STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145382	A. Building B. Wing	04/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Manor	1301 Lee Street Des Plaines, IL 60018

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 34069 Based on interview and record review, the facility failed follow the Physician Notification in Change of Condition Policy by not notifying MD (Doctor of Medicine) about medications administered late. This failure affected one resident (R157) of eight residents reviewed for notification. Findings include: On 4-15-25 at 11:03 AM, surveyor observed V3 (Registered Nurse) preparing medication for administration. V3 replied R157's medications were due at 9:00 AM. On 4/17/25 at 09:39 AM, V2 (Registered Nurse) said there is a 1-hour window before and after the scheduled time. The nurse is supposed to write a note on the delay in administration of medication. Depending on the medication you would let the MD know about late administration. On 4/17/25 at 10:08 AM, V1 (Director of Nursing) said there is 1 hour window before and after the scheduled time for administration. For Doxycycline the MD should be notified because it's an antibiotic and the schedule can be re-adjusted. Eliquis and Amlodipine are once a day hence it does not need MD notification. The nurse should make a note explaining why the medication was administered late. V3 did not document any notes explaining late administration or MD notification. V3 is on vacation (after 4-16-25) however facility is trying to reach V3 for interview. On 4/17/25 at 11:06 AM, V3 (Registered Nurse) said R157 medications were due at 9:00 AM. V3 was not available for interview after 4-15-25. Facility made several attempts to contact V3 for interview. Surveyor reviewed R157's Medication Administration record and noted medications administered at 10:58 AM. Surveyor reviewed Nursing Progress Notes and did not see any physician notification notes re: late medications.

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 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40102 Based on observation, interview and record review, the facility failed to coordinate an appointment with the audiologist to remove hardened ear wax from a resident's bilateral ear canals causing an increase in hearing loss for one out of one (R73) resident reviewed for hearing loss in a total sample of 36. Findings Include: R73 is a [AGE] year old with the following diagnosis: Alzheimer's disease, Parkinson's disease, vascular dementia, and paraplegia. The Audiology Progress note dated 12/18/24 documents R73 had a very hard time communicating because R73 could not hear what was being said even while wearing headphones with amplified microphone. R73 reports having poor hearing, but recently, it seems to have gotten worse. Wax was noted in both ears and removal was attempted. In the right ear, about half of the wax was successfully removed. In the left ear, the wax was too hard for any amount to be removed at the time of the appointment. The hearing aid was cleaned and working well. After half of the ear wax was removed from the left ear, R73 told the physician R73 could hear again out of the hearing aid. R73 was happy about this. The deep hardened waxed in both ears is currently making the hearing worse than what it is. Plan to use wax softening drops. Ear wax removal was scheduled for the next visit to attempt to remove more wax once it has been softened by the eardrops. On 04/15/25 at 10:45AM, the surveyor introduced self to R73, and R73 requested the surveyor write down what was being said due to not being able to hear. R73 stated R73 is hard of hearing and has a hearing aide for the left ear. R73 put on glasses to read what the surveyor wrote but told the surveyor the glasses were old and the wrong prescription so R73 could not see or hear what the surveyor was attempting to communicate. On 4/17/25 at 10:50AM, the surveyor tried to speak to R73 but R73 interrupted the surveyor stating R73 could not hear in either ear. The left hearing aide was in place. The surveyor again tried to write down the conversation but R73 told the surveyor that R73 could not see what was written on the paper. On 4/17/25 at 10:57AM, V4 (CNA) stated the nurse puts R73's hearing aides in every morning. V4 reported the hearing aides don't help R73 hear any better and R73 still is hard of hearing with the hearing aide in place. V4 stated staff write out conversations on a piece of paper or type out messages on their phones to communicate with R73. V4 reported staff will also get close to R73's and speak directly into R73's ear. V4 stated R73 can verbalize needs but it is hard for R73 to understand staff. V4 denied being aware of R73's audiology appointments and denied being aware of any excessive amounts of ear wax. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/17/25 at 11:02AM, V10 (Nurse) stated R73 wears the hearing aide in the left ear. V10 denied R73 had a hard ear wax build up in the ears and denied knowing about a build up of wax in the past. V10 denied knowing how often the audiologist comes to see residents. V10 stated R73 is hard of hearing and staff communicates with R73 by getting close to R73 and speaking loudly as well as using a thumbs up or thumbs down. V10 reported when a resident has a wax build up, the audiologist will order ear drops to soften the ear wax and then remove the ear wax. V10 denied being aware of how soon the doctor comes after the drops are administered. At 1:33PM, V11 (Infection Prevention Nurse) stated the facility was in COVID outbreak status from 1/4/25 through 3/13/25 when the facility received the last positive. V11 reported the facility does not allow outside physicians to the floor where the outbreak is located. V11 confirmed that outbreak status ends two weeks after the last positive which would have been 3/27/25. At V12 (Former Social Services) stated R73's sister called and wanted an update on the hearing aides. V12 reported some wax was removed the last appointment and still had some wax in the ears that was contributing to the hearing loss. V12 stated R73 got the wax softening ear drops but then the facility was under lock down