STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Rolling Meadows,the	4225 Kirchoff Road Rolling Meadows, IL 60008

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 - 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 that staff provide shower and grooming for residents who are dependent on staff for Activities of Daily Living (ADL). This failure affected four (R16, R24, R28, and R86) of five residents reviewed for ADL care. Findings include: R24 is [AGE] years old and has resided at the facility since 2016, past medical history includes hemiplegia and hemiparesis following nontraumatic intracranial hemorrhage affecting right dominant side, chronic obstructive pulmonary disease, chronic kidney disease stage 1, pain in left leg, etc. On 03/24/25 10:20AM, R24 was observed in her room, awake and alert and stated that she has been at the facility for a while, R24 said that she has issue with showers because it seems like they do not have enough people to do the showers. R24 said that she does not receive her showers two times a week as scheduled. Resident stated that she does not have any wounds that she is aware of, but her bottom feels raw, and she cannot see back there. Resident cannot recall the last time she was showered, added that she mostly gets bed bath. Shower schedule for the second floor documented that R24 is supposes to get shower on Monday and Friday on day shift. Review of shower sheets from January to March showed that R24 received about 4 showers. Restorative care plan initiated 4/30/2016 states that R24 that has ADL Self-care deficit related to physical limitations. Interventions include Assist to bathe/shower as needed. Shower Tues-Fridays. Assist with daily hygiene, mobility task, toileting, grooming, dressing, oral care and eating as needed, Resident is totally dependent on 1 staff for showering/bathing, etc. R86 is [AGE] years old and have resided at the facility since 2021, past medical history includes unspecified cord compression spinal stenosis cervical region, lymphedema, bilateral primary osteoarthritis of knee, hypothyroidism, etc. 03/24/25 10:45AM, R86 was observed in her room with her husband, awake, alert and oriented and stated that she has been here for three years, everything is going wrong, she is supposed be transferred with a sit to stand machine, the facility still has her marked as a being transferred by a mechanical lift. R86 added that she does not get her scheduled showers, only bed baths, and has only received three showers since admission to the facility. (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R86 is scheduled for showers on Tuesday and Friday, shower sheets for January through March 2025 showed that R86 received about three showers and mostly bed baths. Care plan initiated 12/21/2021 states, R86 has an ADL self-care performance deficit r/t dx of Spinal Stenosis, Cord Compression, Lymphedema, Morbid Obesity. Interventions: BATHING/SHOWERING: The resident requires substantial assistance by 1 staff with bathing/showering. Provide sponge bath when a full bath or shower cannot be tolerated. The resident requires partial assistance by 1 staff to turn and reposition in bed. The resident requires partial assistance by 1 staff for upper body dressing and substantial assistance for lower body dressing. R28 is [AGE] years and has resided at the facility since 2024, past medical history includes type 2 diabetes, chronic respiratory failure, dependence on renal dialysis, absence of right leg below the knee, acquired absence of left leg below the knee, end stage renal disease, etc. 03/24/25 10:45AM, R28 was observed in her room, awake and alert and stated that she is doing okay. Resident said that she does not get out of bed, do not get showers only bed baths. R28 was asked if she would like to get showers and she said that will be fine for a change. R28 is scheduled for showers on Tuesday and Saturday on second shift. Review of shower sheet from January to March showed that R28 received one shower, a couple of bed baths. Care plan initiated 2/16/2024 states: The resident has an ADL self-care performance deficit r/t bilat BKA, needs assistance with personal care. Interventions: The resident requires substantial assistance with showering/bathing. The resident requires supervision by 2 staff to turn and reposition in bed. The resident requires partial moderate assist with 1 staff with personal hygiene and oral care. The resident is totally dependent on (2) staff for toilet use. R16 is [AGE] years and has resided at the facility since 2019, past medical history includes but not limited to malignant neoplasm of colon, morbid (severe) obesity, frontotemporal neurocognitive disorder, anxiety disorder, history of falling, etc. On 03/24/25 11:06AM, R16 was observed in his room sleeping but awakes to greetings. R16 was noted wearing a hospital gown and looked very dirty, resident's room was cluttered with clothes and garbage. R16 have lots of facial hair and overgrown hair, brownish substances noted on long fingernails. 