nurse Practitioner) dated 3/13/2024 documents Chief Complaint: Follow up mood. History of Present Illness: [AGE] year-old male with Opioid Use, Unspecified, Uncomplicated and Adjustment Disorder with Mixed Anxiety and Depressed Mood. There were no behavior issues to report. Staff nurse had no complaints and did not report any behaviors. R102's Psychotropic Progress note dated 3/21/2024 documents Chief Complaint: Follow up adjustment disorder. There were no behavior issues to report. Staff nurse had no complaints and did not report any behaviors. R102's Psychotropic Progress note dated 3/29/2024 documents Chief Complaint: Follow up mood There were no behavior issues to report, and his mood has been baseline per staff. Staff nurse had no complaints and did not report any behaviors. (continued on next page)

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	145070	A. Building B. Wing	04/25/2024

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

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R102's Health Status Progress Note dated 4/4/2024 created by V11 (Psychotropic Nurse) documents a Change In Condition/s reported on this change in condition evaluation are/were: Behavioral symptoms (e.g. agitation, psychosis). R102's Progress note dated 4/4/2024 documents he is being aggressive, being delusional, trying to elope out the front door, and is not able to be redirected. Writer called resident's Psych Physician and left a voice message. Writer asked the Physician. to call back to the facility concerning the resident. Writer notified Director of Nursing to make her aware of resident's behavior. Writer called Insight hospital and gave nursing report. Writer called transportation to schedule pick-up for the resident. R102's Progress note dated 04/6/2024 documents he became verbally and physically threatening to writer. Resident is not able to be redirected after several failed attempts to calm him down. Resident stormed out of the facility unescorted against writer and other staff request . Code yellow was called staff quickly responded to bring him out the courtyard back inside. Physician was notified ordered to send resident out to insight hospital for psychiatric evaluation. R102's social service progress note dated 4/8/2024 by V21 (Social Services) documents Note Text: Behavior monitoring Day 1 of 3. Writer met with (staff) to conduct well-being check. Resident went outside with writer along with psychotherapist for about an hour. R102's social service progress note dated 4/10/2024 12:37 documents a code yellow was called to the receptionist area and upon arrival the resident was at the front door trying to elope, being physically/verbally aggressive. Writer tried to talk to the R102, and he continued to scream/yell. R102 was not able to be redirected. The writer informed the V13 (Nurse Practitioner) and orders were to send the resident to local hospital. A petition will be sent along with the resident. R102's social health status progress note dated 4/16/2024 documents writer approached resident regarding skin assessment, resident was pacing and appeared upset, writer asked R102 if he was ok, he yelled No and kept walking. Writer later saw R102 on the 2nd floor of the building attempting to get into the social services office, he appeared upset, staff was able to redirect him. Writer unable to complete an assessment on the resident due to aggressive behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R102's progress note dated 4/23/2024 at 2:16 PM documents he is showing aggressive behaviors towards staff physically and verbally. The resident is not able to be redirected. A petition to hospital has been presented to the writer for the resident. The writer has contacted ambulance service for transport to hospital was given. The Director of Nursing and V13 (Nurse Practitioner) is aware of the residents petition/transport; at 3:30 PM Behavior follow up note: documents Writer was made aware by nursing staff that resident was inside of nursing office exhibiting with verbal aggressive behavior and demanding that nursing staff change his current out on pass order from supervised to independent. R102 voiced that he is capable of going out alone and wants order changed immediately. Writer approached resident and he was in an agitated mood. R102 was asked kindly to exit nursing office and go speak to social services in their office. When R102 entered office, he was asked to sit as he was standing in doorway of social services office yelling and screaming stating, I want my pass changed now! I don't understand why I can't go out by myself! R102 was reassured that he was safe and that he ok with staff. Resident was then asked again to sit and calmy express himself, resident refused. Resident was then notified of outside pass procedures, his gait imbalance, poor decision making, and