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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145450	A. Building B. Wing	02/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Lakeland Rehab & Hcc	820 West Lawrence Chicago, IL 60640

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47303 Based on interviews and record review, the facility failed to ensure that one dependent resident (R3) was properly dressed when going out into the community. This failure has affected one of three residents reviewed for resident's rights. Findings include: R3 is a [AGE] year old with diagnosis including but not limited to: Hemiplegia and Hemiparesis following cerebral infarction affecting left dominant side, polyosteoarthritis, generalized edema, muscle weakness, chronic pain and cognitive communication deficit. R3 has a BIMS (Brief Interview of Mental Status) score of 15, which indicates cognitively intact. On 2/10/25 during investigation at 11:18 AM, R3 said, I went out for my dental appointment about two weeks ago with my gown, jacket and a hat on. The staff didn't know about my appointment until the last minute. I was in the dining room about to have lunch, when my CNA (Certified Nurse Assistant) came and got me to take me to my room and put a purple jacket on top of my gown. I was freezing. It was about 10 degrees outside. My sister met me at the appointment and was very upset when she saw me. I was embarrassed and humiliated. I did not feel important at all and don't want anyone else to go through what I went through. Surveyor observed a purple jacket on R3's motorized wheelchair with a female's name written inside of the jacket. Surveyor asked if the purple jacket was the jacket that R3 had worn on top of his gown on the day of his dental appointment. R3 said that his CNA had placed the purple jacket on him and that he did not know who the jacket belonged to. Surveyor inquired about R3's appointment. On 2/10/25 at 1:10 PM, V21 (Transportation personnel) said that she was told by R3's CNA that he (R3) did not want to get dressed for his appointment and wanted to wear his gown. He had on a jacket and a hat as well. (continued on next page)