for COVID for at least two months so the audiologist was not able to see R73. V12 reported V12 didn't call the audiologist to come to the facility after the lockdown was completed. V12 stated the last time the audiologist was in the facility was 03/05/25 but didn't see R73 on that visit. V12 stated the audiologist only sees 10 people per visit and if R73 was seen the last time then R73 will be moved to the end of the list. V12 stated 95% of R73's hearing loss is gone and R73 complained to the facility she couldn't hear any longer sometime before December. V12 reported staff communicates with R73 by writing information down for R73 to read or cupping their hand and yelling into R73's ear. V12 stated V12 last worked in the facility on 4/14/25 and R73 still did not have the wax removed to improve hearing. V12 denied reading the audiology note that R73 should have been assessed by the audiologist on the next visit to the facility. A Nursing note dated 1/16/25 documents R73 tested positive for Covid. The Covid Surveillance Line List documents the facility first went into outbreak status on 1/4/25 and had the last positive test on 3/13/25. Two weeks after the last positive was 3/27/25. A Social Service note dated 4/7/25 documents social services received a call from R73's family member. The family member wanted an update on the hearing aids. The family was informed that the facility was under isolation precautions due to Covid approximately two months. Social services explained that R73 had hardened ear wax that still needed to be removed per December 2024 audiology progress note. The Medication Administration Record (MAR) dated 12/2024 documents R73 received the wax softening drops to both ears two times a day for five days from 12/19/24 through 12/23/24. The Care Plan dated 12/27/24 documents R73 has a problem with receptive communication, is only sometimes able to understand communication from others and has highly impaired hearing abilities. Although an audiologist has prescribed hearing assistive devices, the hearing aids do not help R73 any better with them. R73 is now deaf in both ears. Social services communicates with R73 in writing. An intervention includes refer to ear, nose, and throat doctor to clear wax out of the ears and reevaluate hearing as directed by the physician. (continued on next page)

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Minimum Data Set (MDS) dated [DATE] documents R73 has highly impaired ability to hear. R73 does use a hearing aid. R73's ability to understand others is documented as usually understands but misses some parts of the message during conversation. Section C of the MDS documents a Brief Interview for Mental Status score as six (severe cognitive impairment). The policy titled, Hearing Impaired Resident, Care of, that is undated documents, Staff will assist hearing impaired residents to maintain effective communication with clinicians, caregivers, all the residents, and visitors. Policy Interpretation and Implementation .2. Staff will assist the resident or representative with locating available resources, scheduling appointments and arrange transportation to obtain needed services.

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 40066 Based on interviews and records reviewed the facility failed to complete a wound assessment and document treatment and findings of the assessment of one resident (R91) who developed a reddened area on her left and right buttock, and failed to ensure there were effective interventions to prevent further deterioration. This failure affected one of five of 5 (R91) reviewed for pressure ulcers in a sample of 36. This failure resulted in R91 developing an unstageable pressure ulcer that required debridement. The findings include: R9's diagnosis include but are not limited to Alzheimer's Disease, Parkinson's Disease, Diabetes, Retention of Urine, Vascular Dementia, Cognitive Communication Deficit, and Need for Assistance with Personal Care. On 04/15/25 at 10:50 AM R91 in bed, sleeping on air mattress, on back. R91 did not verbally respond to the surveyor for interview. On 04/16/25 at 11:15AM R91 in bed, sleeping, did not wake when spoken to. On 4/16/25 11:17AM V16, LPN said R91 has a sacral wound, at stage IV and she is on hospice. V16 said R91 stays in bed. V16 said R91 was on antibiotic for her pressure ulcer but she just finished the treatment. On 4/17/25 at 8:25AM V17, CNA, said I turn R91 every 2 hours. R91 awake, eyes open, eating breakfast, looking out the window. No verbal response. At 8:38AM V17 said R91 is completely dependent on staff, she can't move. V17 said we have to turn her; she doesn't help or try to get up. During an interview, in Spanish, in the conference room with the surveyors on 4/17/25, V17 said he reported to wound care a red area, unopened, just red on her buttocks, about the size of a lime. (V17 made a gesture with his fingers in a circle shape and the surveyor asked if that was about the size of a lime and V17 said yes.) V17 said there was no documentation or anything I wrote to report this. V17 said it is just a verbal report to the nurse, right away. V17 said we kept applying the barrier ointment to her and turning her. V17 said it was between 3-7 days when I reported to the nurse before the hospice nurse saw the wound. V17 said I told V19 about it when I first saw it. On 04/17/25 at 09:25 AM V18, Wound Care Director, said R91 has a stage IV pressure ulcer. V18 stated it is the worst one (wound) in the building. V18 said R91's wound was unavoidable because of poor nutrition and her declining health. V18 said the wound has undermining. V18 said we were treating her with antibiotics. V18 said the wound treatment was already done today. V18 said R91's wound was facility acquired, seen initially on 1/21/25 as a stage 3. V18 said R91 had a history of pressure ulcers prior to this one. V18 said the first person to report R91's wound was the hospice nurse to V16 on 1/21/25. V18 said initially R91's wound was classified by the wound doctor as an end of life wound but we can only do for 4 weeks so we classified as IV. V18 said I coded R91's wound wrong initially as stage 3 on the MDS, but I should