safety awareness. R102 then continued to express agitation towards staff with noted verbal aggression, while resident was in the doorway of social services office another resident approached social services office to notify them of his return from Association House Skills Training. R102 then turned towards peer and yelled loudly, this is my time I'm busy leave now! Peer was immediately assisted out by social service designee to his room. R102 remained in social services office with noted uncontrollable verbal aggressive behavior. Social services continued to encourage resident to speak in a soft tone of voice resident refused. R102 was then asked to be taken on a walk down to his room to calm down. Once R102 reached first floor nursing station he refused to present in a calm manner. Social services was notified by nursing staff to petition resident out for psychiatric evaluation, noted aggression towards staff and peer and uncontrollable verbal outburst. R102 has a history exhibiting with, exit seeking behavior, aggressive/inappropriate behavior, attention seeking behavior, conflicts/altercations with others, and acting impulsively, and erratically. R102's current medical diagnoses are Aphasia Following Cerebral Infarction, Symptoms and Signs Involving Emotional State, Other Symptoms and Signs Involving Appearance and Behavior, Recurrent Major Depressive Disorder, Adjustment Disorder with Mixed Anxiety and Depressed Mood, and Opioid Use. R102 suffers from a family history of verbal abuse. R102 currently receives psychotherapy and agrees with counseling sessions at this time. Social Services will continue to follow up, intervene, and council resident as needed. R102 is currently petitioned out to hospital for assessment review. Care plan updated. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/24/24 at 12:45 PM V21 (Social Services Designee) stated, a lot of R102's frustrations are from him wanting to go outside so sometimes staff will take him outside for a walk upon request. V21 stated R102 also visits with psychotherapist 3-4 times per week, engages in activities, and his needs are addressed by social services when expresses them. V21 stated, she is not aware of any group programs for residents, but the psychotherapist or social services director may have more information. V21 stated she keeps in touch with V26 (Psychotherapist/Psychologist) often regarding R102's behaviors. V21 stated she believes V25 (Psychiatric Nurse Practitioner) works along with the V11 (Psychotropic/Fall Nurse). V21 stated, she only communicates with V26. V21 stated, it's pretty important to communicate behaviors to R102's psychotropic care team which is why she tries to communicate consistently with V26 so she can meet with R102. V21 stated R102 wants to be outside probably daily and even wants to go out at times after he's already been out. V21 stated, on occasion R102 can be taken outside multiple times a day depending on who's available. V21 stated, R102 likes to watch videos on his computers, but mainly likes sitting outside when he can. V21 stated, if activities are not being offered enough or R102 isn't able to go outside frequently enough it may contribute to more behaviors. V21 stated R102 exhibits these behaviors sometimes even when offered activities and outside time. V21 stated, if activities and outside time are still not adequate for R102 we'll try to work with him and she personally will invite him to her office just to vent his frustrations which can be helpful. V21 stated, if none of these options are sufficient they may offer him something from the kitchen, activities, or see if there's anyone he wants to speak to. V21 stated, she believes V26 can refer residents to outside services or providers for psychosocial services if needed. R102's current care plan documents he is a younger individual [AGE] years of age and presents with a Substance abuse history and difficulties expressing himself. He may present with poor motivation, lack of energy. May state he is bored or act bored. Interventions include: Assess the need for additional, formal education needs and offer referrals, as appropriate for educational opportunities; Assure the resident is in an appropriate treatment setting. R102 has a history of aggressive, inappropriate, attention-seeking and/or maladaptive behavior. R102's history includes conflicts/altercations with others, acting impulsively, and erratically by throwing chairs. R102 has been noted flipping over tables when he is stressed and refuse staff redirection/reorientation to setting. On 11/21/23 R102 was noted with aggression towards staff. Interventions include: If R102's symptoms warrant further assessment of ongoing management, Refer him to a mental health professional, including a consulting psychiatrist, for evaluation; Intervene when any inappropriate behavior is