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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145329	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norridge Gardens	7001 West Cullom Norridge, IL 60634

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 35267 Based on interview and record review, the facility failed to provide showers twice a week per facility policy. This applies 2 of 5 residents (R3, R6) reviewed for showers in the sample of 7. The findings include: 1. Face sheet, dated 10/30/24, shows R6's diagnoses include Parkinson's disease, cerebral infarction, chronic obstructive pulmonary disease, morbid obesity, depression, difficulty walking, encephalopathy, need for assistance with personal care, reduced mobility, lack of coordination, unsteadiness on feet, and chronic diastolic heart failure. MDS (Minimum Data Sheet), dated 9/20/24, shows R6 was cognitively intact and was dependent on staff for bathing. Care plan, as of 10/28/24, showed R6 was to be provided a sponge bath if she was unable to tolerate a full bath or shower. On 10/29/24 at 1:15 PM, R6 was lying in bed and her hair appeared to have an oily substance throughout. R6 stated stated she was only getting baths once a week because the staff told her they did not have time to provide her baths. On 10/30/24 at 10:42 AM with V2 (Director of Nursing), R6 stated she was not getting scheduled baths on Friday afternoons due to inconsistent staffing on Friday PM shifts. R6 stated she wished to move her scheduled bath times to Friday AM shifts so that she would consistently receive baths on Fridays. R6 stated she never refused her scheduled baths. Review of R6's Bathing record documentation, dated 9/1/24 to 10/28/24, shows R6 was to be offered baths every Tuesday and Friday. The documentation shows R6 was being offered a bath on Tuesdays 9/24/24 and Tuesday 10/22/24. The documentation shows R6's documentation included RR (Refused) or NA (Not Applicable) on Friday 9/6/24, Friday 9/20/24, Friday 9/27/24, Friday 10/18/24, and Friday 10/25/24. (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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24, 3:53 PM, V2 (Director of Nursing) stated documentation of showers/baths which shows residents marked as RR or NA on their scheduled bath days show that the CNA (Certified Nursing Assistant) was documenting the resident refused their shower/bath. V2 stated it was her expectation that if a resident refused a bath/shower, the nurse would be informed, the nurse would speak with the resident, and the nurse would document the conversation with the resident as well as the resident refusal of the shower/bath. Review of R6's nursing progress notes, dated 9/1/24 to 10/28/24, showed no documentation that R6 refused showers. On 10/31/24 at 8:43 AM, V1 (Administrator) stated it was her expectation that all residents were offered a shower/bath twice weekly at the facility. Resident Shower or Bed Bath Policy/Procedure, dated 11/2015, shows If not contra-indicated, shower is to be given to residents at the facility at least twice a week and as needed If the resident refused to have a shower or bed bath, inform the nurse 2. Face sheet, dated 10/30/24, shows R3's diagnoses included osteoarthritis, seizures, anxiety, depression, morbid obesity, idiopathic and hereditary neuropathy, artificial hips, overactive bladder, and hypertension. MDS, dated [DATE], shows R3's cognition was moderately impaired and R3 required substantial/maximal assistance from staff for bathing. Care plan, as of 10/28/24, failed to show R3 had any history of refusing showers/baths on scheduled days. On 10/29/24 at 12:50 PM with R4 (Roommate), R3 stated she felt like she had to fight to get her showers because the staff were too busy. R4 stated she was not receiving her showers/baths on her scheduled bathing days. On 10/30/24 at 10:30 AM, R3 stated she never refused her baths/showers on her scheduled bathing days. R3 stated she always asked for her showers on her scheduled shower days but the staff told R3 they were too busy to provide her with the showers. R4 stated R3 never refused any of her showers on her scheduled shower days. R4 stated, If anyone refuses, it is the staff! R4 stated on R3's scheduled shower days, the staff tell R3 they have no time to provide her scheduled showers or tell R3 it was not her scheduled day to receive a shower. Review of R3's nursing progress notes, dated 9/1/24 to 10/28/24, shows no documentation of R3 refusing offers of baths/showers. Review of R3's bathing documentation, dated 9/1/24 to 10/28/24, shows R3 was documented as refusing showers/baths on the following dates: 9/2/24, 9/5/24, 9/9/24, 9/12/24, 9/23/24, 9/26/24, 9/30/24, 10/24/24, and 10/28/24.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 35267 Based on interview and record review, the facility failed to ensure nursing staff remained with a resident until all of the resident's medications were administered per facility policy. This applies to 1 of 6 residents (R2) reviewed for medications left at bedside in a sample of 7. Findings include: Facility Incident report, dated 8/25/24, shows on R1's family observed medications at R2's bedside. The report shows R2 denied that they were her medications and stated she already took her medications. The report shows the medications were removed immediately and the resident was assessed with no concerns. The report shows R2 was monitored for changes in condition on 8/25/24. The incident investigation shows a re-education regarding medication storage and administration was given to facility nursing staff. On 10/29/24 at 10:41 AM with V2 (Director of Nursing), V3 (Infection Peventionist Nurse / Manager on Duty) stated she was the Manager on Duty on 9/25/24 when a nurse supervisor informed her a family found medications inside a resident room. V3 stated she investigated and spoke with the nurse and supervisor on duty at the time the medications were found. V3 stated there were approximately 14 medications and no narcotics. V3 stated the medications included vitamins, supplements, and other typical morning medications. V3 stated when she spoke with the residents in the room, R1 stated she already received and took her morning medications, and R2 stated she also took her medications V3 stated when she further questioned R2, R2 stated she may have forgotten to take her mediations she was provided earlier that mourning by the nurse. V3 stated V5 (Registered Nurse) was on duty and caring for R1 and R2 at the times the medications were found in the residents' room and denied leaving the medications not taken by R2 in R2's room. V3 stated V5 insisted she watched R2 take her medications that morning and stated she did not leave the medication at the bedside. Manager on Duty Statement, dated 8/25/24, shows medications were left on R2's bedside table. The statement shows R2 stated she put the medications on the bedside table intending to take them and forgot to do so. On 10/30/24 at 11:29 AM, V4 (Registered Nurse Supervisor) stated on 8/25/24 she was informed that medications were found at R2's bedside. V4 stated R2 stated the medications were hers and R2 forgot to take the medications. V4 stated she verified that the medications were R2's AM doses of medications and then destroyed the medications. V4 stated the medications should never have been left with the resident and the administering nurse should visualize the residents taking their mediations when medications are administered. MDS (Minimum Data Set), dated 9/6/24, shows R2's cognition was moderately impaired. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 1:30 PM, R2 stated on 8/25/24 she forgot to take her morning medications when the nurse handed her the medications. R2 stated she left the medications sitting on the dresser in her room. On 10/30/24 at 1:46 PM, V5 (Registered Nurse) stated she provided R2 with her AM medications on 8/25/24 and watched R2 take her medications that morning. MAR (Medication Administration Record), dated 8/25/24, shows R2's AM medications included cholecalciferol 5000 Units, duloxetine 60 mg (milligrams), glipizide 10 mg, lamotrigine 24 mg, miralax 17 grams, multivitamin 1 tablet, venlafaxine extended release 75 mg, Vitamin E-400, memantine 10 mg, sennosides-docusate sodium 8.6-50 mg, and tramadol 50 mg. Facility document Administering Oral Medications, revised 3/2020, shows, Remain with the resident until all medications have been taken.