STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145268	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Terrace	1511 Greenwood Road Glenview, IL 60025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review the facility failed to ensure ongoing monitoring and assessment to identify suprapubic stoma site drainage and skin impairment and obtain appropriate treatment from the Physician. This deficiency affects one (R195) of three residents in the sample of 35 reviewed for Suprapubic catheter care management and quality of care. Findings include: On 6/11/25 at 9:27AM, observed R195 lying in bed with low air loss mattress. V19 CNA (Certified Nurse Assistant) lifted the top sheet and observed R195's disposable brief soaked with serosanguineous drainage on suprapubic area. V19 opened his brief and observed no dressing on suprapubic catheter site with moderate amount of serosanguineous drainage. The stoma site and surrounding skin noted with redness and irritation. The suprapubic catheter is not secured to the abdomen. The catheter is connected to the urinary drainage bag covered with privacy bag. R195 denied any pain. He said that he had a shower yesterday and did not have dressing after it was removed for the shower. R195 said that the nurses usually do his dressing twice a day. Called V7 (Agency Nurse) and showed observation made. V7 said that they do dressing to R195's suprapubic site every shift due to his drainage. V7 said that no one informed him that R195 does not have dressing on his suprapubic site. V7 called for V21 WCN (Wound Care Nurse). On 6/11/25 at 9:31AM, V20 Agency CNA said that she is the assigned CNA for R195, but she is not aware that he did not have his supra pubic catheter dressing on. She has not yet provided him with morning care. On 6/11/25 at 9:40AM, called V21 WCN and showed observation made. V21 opened his brief and observed no dressing on suprapubic catheter site with moderate amount of serosanguineous drainage. The stoma site and surrounding skin with redness and irritation. V21 said that he will assess, document and call physician for treatment orders. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R195 is admitted on 5/2024 with diagnosis listed in part but not limited to Obstructive and reflux uropathy, Benign prostatic hyperplasia, Limitation of activities due to disability, need for assistance with personal care. Active physician order sheet indicated: Zinc oxide to urinary meatus topically two times a day for skin irritation/rashes. Indwelling catheter type: Suprapubic catheter, catheter size 16F, 10cc balloon reason for use: Obstructive and Reflux uropathy ordered 6/11/25 after surveyor asked for his medical records. Suprapubic catheters care every shift. Change catheter drainage bag PRN (as needed). Change foley bag, tubing, and tube holder every night shift weekly. Monitor drainage around the stoma every shift. Monitor skin integrity around the stoma every shift. Suprapubic catheter: catheter care every shift. Cleanse area with NS (normal saline) pat dry leave open to air. Apply dressing only if site is observed with drainage and sign and symptoms of infection ordered date 6/12/25 after surveyor interviewed with V21 on 6/12/25. R195's skin/wound evaluation dated 6/11/25 documented by V21 WCN indicated seen patient today for skin assessment. Staff cleaned the area and upon assessment, skin surrounding the suprapubic catheter is intact, no redness, no drainage, and no s/s of infection. Patient is not in pain. Catheter is patent and draining clear colored urine. Dressing applied as ordered. Patient tolerated the procedure well. Patient made comfortable in bed. Call light within reach. Preventive measures in place. On 6/12/25 at 9:33AM, Reviewed R195's medical records with V21WCN. Informed V21 of discrepancy with his documentation from what was observed yesterday with R195's suprapubic catheter site. V21 said that he observed R195's disposable brief on his suprapubic area was soaked with serosanguineous drainage. He said that he opened R195's brief and observed no dressing on suprapubic catheter site with moderate amount of serosanguineous drainage. The stoma site and surrounding skin with redness and irritation. He said that after he cleansed it, it did not look so bad and took picture. V21 took his phone and showed to 2 surveyors the picture he took of R195's suprapubic site. Surveyor asked V21 to describe the suprapubic site in the picture. V21 said that there is redness on the site and surrounding area. V21 said he was asked by his supervisor to take picture of R195's suprapubic site and sent the picture to her. Surveyor informed V21 that this is an invasion of resident privacy of taking picture from his personal phone. V21 said that he did not call the physician for treatment because they are putting barrier cream - Zinc oxide to the suprapubic site and they don't need physician order because it's a barrier cream. Informed V21 that R195's physician order sheet indicated Zinc oxide ointment to be