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

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/18/25 at 2:50 PM, R3 said that he would never want to wear a gown outside of the facility and is insulted that someone has lied on him. R3's order report documents, dental consultation on 1/22/25 at 1:30 PM. R3's Care Plan documents, R3 has an ADL (Activities of Daily Living) self-care performance deficiency. Facility policy titled Dressing/ Grooming documents, maintain the resident's self-esteem, privacy and confidentiality.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. 43351 Based on interview and record review, the facility failed to follow their own policy of initiating a fingerprint based criminal history records check of an employee in an effort to prevent abuse at the facility. This failure has the potential to affect all the residents residing on the 3rd floor Vent Unit. Findings include: The (02/18/2025) email correspondence with V2 (Director of Nursing) upon request of V28's (Certified Nursing Assistant) floor assignment documented, in part Her floor assignment is Vent on 3rd floor. The (02/09/2025) daily census on 3rd floor Vent Unit was 33. On 02/11/2025 at 9:52am, V24 (Business Office Manager/HR Manager) stated the purpose of conducting background check is to ensure who we are hiring are people who do not have anything in their background like criminal situation such as theft, murder, abuse like physical, mental, verbal, misappropriation of finances, sexual, and neglect. I do the background checking after interviewing prospective employee and before hire. On 02/11/2025 at 9:54am, during the review of V28 (Certified Nursing Assistant) employee file with V24 (Business Office Manager/HR Manager. V24 stated her work eligibility is not yet determined. She was hired prior to my employment at the facility. On 02/18/2025 at 11:20am, V24 stated not yet determined means the staff was not fingerprinted yet. Once she goes and does the fingerprinting, State Agency will perform another background and once cleared it will change to 'not yet determined' to 'eligible' or 'not eligible'. It is my assumption that since she did not have abuse on record it was a good hire; it just that the final step was not completed. On 02/18/2025 at 11:32am, V1 (Administrator/Abuse Coordinator) stated I don't know what it means not yet determine. I have never seen that. I will not hold employment just because it did not say 'eligible'. I was not even here at the time of her (V28) hire date. On 02/18/2025 12:03pm, V27 (Senior Business Office Manager) stated in the IDPH portal we check if there is already a 'Fee App'. The FEE_APP will tell us if the potential employee has been fingerprinted. If not, we will initiate the fingerprinting. The potential employee will be given a voucher to do the fingerprinting. And they have 10 days to get it done. (V28) was hired prior to (V24). The not yet determined on the Work Eligibility means she was not fingerprinted. It means we do not know if she is eligible to work at the facility because it can go both ways, could be 'not eligible' or 'eligible'. The purpose of doing the background check is to ensure they are eligible to work and that they have a clean background. The main purpose of the background checking is to not hire any potential employee who have background to prevent abuse amongst residents and employees. I will not let her work on the floor until she gets fingerprinted and verify that she is indeed eligible. We are not in compliance with the background checking of the potential employee. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/18/2025 at 12:21pm, V27 stated she does not have the disclosure for background check. I just learned about it now when (V24) showed me her (V28) employee file. The disclosure should be included in the employee file because it will help us identify that she is the person applying for the position. I don't know why it was missed, to be honest. The (undated) Active Listing documented that V28's seniority date was on 03/15/2024. V28's (undated) Health Care worker Registry documented, in part Work Eligibility: NotYetDetermined. Of note, no FEE_APP noted on the result. V28's Health Care Worker Background Check Authorization (Authorization and Disclosure for Criminal History Records Information) was signed on 2/14/2025. V28's Livescan Fingerprint Request Date of Request was on 2/18/2025. The (09/20) abuse policy documented, in part policy this facility affirms the right of our residents to be free from abuse, neglect, misappropriation of resident's property, corporal punishment, and involuntary seclusion. The purpose of this policy is to assure that the facility is doing all what that is within its control to prevent occurrences of mistreatment, neglect or abuse of our residents. This will be done by: 1. Conducting pre employment screening of employees. 1. Abuse prevention program. 1. Pre employment screening of potential employees. This facility will not knowingly employ or engage any individual convicted of resident abuse, neglect, mistreatment, or misappropriation of resident's property. The facility will not knowingly employ or engage any direct care staff convicted of any of the crimes listed in the healthcare workers background check act. The facility will not knowingly employ or engage an individual with a disciplinary action in effect against their professional license by the state licensure body as a result of a finding of abuse, neglect, exploitation, mistreatment or misappropriation of residence property be it by prior to a new employee starting a working schedule: c. Check the State healthcare worker registry for all new employees. D. Complete the State police healthcare worker background check application on all new hires. The (08/2011) Fingerprint-based Criminal History records check documented, in part Policy: the (facility) will not knowingly higher, employee or retain any individual who has been convicted of committing or attempting to commit offenses which are related to working in healthcare facility. It is the policy of this facility to check the health care worker registry on all individuals making application for employment with this facility. B. Procedure: 1. The facility, will check the health care worker registry to determine: i) Whether a fingerprinted based criminal history records check has been previously completed, which is indicated by identifier of FEE_APP or CAAPP. (1) as long as the applicant has had such a background check and stays active on the health care worker registry, no further fingerprint based criminal history records check will be deemed necessary. 