have classified it as a Deep Tissue Injury (DTI). (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 4/17/25 at 11:38AM V19, Wound Nurse, said R91 had a history of wounds that had healed. V19 said the CNA, V17, reported redness to R91's left and right buttocks. V19 said when I saw the area it was red, but she had nothing in her sacrum. V19 said the redness was from pressure, it was superficial Stage 1 when I saw it. V19 said I did not document an assessment of the wound. V17 said I should have documented it. V17 said I went on vacation on 1/17/25 and I was back to work on 2/24/25. On 4/18/25 at 8:58AM V18 said when I spoke with the hospice nurse, she said R91 skin was clear on her hospice admission assessment on 1/16/25. Her skin was reported impaired on 1/21/25. V18 said we had a treatment for a dressing to be applied in January, but we didn't put it on the treatment record. On 4/18/25 at 11:02 AM V23, Wound Doctor, said the facility had a clerical error and the wound order was not on the treatment records. When a wound is found in an ideal world there would be a wound assessment so we can determine what kind of wound it is (like pressure) and to determine if there is improvement or decline by monitoring the wound. On 4/18/25 at 11:54am V1, Director of Nursing, said the purpose of the TAR is to record and document that wound care treatments are done. V1 said if the order is not on the TAR there is no way to show the treatment was done. V1 said I expect all orders to be on the physician order sheets and the TAR. Hospice General Note on 1/16/25 documents clear skin. Treatment Administration Record (TAR) January 2025 has order for Chamosyn that was initiated July 2024, no other treatment. Progress notes for R91 dated 1/21/25 6:29PM new pressure ulcer on sacral. Current treatment bordered foam. There are no notes or assessments documenting what V17 said she saw, the redness. V17 started vacation on 1/17, so the area was seen prior to 1/17/25. Progress notes for R91 dated 1/21/25 at 7:54PM wound care noted purplish color discoloration on sacral area. R91's Wound Assessment Details dated 1/21/25 notes stage 3 size 1.50 x 0.40 x 0.20 with light serous drainage. (picture is included on assessment) Notes section written by V18 states this is a deep tissue injury. Will close the assessment and have new assessment with proper staging. Treatment identified foamed silicone three times per week. R91's Wound Assessment Details dated 4/12/25 notes stage 4, slough 20%, heavy serosanguineous drainage, 4.8x 4.8x 1.1. undermining present at 12:00 16cm. Review of Treatment Administration Record January-February 2024. Treatment documented includes Chamosyn moisture barrier to left and right buttock initiated on 7/25/24 and discontinued 4/7/25. Apply sacral wound topically every day and evening for wound care moist to dry packing after sodium hypochlorite solution 2/20/25-4/7/25. On 2/19/25 a Silver alginate foam added to sacral wound. (no treatment initiated documented on 1/21/25) (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Wound Evaluation and Management Summary dated 1/30/25 documents debridement procedure on R91's sacrum. Wound Evaluation and Management Summary dated 2/6/25 Dressing silicone border apply three times per week for 16 days. Leptospermum honey apply 3 times per week for 30 days. (This treatment is not on the TAR for February) The facility presented Unavoidable Wound Documentation dated 1/24/25, 3 days after identified as stage 3. The facility Pressure Ulcer Policy dated 1/19/22 states the nurse shall describe, document/report the following: full assessment of pressure sore including location, stage, length, width, and depth. The facility Wound Care Policy dated October 2020. Verify there is a physician's order for this procedure.

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40066 Based on interviews and records reviewed the facility failed to follow their practice and provide 2 person assist with bed repositioning of a dependent resident. This failure affects one of three residents (R91) reviewed for falls. This failure resulted in R91 falling out of bed when staff turned her and sustained head injury requiring 1 staple to the back of her head. The findings include: R91 is nonverbal and diagnosis include but are not limited to Alzheimer's Disease, Parkinson's Disease, Diabetes, Retention of Urine, Vascular Dementia, Cognitive Communication Deficit, and Need for Assistance with Personal Care. On 4/17/25 at 12:33PM V7, Assistant Director of Nursing, said on 4/5/25 around 6:00am R91 had a fall. V7 said I interviewed staff on Monday, including V20, CNA. V7 said V20 said when doing care and turning R91 she slid from the bed. V7 said R91 was on an air loss mattress. V7 said the nurse was called and there was blood. V7 said R91 was sent to the hospital for evaluation. V7 said R91 returned with 1 staple to the back of the head. V7 said it was a serious injury. V7 said R91 required 2 persons for repositioning, she should have been 2 person assist for repositioning in the bed. V7 said the root cause of R91's fall was the CNA was unable to properly turn the patient. V7 said V20 should have known to use 2 persons. V7 said in-service was done with V20 to ensure V20 uses the proper staff persons. On 4/17/25 at 1:39PM V21, Restorative Nurse, said repositioning in bed is always 2 person assist if the resident is dependent and also if they are 2 person transfer. V21 said I do the assessment quarterly. R91's incident report dated 4/5/25 CNA reported to nurse he was giving CNA care and as he turned R91 on R91 left side R91 slid off the bed. Laceration to the back of head. R91's Progress Notes dated 4/5/25 notes 2 staff persons from ambulance transported resident back to the facility. R91 noted with skin tear on left posterior cephalic, with one staple applied from the hospital. Attempts to reach V20, CNA, on 4/17/25 at 1:04PM and 1:25PM unsuccessful. R91's Restorative Evaluation dated 1/21/25 notes she is dependent with ADL. Assessment and Care plan do not identify 1 or 2 persons for assistance. R91's hospital record dated 4/5/25 notes a laceration repair to the back of her head and 1 staple used.