observed. Communicate assertively that he must exercise control over impulses and behavior (Social skills training); Provide supportive intervention as needed; R102 demonstrates strong activity participation, may refuse some activities at certain times, goes outside as an activity at his request, also enjoys arts and crafts. Interventions include: Escort the resident to preferred setting as requested; establish a rapport with the family. R102 demonstrate(s) movement behavior that may be interpreted as wandering, pacing or roaming. R102 attempts to leave the facility without a responsible escort (elopement) and will become agitated, oppositional and combative when redirected by staff. R102's care plan does not include personalized behavioral interventions to address causes of or prevent behaviors. R102's progress notes do not document any communication with V25 (Psychiatric Nurse Practitioner) or V26 (Psychotherapist/Psychologist) regarding R102's elopement, aggressive, inappropriate, attention seeking or maladaptive behaviors. (continued on next page)

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F 0740 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R102's point of care activities reports from 03/26/2024 - 04/24/2024 documents he primarily engaged in self-directed indoor audio related (such as listening to music) activities daily, and only engaged in indoor group activity once during the month on 03/26/2024 and once in outdoor group activity on 04/17/2024. R102's medical records do not include documentation of referrals for group or supervised outside psychosocial services activities and do not include documentation of him being offered time outside with staff. On 04/24/24 at 01:27 PM V11 (Psychotropic/Falls Nurse) stated, V26 (Psychotherapist/Psychologist) is the psychologist or social therapist that meets with the residents and attempts to visit with residents twice weekly for 30 minutes. V11 stated, If V26 notices behaviors she provides suggestions and then she communicates that to V25 (Psychiatric Nurse Practitioner) who comes in to the facility twice weekly. V11 stated, every week she always updates crystal with a list of all residents on psych medication or with a psych diagnosis and residents that may have had behaviors that week. V11 stated the IDT (Interdisciplinary Team) meets once weekly and discuss behaviors and requests V25 to prioritize these residents when she comes in and conducts her rounds. V11 stated, she believes R102 had a stroke at a young age 32. V11 stated, she is always been able to sit and talk with R102 and has not had to send him out, but at times he cannot be calmed down or deescalated. V11 stated,she gave R102 a supervised pass but that does not seem to be sufficient. V11 stated, she believes R102 does no belong at the facility and maybe belongs in a different type of facility. As of the exit of the annual certification survey the facility did not provide a policy for substance abuse or behavior health services as requested 04/25/2024. The facility's Comprehensive Care Plan Policy reviewed/receive 04/25/2024 states To meet the resident's physical, psychosocial and functional needs, the facility will develop and implement a comprehensive, person-centered care plan for each resident that includes measurable objectives and target goals. The Facility IDT will develop and implement a person-centered care plan for each resident/patient in conjunction with resident and his/her family/ or legal representative's participation in care. Care plan interventions or approaches will be based on resident or patient health records, comprehensive assessments, resident/patient preferences and reasonable requests from family/legal representative. The comprehensive, person-centered care plan will be measurable and attainable. Care plan interventions are chosen only after careful data gathering, proper sequencing of events, careful consideration of the relationship between the resident's problem areas and their causes, and relevant clinical decision making. Assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50519 Based on observation, interview and record review, the facility failed to have a five percent (5%) or lower medication error rate. There were nine (9) medication errors out of 29 medication opportunities, resulting in a 31.03% medication error rate. This applies to 6 residents (R1, R15, R19, R22, R37, R92) of 10 residents observed during medication administration. Findings included: 1. On 04/23/24 at 09:40 AM Medication observation with V10 (license Practical Nurse) completed for R22. R22 has a diagnosis of cerebral vascular disease, Atrial Fibrillation and Congestive Heart failure. V10 gave the following medications crushed and in apple sauce to R22: Isosorbide mononitrate 30mg 1 tab, Aspirin 81mg 1 tab- Per Physician order sheet dated: April 2024 