2. If the individual has not had a fingerprint-based background check or is not active on the healthcare worker registry, the facility must initiate a fingerprint based criminal history records check. V) if the applicant or employee has not had his or fingerprints collected electronically by a Livescan vendor within 30 days after being hired, the employee shall be terminated.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47303 Based on interviews and record review, the facility failed to ensure that one resident (R2), who is diagnosed with cancer received two scheduled chemo therapy treatments. This failure has caused R2 to stress and worry about the cancer progressing due to missed chemotherapy. Findings include: R2 is a [AGE] year old with diagnosis including but not limited to: Malignant neoplasm of unspecified lung, quadriplegia, secondary malignant neoplasm of other specified sites, acquired absence of left leg above the knee, and unsteadiness on feet. R2 has a BIMS (Brief Interview of Mental Status) score of 15, which indicates cognitively intact. Surveyor inquired about what happened with R2's appointments. On 2/10/25 at 11:52 AM, V15 (LPN/ Licensed Practical Nurse) said, I work with R2 often. He (R2) missed two chemo appointments that I am aware of. The 1st appointment that he (R2) missed was because transportation was not set up. The second missed appointment was because the transportation picked him (R2) up at 6:30 AM and he got to his appointment early. Since there was no escort with R2, he had to be brought back to the facility. We had a hard time rescheduling his (R2) appointment, but the DON (V2) was able to secure an appointment for R2 today. On 12/10/25 at 12:05 PM, V16 (Nurse Practitioner) said that R2's recently missed chemo appointment was because he (R2) was picked up too early by transportation and since he had no escort, was sent back to the facility. Surveyor inquired about the importance of the chemo therapy treatment. At that time V16 said, Since the chemo therapy is only once monthly, it is important to not miss any appointments. The mass could possibly get bigger and the chemo can be less effective if there are missed appointments. Delayed chemo treatments in this early stage is not good. Surveyor inquired about what happened with R2's appointments. On 2/10/25 at 1:10 PM, V21 (Transportation personnel) said, I did not know about R2's first appointment because it did not show up under the order listing report when I ran a report. If the nurse does not enter an end date for the order, it will not show up on the listing report for me to schedule transportation. For the second appointment, R2 got to the appointment too early and he had to be brought back to the facility because there was no one to wait with him. R2 is transported via ambulance and stretcher. I am not sure if I would have been able to get another ambulance out to pick him up on the same day. Typically, we are to schedule the transportation prior and not the day of. Surveyor asked is R2 required an escort for appointments. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 2/10/25 at 1:10 PM, V21 (Transportation personnel) said that since R2 was transported via stretcher, he should have had an escort. On 2/10/25 at 2:10 PM, R2 said, I have missed two chemo appointments. The first time, I don't think that I had transportation set up. The second time, I was taken too early for my appointment and was brought back to the facility because I didn't have an escort. The transportation could not leave me alone because I use a stretcher to transport. The transportation could have transferred me to a bed, but I would need someone to sit with me. I am supposed to go for chemo treatments every six weeks. I'm worried that my cancer has worsened and I can't have this happen again. On 2/18/25 at 2:00 PM, V29 (R2's family) said, My main focus is to make sure that my brother's cancer treatments are consistent and as scheduled. The facility seemed passive about his missed appointments and did not seemed concerned about rescheduling them. These are serious appointments that he (R2) needs and I am concerned for him. R2's Care Plan documents, R2 has a diagnosis of Lung cancer; R2 has an ADL (Activities of Daily Living) self-care performance deficiency due to generalized weakness and impaired mobility secondary to diagnosis of quadriplegia. R2's order report documents, Appointment on 1/20/25 at 10:00 AM cancer center. R2's order report documents, Appointment on 2/3/25 at 7:00 AM cancer center; need a stretcher with escort. R2's progress note dated 1/21/25 and authored by V32 (LPN/ Licensed Practical Nurse) documents, writer spoke with representative at cancer center whom stated that R2 missed three appointments. R2's progress noted dated 2/3/25 and authored by V15 (LPN) documents, R2 went out today for his scheduled appointment with the cancer center. When R2 arrived by ambulance, the medics were told that R2 was too early for his appointment. Writer was advised to arrange for R2 to be transported back to the nursing facility. Facility policy titled Transportation documents, the facility will assist residents in arranging for transportation as needed.