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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** 40102 Based on interview and record review, the facility failed to identify, assess, and develop effective interventions to prevent residents from experiencing unplanned significant weight loss. This affected three of eight residents (R49, R109, and R145) reviewed for weight loss and weight loss prevention. This failure resulted in unplanned weight loss for R49 of 14% in six months, R109 8% in one month, and R145 10% in one month. Findings Include: A. R49 is a [AGE] year old with the following diagnosis: Alzheimer's disease, vascular dementia, hypertensive heart disease with heart failure, and dysphagia. A Nursing note dated 3/9/25 documents R49 refused to eat even though staff attempted to feed. There is no notification the physician was notified of poor appetite. A Nursing note dated 3/10/25 documents R49 is still having a poor appetite. R49 verbalized being hungry but is not eating food. R49 drank 1 cup (4 oz) of ensure for breakfast and lunch. The nurse practitioner was notified. A Nursing note dated 3/14/25 documents staff attempted to feed R49 but R49 refused. R49 verbalized being hungry but is not eating food. R49 drank 1 cup (4 oz) of ensure for breakfast and lunch. There is no notification the physician was notified of poor appetite. A Physician note dated 3/14/25 documents request to follow up by nursing for poor appetite. Plan to provide nutritional supplementation, nutrition consult, and monitor labs. A Nursing note dated 3/17/25 documents the nurse practitioner was made aware of R49 not eating and weight loss. R49 only appears to be gurgling fluids and not swallowing. Order received for labs to be completed tomorrow. A Nursing note dated 3/18/25 documents R49's sodium level was elevated so R49 was sent to the hospital for an evaluation. A Nursing note dated 3/26/25 documents R49 returned to the facility from the hospital. A Nursing note dated 3/27/25 documents R49 still has a poor appetite when staff attempted to feed. A Nursing note dated 3/28/25 documents the nurse practitioner was notified of R49's poor oral intake and no new orders were put in place. A Nursing note dated 3/30/25 documents R49 only had a couple spoons for breakfast and lunch. A Nursing note dated 3/31/25 documents R49 still has a poor appetite and had two sips of thickened ensure. (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.	A Nursing note dated 4/1/25 documents the nurse called pharmacy to follow up on the appetite stimulant, but it is not covered by insurance. The nurse practitioner was notified, and the medication was discontinued. A Physician note dated 4/1/25 documents R49 had a poor appetite and refusing meals since arrival. R49 is on nutritional supplementation but an appetite stimulant is not covered by insurance, so it was removed from the MAR. A Nursing note dated 4/2/25 documents R49 was sent to the hospital for pneumonia and heart failure. A Nursing note dated 4/10/25 documents R49 returned from the hospital on hospice. The Dietary/Nutrition note dated 1/19/25 documents the most recent recorded weight was documented as 116.9 pounds. R49 is pureed with super pudding with meals with a supplement of ensure 4 oz three times a day. R49 had an unintentional weight loss related to dysphagia and inadequate energy intake as exhibited by weight loss and documented poor intake. Weights show a 7.5% decrease in three months and an almost 12% decrease in six months. R49's appetite varies from 0-100%. There is an order for daily weights and to notify the physician of weight change per criteria. Appears that different weighing methods are used at times with significant differences between them. The Dietary/Nutrition note dated 2/26/25 documents the most recent recorded weight was 120.2 pounds. This still is considered a greater than 10% decrease within six months. R49's appetite is poor. R49 is only taking sips of ensure per progress notes. No new interventions were put in place to address the significant weight loss for six months. There is no documentation of a March dietary note. A Dietary/Nutrition note dated 4/17/25 documents the most recent recorded weight was 108.6 pounds. This is an unintended weight loss related to dysphagia and inadequate energy intake as exhibited by weight loss and documented poor intake. Weights show a greater than 5% decrease in one month. R49 is now on hospice and intake is very poor. Only taking bites of each meal. Super cereal and super pudding were offered but R49 does not take more than a few bites. Continue plan of care per hospice. R49's weights are documented as follows: 4/10/25 - 108.6 pounds, 3/27/25 - 113.2 pounds, 3/17/25 - 107.4 pounds, 3/15/25 - 126 pounds, 3/7/25 - 127 pounds, 2/20/25 - 120.2 pounds, 2/15/25 - 128.1 pounds, and 1/14/25 - 116.9 pounds. (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.	