reads: Aspirin Oral Tablet 325 MG (Aspirin) Give 1 tablet by mouth one time a day, identified wrong dose was given. Isosorbide Mononitrate ER Tablet Extended Release 24 Hour 30 MG Give 1 tablet by mouth one time a day. 2. On 04/23/24 10:00 AM Medication observation with V10 for R37. R37 was admitted on [DATE], with the diagnosis of Diabetes II, and Low back pain. V10 said, the Lidocaine patch is not available. Per Physician order sheet dated: April 2024 reads: Lidocaine External Patch (Lidocaine) Apply to behind neck topically one time a day. 3. On 04/23/24 10:03 AM Medication observation with V10 completed for R19. R19 is a [AGE] year-old female originally admitted on [DATE] with diagnosis that include and are not limited to: fibromyalgia, hypertension and osteoarthritis. 4-23-2024 at 10:05am V10 said, I am holding the medications since her blood pressure is lower than 110. Per Physician order sheet dated: April 2024 reads: Furosemide Tablet 20 MG Give 1 tablet by mouth one time a day was not given, no written parameters to hold medication as per order dated: 11-15-2023. Per Medication administration dated April 23-2024 documentation reads: 5- hold medication. 4. On 04/23/24 at 10:22 AM Medication observation with V10 completed for R15. R15 was admitted to the facility on [DATE] with the diagnosis of Heart failure, Chronic Obstructive pulmonary disease, Chronic Viral Hepatitis C, and Hypertension. V10 said, I am holding R15's blood pressure medication per parameters, I do not have any medications to give R15 now. I am done with R15. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Per Physician order sheet dated: April 2024 reads: Folic Acid Tablet 1 MG Give 1 tablet by mouth one time a day for Elevated MCV- not given. Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate Dihydrate) 2 puff inhalers orally two times a day- not given. 5. 04/23/24 10:28 at AM Medication observation with V10 completed for R1. R1 was admitted to the facility on [DATE] with diagnoses that include and are not limited to diabetes and heart failure. V10 said, we do not have the Flonase suspension, I must call the pharmacy to reorder the medication. Maybe the night nurse threw it out because it did not have a date open in the box. Per Physician order sheet dated: April 2024 reads: Biofreeze Gel 4 % (Menthol (Topical Analgesic)) Apply to both ankles topically two times a Day- not given. Flonase Suspension 50 MCG/ACT (Fluticasone Propionate)1 spray in both nostrils two times a day- not given. R1 said am not getting the Flonase for 7 days, I keep asking the nurse. 6. On 04/24/24 at 08:55AM Medication observation with V12 (licensed Practical Nurse) completed for R92. R92 is a [AGE] year-old male originally admitted on [DATE] with medical diagnosis that include and are not limited to: heart failure, Atrial Fibrillation and hypertension. V12 administered to R1 the following medication: Gabapentin Oral Capsule 100 MG 2 capsule by mouth. Per Physician order sheet dated: April 2024 reads: Gabapentin Oral Capsule 100 MG Give 3 capsule by mouth three times a day. Incorrect dose given. On 04/23/2024 at 12:40 PM, V13 (Nurse Practitioner) said, when blood pressure medications do not have parameters to hold, my expectation is for the nurse to call the provider for further orders. On 04/24/24 at 01:29 PM V4 (Assistant Director of Nursing) said, any extended Released medication should not be crushed, we need to have a doctor's order for the medication to be crushed, after checking R22's physician's orders, V4 said, I do not see any order for R22's for medications to be crushed. On 2-24-2024 at 3:00pm V4 presented: 1. Policy titled: Medication Administration General Guidelines, undated: reads, long acting or enteric coated dosage should not be crushed; alternative should be sought. 2. Policy titled: Meds that should not be Crushed Dated 2/2023, reads crushing extended-release meds can result in administration of a large dose at once.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50519 Based on observation, interview and record review, the facility failed to ensure stock medications, eye drops and insulins were labeled with open and expiration date, failed to label multidose vials and multidose liquid medications and failed to dispose expired medications. These failures affected 8 (R2, R7, R8, R16, R23, R42, R69 and R100,) residents reviewed for medication storage and labeling and have the potential to affect 126 residents receiving medications on all floors. Three out of six medication carts and three out of three medication rooms reviewed for medication storage and labeling. Findings include: On 04/23/24 at 11:00am, medication storage and labeling observation completed with V10 (Licensed Practical Nurse) on the second-floor south medication cart, 1-Humalog insulin vial opened and not dated for R2. 