STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145341	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore Village	350 West Schaumburg Road Schaumburg, IL 60194

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 34490 Based on observation, interview and record review the facility failed to ensure a resident's legs were properly supported while sitting in her wheelchair for 1 of 26 residents (R57) reviewed for accommodation of need in the sample of 26. The findings include: R57's Face Sheet shows she has diagnoses of: history of venous thrombosis and embolism, back pain, scoliosis, osteoporosis, history of a fracture and left foot pain. R57's Vitals Summary Report shows that she is 60 inches tall. On 11/18/24 at 11:39 AM, R57 was sitting in her wheelchair in her room. R57's feet were hanging approximately 6 inches from the floor and R57 did not have any leg rests on her wheelchair. R57's legs were reddish purple in color. On 11/19/24 at 1:00 PM, R57 said that if she puts her feet on the bar of the tray table, she is comfortable but if her legs are just hanging, it is not very comfortable. R57 said that she is about five feet tall. On 11/19/24 at 1:42 PM, V20 (Therapy Director) said that for proper positioning in a wheelchair, a resident's feet should be either flat on the ground or placed on foot rests that are adjusted to ensure that their feet are supported. V20 said that the legs should be supported to prevent swelling or pressure on the back of the legs. V20 said that R57 does not self propel her wheelchair so she should have leg rest on her wheelchair when she is sitting in it. V20 went to R57's room and was only able to find two left-sided foot rests. The facility's Resident Rights and Dignity - Accommodation of Needs Policy revised on 12/8/21 shows, The facility's actions of the environment and its' associates are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity and well being. The resident's individual needs a preferences will be accommodated to the extent possible.

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

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on interview and record review the facility failed to ensure a resident's advanced directives were discussed and implemented upon admission for 1 of 26 residents (R282) reviewed for advanced directives in the sample of 26. The findings include: R282's Face Sheet shows that he admitted to the facility on [DATE]. The Face Sheet shows that his original admission was 4/8/22. R282's Electronic Medical Record (EMR) has a POLST (Physician Orders for Life Sustaining Treatment) Form that shows that R282 does not want resuscitation. This form was uploaded into R282's EMR on 10/21/2024. R282's Physician's Order Sheet Printed on 11/20/24 shows an order dated 11/15/24 for R282 to be a full code (attempt resuscitation). R282's EMR does not document that social services discussed R282's advanced directives with him or his power of attorney prior to 11/20/24. R282's Social Services Note dated 11/20/24 shows, Verified POLST Form with resident and spouse, both resident and spouse confirm request for DNR (Do Not Resuscitate). On 11/20/24 at 1:00 PM, V2 (Director of Nursing) said that a resident's advanced directives are discussed by the nurse upon admission. V2 said that residents are a full code until they receive a valid POLST form. V2 said that if a resident has a valid POLST form on file, the facility staff should follow those directives unless the resident has other wishes and the discussion should be documented in their medical record and verified with the physician. V2 said that social services follows up with new residents the following day to ensure that their advanced directives are correct. V2 said that she does not know why R282's POLST Form directives were not implemented or why social services did not follow up with him the day after his admission. The facility's Emergency-First Aid-Do Not Resuscitate Order Policy revised 10/18/22 shows, DNR/POLST orders will remain in effect until the resident (or legal surrogate) provides the facility with a signed and dated request to end the DNR/POLST order.