applied to urinary meatus twice a day for skin irritation/rashes not for suprapubic site. Informed V21 that R195's reason for suprapubic catheter usage ordered date 6/11/25 was changed to Obstructive and reflux uropathy from BPH (Benign Prostatic Hypertrophy) after observation made with R195 and requested for documents yesterday. On 6/12/25 at 10:40AM, Informed V8 WCC (Wound Care Coordinator) of above observations and concerns. V8 said that they cannot use their own personal cell phone to take picture of resident's suprapubic catheter site. Informed V8 that the nurses are not documenting drainage and changes in suprapubic site. Informed V8 that they failed to ensure ongoing monitoring and assessment to identify suprapubic stoma site drainage and skin impairment and obtained appropriate treatment from the Physician. Facility's policy on Suprapubic Catheter reviewed 7/31/24 indicated: Policy statement: The facility shall follow nursing guidelines for safe, aseptic care, removal and change of a suprapubic catheter in order to prevent infection and help maintain catheter patency. Care guidelines: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Dressing around the stoma shall be changed daily and PRN. Monitor stoma site for any redness or maceration. 3. All suprapubic catheters must be secured to abdomen with an appropriate anchor device to prevent accidental dislodgement or removal. Facility's policy on Skin regimen and Treatment formulary reviewed 3/24/25 indicated: Policy statement: It is the policy of this facility to ensure prompt identification, documentation and to obtain appropriate treatment for residents with skin breakdown. Procedures: 1. Charge nurses must document in the electronic health record any skin breakdown upon assessment and identification. 2. Routine daily wound care treatment/dressing change is administered by the wound care nurse or designee daily unless otherwise indicated by the patient's attending physician c. other skin condition.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 3. On 6/10/25 at 10:45AM, observed R186 lying in bed with LAL (Low air loss) mattress. V7 Agency LPN (Licensed Practical Nurse) checked the linens over the mattress. Observed linen folded in quarters and flat sheet over the mattress. R186 is wearing disposable adult brief. Surveyor asked V7 of what the setting for R186's LAL mattress. V7 said he does not know. He said that the wound care team is responsible for setting and monitoring of resident's LAL mattress. Surveyor requested for the V8 WCC (Wound Care Coordinator) and requested to observe wound care. On 6/10/25 at 10:46AM, informed V8 WCC of above observation. V8 said that resident on LAL mattress should only be on a flat sheet unless indicated in resident's care plan. On 6/10/25 at 11:10AM, observed V8 adjusting R186's LAL mattress control panel. V8 said that R186 is not on appropriate setting as manufacturer recommendation. V8 said R186 weighs 84lbs and her setting was at 110lbs. V8 said that V10 Wound Tech usually make rounds to checks all the residents in the unit with LAL mattress for appropriate setting. On 6/10/25 at 11:55AM, observed V8 WCC, V9 WCN (Wound Care Nurse) and V10 Wound Tech provide wound care to R186. During wound care, V8 WCC giving instruction and cuing V9 WCN during wound care. On 6/11/25 at 3:02PM, Informed V2 DON (Director of Nursing) of above observations and concerns. R186 is initially admitted on [DATE] with admission diagnosis listed in part but not limited to Sequelae of Cerebral Infarction, Atherosclerosis of native arteries of right leg with ulceration of other part of foot, non-pressure chronic ulcer of other part of left foot, Altered mental status, Palliative care, Diaper dermatitis, Type 2 Diabetes Mellitus. Most recent Braden scale assessment dated [DATE] indicated she is at high risk for skin impairment. Active physician order sheet indicated: Alternating pressure mattress: diagnosis vascular wound and prevention care. Treatment: Left medial ankle-Cleanse wound with normal saline solution (NSS). Xeroform secondary dressings-ABD, rolled gauze every MWF and PRN (as needed). Mid vertebrae -Cleanse wound with NSS. Skin prep. Bordered foam. Report to MD for any abnormalities, continue offloading the areas. Keep area clean and dry as needed for skin protection every TTH and PRN. Right dorsal foot- Cleanse wound with NSS. Xeroform dressings- ABD, rolled gauze every TTHS and PRN. Right hip-Cleanse wound with NSS. Apply foam dressing for protection every TTHS and PRN. Right lower back-Cleanse wound NSS. Xeroform dressing- bordered foam every TTHS and PRN. Sacrum-Cleanse wound with NSS. Calcium alginate, bordered foam dressing every day and PRN. Wound care physician visit dated 6/3/25 indicated sudden onset of pear-shaped skin breakdown and discoloration in the sacral area and right lower back area indicating a Kennedy terminal ulcer. The staff report the patient is declining in health overall, with decreased appetite and weight loss. The patient is also being seen for chronic venous wounds on the BLE. The patient was awake and resting in bed, prevalon boots in place. The patient has thin and fragile skin with history of wounds. Foley catheter in place. Comprehensive care plan indicated that she has an actual and a potential for further impairment to skin integrity due to present of comorbidities, limited mobility, fragile skin, and fracture status post fall. R186's Low air loss mattress manufacture's functions guide indicated: Pressure adjust knob adjustable by patient's weight. Turn the pressure adjust knob to see a comfortable pressure level by using the weight scale as guide. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy on Specialized mattress and appropriate layers of padding revised 8/19/23 indicated: 1. Limit the amount layers on top of specialized air mattress such as low air loss mattress according to the resident's needs and individual's condition in order to manage comfort, positioning, and moisture . 3. Use specialized air mattresses like low air loss mattress on the resident with stage 3 or 4 pressure sores to ensure moisture, heat, and friction control. Based on observation, interview and record review, the facility failed to ensure low air loss mattress devices were on the correct weight setting for residents who are at risk for developing pressure injuries. This failure has the potential to affect three (R61, R186 and R200) out of four residents reviewed for pressure injury prevention and treatment in a final sample of 35 residents. Findings Include: 1. On 6/10/25 at 12:50PM, observed R61 in bed with low air loss mattress in use. Air loss mattress is set to 7. Confirmed with V25 (Unit Nurse Manager) that the setting is on 7. V25 looked at a paper with R61's weight record and reset the mattress to 4. R61 is 116.0 lbs. dated 6/10/25. R61 Braden Scale and Clinical Evaluation dated 6/5/25, reads: High Risk 7. 0 and R61 with history of healed pressure injuries to left and right buttocks and coccyx. On 6/12/25 at 10:30AM, V8 (Wound Care Coordinator) stated that R61 does not have any active pressure injury at this time, however R61 has a history of pressure injury. R61 is high risk for skin alteration and specialty mattress is being used as a preventative measure. V8 stated that they use a specialty mattress such as low air loss mattress for residents who are high risk for skin alteration, resident with multiple stage 2 pressure injuries and resident with stage 3 or higher. 2. On 6/10/25 at 10:28AM, observed R200 in bed with low air loss mattress in use. Air loss mattress is set to 150 lbs. V24 (LPN) confirmed that the setting is set to 150 lbs. V24 mentioned that R200 is 98 lbs. and needs to be set to 90 Lbs. V24 reset the specialty mattress on 90 lbs. Record reviewed. R200 is 98.0 lbs. dated 6/2/25. R200 Braden Scale and Clinical Evaluation dated 5/19/25, reads: High Risk 9.0 and R200 with a history of left elbow unstageable pressure injury healed 4/16/25. Braden Scale and Clinical Evaluation shows that above 20 is low risk and below 20 is high risk. On 6/12/25 at 10:30AM, V8 (Wound Care Coordinator) stated that the setting for the specialty mattress such as the low air loss mattress is based on resident's weight. The setting should be closer to resident weight if the increment is 30 lbs. (pounds) per dial. If resident is 98 lbs., then it should be set to 120, closer to resident's weight but not under, due to the bed will be too soft and the purpose of the bed will not be effective. V8 also stated that R200 is a hospice resident and assessed as high risk for skin alteration. R200 has history of pressure injury in which it was healed. The mattress is for comfort and preventative measures. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Proactive Manual states that Weight/Pressure set up: User can adjust air mattress to a desired firmness according to patient's weight or the suggestion from health care professional. Wound Care Guidelines with a revised date of 1/24/24, reads in part: The goal of this care guidelines is to achieve compliance to regulatory requirements and provide evidence-based recommendations for the prevention and treatment of pressure injuries that can be used by the health professionals in the facility. The purpose of the prevention recommendations is to guide evidence-based care to prevent development of pressure injuries and the purpose of the treatment focused recommendations is to provide evidenced-based guidance of the most effective strategies to promote pressure injury/ulcer healing. The score from the Braden Scale and Clinical Evaluation should be interpreted/calculated to determined level of risk: Low Risk and High Risk. Each risk factor and potential cause(s) identified be reviewed individually and addressed into the resident's care plan. Facility shall develop a plan of care and implement intervention according to the resident's Braden Scale and Clinical Evaluation of identified risk factors.