2-Cromolyn Sodium Ophthalmic Solution 4% opened and undated for R69 3- Levetiracetam 100mg/ml for R8 opened and undated. Floor stock Medication observed to be open and undated as follows: 1 Bottle Pro Stat 1 Bottle Bismuth Subsalicylate 1 Bottle Acetaminophen 160mg/ml 1 Bottle Milk of Magnesium 1 Bottle Geri-Tussin (Guaifenesin) 1 Bottle Clear Lax V 10 said, I do not see any open date on the vials eye drops and floor stock medication, the medications should be dated after opening. Per Physician order sheet dated: April 2024 reads: 1. R2 was admitted on [DATE] with diagnosis that include and are not limited to: diabetes mellitus, has a current order for HumaLOG Injection Solution 100UNIT/ML (Insulin Lispro) per sliding, order active as 2-19-2023. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	2. R69 was admitted on [DATE] with diagnosis that include and are not limited to: diabetes, has a current order for Cromolyn Sodium Ophthalmic Solution 4% (Cromolyn Sodium) Instill 1 drop in both eyes one time a day, active date 1-13-2023. 3. R8 was admitted [DATE] with diagnosis that include and are not limited to: epileptic syndrome and Cerebral infaction, has a current order for levETIRAcetam Oral Solution 100 MG/ML (Levetiracetam) Give 10 ml by mouth two times a day order active as 2-14-2024. On 4/23/24 12:40pm medication storage and labeling observation completed with V30 (Licensed Practical Nurse) on the First Floor South Medication Cart, 4. Lactulose Suspension 10gm for R42 opened and undated. Floor stock Medication observed to be open and undated as follows: 1 Bottle Milk of Magnesium 1 Bottle Bismuth Subsalicylate 1 ClearLax, Polyethylene Glycol 3350 Powder. First Floor North Refrigerator observed to have a multidose vial of Tuberculin opened and undated. V30 said, we as nurses need to document the date the bottles are open, I do not see any dates documented. 4. Per Physician order sheet dated: April 2024 reads: R42 was admitted on [DATE] with diagnosis that include and are not limited to chronic viral hepatitis has no current order for, Lactulose Oral Solution 10 GM/15ML (Lactulose), order was discontinue on 4-8-2024. 04/23/24 at 01:10 pm, medication storage and labeling observation completed with V14 (Licensed Practical Nurse) on the third Floor South Medication Cart, Briomidine 0.2% eye drop and Latanoprost 0.005% eye drops for R23 opened and undated. Lantus insulin vial for R100 opened and undated. Humalog insulin vial for R7 opened and undated. Haloperidol 2mg/ml for R16with documented expiration date of: 03/21/24. Scolamine gel 2.5mg/ml for R16 with documented expiration date of: 11/1/23 Floor stock Medication observed to be open and undated as follows: 1 Bottle Iron Supplement suspension 220mg/5ml 1 Bottle Geri-Tussin (Guaifenesin) (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1. R23 was admitted on [DATE] with diagnosis that include and are not limited to: Cerebral infarct, has a current order for: Latanoprost Ophthalmic Solution 0.005 %(Latanoprost) Instill 1 drop in both eyes at bedtime with active order of 2-2-2024. Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) Instill 1 drop in both eyes every 8 hours with active order of 2-2-2024. 2. R100 was admitted on [DATE] with diagnosis that include and are not limited to: diabetes mellitus has a current order for Insulin Glargine Solution 100 UNIT/ML Inject 22 unit subcutaneously, with active order 4-16-2024. 3. R7 was admitted on [DATE] with diagnosis that include and are not limited to: diabetes mellitus has a current order for HumaLOG Injection Solution 100UNIT/ML (Insulin Lispro) Inject as per sliding scale, with active order 11-8-2023. 4. R16 was admitted on [DATE] with diagnosis that include and are not limited to: dementia, per April 2024 no current orders for the above medications. On 04/23/24 at 01:30 PM V14 said, the insulin vials, eye medications and floor stock medications must be dated when medication is opened and when it needs to be discarded. On 04/23/24 at 01:35 pm V11 Unit Manager/Psych Nurse said, I expect the staff to discard the medications when expired and they need to date the medications when it is opened. Medication must be returned to pharmacy when residents are discharge from the facility and/ or expired. 04/23/24 at 01:00 PM Director of Nursing (DON) V3 said, the Insulins, eye medications and house stock must be dated when it is opened. V4 (assistant Director of Nursing) presented: 1. Facility Policy: storage of medication, undated: reads; medications and biologicals are store safely, securely, and properly. All expired medications will be removed from the active supply. 2. Administering medications, dated: 05/18/23 reads: the expiration/beyond use date on the medication label, is checked prior to administering. when opening a multi-dose vial-dose container, the date opened is record on the container.