On 4/17/25 at 11:32AM, V5 (Dietitian) stated V5 comes to the facility two or three times a month or as needed when contacted by staff. V5 reported V4 oversees residents on tube feeds or with weight loss concerns. V5 stated R49 was last seen in February. V5 reported R49 is on daily weights for heart failure. V5 stated in February R49 had a 7.5% weight loss from the previous visit due to multiple hospitalization s and diuretic use. V5 reported R49 had a poor appetite for about two months and was only taking sips of the nutritional shake. V5 stated R49 had super puddings twice a day and ensure twice a day in place as interventions but no other interventions were added at that time because R49 was not eating. V5 denied being notified of R49 weight loss for the month of March so R49 was not seen during March. V5 reported if R49 continued to have a poor appetite then staff should have notified V5 to put in other interventions. V5 stated V5 was last in the building assessing residents on 4/8/25. V5 reported additional supplements will be added for R49 on V5's next visit. On 4/18/25 9:12AM, V7 (ADON) stated we asked that one or two CNAs go around the first week of the month to get resident weights. V7 reported one weighing scale per floor is used to ensure accuracy. V7 stated the weights are entered in an excel sheet and sent via email. V7 reported if there is a significant weight loss then V22 will let V7 know and a reweigh will be conducted and if it is still a significant weight loss then V22 will contact V5. V7 stated weekly weights and calorie counts are put in for residents with noted weight loss. V7 reported the nurse will document the calorie count in PCC. V7 stated the physician is notified of the recommendations of the dietitian. V7 reported if here is an issue with weight the dietitian is contacted. V7 stated the weight meetings are performed quarterly and residents are discussed for who is having weight loss. V7 reported V7 goes over the weights for the residents. V7 stated if a resident is losing weight, then weekly and daily weights will be completed if they have medical conditions. V7 stated residents should also be weighed upon readmission to see if there is a significant change in weight. V7 stated more than 5 pounds of weight loss is a significant weight loss. V7 reported it will trigger in the system. It will show in PCC once the weight is entered the system will generate a remark about the weight loss. V7 reported the dietitian will recommend supplements and will be placed in PCC and communicated to the nurses. V7 stated V7 is responsible for talking to the physician about other recommendations besides supplements. V7 reported interventions will also be documented in the care plan and family will be involved to see if they have any suggestions. V7 stated the same case with R49. V7 reported R49 had a poor appetite for about two months. V7 stated R49 would say R49 would want to eat but then not consume any food. V7 reported R49's poor appetite was addressed by V22. V7 stated R49 also had worsening CHF and began having frequent hospitalization s. The Physician Order Summary documents R49 receives a pureed no added salt diet with nectar thick liquids. R49 needs feeding assistance for all meals. A calorie count with all meals for three days was ordered on 2/24/25. The facility did not provide any documentation of a completed calorie count during this investigation. Weekly weights were ordered on 4/10/25 for four weeks. The Medication Administration Record dated 03/2025 documents an appetite stimulant was ordered on 3/31/25 but was not administered due to the medication not being available. An order dated 12/3/24 documents staff need to monitor oral intake and notify if R49 has a poor appetite or decreased oral intake. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lee Manor	1301 Lee Street Des Plaines, IL 60018

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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 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status could not be completed because R49 cannot/is rarely understood. Section K of MDS documents R49 had a loss of 5% or more in the last month or 10% or more in the last six months and is not on a physician-prescribed weight loss regimen. Within the last seven days, total calories received are 25% or less than what R49 should be consuming. The Dietary Profile dated 11/10/24 documents R49 has a body mass index of 18.4%. R49 has supplements of ensure 4 or three times a day, super cereal at breakfast and super pudding at breakfast, lunch, and dinner. Appetite is fair but R49 appears underweight. Goal is to improve oral intake to 75% with gradual weight gain desire. The Dietary Profile dated 4/5/25 documents R49 is still taking the same supplements. R49 is documented as having a good appetite. Plan to reassess upon readmission. R49 was sent to the hospital on 4/2/25. The POC Amount Eaten charting dated 01/2025 documents R49's appetite differs from 0-100% eaten with the majority being 51-75%. The POC Amount Eaten charting dated 02/2025 documents R49's appetite varies from 0-75% with the majority being 26-50%. The POC Amount Eaten charting dated 03/2025 documents R49's appetite varies from 0-50% eaten with the majority being 0-25%. The Care Plan revised on 4/11/25 documents R49 has a diagnosis of congestive heart failure. An intervention dated 10/06/23 documents monitor for signs of malnutrition and encourage adequate nutrition. The Care Plan revised on 2/4/25 documents R49 is at increased nutrition risk related to recent significant weight gain, receiving a mechanically altered diet, and currently on diuretic therapy. Interventions created on 2/6/20 document provide and serve ensure 8oz as ordered and monitor intake and record each meal. There are no other interventions documented on the care plan that were added to address R49's significant weight loss or poor appetite. B. R109 is a [AGE] year old with the following diagnosis: Alzheimer's disease, vascular dementia, and diastolic heart failure. A Physician note dated 3/11/25 documents R109's adult failure to thrive is stable. R109 has had an improved appetite per documentation. There is no documentation the physician was notified of the weight loss in March. A Physician note dated 