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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** 34117 Based on observation, interview and record review the facility failed to ensure residents who require staff assistance with ADLs (Activities of Daily Living) received showers/baths. This applies to 2 of 26 (R58, R39) residents reviewed for activities of daily living in the sample of 26. The findings include: 1. R58's face sheet shows she is a [AGE] year old female including Parkinson's disease, congestive heart failure, contracture of the right hand, osteoarthritis, history of falls, atrial flutter, chronic kidney disease, and gout. R58's Minimum Data Set assessment dated [DATE] shows she is cognitively intact, has no rejection of cares, and requires substantial/maximum assistance with showers/bathing. On 11/18/24 at 10:26 AM, R58 was sitting in her wheelchair in her room. Her right hand was clenched and and she had tremors to her left hand. She said she is supposed to get showers twice a week on Wednesday and Saturday on PM shift. She said the last time she had a shower was a couple of weeks ago, when she asks the staff for her shower their response is we are short handed and alot of them are agency staff. On 11/19/24 at 9:07 AM, R58 said she was not offered a shower on Saturday. This surveyor located the shower book at the common area on the Gingko Unit. The shower schedule book showed R58's last documented shower was 11/2/24 (17 days ago) and 10/16/24 she received a bed bath. (There were no other showers/baths recorded on the sheet). On 11/19/24 at 12:56 PM, V7 (Certified Nursing Assistant-CNA) said R58 is alert and oriented, she complains about agency staff not providing cares. Residents should receive showers twice a week, staff document in the electronic health record (EHR) and the shower sheet with the nurse signing off the resident received their shower. Residents have reported they do not receive their showers by agency staff on the 2nd shift. On 11/20/24 at 10:35 AM, V2 (Director of Nursing) said staff should chart resident showers in the EHR. The shower sheet is the worksheet that should be filled out by the CNA and signed off by the nurse. The charting in the EHR is the documentation. The Gingko Unit Shower Sheet Schedule shows R58's showers are scheduled for Wednesday and Saturday on the PM shift. R58's Shower/Bath report provided on 11/20/24 shows there were no showers documented for 30 days. R58's Shower Sheet forms provided on 11/19/24 shows a bed bath was given on 10/16/24, 11/2/24 a shower was documented given and a new recorded shower date of 11/16/24 refused during AM shift. 34490 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. On 11/18/24 at 11:45 AM, R39 was laying in bed. There was a strong urine odor present in the room. R39's hair appeared greasy. On 11/18/24 at 11:45 AM, R39 said that she is supposed to get showers every Tuesday and Friday but she has not had a shower in over a week. On 11/18/24 the unit's shower binder was reviewed. The binder shows that R39 is to receive showers on the PM shift on Tuesday and Fridays. The last documented shower for R39 was from 11/8/24. There were no documented showers for 11/12 or 11/15. R39's Bathing Task shows that she received a shower on 11/8/24 and no additional showers or bed/towel baths until 11/18/24. No refusals of showers were documented between 11/8/24 and 11/18/24. R39's Kardex Report shows, Bathing/Showering: [R39] needs assistance with bathing. On 11/19/24 at 1:27 PM, V19 (Certified Nursing Assistant) said that showers are provided to residents twice a week. V19 said that all showers are charted in the computer and on the shower sheet in the binder. The facility's Personal Care-ADL Support Policy shows, Appropriate care and services will be provided for residents who are unable to carry out ADLs independently, with the consent of the resident and in accordance with the plan of care, including appropriate support and assistance with: Hygiene (bathing, dressing, grooming, and oral care)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview and record review the facility failed to ensure a gait belt was used during a transfer and failed to ensure interventions were added to a resident's plan of care after a fall to prevent additional falls for 2 of 26 residents (R39 and R110) reviewed for safety in the sample of 26. The findings include: 1. On 11/18/24 at 11:48 AM, V23, Certified Nursing Assistant (CNA) transferred R39 to the toilet using a gait belt. V23 removed the gait belt to provide care and change R39's shirt. After R39 used the toilet, V23 directed R39 to stand and hold onto the bar on the wall. V23 did not reapply the gait belt before directing R39 to stand up. While V23 was providing perineal care, R39 stated, I can't hold on much longer .I'm getting heavy. V23 then pulled up R39's incontinence brief and pants up and assisted her to sit back into her wheelchair. On 11/19/24 at 1:27 PM, V19 (CNA) said that gait belts should be used on all resident transfers for the resident's safety. R39's (Resident Care Informaiton) Report shows that she needs assistance of one staff member for transfers. The facility's Positioning/Moving-Safe Resident Handling Policy revised on 12/29/21 shows, Gait belt usage-Gait belt usage is recommended for a 1 person transfers with the exception of bed mobility and/or medical contraindications. 33760 2. R110's Physician Order Sheet dated 11/24 shows R110 has diagnoses of senile degeneration of brain, dementia, weakness, anxiety and depression. R110's facility assessment dated [DATE] shows R110 has severe cognitive impairment. BIMS (Brief Interview of Mental Status) of 3. R110's fall risk assessment shows R110 is high risk for falls. Review of R110's fall incident reports shows: -9/27/24 (V14, Restorative Registered Nurse/RN) was assisting (R110) to her recliner from her wheelchair. As resident was screaming to go back to her recliner while transferring with 1 staff assist, (R110)'s knee buckled and was lowered slowly to the floor. -10/4/24 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(R110) was being transferred (with 1 assist). (R110) became weak and was lowered to the floor. (R110) sustained injury after the fall including left knee skin tear, and abrasion to left rear back. On 11/20/24 at 11:20 AM, V14 (Restorative RN) said on 9/27/24, R110 was having behaviors, yelling and screaming. R110 was wanting to be transferred to her recliner. V14 said she applied a gait belt but R110 was already resistive and was having behaviors. Two (2) person assist should have been safer for R110 due to her behaviors. V14 said after the 2nd fall incident (10/4/24) of R110 again being lowered to the floor, was when she adjusted R110's transfer assessment to use 2 staff assist or sit to stand assist when needed. (No fall intervention was done after the 9/27 fall.) R110's Transfer Mobility assessment dated [DATE] shows, .needed maximum assist staff to stand up r/t [related to] weakness, poor trunk support, unsteady standing balance .May use sit to stand lift PRN [as needed].