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	145070	A. Building B. Wing	04/25/2024

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50519 Based on observation, interview, and record review the facility failed to follow its enhanced barrier precaution policy by failing to place any signage with informational material on one (R47) resident door or making personal protective equipment (PPE) available inside or outside resident's room perform hand hygiene between glove changes during wound care observation, failed to clean blood pressure machine and glucose monitor device after used between patients. and failed to keep linen in a closed hamper with the lids closed. These failures affect six (R15, R19, R22, R29, R38, R47) residents reviewed for infection control practices Findings Include: On 04/23/24 at 09:15 am, surveyor observed V10 (License Practical Nurse) taking blood pressure on R15, then on R22 without cleaning the blood pressure cuff. R15 was admitted on [DATE] with diagnosis that include and are not limited to hypertension and heart failure. R22 was admitted on [DATE] with diagnosis of hypertension and cerebral infarction. On 04/23/24 at 10:12 AM surveyor observed V10 taking R19's blood pressure and putting it in top of the cart without cleaning the cuff, when asked if task was completed V10 said, yes. R19 was admitted on [DATE] with diagnosis that include and are not limited to hypertension and heart failure On 4-23-2024 at 10:30 AM V10, said the blood pressure equipment needs to be cleaned with the disinfectant, and I did not do it. On 04/24/24 at 8:50am, during medication pass, V12 (License Practical Nurse) was observed performing blood sugar check for R38, then placed the machine on top of the medication cart, when asked if task was completed, V12 said yes. No cleaning of the equipment observed to be done. V12 said, the blood glucose machine needs to be clean after each resident's use, and I didn't do it. R38 was admitted on [DATE] with diagnosis that include and are not limited to: diabetes type 2 On 04/24/24 at 8:55 am, during medication pass with V12, observed to use bare hands to touch medications and giving it to R22. V12 said I should have not touched the medications with my own hands, I need to perform hand hygiene or wear gloves because is an infection control problem. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 04/24/24 at 9:46 Observed V18 (wound care nurse) performing a dressing change for R29 and after removing soiled dressing V18 donned and doffed gloves on two different occasions without any hand hygiene or hand washing. Surveyor observed a soiled linen and garbage hamper with both lids open in R29's room. V18 said, I am expected to sanitize my hands every time I remove the gloves, but I did not do it, my expectations, the staff is to keep the hamper with soiled linen outside of the room and with the lids closed. R29 was admitted on [DATE] with diagnosis that include and are not limited to: diabetes, pressure ulcer of sacral. On 04/24/24 at 1:29 PM V4 (Assistant Director of Nursing) said, the staff must clean the equipment after each resident used, hampers are not to have the lids open, not supposed to be inside the resident's rooms, hampers are to stay outside the room to be used. I expect for the nurses to perform hand hygiene when performing dressing changes and each time they are changing gloves. On 04/25/24 at 2:30 pm V19 (Infection Preventionist) said, the facility expectation is: blood pressure monitors and blood glucometers are supposed to be sanitized after each resident use, medications can not be touched with bare hands before giving to residents, hampers with soiled linen are to be kept outside the room with the lid closed. Nurses are expected to perform hand hygiene before wound care, after removing the gloves and after each resident. V4 (Assistant Director of Nursing) presented: 1. Policy Titled: Cleaning and Disinfection on the Resident-Care items and Equipment, dated 05/28/23 reads: Reusable Items are cleaned or sterilized between residents. 2. Policy titled: Administering Medications dated: 5-18-2023 reads: staff follows stablished facility infection control procedures (e.g., handwashing, antiseptic techniques, gloves) for the administration of medication as applicable. 