3/18/25 documents R109's adult failure to thrive is stable. Recommendation to add spices and soy sauce to improve taste. A Dietary/Nutrition dated 1/19/25 documents the most recent weight was 127.6 pounds. R109 has had an unintentional weight loss related to variable intake. R109 has had a greater than 5% increase in one month. There is no dietary note for February or March. A Dietary/Nutrition note dated 4/17/25 documents the most recent weight was 116.9 pounds. This is an unintentional weight loss. R109 has variable intake. Super pudding at dinner was added on 4/6/25. An appetite stimulant was also added to promote increased appetite. COVID outbreak on the floor in February which may have contributed to weight loss. April weight was requested. R109's weights are documented as follows: no weight for April, 3/11/25- 116.9 pounds, no weight for February, 1/13/25- 127.6 pounds, 12/11/25- 121 pounds, no weight for November, 10/29/24- 122 pounds, and 10/22/24- 124 pounds. (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.	On 4/17/25 at 11:32AM, V5 reported R109 is ordered weekly weights due to heart failure. V5 reported V5 recommended a calorie count in November be completed to see how much R109 was eating. V5 denied ever looking at the calorie count or following up to see if the calorie count was completed. When asked why V5 never followed up with the completion of the calorie count, V5 said, I don't know. I guess I'm stupid. V5 stated V5 was not notified of the weight loss in December but should have been so new interventions could have been put in place. V5 reported R109 was last seen in 01/2025 due to having a significant weight loss from 127 pounds to 116 pounds. V5 stated R109 has not been seen in April yet due to no April weigh being recorded. V5 stated weights should be taken at least monthly or weekly/daily depending on the physician order. V5 reported V5 only recommends supplements, and the physician is responsible for managing medications and adding appetite stimulants. V5 denied needing to make recommendations for the appetite stimulants because the nursing staff should be talking with the physician if they want to get that ordered. V5 confirmed weight loss for R49, R109, and R145 was unintentional. On 4/18/25 at 9:12AM, V7 reported R109 was sent to the hospital and had significant weight loss when R109 returned. V7 stated the food preferences are being address. V7 reported R109 has also had a poor appetite. V7 reported the PCP will start any medications to increase appetite. V7 stated during the COIVD outbreak some February weights weren't done, and the platform scale couldn't be used. V7 stated the facility does have other scales that could have been used at that time. The Physician Order Summary documents R109 is ordered a general mechanical soft diet that needs assistance feeding each meal. A calorie count with all meals for three days was ordered on 2/24/25. The facility did not provide any documentation of a completed calorie count during this investigation. An order on 10/25/24 documents ensure plus twice a day. An order on 4/6/25 documents super pudding to be given at lunch and dinner. An order for weekly weights to be performed was ordered on 10/26/24. The Medication Administration Record dated 03/2025 documents the appetite stimulant was started on 3/18/25. The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score could not be completed because R49 cannot/is rarely understood. Section K of MDS documents R49 had a loss of 5% or more in the last month or 10% of more in the last six months and is not on a physician-prescribed weight loss regimen. The Dietary Profile dated 4/6/25 documents the most recent weight as 116.9 pounds. R109 is on ensure plus twice a day and recommendations including super pudding with lunch and dinner. R109's appetite is documented as good. Will continue to monitor intake, labs, and skin with a weight goal for tolerance of current diet with gradual weight gain. The POC Amount Eaten charting dated 03/2025 documents R109's appetite differs from 0-100% eaten with the majority being 26-50%. The POC Amount Eaten charting dated 04/2025 documents R109's appetite varies from 0-100% with the majority being 50-75%. (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 Care Plan revised 10/10/24 documents R109 is at increased risk for nutrition related to mechanically altered diet with recent significant weight loss. An intervention was created on 10/1/19 to provide supplements as ordered and monitor intake and record each meal. No new interventions were documented after this date. There is a revision dated 4/9/25 but no new interventions are noted. C. R145 is a [AGE] year old with the following diagnosis: malignant neuroendocrine tumors, encounter for gastrostomy, and dysphagia. A Nursing note dated 1/12/25 documents R145 was sent to the hospital for elevated white blood cell count. R145 was not in any acute distress. R145 was admitted with pneumonia. A Nursing note dated 1/28/25 documents R145 readmitted to the facility. A Physician note dated 1/28/25 documents R145 was recently treated at the hospital for infection. R145 also had unintentional weight loss, dysphagia, and regurgitation of undigested food. The Dietary/Nutrition note dated 12/20/24 documents the most recent documented weight as 191.6 pounds. R145 appetite varies from 51-100%. There has been a greater than 10% loss over the past six months. R145 is on a nutritional shake for added calories. No other interventions were added at this visit. The Dietary/Nutrition note dated 1/29/25 documents the weight still as 191.6 pounds. R145 