03/25/25 10:58AM, R16 was observed in his room sleeping but responds to greeting, stated that he is doing okay and noted with long dirty fingernails on both hands, overgrown hair, and lots of facial hair, still wearing a hospital gown. R16 is scheduled for showers on Monday and Thursday second shift. Shower sheets for January to March documented about four showers for the resident. Restorative care plan dated 8/27/2019 states R16 has an ADL self-care performance deficit r/activity Intolerance, Fatigue, Limited Mobility. Intervention include Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. The resident requires supervision by x1 staff with showering as necessary. The resident requires supervision by x1 staff to turn and reposition in bed as necessary. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 03/26/25 03:00 PM, V1 (Administrator) said that some residents refuse their shower, when a resident refuses shower, they offer a bed bath and if resident still refuses, the staff is supposed to go back different time to see if resident will accept. Shower refusals are supposed to be documented in medical record by staff. Surveyor requested any progress notes documented for shower refusal for any of the residents, but none was provided. Activity of daily living support with showers policy reviewed 5/22/2024 states in part: residents will be provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADL). Residents who are unable to carry out ADL independently will receive the services necessary to maintain good nutrition, grooming and personal oral hygiene. Under procedure 2 (g). Showers will be offered and encouraged twice a week. If resident refuses alternative bed bath/sponge bath with perineal care will be given as option. If resident continues to refuse, MD/POA will be notified if a pattern has been established weekly and as indicated.

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F 0689 Level of Harm - 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** 40718 Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision for residents at high risk for falls and failed to implementing interventions for a resident with wandering behaviors. These failure applied to three of five residents (R52, R56, and R61) reviewed for falls and resulted in R52 sustaining a right hip fracture and a head injury requiring medical treatment. Findings include: Per the facility's incident log from 09/01/2024 - 03/24/2025 the facility has had 73 unwitnessed falls with 18 of them involving memory care residents, R52 had a fall each month from December 2024 - March 2025 with two of them being unwitnessed, and R61 had four falls within three weeks of admission with three of them being unwitnessed. 1. R52 is a [AGE] year-old female with a diagnosis history of Dementia with Behavioral Disturbance, Anxiety Disorder, Age Related Cataracts, and Stroke who was admitted to the facility 02/06/2019. The facility's incident log from 09/01/2024 - 03/24/2025 documents R52 had a witnessed fall on 12/18/2024 at 9:13 AM, and unwitnessed falls on 01/12/2025 at 4:30 AM, and on 02/09/2025 at 6:55 AM Per the facility's reportable event log received 03/24/2025 R52 had a fall on 12/18/2024 that resulted in a right hip fracture and a fall on 01/12/2025 that resulted in a laceration of her head. R52's quarterly Minimum Data Set, dated dated dated [DATE] documents she requires supervision or touching assistance for walking 10-150 ft. R56's fall risk assessments dated 12/18/2024 and 12/24/2024 documents she is at high risk for falls. R52's current care plan created 02/18/2019 documents she exhibits behavioral symptoms as evidenced by wandering and at times can be difficult to redirect and unaware of her safety needs with an intervention implemented 02/18/2029 of approaching/speaking in a calm manner and an intervention implemented 05/17/2019 of walking with R52 when she is wandering to ensure safety. R52's current care plan created 04/20/2019 documents she is at risk for falls related to diagnosis of dementia, confusion, poor communication/comprehension, poor safety awareness, wandering, and behaviors of feeling around door joints and attempting to open the door and leave the unit with intervention implemented 04/20/2019 including follow facility fall protocol, interventions implemented 03/21/2024 including staff to assist her in the dining room when meals are ready, allow her more sleep instead of having her wait in the dining room for meals; and intervention implemented 02/09/2025 of ensuring there is adequate supervision in the dining room. R52's current care plan created 12/19/2024 documents she has had an actual fall on 12/18/2024 which resulted in a fracture with interventions including staff checking her location and activity to ensure if she is properly and safely positioned in bed or chair/wheelchair. R52's current care plan initiated 01/12/2025 documents she had a fall on 01/12/2025 which resulted in a laceration on her left temple. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall Risk Management report dated 12/18/2024 documents R52 was observed walking down the hall after breakfast towards the door and when she was getting close by the door the nurse called her trying to redirect her and she turned around quickly, lost her balance and fell landing on the right side of her hip. The facility's reportable event investigation report dated 12/19/2024 documents on 12/18/2024 R52 was observed walking towards the door and when she was getting close to it, the nurse called her and tried to redirect her, she turned around quickly, lost her balance, had a change in plain and was sent to the emergency room for further evaluation and treatment and was admitted with a right hip fracture. Fall Risk Management report dated 01/12/2025 documents at 4:30 PM R52 was found on the floor with a laceration on her head and was bleeding, while V20 (Nurse) was passing medications with her cart she turned around for a second and the next thing she heard behind her was the sound of a fall; contributing factors to R52's fall included confusion, impulsiveness, need for two person assistance with transfers, history of falls, observations of attempts at getting up without assistance recently, recently having surgery on her right hip, and diagnosis of fracture of right lower leg. R52's hospital discharge report dated 01/12/2025 documents she was diagnosed with a closed head injury, and scalp laceration and received laceration repair. The facility's reportable event investigation report dated 01/18/2025 documents R52 had an unwitnessed fall at approximately 4:40 PM on 01/12/2025 and sustained an approximately 3-centimeter laceration to her head, was sent to the emergency room for further evaluation and treatment and returned the same day to the facility with three staples to be removed in 7 days. Fall Risk Management report dated 02/09/2025 documents R52 had an unwitnessed fall and was observed sitting on the floor in front of her wheelchair by the dining room with the root cause being losing her balance and falling when attempting to stand up from her wheelchair. On 03/26/25 at 03:28 PM V18 (Restorative Nurse) stated he is the fall coordinator. V18 stated R52 has always been able to walk, and she fell on [DATE] due to suddenly turning around. V18 stated R52 had a fall at 4:30 PM on 01/12/2025. V18 stated R52 was sitting in the dining room and trying to stand. V18 stated a nurse was present and tried to catch her but didn't make it in time. V18 stated he believes the nurse was administering medications at the time. V18 stated there are usually a lot of residents in the memory care dining room. V18 stated usually there are two aides in the dining room at mealtimes and at that time there was not two aides possibly due to passing trays. V18 stated at least two aides are needed in the dining room for proper supervision. V18 stated on 02/09/2025 R52 was near the dining room in her wheelchair and attempted to stand up and loss her balance and fell . V18 stated this was an unwitnessed fall so there weren't any staff present. V18 stated there should be some staff present to monitor residents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/27/2025 at 8:47 AM V2 (Director of Nursing) stated if there are several residents in the dining room, they would be sending more than one staff to supervise but it is not always their protocol to always assign and/or station two nurses or CNAs (Certified Nursing Assistant) at all times when residents are present in the dining room. V2 stated she understands that residents need supervision. V2 stated she was the one who conducted and completed the investigation after R52's fall incident and the nurse was by the dining room door beside her med cart where she can see the resident, but unfortunately, she wasn't able to get to the resident as fast as she could to prevent her fall. On 03/27/2025 at 10:19 AM V2 (Director of Nursing) stated on 01/12/2025 when R52 had a fall there were 36 total residents in the memory care unit. V2 reported there are 12 residents in the memory care unit that are at high risk for falls. In response to the surveyor asking if a nurse is the only staff in the dining room with multiple residents on the memory care unit, and she is passing medications while someone is falling, doesn't that make it difficult to assist the resident who begins to fall or even monitor all the residents present in the dining room; V2 replied that on 01/12/2025 the CNA (Certified Nursing Assistant) was asked to assist another resident with toileting and a nurse was in the dining room to oversee the residents