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34490 Based on observation, interview and record review the facility failed to ensure a newly admitted resident on tube feeding was weighed weekly. This failure resulted in R125 losing 16.8 pounds (11.4% weight loss) in 18 days. The facility failed to monitor weights, assess residents who have had a significant weight loss and implement interventions to prevent further weight loss. This failure resulted in R20 losing 12.6 pounds (7. 67% weight loss) in 1 month and R231 losing 10.2 pounds (6.6% weight loss) in 13 days. This applies to 3 of 5 residents (R20, R125 and R231) reviewed for nutrition in the sample of 26. The findings include: 1. R125's Face Sheet shows that he admitted to the facility on [DATE] with diagnoses of: severe protein-calorie malnutrition, gastrostomy, dysphagia and parkinsonism. R125's Physician's Order Sheet (POS) printed on 11/20/24 shows an order dated 10/24/24 for, Weekly weights x 8 weeks . The POS shows orders for NPO (nothing by mouth) and an order for enteral feeding. R125's Nutritional Risk assessment dated [DATE] shows, admitted with diagnosis of metabolic encephalopathy, osteomyelitis of left ankle and foot He is NPO d/t [due to] dysarthria and on new peg tub for enteral feeding .Wife denies any notable significant changes to weight in past month .at risk for unintended weight loss .dehydration pressure injury weight goal-weight will be maintained +/- 5% or gain by review Interventions: Monitor weight weekly for 8 weeks and then monthly or as indicated .Additional Comments: Will continue to monitor weight, TF (tube feeding) tolerance and intervene as needed. RD (Registered Dietitian) available for consult PRN (as needed). R125's Weights and Vitals Summary printed 11/20/24 shows a weight of 147.8 pounds on 10/24/24 and a weight of 131 lbs on 11/11/24 (11.4% weight loss in less than a month). There are no other documented weights between 10/24/24 and 11/11/24. On 11/20/24 at 9:22 AM, V4 (Registered Dietitian) said that all new admissions are weighed upon admission and then weekly to monitor for weight loss or gain. V4 said that any one who is triggered to be at high risk for weight loss have weights done weekly. V4 said that if a resident is on tube feeding, they are at high risk for weight loss and their weights should be closely monitored. V4 said that she saw R125 when he first arrived at the facility. V4 said that he was admitted with continuous tube feeding orders so she changed the rate and time frame so he did not have to be on continuous feedings but would still get the same amount of calories and nutrition. V4 said that R125 did not have any documented weights for some time and she is not sure why. V4 said that once R125 got a weight done, it showed a weight loss so she increased his tube feeding rate. V4 said that weekly weights would have helped identify a weight loss sooner so interventions could have been implemented to prevent further weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The facility's Nutrition-Hydration-Weight-Assessment and Intervention Policy revised on 1/27/22 shows, The facility shall measure resident weights on admission, for the next two days, and weekly for 4 weeks thereafter .Weights are recorded in the resident's medical record .Any weight change of 5% or more since the last weight assessment will be retaken the next day for confirmation. If the weight is verified, the dietitian shall be notified, and the notification documented in the resident's medical record. The dietitian will respond within 24 hours of notification .The threshold for significant unplanned and undesired weight loss will be based on the following criteria .1 month-5% weight loss is significant; greater than 5% is severe . 33760 2. On 11/19/2 at 10:41 AM, R20 was being served breakfast. Both V9 and V10 (Certified Nursing Assistants-CNA) said R20 is a total feed so she was served at a later time during meals. Review of R20's weights shows: 9/3/2024-169.0 pounds (lbs.), 10/1/2024-170.1 lbs and on 11/14/2024-157.5 lbs. R20's weights show that she had a significant weight loss of 12.6 pounds (7.67%) in 1 month. R20 had no nutritional assessments or nutritional intervention related to this significant weight loss. On 11/20/24 at 9:13 AM, V4 (Dietitian) said R20 was weighed last on 11/6/24 and her weight was totally different from her usual weight. V4 said on 11/7/24 she requested a reweigh. On 11/14/24, R20's reweigh was 157.5 lbs. V4 said she did not know why the reweigh was not done until after a week. V4 said she was also not made aware of R20's reweight results sooner. V4 said when she entered R20's latest weight of 157. 