has had an unintentional weight loss due to dysphagia. R145 went to the hospital on 1/12/25 and returned with a G tube. Plan is to continue feedings as ordered. The Dietary/Nutrition note dated 2/17/25 documents the most recent weight as 167.6 pounds. R145 has had an unintentional weight loss due to dysphagia and is now on G tube feeds. This has been a weight loss of greater than 10% in six months. Feedings were increased due to weight loss. The Physician Order Summary documents a dietary supplement for increased calories was added on 4/3/25. An order for tube feeds at 75 mL an hour for 21 hours was placed on 4/3/25. R145's weights are documented as the following: there is no weight documented for April, 3/10/25 - 170.8 pounds, 2/14/25- 167.6 pounds, there is no weight documented for January, 12/17/24- 191.6 pounds, 12/11/24- 183.9 pounds, 12/3/24- 191.6 pounds. On 4/17/25 at 11:32AM, V5 stated V5 started seeing R145 in 2021 but weight loss did not occur until 2024. V5 stated R145 went to the hospital in 01/2025 but V5 was not notified on any weight loss before R145 left. V5 stated R145 was taking supplements of a nutritional shake before going to the hospital. On 4/18/25 at 9:12AM, V7 stated R145 was sent out and R145 has cancer so R145 had a significant weight loss. V7 reported the dietitian would know what interventions were in place for R145. The Minimum Data Set (MDS) dated [DATE] documents a Brief Interview for Mental Status score as 15 (no cognitive impairment). Section K documents a weight loss of 5% or more in the last month or 10% or more in last six months that is not a physician prescribed weight loss regimen. (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 Dietary Profile dated 1/28/25 documents R145 is nothing by mouth and receives tube feedings. Awaiting readmission weight to complete assessment. The Hospital Records dated 1/12/25 document R145 was admitted to the hospital for an elevated white blood cell count. R145 reported a major unintentional weight loss, dysphagia, and regurgitating undigested food. R145 weight upon admission was 172 pounds. The Care Plan revised on 4/5/25 documents R145 requires tube feeding related to dysphagia and swallowing problems. An intervention documented on 2/24/25 documents the dietitian will evaluate quarterly and as needed to monitor caloric intake and estimate needs. There is no other documentation in the care plan addressing R145's weight loss or nutritional risk with interventions. On 4/18/25 at 10:01AM, V22 (Nutrition Support Coordinator) stated V22 responsibilities are entering the weights into the system that are received from the nursing staff. V22 reported if the weights aren't accurate then a new weight is requested. V22 stated V22 also completes the Dietary Profiles, and the facility completes them to show their weight, how their eating is doing and to provide a baseline. V22 reported the facility has had an in-service because the daily and weekly weights are done. We do a quarterly meeting with all the disciplines and weight loss of all residents are discussed. V22 stated the last quarterly meeting was in April and those meeting minutes kept in the binder. V22 reported if the weight loss is still significant then when the dietitian comes in and the report is printed V5 will see who a significant weight loss is and make sure to see those residents. V22 stated V5 comes in a couple times a week. We will discuss weight loss interventions together to see if we can come up with something. V22 reported the recommendations are given to staff verbally and then given to the doctor to see what can be ordered. V22 stated if a resident continues to have weight loss, then we just document what the interventions are in place and continue to monitor. V22 stated all residents who have significant weight loss should be seen by the dietitian. V22 also reported that V22 audits the weight loss report at the end of the month to make sure everyone is taken care of. On 4/18/25 at 1:22PM, V23 (Associate Medical Director) stated the expectation is to implement interventions when weight loss is first noted. V23 reported the weight loss meetings should be conducted to go over the current interventions. V23 stated the dietitian should be involved and see the residents who are losing weight. V23 reported the dietitian is responsible for finding supplements to help with weight loss. V23 stated residents should be weighed monthly but if they are losing weight it needs to be more often to monitor the weight loss and if any other interventions need to be put in place. V23 stated appetite stimulants, calorie counts, and medication reviews can also be added as interventions for 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 policy titled, Monthly, Weekly, & Daily Weights, dated 12/12/18 documents, Statement of Policy: It is policy of [NAME] Manor Rehabilitation and Nursing Facility that all residents will be weighed monthly per State and federal Regulations unless otherwise indicated. Monthly Significant Weight Loss: All residents will be weighed starting the first day of the month. The weights will be obtained by the CNA and nursing staff. Upon completion of the re-weights, the nutrition support manager will record all of the weights into PCC. The nutrition support manager will generate the weight and vitals expectations report, which will reflect a 5% weight change for one month; 7.5% weight change for three months; and 10% weight change for six months. The weight and vital exception report will be given to the registered dietitian monthly for review. The registered dietitian will follow