while the other was helping with bringing residents to the dining room for dinner. On 03/27/25 at 03:03 PM V18 (Restorative Nurse) confirmed R52 and the nurse that witnessed her fall on 12/18/24 were inside the unit during the incident. V18 stated R52 and the other memory care residents usually roam around the memory care unit and wont usually attempt to leave and when they reach the exit door they turn back around. V18 stated if staff saw R52 approaching the memory care unit exit door they can monitor her to ensure she's ok and they usually just let the residents walk around. V18 stated in R52's particular situation on 12/18/2024 he can't think of anything the nurse could have done differently to prevent her fall because staff weren't expecting her to fall the way she did. V18 stated he doesn't think the nurse calling out to R52 could have startled her. V18 agreed the nurse was likely not close by R52 when she was approaching the door and therefore her voice calling out to R52 would not have been soft and low and agreed that the nurse would have had to call out to R52 loudly enough to be heard and get R52's attention. When asked by surveyor if the nurse could have just guided R52 away from the door rather than calling out to redirect her V18 could not provide any information. 2. R56 is a [AGE] year-old female with a diagnoses history of Alzheimer's, Dementia, Generalized Anxiety Disorder, Restlessness and Agitation who was admitted to the facility 04/12/2023. The facility's incident log from 09/01/2024 - 03/24/2025 documents R56 had an unwitnessed fall 03/21/2025 at 5:15 PM R56's current care plan created 04/25/2023 documents she is at risk for falls related to confusion, gait/balance problems, incontinence, poor communication/comprehension, and poor safety awareness with interventions implemented 04/25/2023 including follow facility fall protocol. R56's quarterly fall assessment dated [DATE] documents she is at high risk for falls. Fall Risk Management report dated 03/21/2025 documents R56 had an unwitnessed fall and was observed sitting on the floor on her right-side by the dining room and the root cause of the fall being she most likely fell asleep in her wheelchair while waiting for dinner. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 03/26/25 at 03:28 PM V18 (Restorative Nurse) stated according to the investigation of R56's fall on 03/21/2025 the nurse reported R56 fell asleep while sitting in her wheelchair and fell forward in the dining room. V18 stated this was an unwitnessed fall. V18 stated staff were likely passing trays and unable to catch R56. On 03/27/2025 at 10:19 AM V2 (Director of Nursing) reported the facility does have enough staff to assist the residents in the dining room. V2 reported the facility usually has nursing and activity staff present in the dining room during meals. In response to surveyor asking should there be multiple staff in the memory care dining room during mealtimes or when multiple residents are present; V2 reported they usually have 2 Nurses, 3 CNAs and 1 Activity Aide to assist with the residents. In response to surveyor asking why should there be multiple staff present in the memory care dining room during meal times or when there are multiple residents; V2 responded they have nursing to assist with feeding the residents and activities assist with passing the trays and just rounding to make sure residents have what they need. 3. R61 is a [AGE] year-old male with a diagnoses history of Dementia with Behavioral Disturbance, Encephalopathy, and Depression who was admitted to the facility 02/10/2025. On 03/24/25 at 10:57 AM Observed R61 in his room in his bed wearing a gown and protective sleeves over both his arms. Observed R61's right arm with multiple scabs and his right-hand knuckles with multiple scabs with dry blood sticking to the sleeve, a bruise, and a small bandage. The Facility's incident log from 09/01/2024 - 03/24/2025 documents R61 had a witnessed fall on 03/04/2025 at 8:30 AM, and unwitnessed falls on 02/13/2025 at 5:11 AM, 02/22/2025 at 2:30 PM, and 03/08/2025 at 11:05 AM. R61's admission Fall Risk assessment dated [DATE] documents he is at high risk for fall. R61's current care plan created 02/11/2025 documents he is at risk for falls related to generalized weakness, increased confusion, impaired cognition, altered mental status, and multiple medical conditions including activity intolerance and has exhibited behaviors of putting himself on the floor with intervention implemented 02/11/2025 of ensuring his call light is within reach and encouraging him to use it for assistance as needed, assessing and anticipating his personal needs and needs of activities of daily living such as toileting, incontinence care, eating etc. during rounds, ensuring he is centered in bed and bed bolsters are properly secured as appropriate and trunk and extremities are properly