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F 0686

Level of Harm - Actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 45196

Based on observation, interview, and record review the facility failed to provide prescribe wound care as ordered by the physician for 4 residents (R1, R5, R6, and R7); failed to set the low air mattress at the appropriate setting for one resident (R10); failed to ensure heel protectors were in place for one resident (R1); and failed to properly assess R1's right heel wound. These failures have affected 5 out of 5 residents reviewed for pressure ulcer prevention; and resulted in R1's heel wound worsening and R1 being hospitalized for sepsis on 2/11/25.

Findings include:

On 02/10/25 at 11:20 am, R7 was observed in bed awake, alert, and unable to communicate. Surveyor observed R7 with a dressing to R7's right foot undated. When Surveyor brought this observation to V6 (Wound Care Nurse), V6 stated, We (referring to staff) don't date dressing here (referring to the facility). It's the facility protocol. When V6 was asked regarding how staff is made aware of when the last time the dressing has been changed for a resident V6 stated, I (V6) asked that same question when I started. We change the dressings every day. We know by the appearance of the dressing. If the dressing doesn't look fresh then the dressing was not changed.

On 02/11/25 at 9:20 am, Surveyor questioned V2 (Director of Nursing, DON) regarding wound care dressings being dated, V2 stated that it is the facility's policy to not date wound care dressings. Surveyor requested V2 to provide the facility's policy for not dating dressings, V2 stated that the facility does not have a policy for not dating wound care dressings.