up on any significant weight changes on a monthly basis. Weekly and Daily Significant Weight Loss/Changes: Weekly and daily weight will be obtained by the CNA nursing staff. Nursing will enter weekly and daily weights into PCC. Upon entering weekly and daily weights into PCC, nursing will compare the weight to be entered to the previous weight obtained, if there is significant weight change, nursing at that time will determine if the weight is correct, or if reweight is necessary at that time. Nursing will also contact nutrition support manager to report any significant weight changes. Nursing will also contact the physician related to any significant weight changes and follow any physician orders related to significant weight changes at that time. The policy titled, Nutrition Assessment In-Depth, dated 2021 documents, .The dietitian exercises clinical judgement to determine the best nutrition approach(s) by recommending interventions appropriate to the individual. The policy titled, Interventions for Weight Loss, dated 2021 documents, Policy: Interventions are provided to address a decline in a client's appetite and food intake, a significant weight loss or insidious weight loss trend. Procedure: Nutrition interventions can be initiated by a member of the healthcare team prior to assessment of the client's nutrition status by the dietitian .Pharmacists can help the staff identify medications that alter taste or cause dry mouth, lethargy, nausea, or confusion. Physicians and nurse practitioners help identify causes of anorexia and weight loss.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. 40066 Based on observations, interviews, and records reviewed the facility failed to accurately assess the number of side rails appropriate for one of one resident's (R137) use of side rails in a sample of 36. The findings include: On 04/15/25 at 11:28 AM R137's bed observed with bolsters, 1/4 side rails upper and lowers in bed and floor matts in the room. 04/15/25 03:16 PM V24, CNA, said R137 is dependent on us, can feed self, she can turn with help, she is confused. V24 said R137 can't get out of bed, her legs restrict her movement. V24 said R137 can't turn without assist from me. 04/15/25 11:28AM quarter rails observed on bed. Top and bottom. 04/16/25 10:33 AM R137 getting turned by V25 and 2nd CNA, IV in left hand, no heel boots, ace bandages on bilateral legs, right knee lidocaine patch. Staff rolled her, R137 not able to turn or grab rail. At the end of care V25 lowered the bed and placed floor matts. V25 raised the lower rails and left the room, the upper rails were left in the up position during care. The 2nd CNA left the room after assisting to reposition R137. On 4/17/25 at 1:39PM V21, Restorative Nurse, said I am not aware R137 has 4 rails on her bed. The family wants us to use that bed. 4/17/24 2:04PM V21, Restorative Nurse, said R137 is supposed to use upper rails, not the lower part. V21 said I don't have an assessment for the bolsters. V21 said the family wants the bed with the bolsters. V21 said I should have an assessment for the bolsters. V21 said the rail and bolster assessments are done quarterly. On 4/18/25 at 8:31AM V7, Assistant Director of Nursing, said on R91's care plan I see intervention to lower the side rails, but it does not say how many to use. V7 said there is nothing in the care plan about the bolsters for R91. Facility presented a document with the delivery date 91's bed was delivered to the facility for use on 5/15/24. Device Observation, Education, Consent form dated 3/4/25 identifies 1/4 side rail to be used as an enabler (no number or pleural use of the word rail). Cognition is confused, impaired decision making, short attention span, short term memory deficit, and diminished comprehension of condition. Unable to recover balance. Mobility is impaired, non ambulatory. Range of motion deficits to all extremities. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No behavioral risk. This device is being used for resident's independence and psychological well being as an enabler. Care plan updated. R91's care plan does not include use of bolster or for 1/4 rails.

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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 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 34069 Based on observation and interview, the facility failed to post Nurse Staffing Data in a prominent area available for residents and visitors. This failure has the capacity to affect all residents. Findings include: On 4-17-25 at 12:50 PM, surveyor toured the 1st floor and was unable to find Nurse Staffing Data verified with V1 (Director of Nursing), V8 (Administrator), and V9 (Receptionist). On 4-17-25 at 1:05 PM, V9 (Receptionist) said she has not seen the Nurse Staffing Data this morning and currently V1 is working on the Nurse Staffing Data at this time. On 4-17-25 at 1:08 PM, V1 (Director of Nursing) said the scheduler is responsible for posting the Nurse Staffing Data and said the scheduler is on vacation at this time. V1 said the Nurse Staffing Data is posted at the Receptionist's Desk and at the 1st floor Nursing Station. V1 said the Nurse Staffing Data explains the staff-to-resident ratios. On 4-17-25 at 1:32 PM, V8 (Administrator) said Nurse Staffing Data shows family and visitors the staff working hours and explains the ratios of staff to residents. The scheduler is responsible for the nurse staffing data is currently on Family Medical Leave of Absence. The Nurse Staffing Data is to be posted at the front desk and Nurse Staffing Data wasn't posted earlier this morning.