aligned and supported; intervention implemented 03/04/2025 of placing him in the dining room in the morning if he is observed up and awake if he will allow. R61's current care plan created 02/19/2025 documents he exhibits poor safety awareness and attempted to get out of chair/bed without staff monitoring and has difficulty comprehending redirection. Fall Risk Management report dated 02/13/2025 documents R61 had an unwitnessed fall in his room and was observed laying on the floor on his right side with his head at the foot of the bed and mattress halfway off the bed and tilted; R61 reported he slid off the bed; Contributing factors include being admitted to facility due to fall and increased confusion, observed with agitation and confusion, and having diagnoses including pneumonia and altered mental status; Root causes of the fall include R61 moving on his bed and the mattress tilted and he slid off to the floor. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Fall Risk Management report dated 02/22/2025 documents R61 had an unwitnessed fall and was found on the floor in the hallway lying on his right side and his wheelchair behind him with the root cause being R61 making his way to the room from the dining room, wanting to go to the toilet, attempting to self-transfer without assistance, and losing his balance and falling. Fall Risk Management report dated 03/04/2025 documents R61 had an unwitnessed fall in his room and was observed sitting on the floor and reported he put himself on the floor; he was observed to have small scratches on both his knees with the root cause including attempting to get out of bed. Fall Risk Management report dated 03/08/2025 documents R61 had an unwitnessed fall and was observed lying on the floor on his right side by the hallway close to the nurses station and was observed with a bump on the right side of his forehead, skin discoloration, skin tears on multiple fingers on his left hand, skin tears on his right hand and right elbow and was sent to the emergency room for evaluation; R61 reporting he wheeled himself on his wheelchair and slipped from the wheelchair; the root cause of the fall includes R61 sliding down from his wheelchair. On 03/26/25 at 03:28 PM V18 (Restorative Nurse) stated R61 is very impulsive and has had previous attempts to get out of bed on his own before falling 02/13/2025 and interventions for this would include low bed, floor mats, encourage toileting, offering to get him up in the wheelchair when already awake, offering activities, and trying to redirect him. V18 stated R61 needs frequent supervision, and should be somewhere he can be monitored. V18 stated if R61 has been sitting in a place for a while he'll try to wheel himself somewhere. V18 stated R61's falls o 02/22 and 03/08 were due to him attempting to ambulate himself in the wheelchair and he will attempt to stand up. V18 stated interventions for this behavior is to have R61 close by staff for monitoring. On 03/27/2025 at 1:34 PM in response to surveyor asking would lack of supervision or insufficient supervision cause of fall to be unavoidable; V2 (Director of Nursing) replied that the need for supervision or level of supervision is a factor, depending on the resident and a high-risk resident that is not adequately supervised is more likely to have a fall than a more mobile resident. The facility's Fall Prevention and Management Policy received/reviewed 03/25/2025 states: The facility is committed to its duty of care to residents and patients in reducing risk, the number and consequences of falls including those resulting in harm and ensuring that a safe patient environment is maintained. High-Risk Precautions will be implemented to residents and patients whose scores on Resident/Family Notification fall Risk screen shows high risk with interventions including but not limited to meaningful and or scheduled rounds.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40920 Based on observation, interview, and record review, the facility failed to ensure that staff provide incontinence care in a timely manner for a resident assessed as dependent on staff for Activities of Daily Living (ADL). This failure affected one (R24) of one resident reviewed for incontinence care. Findings include: R24 is [AGE] years old and have resided at the facility since 2016, past medical history includes hemiplegia and hemiparesis following nontraumatic intracranial hemorrhage affecting right dominant side, chronic obstructive pulmonary disease, chronic kidney disease stage 1, pain in left leg, etc. On 03/24/25 at 10:20AM, R24 was observed in her room, awake and alert and stated that she has been at the facility for a while, she has issue with showers because it seems like they do not have enough people to do the showers. R24 said that she has not been changed today and have been waiting to be changed. R24 said that she