5 lbs, it did not trigger a significant weight loss until it was brought to her attention by this surveyor. V14 said she will do nutritional assessments and recommendations today. 34117 3. R231's face sheet shows she is an [AGE] year old female admitted on [DATE] and readmitted on [DATE] with diagnoses including fracture of left pubis, type 2 diabetes, unspecified dementia, muscle weakness, hypertension, osteoporosis, and history of failing. R231's Weight Report for November documents: 11/6/24 -154.5 lbs, 11/7/24 - 147.5 lbs and on 11/19/24 - 144.3 lbs. R231's weights show that she had a significant weight loss of 10.2 pounds (6.6%) in 13 days. R231's Mini Nutritional assessment dated [DATE] shows a score of 6 indicating she is malnourished. R231's Diet card shows a regular diet, all meals milk only; no juice or coffee. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	R231's Nutrition Risk assessment dated [DATE] documents she is on a regular diet, requires set assistance, partial moderate assistance with feeding, fair appetite, (R231) reports not eating very much, (V8 R231's spouse) reported her intake of about 30%, she reported not being able to choose foods. (R231) is at risk for unintended weight loss due to malnourished score of 6, poor appetite, bed bound, and assistance with feeding. On 11/18/24 at 1:12 PM, R231 was lying in her bed, she said I'm hungry. V8 was in the room and said lunch usually comes between 1:00 PM to 1:30 PM. At 1:30 PM, the noon meal was not delivered. At 1:48 PM, V8 was upset R231's noon meal was not delivered yet. He said my wife is hungry. On 11/19/24 at 9:51 AM, R231 was in her room eating her breakfast meal. Her meal ticket said milk with all meals. There was no milk on her tray, she had a cup of orange juice and coffee. V13 (Unit Manager) entered the room and said to R231, where is V7 (Certified Nursing Assistant) she was in here helping you. On 11/19/24 at 12:56 PM, V7 (CNA) said R231 is alert and forgetful, she is two person transfer with a mechanical lift. She needs to be set up for meals, this morning she encouraged her to feed herself and she was able to do it so she left the room. R231 told her she was hungry and wanted her lunch before therapy. At 1:00 PM, therapy arrived to R231's room she had not been served lunch yet. On 11/20/24 at 12:35 PM, V4 (Dietitian) said R231 came in with pelvic fracture and was sent out to the hospital and readmitted . Staff should weigh residents on admit and re-admission. V8 reported to her R231's normal weight is about 150 pounds. R231 was not weighed when she was readmitted on [DATE], her initial weight on admission was 154 pounds we re-weighed her a day later and she was 147 pounds. On 11/19/24 her weight was 144 lbs. She has lost weight and she recommended nutritional shakes and protein in between meals. If a resident is voicing they are hungry staff should notify us so we can accommodate an earlier meal. She did not know R231 was requesting her meal to be delivered before therapy.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 34490 Based on observation, interview and record review the facility failed to ensure a resident was administered oxygen using a high flow nasal cannula for 1 of 6 residents (R281) reviewed for oxygen administration in the sample of 26. The findings include: R281's Physician's Order Sheet printed on 11/20/24 shows diagnoses of: dependence on supplemental oxygen, hypertension, chronic kidney disease, chest pain, acute respiratory failure with hypercapnia and hypoxia, pulmonary hypertension, pulmonary fibrosis, chronic obstructive pulmonary disease and myocardial infarction. R281's oxygen order dated 11/5/24 shows, Oxygen: 7 liters a. continuous . On 11/18/24 at 9:45 AM, R281 was sitting in his chair in his room with oxygen on. R281's oxygen tubing and cannula were clear and appeared to be regular flow oxygen cannula. R281's oxygen tubing was plugged into an oxygen concentrator set at 7 liters of oxygen. On 11/19/24 at 1:05 PM, R281 was sitting in his room with his oxygen on and had the same clear tubing. R281's oxygen concentrator was still set at 7 liters. On 11/19/24 at 2:24 PM, V21 (Respiratory Therapist) said that any resident that is on more than 5 liters of oxygen should have a high flow nasal cannula and they are green in color. At 2:43 PM, V21 said that she just checked R281's oxygen cannula and it was not a high flow oxygen cannula but should be. V21 said that the difference between a regular oxygen cannula and the high flow cannula is the bore size of the cannula. V21 said that the high flow cannula is large so it is able to administer the larger amount of oxygen. The facility's Respiratory and Pulmonary Conditions-Oxygen Administration Policy revised on 1/25/24 does not show when a high flow oxygen cannula should be used for residents.