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. On 6/10/25 at 10:45AM, observed R186 lying in bed with LAL (Low air loss) mattress. V7 Agency LPN (Licensed Practical Nurse) said that R186 has multiple chronic wounds on BLE and has Kennedy terminal ulcer to sacral area. She is on hospice care. She is non-verbal, may open eyes when called. She needs total care with ADLs (Activity of Daily Living) and transfers. V7 said that they monitor her for pain every shift. R186 is initially admitted on [DATE] with admission diagnosis listed in part but not limited to Sequelae of Cerebral Infarction, Atherosclerosis of native arteries of right leg with ulceration of other part of foot, non-pressure chronic ulcer of other part of left foot, Altered mental status, Palliative care, Diaper dermatitis, Type 2 Diabetes Mellitus. Active Physician order sheet indicated she is on Acetaminophen rectal suppository 650mg insert 1 suppository rectally every 4 hours as needed (PRN) for pain/fever. Hydromorphone HCl solution 2mg/ml give 0.2ml by mouth every 2 hours PRN for dyspnea/pain. Comprehensive care plan indicated she is at risk for pain due to history of femur fracture from fall. Pain tool assessment used for R186 every shift indicated numerical pain scale assessment from 5/25/25 to 6/9/25 which is coded from 0-2. On 6/11/25 at 3:02PM, V2 DON (Director of Nursing) said that they utilized PAINAD (Pain Assessment in Advanced Dementia) for residents with advanced dementia who may be unable to verbally express their pain. Informed V2 that R186's every shift pain assessment record from 5/25/25 to 6/9/25 indicated that the nurses were using the numeric pain scale pain assessment tool. The numeric pain scale is a tool used to assess and quantify pain intensity. It is typically ranges from 0-10 with 0 representing no pain and 10 representing the worst pain. Residents are asked to select the number that best reflects their current level of pain. This pain assessment tool is typically used for resident who is alert and oriented not for cognitively impaired and nonverbal like R186. Informed V2 that the facility failed to ensure to utilize appropriate pain assessment tool for resident with cognitive impairment or non-verbal resident for pain management. Informed V2 that the nurses stated using the PAINAD tool assessment when surveyor asked for it on 6/10/25. Facility's PAINAD (Pain Assessment in Advanced Dementia) tool assessment form indicated: observation of 5 key behaviors: Breathing, Negative vocalization, Facial expression, Body language, and consolability. By observing these behaviors, the nurses can assess the severity of pain in individual with advance dementia. Facility's policy on Pain revised 1/30/25 indicated: Policy statement: It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain. Based on observation, interview, and record review, the facility failed to have an ordered narcotic pain medication available for five and a half hours for a resident (R330) with severe pain and the facility failed to utilize a pain assessment tool for a cognitively impaired/non-verbal resident (R186) for pain management for two out of four residents reviewed for pain in a total sample of 35. Findings Include: (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. R330 is a [AGE] year old with the following diagnosis: lupus erythematosus; fibromyalgia; fracture of the right humerus, right tibia, and right fibula; and wedge compression fracture of the T11-T12 vertebra. On 6/11/25 at 11:10 AM, R330 stated R330 was hit by a car which fractured R330's right arm and lower right leg. R330 reported they live with chronic pain due to R330's lupus diagnosis. R330 stated R330 normally lives at a pain level of seven out of ten with scheduled pain medication. R330 reported the best pain relief is the narcotic pain medication which is ordered as needed so R330 has been requesting it about every four hours. R330 stated R330 also receives scheduled Tylenol but that does nothing to bring down R330's pain. On 6/12/25 at 10:02 AM, V26 (LPN) stated R330 last received the narcotic pain medication around 4AM. V26 reported R330 requested the narcotic pain medication around 8:30AM but the medication was not available. V26 stated the medication should be reordered from pharmacy before the last dose is given. V26 reported the medication card will tell the nurse when to order it from pharmacy. V26 was not able to answer why the medication was not delivered but stated the previous shift nurse should have reordered the medication at the time it was administered so pharmacy would have time to deliver the pain medication. V26 reported the medication was reordered about an hour ago STAT so it is expected to be delivered in about an hour. V26 stated the narcotic medication is usually stocked in the pyxis system but is currently out of stock. V26 reported R330 stated R330's current pain level was ten out of ten. On 6/12/25 at 10:08 AM, R330 stated V26 told R330 that the facility did not have the narcotic pain medication in stock. R330 reported a fentanyl patch was put on