3. Policy Titled: Handwashing/Hand Hygiene, dated 04/12/24 reads: Hand Hygiene before and after direct contact with residents, before performing and after handling blood fluids, and after handling used dressings, and contaminated equipment. 4. Policy: Linen Management, dated: 5-18-2023 reads: It is the policy of the facility to ensure linens are handling in a way to prevent cross contamination; dirty linens are contained in a closed container. 40920 Based on observation, interview and record review, the facility failed to follow its enhanced barrier precaution policy by failing to place any signage with informational material on resident's door or making personal protective equipment (PPE) available inside or outside resident's room. This failure affected one resident (R47) who is currently receiving wound care at the facility. Findings include: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R47 is an [AGE] year-old male who have resided at the facility since 2019, with past medical history including, but not limited to unspecified sequelae of cerebral infarction, hyperlipidemia, chronic kidney disease stage 2, presence of cardiac pacemaker, essential primary hypertension, heart failure, etc. 04/23/24 10:58 AM, 9:45AM, R47 was observed in his room, awake, alert, and oriented and said that he has not been washed up yet, he has a wound on his bottom, but it will not be changed today, they changed it yesterday, and he is due again tomorrow. Resident was not on any type of isolation, there was no signage on the door or any isolation bin inside or outside the room. 04/24/24 11:10AM, observed wound care for resident with V15 (LPN/wound care), V18 (LPN/wound care coordinator) and V20 (Wound care C.N.A) and noted a large area of excoriation on resident's bottom with some spots open and actively bleeding. V18 donned gown and gloves, removed the old dressing and cleaned resident's bottom with normal saline. Staff used hand sanitizer, donned another glove, and applied the ordered treatment to resident. R47 does not have any isolation sign on the door, or any set up for isolation. Surveyor asked V15 if resident was supposed to be on any type of isolation and she said that resident was supposed to be on enhanced barrier precaution, the sign on the door fell off. Surveyor informed V15 that resident have not had any isolation set up or sign on his door since the start of survey 4/22/2024.V15 said, Oh, okay. 04/24/24 12:20PM, V19 (infection prevention Nurse) said that residents on enhanced barrier precaution are those with indwelling catheter, wounds, G-tube or on dialysis. said that she is responsible for setting up the isolation equipment and making sure there is a sign on the door. V19 was asked if she is familiar with R47 and why he is not on any type of isolation and she said that she is not aware that resident needed to be on any isolation, does not know that resident have any wounds, no one communicated that to her. V19 also said that wound team does not give her any report, she mostly goes by word of mouth. A document presented by V1 (Administrator) titled enhanced barrier precaution with a revision date of 3/28/2024 states in part under general: Enhanced Barrier Precautions (EBP) is an approach of targeted gown and glove use during high contact resident care activities, designed to reduce transmission of S. aureus and Multidrug Resistant Organisms (MDRO) EBP may be applied (when Contact Precautions do not otherwise apply) to residents with any of the following: Wounds or indwelling medical devices. Under Guideline, the document states in part: Enhanced Barrier Precautions applies to all residents with any of the following: Wounds, and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of MDRO colonization status. When a resident is placed in Enhanced Barrier Precautions, gown and gloves will be used during high-contact resident care activities. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post clear signage on the door or wall outside of the resident room indicating the type of Precautions and required PPE, Enhanced Barrier Precautions signage and informational material should indicate the high-contact resident care activities that require the use of gowns and gloves. Make PPE, including gowns and gloves available, discretion maybe used in placement of PPE (inside or outside of the room) and may not need to be donned prior to entering the resident's room.