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview and record review the facility failed to ensure staff administered medications to a resident and not leave them on the bedside table. This applies to 1 of 26 residents (R15) reviewed for pharmacy services in the sample of 26. The findings include: R15's face sheet shows she is a [AGE] year old female with diagnoses including congestive heart failure (CHF), chronic pulmonary embolism, type 2 diabetes, asthma, chronic kidney disease, macular degeneration, dyshpagia, anxiety, peripheral vascular disease, hypertension, and GERD (Gastroesophageal reflux disease). On 11/18/24 at 10:20 AM, R15 was in her room sitting in her wheelchair. A cup of crushed medications in water were on her bedside table. R15 said those are my medications, the nurse crushes them because they are hard for me to swallow. At 10:35 AM, this surveyor left the room, R15's cup of medications remained at the bedside table. On 11/20/24 at 10:47 AM, V2 (Director of Nursing) said nursing should not leave medications at the bedside table. They should watch the resident take the medications before leaving the room. R15 does not have an assessment to self administer her own medications. R15's Physician Order Sheets dated November 2024 shows orders including Bumex 2 mg (milligrams) in the morning for CHF, Hydralazine 100 mg three time a day for hypertension, Losartan Potassium 25 mg daily for hypertension, Monteluksat Sodium 10 mg daily for asthma, Ocular Vitamins 2 tablets daily, Senna-Docusate Sodium 8.6-50 mg two tablets for constipation twice a day, and Sprionolactone 25 mg daily for CHF, Sucralfate tablet 1 GM (gram) twice a day. R15's Medication Self-Administration Safety Screen dated 11/19/24 shows deep sea saline nasal spray is the only medication listed to self administer.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34117 Based on observation, interview and record review the facility failed to ensure a resident was free from a significant medication error. This applies to 1 of 26 residents (R58) reviewed for medications administration in the sample of 26. The findings include: R58's face sheet shows she is a [AGE] year old female including Parkinson's disease, congestive heart failure, contracture right hand, osteoarthritis, history of falls, atrial flutter, chronic kidney disease, and gout. On 11/18/24 at 10:26 AM, R58 was sitting in her wheelchair in her room. Her left hand was shaking. She said she takes Carbidopa a medication for her Parkinson's disease in the morning, and is suppose to get her 2nd dose at 11:00 AM and sometimes she doesn't get her medication till 2:00 PM. On 11/19/24 at 9:07 AM, R58 said yesterday she did not get her medication for her Parkinson's on time, it was late. On 11/20/24 at 10:47 AM, V2 (Director of Nursing) said nursing should follow the five rights when administering medication including the right person, right time, right dose, right route and right drug. V2 said she followed up with R58's nurse V6 (Licensed Practical Nurse/LPN-Agency) about the medication being late. V6 reported R58 was in the dining room when the medication was scheduled at 11:00 AM. V2 said lunch is at 12:00 PM for residents in the dining room. It's important to ensure residents received their medication at the scheduled time. R58 has Parkinson's and if she does not receive her medication at the scheduled time it can affect her movements causing increased stiffness. R58's Physician Order Sheets dated November 2024 shows orders for Carbidopa-Levodopa 25-100 mg (milligrams) give two tablets three times a day. R58's Medication Administration Audit Report provided on 11/20/24 shows orders at 11:00 AM to administer Carbidopa-Levodopa. R58's administration time recorded at 1:47 PM (approximately three hours later). The facility's Medication Administration Policy and Procedure revised 2022 states, . medications are administered in a safe and timely manner, and as prescribed .medications are administered in accordance with prescriber orders, including any required time frame .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145341	A. Building B. Wing	11/20/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Encore Village	350 West Schaumburg Road Schaumburg, IL 60194