this morning but has not been on long enough to give any pain relief. R330 stated pain was a ten out of ten in R330's right arm, right leg, and lower back. R330 described the pain as sharp in the upper and lower extremities and aching in the lower back. R330 reported refusing to work with therapy when asked earlier this morning due to R330's uncontrolled pain. On 6/12/25 at 12:21 PM, V5 (ADON) stated V5 called pharmacy to get an update and the medication will be delivered in about 30 minutes. V5 reported the narcotic pain medication still has not been given yet. V5 was unable to give a number on the pain scale for R330 at this time. On 6/12/25 at 12:27 PM, V27 (Physical Therapist) stated V27 worked with R330 today around 11AM. V27 reported R330 constantly complained of pain throughout the entire session. V27 stated the nurse told V27 that the medication was not in stock, and they needed to wait for it to be ordered. V27 reported R330 was able to participate in therapy but wasn't able to complete all the planned exercises because of R330's pain level. V27 stated R330 rated the pain a ten out of ten at the beginning of the session and a fourteen out of ten at the end of the session. On 6/12/15 at 12:32 PM, V2 (DON) stated the nurse is responsible for reordering the medication from pharmacy when the medication card is running low. V2 reported each medication card will indicate when pharmacy needs to be called for more medication to be sent. V2 stated the nurse should order the medication at this time so it is available for the next dose. When asked why the pyxis system wasn't accessed to give the narcotic medication, V2 said, I don't know. I will have to check. On 6/12/25 at 1:47 PM, V5 stated the staff did not access the pyxis system to get the narcotic medication out because that medication was out in the pyxis as well. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Physician Order Summary documents to offer pain medication 30-60 minutes prior to treatment which was dated 6/10/25. The following scheduled pain medication was ordered on 6/9/25: Tylenol 325 mg two tablets every six hours, a transdermal fentanyl patch 100mcg/hour that started on 6/12/25, and a lidocaine patch 4% to the left knee and right shoulder every morning. The narcotic pain medication (oxycodone) is ordered as needed only. Oxycodone 15 mg three tablets every four hours as needed was ordered on 6/9/25. The Medication Administration Record dated 06/2025 documents pain scores are documented once a shift and range from a zero (no pain) to a ten (severe pain). On 6/12/25, the scheduled Tylenol was administered at 6AM and 12PM. Oxycodone was administered at 4:17 AM and was not administered again until 1:42 PM. The Physical Therapy Treatment note dated 6/12/25 documents R330 rated pain a ten out of ten that was on the right upper and lower extremity and back. R330 was able to walk 15 feet to the bathroom and back but refused to walk more due to pain. R330 presented with excruciating pain during the session. The therapist spoke with the nurse that reported they are waiting for the pain medication to arrive. The Nursing admission dated 6/9/25 documents R330 had complaints of pain upon admission to the right lower extremity and right shoulder. At this time, R330 rated the pain a three out of ten and described it as an intermittent ache. R330 reported medication, rest, and ice relieve the pain. A Physician note dated 6/12/25 documents due to lupus and musculoskeletal changes R330 is on medication for chronic pain. The Care Plan dated 6/9/25 documents R330 is at risk for pain (chronic) related to lupus. Interventions include to medicate prior to therapy/treatment and provide analgesic as ordered. The policy titled, Pain, dated 1/30/25 documents, Policy Statement: It is the policy of the facility to ensure that all residents are assessed for pain in every situation where there is a potential for pain .Procedures 1. Upon admission and readmission, the nurse will assess the resident for pain. For those identified with pain upon admission/readmission assessment, an order for pain medication will be obtained from the physician. If available in the convenience box or facility house stock, the pain medication ordered will be administered to the resident as soon as possible. A policy on reordering medication was requested but was not given by the facility.