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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
	145522	A. Building B. Wing	06/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Beacon Hill	2400 South Finley Road Lombard, IL 60148

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** 34506 Based on observation, interview, and record review, the facility failed to ensure residents were treated in a dignified manner by not covering a urinary drainage bag for two of three residents (R12, R150) reviewed for dignity in the sample of 14. The findings include: 1. R12's Admission Record dated June 11, 2024 shows he was admitted to the facility on [DATE] with diagnoses including sepsis, urinary tract infection, need for assistance with personal care, urinary retention, and alzheimer's disease. On June 10, 2024 at 11:47 AM, R12 was laying in his bed on his right side. R12's urinary drainage bag had cloudy urine in it that was visible from the hallway. On June 11, 2024 at 9:04 AM, R12 was sitting up in his bed. R12's urinary drainage bag was half full and visible from the hallway. 2. On June 10, 2024 at 10:00 AM and 10:46 AM, R150 was laying in her bed. Her urinary drainage bag had urine in the bag and was visible from the hallway. On June 12, 2024 at 2:11 PM, V2 DON (Director of Nursing) said urinary drainage bags should be covered for the dignity of the resident. The facility's Dignity Policy revised February 2021 shows, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feeling of self worth and self esteem. Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist resident; for example: helping the resident to keep urinary catheter bags covered.

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 34506 Based on interview and record review the facility failed to address a residents advance directive status upon admission for one of residents (R3) reviewed for advance directives in the sample of 14. The findings include: R3's Admission Record dated June 11, 2024 shows he was admitted to facility on April 16, 2024 with diagnoses including gastrointestinal hemorrhage, muscle weakness, need for assistance with personal care, chronic diastolic congestive heart failure, aortic aneurysm, and high blood pressure. On June 10, 2024 at 2:29 PM, R3 had no code status listed in his electronic medical record. R3's order recap summary shows there were no orders entered for R3's code status until June 10, 2024 after a POLST (Practitioner Order for Life Sustaining Treatment Form) was requested by the surveyor. An order was entered for a FULL code status on June 10, 2024. On June 11, 2024 at 12:57 PM, V3 SSD (Social Service Director) said POLST form/code status should be addressed upon admission. The social services department addresses the code status when residents are admitted . V3 said that R3 was admitted to the facility prior to V3's start date to the facility. V3 said an order was entered on June 10, 2024 for a FULL code status for R3, because he could not find an advanced directive form signed by R3. V3 said he addressed R3's code status today (June 11,2024) and R3 said he requested to be a do not resuscitate. The facility's Advance Medical Directives and Refusal of Care and Treatment policy and procedures reviewed December 1, 2021 shows, The agency will clearly and carefully document whether the client has executed an advance directive in the client's clinical record.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35119 Based on interview and record review the facility failed to ensure Minimum Data Sets for residents were submitted on time for 3 of 14 residents (R9, R26, R30) reviewed for Minimum Data Sets in the sample of 14. The findings include: R9's quarterly Minimum Data Set (MDS) dated [DATE] shows ready to export. R26's quarterly Minimum Data Set (MDS) dated [DATE] shows ready to export. R30's quarterly Minimum Data Set (MDS) dated [DATE] shows ready to export. On 06/12/24 at 01:28 PM, V11 MDS Coordinator said R9, R26, and R30's quarterly MDS are completed, just not sent. V11 said MDS should be done and sent within 28 days. V11 said she was not sure why these 3 MDS were not exported, but they should have been and were now past the 28 days. V11 said she was not sure why R30's MDS was not on the MDS Accepted batch report but she would make sure it was exported today. The facility's electronic medical record MDS Accepted batch report shows R9 and R26's quarterly MDS status is export ready.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34506 Based on interview and record review, the facility failed to perform quarterly care plan meetings for one of 14 residents (R26) reviewed for care planning in the sample of 14. The findings include: R26's Admission Record shows she was admitted to the facility on [DATE] with diagnoses including dysphagia, muscle weakness, history of falling, and dementia. On June 10, 2024 at 12:04 PM, V13 R26's daughter and power of attorney said that she went a year without any care plan meetings at the facility in regards to her mothers (R26) care. R26's Plan of Care note shows a care plan meeting was held on August 30, 2022. R26's Care plan summary notes show that another care plan meeting was not held again until January 29, 2024. On June 11, 2024 at 2:17 PM, V3 SSD (Social Service Director) said he was unable to find evidence that a care plan for R26 was done prior to January 2024. V3 said the last care plan prior to January 2024 was in 2022. V3 said that care plan meeting should be held at least quarterly. V3 said that the receptionist now arranges all the care plan meetings. V3 said he did not know why there was no care plans in 2023. On June 12, 2024 at 2:11 PM, V1 (Administrator) said care plan meeting should be scheduled quarterly. V1 said there was a period of time when the previous facility social services department was not scheduling the care plans and the care plans weren't happening. The facility's Comprehensive Care Plan policy revised September 6, 2022 shows, The Interdisciplinary Team must review and update the care plan: At least quarterly, in conjunction with the required quarterly MDS assessment.