On 02/11/25 at 12:20 pm, Surveyor questioned V12 (Wound Care Coordinator) regarding wound care dressings being dated, V12 stated, We are told that it is the policy of the facility to not date the residents wound care dressings. Surveyor requested V12 to provide the facility's policy for not dating dressings, V12 stated that the facility does not have a policy for not dating wound care dressings. V12 stated, This is the first place (referring to the facility) that I (V12) was told not to date the wound care dressings. I don't know why we are not allowed to date the wound care dressings. I am just following the facility's policy.

On 02/11/25 at 12:35 pm, Surveyor and V12 reviewed the Treatment Administration Record (TAR) for R5, R6 and R7's TAR's and observed the following:

Review of R7's TAR showed that R7 did not receive wound care on 02/08/25

Review of R6's TAR showed that R6 did not receive wound care on 02/03/25

Review of R5's TAR showed that R5 did not receive wound care on 02/01/25, 02/02/25, 02/03/25, 02/04/25, 02/06/25, 02/08/25 or 02/09/25.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 02/11/25 at 12:40 pm, Surveyor questioned V12 regarding the missing signatures on R5, R6, and R7's TAR and V12 stated that after a treatment (wound care dressing change) is performed it should be signed out immediately on the residents TAR when the dressing change has been completed. V12 stated that if treatments are not signed out on the TAR the treatment has not been performed. V12 then stated, Not documented not done. V12 explained that the purpose of the documentation on the TAR is to verify that the treatment has been performed for the resident. When V12 was asked regarding what could happen if a resident goes without getting ordered wound care by the physician and V12 stated that the resident's wound could worsening and increase chances of a wound infection. V12 stated, We should be following the physicians orders for scheduled changes for wound care to prevent worsening wound and an increased risk of infection. R5's face sheet shows that R5 has a diagnosis which includes but not limited to end stage renal disease, dependence on renal dialysis, hypertensive heart disease with heart failure, chronic systolic (congestive) heart failure, type 2 diabetes mellitus without complications, asthma, anemia in chronic kidney disease, pancreas transplant status, kidney transplant rejection, complete loss of teeth due to periodontal disease, depressive episodes, opioid dependence, atelectasis, personal history of nicotine dependence. R5's Brief Interview for Mental Status (BIMS) dated 12/26/24 shows that R5 has a BIMS score of 15 which indicates that R5 is cognitively intact. R5's Physician Order Sheet (POS) dated active orders as of 02/10/25 shows that R5 has orders for Optifoam Ag (Silver) Adhesive 4 x 4 External apply to left ischium topically every day shift for skin condition apply Xeroform. R5's TAR dated 02/10/25- 02/28/25 shows no signature for R5's orders to receive wound care with Optifoam Ag (Silver) Adhesive 4 x 4 External apply to left ischium topically everyday shift for skin condition apply Xeroform on 02/01/25, 02/02/25, 02/03/25, 02/04/25, 02/06/25, 02/08/25 or 02/09/25. R6's face sheet shows that R5 has a diagnosis which includes but not limited anoxic brain damage, peripheral vascular disease, and type 2 diabetes mellitus with ketoacidosis without coma. R6's Brief Interview for Mental Status (BIMS) dated 12/10/24 does not show a BIMS score for R6 and indicates that R6 has memory impairment. R6's POS dated active orders as of 02/10/25 shows that R5 has orders for Medi honey wound/burn dressing past (wound dressings) apply to right anterior lower leg topically as needed for skin condition cleanse area W/NS (with normal saline), apply Medi honey/hydrogel sheet and cover with dry dressing . Skintegrity (skin integrity) Hydrogel Gel (Wound Dressing) apply to right anterior lower leg topically as needed for skin condition cleanse area W/NS, apply Medi honey/hydrogel sheet and cover with dry dressing. R6's TAR dated 02/10/25- 02/28/25 shows no signature for R6 to receive wound care with for Medi honey wound/burn dressing past (wound dressings) apply to right anterior lower leg topically as needed for skin condition cleanse area W/NS (with normal saline), apply Medi honey/hydrogel sheet and cover with dry dressing . Skintegrity (skin integrity) Hydrogel Gel (Wound Dressing) apply to right anterior lower leg topically as needed for skin condition cleanse area W/NS, apply Medi honey/hydrogel sheet and cover with dry dressing on 02/03/25. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R7's face sheet shows that R5 has a diagnosis which includes but not limited to anoxic brain damage, non-pressure chronic ulcer of other part of foot with unspecified severity, and encephalopathy. R7's Brief Interview for Mental Status (BIMS) dated 12/31/24 does not show a BIMS score for R7 and indicates that R7 has memory impairment. R7's POS dated active orders as of 02/10/25 shows that R7 has orders for Puracol Plus External Pad (Microscaffold Collagen) apply to R (right) lateral foot topically everyday shift for skin condition clean with N/S (normal saline) apply puracol /4x4/ ABD (abdominal)/ kerlix and offload. R7's TAR dated 02/10/25- 02/28/25 shows no signature for R7 to receive wound with Puracol Plus External Pad (Microscaffold Collagen) apply to R (right) lateral foot topically every day shift for skin condition clean with N/S (normal saline) apply puracol /4x4/ ABD (abdominal)/ kerlix and offload on 02/08/25. The facility's document dated 03/02/21 and titled Prevention and Treatment of Pressure Injury and other Skin Alterations documents, in part: Policy: . 3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. The facility's job description document dated 11/2021 and titled Wound Care Coordinator documents, in part: Essential Functions: A. Must ensure that all nursing procedures and protocols are followed in accordance with established policies. B. Directly supervise the nurses, CNA's and other members of the IDT (interdisciplinary team) that would care treatments and protocols are followed accordingly. D. Responsible/overseas for assessing and documenting women status in skin care. E. Administer or assist with wound treatments as ordered by physician. F. Review treatment orders for completeness of information and accuracy of transcription of the physicians orders. G. Review home assessments for completeness and accuracy. 47303 R1 is [AGE] year old with diagnosis including but not limited to: pressure ulcer of sacral region, pressure ulcer of left heel, pressure ulcer of right heel, severe sepsis with septic shock, hemiplegia and hemiparesis following cerebral infarction affecting left side. On 2/10/25 at 10:43 AM, R1 observed was lying flat on his back. At that time, no heel protectors were observed on R1's feet and no pillow was observed under R1's legs. On 2/10/25 at 10:47 AM, V6 (Wound care nurse) said that R1 had DTIs (Deep tissue injuries) on both heels. Surveyor asked who was responsible for applying resident's pressure relieving heel protectors. On 2/10/25 at 10:47 AM, V6 said that the assigned Nurses, CNAs (Certified Nurse Assistants), and wound treatment team worked together to ensure that all pressure-relieving interventions are in place. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Surveyor inquired about expectations regarding wound assessments and wound prevention. On 2/18/25 at 12:30 PM, V12 (Wound Care Coordinator) said, Upon the initial wound assessment, we capture the size of all wounds in order to monitor the progress of each wound. For wound prevention, we offload boney areas of the resident and the floor staff reposition every two hours. Surveyor inquired about expectations regarding new wound orders. On 2/18/25 at 12:30 PM, V12 (Wound Care Coordinator) said that whoever rounds with V13 (Wound Care Doctor) takes the order recommendations and enters them into the Medical chart within 24 hours. Surveyor inquired about R1's recent hospitalization . On 2/18/25 at 12:30 PM, V12 (WCC) said that R1 had been hospitalized on [DATE] for sepsis. Surveyor inquired about weekly assessments and new orders. On 2/19/25 at 12:46 PM, V13 (Wound Doctor) said, I round weekly and give verbal orders as we round. At the end of my rounds, I also give them (treatment team) a printout of my progress notes with the orders. Surveyor inquired about the expectations regarding entering and following new wound care orders. On 2/19/25 at 12:46 PM, V13 (Wound Doctor) said, I would expect for the orders to be put in within the next day. Some orders may be for the next day or the following day. The orders are expected to be followed to have a goal of wound healing and prevention of infection. Surveyor asked if an infected wound causes sepsis. On 2/19/25 at 12:46 PM, V13 (Wound Doctor) said, Yes, an infected wound can cause sepsis. Surveyor asked what the treatment expected date meant. On 2/19/25 at 12:50 PM, V13 (Wound Doctor) said, The treatment expected date is the date treatment will end. Some treatments may continue past the end date if I (V13) don't make any changes. Surveyor asked what could happen if heel protectors are not used as ordered. On 2/19/25 at 12:50 PM, V13 (Wound Doctor) said, If there are no heel protectors or pillows, that can cause pressure and worsening of a wound. R1's Care Plan documents, R1 has an actual alteration in skin integrity related to pressure ulcers; Treatment as ordered. R1's Section M- Skin Conditions assessment dated [DATE] documents, R1 is at risk for developing pressure ulcers. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Alden Lakeland Rehab & Hcc		STREET ADDRESS, CITY, STATE, ZIP CODE: 820 West Lawrence Chicago, IL 60640	