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview, and record review the facility failed to ensure an accurate count of controlled medication on the controlled drug administration record sheet. This deficiency affects 1 of 3 medication carts reviewed for Controlled Medication count Management. The facility also failed to follow its policy on medication administration on prohibiting pre-pouring of medications. This deficiency affects two (R110 and R525) of twelve residents in the sample of 35 reviewed for administration of medication. Findings include: On 6/10/25 at 9:10AM, checked medication cart with V4 LPN (Licensed Practical Nurse). Observed pre-poured medications in plastic medication cup inside the top drawer and controlled/narcotic drawer. V4 said that she prepared the medication for R525 and R110. V4 said that she is about to give the medication, but she answered another resident's call light. V4 said that she should not pre-pour the medications. Medications prepared should be given to the resident immediately. Reviewed and counted controlled/narcotic medications with V4. Observed discrepancies for R525's Controlled medication bingo card of Tramadol 50mg indicated 15 tablets medications left while the Controlled drug administration record documented 17 left medications and Alprazolam 0.25mg indicated 5 tablets medication left while the controlled drug administration record documented 6 left. V4 LPN said that she forgot to sign the date, time, and amount the controlled medication that she took at controlled administration record. On 6/10/25 at 9:19AM, informed V5 ADON (Assistant Director of Nursing) of above observations. V5 said that medications prepared by the nurse should be administrated immediately. The nurse (V4 LPN) should not be pre- pouring medication for the residents. V5 said that after removing the controlled medication from the bingo card or individual packet, the nurse will sign off the accompanying controlled medication sheet indicating the medication is taken. On 6/11/25 at 3:02PM, informed V2 DON (Director of Nursing) of above observations and concerns. V2 said that it is not their facility's practice to pre-pour medications of residents for medication administration. Facility unable to provide medication policy specific for prohibiting pre-pouring of resident's medications. Facility's policy on Controlled Medication Count revised 7/26/24. Policy statement: It is the policy of the facility to maintain an accurate count of schedule II-controlled medications. Procedure: 1. After removing the controlled medication from the bingo card or individual packet, the nurse will sign off the accompanying controlled medication sheet indicating the medication is taken. Facility's policy on Medication Administration revised 8/16/24 indicated: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145268	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Terrace	1511 Greenwood Road Glenview, IL 60025

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy statement: It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedure.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145268	A. Building B. Wing	06/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenview Terrace	1511 Greenwood Road Glenview, IL 60025

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review the facility failed to use appropriate infection control practices when taking blood pressure during medication administration. This deficiency affects one (R526) of one resident observed taking blood pressure during medication administration observation in the sample of 35 reviewed for Infection Prevention and Control Program. Findings include: On 6/10/25 at 12:28PM, V7 Agency LPN (Licensed Practical Nurse) said that he has to take BP (blood pressure) of R526 before administering her medications. V7 placed the BP cuff on upper arm of R526 without disinfecting the BP monitor portable machine prior to use. V7 obtained 110/75mmHg. After taking the BP, he placed the BP portable machine on top of the medication cart without disinfecting it after using. V7 prepared medication for R526 and administered the medication orally. On 6/10/25 at 12:34PM, V7 Agency LPN said that he is done with his noon time scheduled medications administration. V7 pushed his medication cart in front of the nursing station. V7 still did not disinfect the BP portable machine that he placed on top of the medication cart. At 12:45pm, informed V7 of observation made that he did not disinfect the BP portable machine before and after he used it to take BP of R526. V7 said that he forgot to disinfect the BP portable machine including BP cuff before and after using it with R526. On 6/11/25 at 3:02PM, Informed V2 DON (Director of Nursing) of above observations and concerns. On 6/11/25 at 8:25AM, Informed V17 Infection Coordinator of above observation and concern. V17 said that BP portable machine- including BP cuff should be disinfected before and after using it with resident. Facility's policy on medical equipment, instruments and Health IT Devices Infection Control Plan revised 8/16/24 indicates: Policy Statement: it is the policy of this facility to prevent infection and create/maintain a safe environment for the residents, their visitors and staff thru proper handling, cleaning, and sanitizing of medical care equipment, instruments and or other related health IT devices. Procedures: 7. Nursing personnel shall wipe down/clean reusable equipment between residents using a facility approved cleaner/disinfect 12. Some medical care equipment items shall be cleaned and or sanitized with facility approved disinfectant agent between each resident use.