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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 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. 37232 Based on observation, interview, and record review the facility failed to ensure medications were securely stored for 1 of 26 residents (R121) reviewed for medication storage in the sample of 26. The findings include: On 11/19/24 at 10:41 AM, R121 was in his room sitting in a chair. On the bedside table was a fluticasone-salmeterol respiratory inhaler and an azelastine nasal decongestant spray. R121 said the medications are kept on the bedside table. R121's Order Summary Report printed on 11/19/24 showed an order for fluticasone-salmeterol inhaler to be given two times a day. The same document showed an order for azelastine nasal decongestant spray to be given two times a day. On 11/19/24 at 10:45 AM, V22 (Licensed Practical Nurse- LPN) said R121 keeps the inhaler and nasal spray on the bedside table. V22 said R121 needed to be reminded on how to use the medications. V22 explained that R121 will forget to hold his breath when using the inhaler. On 11/20/24 at 11:53 AM, V15 (LPN) said medications are not left in a resident's bedside table because medications needs to be secured. V15 added that medication sitting on a bedside table are not secured. V15 said there are confused residents and you never know if a resident wanders into another resident room also the medication could be misplaced. On 11/19/24 at 11:01 AM, V2 (Director of Nursing) said for a resident to keep medications in their room there would need to be an assessment done. V2 said the assessment could be found in the assessment section of the resident's electronic medical record. On 11/19/24 at 11:05 AM, there was no assessment in R121's electronic medical record for R121 to keep medications at the bedside. The facility's Medication Storage policy with a reviewed date of 10/15/24 showed medications used in the facility are stored in a locked compartment. The facility's Medication Self Administration policy with a reviewed date of 10/15/24 showed a resident's ability to safely and securely store the medication is a factor when determining whether self administration of medication is appropriate. The same policy showed self administered medications are stored in a safe and secure place, which is not accessible by other residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145341	A. Building B. Wing	11/20/2024

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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. 33760 Based on observation, interview and record review the facility staff failed to wash their hands and change their gloves to prevent the spread of infection and failed to ensure staff donned all applicable Personal Protective Equipment for a resident with Enhanced Barrier Precautions (EBP) for 2 of 26 residents (R20 and R12) reviewed for infection control in the sample of 26. The findings include: 1. On 11/18/24 at 10:27 AM, V9 and V10 (both Certified Nursing Assistants- CNAs) provided incontinence care to R20. R20 had a bowel movement. V10 provided incontinence care to R20. Wearing the same soiled gloves and without washing her hands, V10 applied a new incontinent pad, turned R20 side to side to put clothes on. Then R20 was transferred to her wheelchair using a mechanical stand lift, V10 continued to touched multiple surfaces, adjusting R20 in the mechanical lift and positioning V10 in her wheelchair. After doing all these tasks was when she removed her gloves and washed her hands. On 11/20/24 at 8:30 AM, V11 (Registered Nurse-RN) said staff should wash their hands and change their gloves when completing a dirty tasks and going to clean tasks to prevent cross contamination. The facility policy on Hand Hygiene dated 8/30/23 shows, .Integration of glove use along with routine hand hygiene is recognized as the best practice for preventing healthcare associated infections. 2. On 11/19/24 at 9:10 AM, a sign posted outside of R12's door showed, - Enhanced Barrier Precautions. V12 (Wound Nurse) donned gloves but did not wear a gown when he provided wound treatment to R12's sacral wound. At 12:10 PM, V2 (Director of Nursing) said staff will be reeducated again regarding EBP-wearing gloves and gown for high contact care like wound care. The facility policy on Enhanced Barrier Precautions (EBP) showed EBP, is an approach of targeted gown and gloves use during high contact resident care activities designed to reduce transmission of MDRO (multi-drug resistant organisms) and other pathogens.