is very wet right now, she was not changed during the night shift, the last time she was changed was yesterday before she went to bed. R24 stated that she does not have any wounds that she is aware of, but her bottom feels raw, and she cannot see back there, it is usually painful when she sits for a long time. On 03/24/25 at 11:30AM, observed incontinence care for R24. Upon entering the room, noted a very strong urine odor, and observed two adult brief that were both soaked with urine and brownish in color. Resident's bed pad and sheet were noted to be wet with brownish colored ring like stain in the middle. V5 (C.N.A) confirmed that resident's bed she and the bed pad are wet with urine. with urine. R24 was noted with redness and excoriation all over her bottom, with some whitish substances. V 5 stated that they apply barrier cream to resident's bottom after every incontinence brief change. Regarding the two adult briefs, V5 said that R24 have that because he gets wet very often, but she is not the one that put the two adult briefs on her. Care plan dated 1/2/2025 states that resident has urinary incontinence related to functional incontinence, impaired mobility, and physical limitations. Goal states that resident will have no complications related to incontinence. Interventions: Provide assistance with toileting, provide incontinence care as needed, report changes in amount and frequency, use absorbent pads/ briefs as needed. On 03/26/25 at 03:00 PM, V2 (DON) said that residents can wear two incontinence briefs at a time if it is their preference and it will be care planned. V2 added that R24 gets upset if she does not get two incontinence briefs. Surveyor asked V1(Administrator), V2 (DON) and V17 (CNO) if having two incontinence briefs justify leaving resident soaking wet, and whether it is acceptable for a resident to wait a whole day before their incontinence brief is changed and they all said that it is not acceptable, residents should be changed as needed. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Urinary incontinence care policy revised 2/13/2025 states in part; Our facility will ensure and provide appropriate services and treatment to help residents restore or improve bladder function and prevent urinary tract infections to the extent possible. Incontinence care will be provided by nurse or C.N.A every shift based on incontinence needs of resident. Staff will ensure that incontinence needs are met.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145350	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pearl of Rolling Meadows,the	4225 Kirchoff Road Rolling Meadows, IL 60008

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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 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** 40920 Based on observation, interview, and record review, facility staff failed to follow facility medication administration policy of ensuring that staff document the administer narcotic medications in the narcotic count sheet, and failed to ensure that the narcotic medications are properly reconciled by staff. These failures affected three (R39, R43 and R70) of five residents reviewed for psychotropic medications and have the potential to affect residents in the North wing, TCU, and memory care units of the facility. Findings include: R39 is [AGE] years old and has resided at the facility since 2026, past medical history includes, but not limited to malignant neoplasm of unspecified kidney, except renal pelvis, chronic pancreatitis, unspecified dementia, type 2 diabetes, anemia, etc. Physician order dated 6/7/2024 showed the following: Morphine Sulfate (Concentrate) Solution 20 MG/ML *Controlled Drug* Give 0.25 ml sublingually every 2 hours as needed for pain; sob. 03/25/25 11:15AM, reviewed the standard even medication storage cart on the second floor with V7 (LPN) and noted the following: R39 had one bottle of morphine sulfate, 20mg/ml solution. the narcotic administration sheet documented 5ml as the amount left, review of the medication bottle showed 3.5ml on hand. V7 said that she is not sure what happened but will follow up with the director of nursing. R43 is [AGE] years old and has resided at the facility since 2028, past medical history listed include, but not limited to restlessness and agitation, generalized anxiety disorder, personal history of malignant neoplasm of breast, vitamin D deficiency, anemia, etc. Physician order dated 11/13/2023 showed the following: Ativan Solution 2 MG/ML (Lorazepam) *Controlled Drug*Give 0.5 milliliter sublingually three times a day related to restlessness and agitation (R45.1) may use Ativan prn (as needed) in between scheduled if needed hold if RR <12, then call NP/MD. On 03/25/25 11:45AM, reviewed the odd cart in the memory unit with V8 (LPN) and noted the following: R43 had a bottle of Lorazepam 2mg/ml solution in