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Wound Assessment performed by V13 (Wound Doctor) on 12/24/24 documents no measurements for R1's right heel wound. R1's Wound Assessment performed by V13 on 2/11/25 documents a measurement of 1x1x0 (Length x Width x Depth) for R1's right heel wound. R1's Wound Assessment performed by V13 on 12/24/24 documents the following intervention in the plan of care: offload heels with heel protectors or pillow. R1's Wound Assessment performed by V13 on 12/24/24 documents the following new orders: 1. Sacral wound cleansed daily and PRN (as needed) with normal saline and dressed with Medihoney and Adaptic for thirty days, through 1/23/25. 2. Left heel cleansed three times per week with normal saline and dressed with betadine paint and Xeroform for thirty days, through 1/23/25. 3. Right heel cleansed three times per week with normal saline and dressed with betadine paint and Xeroform for thirty days, through 1/23/25. 4. Right ankle cleansed three times three times per week with normal saline and dressed with betadine paint and Xeroform for thirty days, through 1/23/25. 5. Right lateral lower leg cleansed three times per week with normal saline and dressed with betadine paint. R1's Wound Assessment performed by V13 on 2/11/24 documents the following new orders: 1. Sacral wound cleansed daily and PRN (as needed) with normal saline and dressed with Medihoney and Adaptic for thirty days, through 2/27/25. 2. Left heel cleansed three times per week with normal saline and dressed with betadine paint and Xeroform for thirty days, through 2/27/25. 3. Right heel cleansed three times per week with normal saline and dressed with betadine paint and Xeroforn for thirty days, through 2/27/25. 4. Right ankle cleansed three times three times per week with normal saline and dressed with betadine paint and Xeroform for thirty days, through 2/27/25. 5. Right lateral lower leg cleansed three times per week with normal saline and dressed with Medihoney and Adaptic. R1's Order Summary Report with active orders as of 2/10/25 excludes new wound care orders given by V13 (Wound Doctor) on 12/24/24 and 2/11/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R1's Order Recap Report documents all orders entered between 1/1/25- 2/28/25 and excludes any wound care orders given by V13 on 12/24/24 and 2/11/24. 43351 Findings include: On 02/10/2025 at 11:29am, with V4 (Assistant Director of Nursing) inside R10's room. R10 was lying on a low air loss mattress set at 280lbs alternating every 10 minutes. This observation was pointed out to V4. V4 stated setting is at 280lbs alternating every 10 minutes. This surveyor inquired about R10's weight. V19 (R10's family member) stated she weighs about 180lbs. Review of R10's 02/3/2025 weight indicated that R10 weighed 161.2lbs. On 02/11/2025 at 12:42pm, V12 (Wound Care Coordinator) stated if a resident weighs 160lbs, the setting of her low air loss mattress should be at 180lbs. The setting should not be at 280lbs because there will be too much air and it will constrict the flow of the low air loss mattress which makes the mattress harder defeating the purpose of the low air loss mattress and the resident will have a chance of acquiring pressure wound. On 02/19/2025 at 12:46pm, V13 (Wound Doctor) stated if the setting of a low air low mattress are too high, the mattress will be too hard and does not work well to prevent pressure ulcers. R10's (Active Order as Of 02/11/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) anoxic brain damage, essential primary hypertension and Type 2 Diabetes Mellitus. Order Summary: low air loss mattress. R10's (01/09/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: no entry. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000. Cognitive Skills for daily decision making: 3 severely impaired. M0150. Risk of Pressure Ulcers/Injuries: 1- Yes. M1200. Skin and Ulcer Injury Treatments. B - Pressure reducing device for bed. R10's (04/10/2024) care plan documented, in part has potential for alteration in skin integrity. Skin will remain intact. Pressure redistribution support (low air or alternating air) in bed. The (undated) Protekt Aire medical products operation Manual documented, in part General: Protekt pump and mattress is high quality and affordable air mattress system suitable for medium and high-ris pressure ulcer treatment. They have been specifically designed for prevention of bedsores and offer an affordable solution to 24-hour pressure area care. Pressure Set-Up. Note. It is recommended to press auto firm on the panel when the mattress is first inflated. Users can then easily adjust the air mattress to a desired firmness according to the patient's weight and comfort.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 43351 Based on interview and record review, the facility failed to ensure dietary recommendations for residents on feeding tube were ordered and carried out timely for 5 (R1, R14, R15, R16, and R17) residents reviewed for tube feeding in the total sample of 17 residents. Findings include: The (01/16/2025 - 01/16/2025) General Notes Report documented, in part (R1) - Note type: Dietary Recommendations. Rec (recommended) to adjust TF (tube feeding) to Diabetisource AC to infuse 1350cc/day @75cc/hr + 175CC/HR H2O (water) Flush Q (every) 4HR. (hour) Created By/Revised By: V8 (Dietitian). (R14) - Note type: Dietary Recommendations. Rec (recommend) to adjust TF (tube feeding) to Novasource Renal to infuse 1000cc/day @ 80cc/hr to start at 6pm, please notice time change and rate change. Created By/Revised By: V8. (R15) Note type: Dietary Recommendations. Rec to increase rate of TF to Diabetisource AC to infuse 1200cc/day@ 80cc/hr. (R1) Note type: Dietary Recommendations. Rec to adjust TF to Diabetisource AC to infuse 1350cc/day @75cc/hr + 175cc H20 (water) flush q (every) 4 HR. vit C for tissue healing. Created By/Revised By: V8. (R16) Note type: Dietary Recommendations. Rec to increase rate and flush to Peptamen 1.5 to infuse 1000cc/day @55cc/hr + 300cc H2O flush q 6 HR. Created By/Revised By: V8. (R17) Note type: Dietary Recommendations. Rec to change isosource 1.5 to infuse 1100cc/day @60cc/hr. Created By/Revised By: V8. On 02/11/2025 at 11:59am, V2 (Director of Nursing) stated if there is a recommendation from the Dietitian for the rate of feeding and water flush, order will be written for these recommendations. V8 (Dietician) always speaks with the doctor about her recommendations, and she will write the recommendations on the General Notes Report. Our (V22- Clinical Support Nurse) responsibility is to review the recommendation. (V22) will run the report and if the recommendation is from the dietician, all she (V22) has to do is to write an order for the recommendation. If the recommendation is done on 01/16/2025, the order should be in place at least 24 hours or within 2-3 days. On 02/11/2025 at 1:19pm, V22 (Clinical support Nurse) the dietician emails me directly the General Notes Report. When she (V8) emailed me a recommendation, it is kind of a direct order from the doctor for the residents. I am expected to write the order within 24 hours. If she emails on a Friday, I check it on Monday and I will do the order on Monday. If it falls on Thursday, I will make sure it is done before the end of workday on Friday. I don't want the resident to wait for 3 days before I place the order. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/11/2025 at 1:28pm, V22 stated the importance of placing the order for the recommendation made by the dietician is for the sake of the resident, for their health, to promote their good health and state of being and good quality of care. On 02/11/2025 at 1:31pm, this surveyor inquired if there was a recommendation made by the dietitian on 01/16/2025, when was she (V22) expected to place an order for the recommendation. V22 stated I would say I am expected to place the order on 01/17/2025. I was not on vacation in January of 2025. V22 was requested to check if there was an email sent to her by V8 on 1/16/2025. V22 stated I see that she sent me an email on 1/25/25 that she is resubmitting the recommendation from 1/16/25 and there was also an email she sent on 01/16/2025. I am not sure what happened, I guess I missed the email she sent on 01/16/2025. This surveyor requested to check if there was on order placed for R1 tube feeding on 01/16/2025. V22 stated I did not see an order for 01/16/2025. It means I did not see the recommendation or the order. I don't remember seeing the email order. If I saw the email on 01/16/2025, I would have placed the order in the electronic health record. This surveyor inquired if there was a deficient practice for not being able to see the email that was sent on 01/16/2025 and not being able to carry out the order. V22 stated 'yes, that is true.' On 02/18/2025 at 3:29pm, V2 (Director of Nursing) stated if she (V22) admitted she missed the whole email that was sent to her by (V8) on 01/16/2025, then it did not only affect (R1) but also (R14), (R15), (R16), and (R17). The affect would be a potential weight loss. With (R14), it was the change in time because we don't want her tube feeding time to interfere with her dialysis. R1's (Active Order as Of: 02/11/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) Type 2 Diabetes Mellitus, encounter for attention to gastrostomy, and dysphagia. Enteral Feed Order every shift tube feeding Diabetisource AC 1.2 to infuse 1350ml/day at 75ml/hour. R1's (01/27/2025) Order Details documented, in part every shift TUBE FEEDING: DIABETICSOURCE AC 1. 2 TO INFUSE 1350 ML/DAY AT 75 ML/HOUR. Created by V22. Order was placed 11days after the recommendation date. R1's (12/23/2024) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: no entry. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000. Cognitive Skills for daily decision making: 3 severely impaired. Section K0520. B. Feeding tube 2. While not a resident and 3 - while a resident. R14's (Active Order as Of: 02/11/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) encounter for attention to gastrostomy. R14's (12/27/2024) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 00. Indication R14's mental status as severely impaired. Section K. Swallowing/Nutritional Status. K0520. Feeding tube: 3. While a resident. Section O. Special Treatments, Procedures, and Programs.O0110. J1. Dialysis. B - while a resident. R14's (02/14/2025) Order Details documented, in part every shift ENTERAL FEEDING; NOVASOURCE RENAL TO INFUSE 1000CC/DAY @ 80CC/HR TO START AT 6PM. Created by V22. Order was carried out 29 days after the recommendation date. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15's (Active Order as Of: 02/11/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) encounter for attention to gastrostomy and dysphagia. Enteral Feed: enteral Feed Order every shift tube feeding start @ 12 noon diabetic ac to infuse 1200 ml/day@ 80ml/hour. R15's (01/27/2025) Order Details documented, in part every shift TUBE FEEDING: START @ 12 NOON Diabetic Ac TO INFUSE 1200 ML/DAY @ 80 ML/HOUR. Created by V22. Order was carried out 11days after the recommendation date. R15's (01/16/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 14. Indicating R15's mental status as cognitively intact. Section K 0520. Feeding tube - 3. While a resident. R16's (Active Order as Of: 02/11/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) encounter for attention to gastrostomy and dysphagia. R16's (1/27/2025) Order Details documented, in part one time a day TUBE FEEDING: START @ 12PM. Peptamen 1.5 TO INFUSE 1000ML/DAY @ 55 ML/HOUR. Created by V22. Order was carried out 11days after the recommendation date. R16's (12/27/2024) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: no entry. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000. Cognitive Skills for daily decision making: 3 severely impaired. Section K0520. B. Feeding Tube: 3 - while a resident. R17's (Active Order as Of: 02/11/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) encounter for attention to gastrostomy. Enteral Feed. Every shift start 1200PM. Type Isosource 1.5 to infuse 1100ml/day at 60cc/hr. R17's (1/27/2025) Order Details documented, in part every shift TUBE FEEDING: START 1200 PM. TYPE ISOSOURCE 1.5 TO INFUSE 1100 ML/DAY AT 60cc per/hr. Created by V22. Order was placed 11days after the recommendation. R17's (01/21/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: no entry. C0700. Short-Term memory Ok: 1 memory problem. C0800. Long-Term Memory Ok: 1. Memory Problem. C1000. Cognitive Skills for daily decision making: 3 severely impaired. Section K0520. B. Feeding tube: 2 - while not a resident and 3 - while a resident. The (01/25/2025) email correspondence by V8 to V22 and other facility staff documented, in part I am resubmitting the recommendations from 1/16, I think they got missed. I am also attaching the recommendations from today. There may be duplicates because I am resubmitting some that were not done. The (01/27/2025) email correspondence by V22 to V8 and other facility staff documented, in part All orders noted and carried out. (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The (02/18/2025) email correspondence with V2 documented, in part (Facility) does not have a policy directly related to dietary recommendations. However, the expectation is that once the recommendation has been given by the dietician and the physician is in agreement with said recommendation the order will be transcribed and carried out. The (5/15/2024) Clinical Support Nurse job description documented, in part Job Summary: The Clinical Support Nurse is a remote position that aims to provide assistance with a timely and accurate completion of nursing documentation processes. Job duties: B. Responsible for collaborating with members of the interdisciplinary team, DON and or ADON to ensure the accurate completion of nursing documentation components on an ongoing basis including but not limited to: 10. Dietary Recommendations carried out.