the refrigerator. The narcotic count sheet documented on that the resident had 17.5ml left, review of the bottle showed more than 30ml remaining. V8 said that there is still a lot left because the medication comes full when it is received. The amount documented as received on 3/16/2025 in the narcotic count sheet is 30ml. R70 is [AGE] years and has resided at the facility since 2024, past medical history includes, but not limited to primary osteoarthritis right and left shoulder, type 2 diabetes, ocular pain left eye, legal blindness, etc. Physician order dated 3/21/2025 show the following: Morphine Sulfate 20mg/ml *Controlled Drug*Give 0.25 ml by mouth two times a day for pain/SOB Hold for drowsiness and/or for respirations less than 14 and Give 0.25 ml by mouth every 4 hours as needed for pain/ SOB Hold for drowsiness and/or for respirations less than 14. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/25/25 11:15 AM, reviewed the TCU unit medication cart with V9 (RN) and noted the following, R70 had one bottle of morphine sulfate 20mg/5ml solution in the refrigerator. Narcotic count sheet documented 28.5 mg as the quantity remaining, the actual medication on hand was 25mg. This observation was presented to V9, and she said that she does not know why the quantity on hand is less that the amount documented in the narcotic count sheet. On 03/26/25 9:39 AM, V2 (DON) said that she investigated and found out that some nurses were giving the medication to V9, but were not documenting in the narcotic sheet but document in the medication administration record (MAR). Nurses are supposed to sign both the narcotic sheet and the MAR whenever medication is administered. For R43, V2 said that the resident still has a lot of medication remaining because the medication comes full, moving forward, the facility will start documenting the actual amount received to help with accurate reconciliation. Facility protocol on controlled substances dated 8/13/2023 under documentation guideline started in part: complete documentation in the narcotic book prior to administering controlled substances to the resident. Check the count with each administration to ensure accuracy. Initial the Medication administration record (MAR) after administering medication. Counting: All controlled substances including the ER narcotic kit and medications in the refrigerator must be counted at each shift change. Both the oncoming and outgoing nurse should look at the card and narcotic book to ensure accuracy.

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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 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 46344 Based on interview and record review, the facility failed to provide residents with palatable and attractive food. This failure affected 13 of 13 residents (R20, R24, R28, R38, R32, R84, R70, R41, R117, R126, R69, R78, and R35) reviewed for dining. Findings include: On 3/24/2025 at 10:17AM, R20 said that the food is very bad, she does not eat anything from the facility and has to order food from outside all the time. At 10:20AM, R24 said the food is not good and they do not really have a lot of alternatives to choose from. At 10:45AM, R28 said she does not like the food and has her family bring her food from outside. At 10:50AM, R38 said the food is not good. At 10:54AM, R32 stated he hasn't had a warm breakfast in months. At 11:15AM, R84 and R70 said the food is always cold. At 11:35AM, R41 said the food is horrible. I have to have my family grocery shop for me, and I eat what I have in my refrigerator. It is to be noted that R41 had her own refrigerator in her room with multiple various food items for meals and dry storage goods stored. At 11:40AM, R117 said the good is very poor quality and when you ask for extra items, they do not give it to you. At 11:48AM, R126 said the food is not good. Said the waffles are always hard. At 11:56AM, R69 said I do not like the food, and it is too bland. On 3/26/2025 at 1:15PM, R78 said the food is terrible. I believe they have a really low budget and serve us cheap food products. R35 said at this time that the food is always cold. It is to be noted that there were seven grievances dated 1/1/2025-3/22/2025 showing a concern related to the food being served including but not limited to food being served cold and disliking the food. Resident Council Meeting Minutes dated 1/23/2025 states in part but not limited to the following: The cake is not frosted enough, some of the dishes did not have enough sauce or spices. The food is sometimes cold. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/2025 at 10:50AM, V12 (Dietary Director) was interviewed regarding resident food concerns. V12 said I do not always attend the resident council meetings. Said when residents express food concerns the staff should be letting me know so that I can follow-up with them.