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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** 35119 Based on observation, interview, and record review the facility failed to identify a pressure injury before becoming a deep tissue injury and failed to ensure pressure reducing interventions were in place for 2 of 3 residents (R34, R12) reviewed for pressure injuries in the sample of 14. These failures contributed to R34 developing a deep tissue injury and the worsening of R12's deep tissue injury. The findings include: 1. On 06/10/24 at 12:56 PM, R34 was sitting up in his wheelchair at the bedside with the over bed tray table in front of him eating lunch. R34's left heel was resting directly on the floor. R34 stated I have a sore on my bottom due to radiation and one on my heel that developed here from my heel being on the bed too much. They put on an air mattress and heel boots after I got the wounds. On 06/12/24 at 09:25 AM, V4 (Wound Registered Nurse) said R34 was admitted with redness that was blanchable to the sacral area, no other wounds. V4 said R34 now has a pressure wound to the sacral area from radiation burns and an unstageable pressure wound to his left heel. V4 said R34's heel pressure wound was found as a deep tissue injury which has deteriorated and opened up. R34's Admission Skin Only Evaluation dated 5/2/24 shows R34 has a burn to his coccyx area. There were no other skin injuries documented. R34's Skin Only Evaluation dated 5/8/24 shows R34 has a burn to his coccyx area. There were no new skin injuries documented. R34's next Skin Only Evaluation is dated 5/29/24 and shows R34 has a burn to his coccyx area, but there were no other skin injuries documented. R34's Skin and Wound Evaluation dated 5/31/24 shows R34 has a deep tissue injury to his left heel, in-house acquired, measuring 6.0 cm (centimeters) x 2.5 cm x 3.0 cm. On 06/12/24 at 12:00 PM, V4 said nurses are to do a weekly skin evaluation and skin should be checked daily during care. V4 said she was notified on 5/31/24 of R34's wound and she did an assessment. V4 said she was not sure why R34's left heel wound was not found before it became so large. On 06/12/24 at 12:45 PM, V12 (Nurse Practitioner) said the facility is to follow their skin check protocol for assessing residents for wounds and implement pressure reducing interventions. V12 said she was notified when R34's wounds were found and assessed them. V12 said R34 was referred to the wound doctor. On 6/12/24 at 1:01 PM, V4 said there was no documentation of R34's heel wounds until 5/31/24 and there were no weekly skin assessments done between 5/8/24 to 5/29/24. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	R34's Initial Wound Evaluation and Management Summary by the wound doctor dated 6/5/24 and shows R34 has unstageable necrosis to the left heel measuring 3 x 3.2 x 0.1 cm. R34's Admission Scale for Predicting Pressure Sore Risk dated 5/2/24 shows R34 is at moderate risk for developing pressure. The facility's undated Prevention of Pressure Injuries Policy shows Assess the resident on admission (within eight hours) for existing pressure injury risk factors. Repeat the risk assessment weekly and upon any changes in condition. 34506 2. R12's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including sepsis, urinary tract infection, lack of coordination, need for assistance with personal care, alzheimer's disease, muscle weakness, and major depressive disorder. R12's Scale for Predicting Pressure Sore Risk dated May 26, 2024 shows he is at risk for developing pressure injuries. R12's Treatment Administration Record dated June 1, 2024-June 30, 2024 shows, Off load heels at all times when in bed. Turn and reposition every two hours and as needed every shift. R12's Care Plan initiated May 29, 2024 shows R12 has a deep tissue injury to his left lateral heel related to decreased mobility. Remind and assist resident to turn/reposition at least every two hours, more often as needed or requested. Off load heels at all times when in bed. R12's Initial Wound Evaluation and Management Summary dated June 5, 2024 shows that R12 has a deep tissue injury to his left heel that measures 1.5 cm long, 2.0 cm wide and the depth is not measureable. The surface area of R12's pressure injury was 3.0 cm squared. Recommendations include float heels in bed and offload wound. On June 10, 2024 at 11:47 AM, R12 was laying on his right side in his bed. R12's right heel was directly on the bed. V10 CNA (Certified Nursing Assistant) placed tennis shoes onto R12's feet. While V10 was placing R12's left tennis shoe on, R12 winced and said ouch. At 1:01 PM, V10 removed R12's tennis shoes and socks. R12 had a large darkened area to his left outer heel. On June 11, 2024 at 1:50 PM, R12 was sitting up in his bed eating his lunch. V8 CNA lift R12's blanket and R12's bilateral heels were directly on the bed, with no socks on. R12's Wound Evaluation and Management Summary dated June 12, 2024 shows R12's deep tissue area measured 3.0 centimeters long and 3.5 cm wide. The surface area of R12's pressure injury is 10.5 cm squared. (>3 x larger than prior wound evaluation.) Recommendations include float heels in bed and offload wound. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On June 12, 2024 at 9:32 AM, V4 Wound Care Nurse) said pressure injury prevention interventions include offloading heels with pillows. V4 said she ordered R12 heel boots yesterday (June 11, 2024) because she noticed R12's heels were not off loaded. V4 said she would not recommend R12 wearing closed toes shoes, but that has not been put in place yet for R12. V4 said R12's wound was small and dry when it was first identified. V4 said if heels are not offloaded, then the pressure injury could deteriorate and can slow the healing process. The facility's Wound Care Policy reviewed April 1, 2022 shows, It is the policy of (facility) to utilize evidence based clinical practices to provide pressure injury and wound treatments in our skilled nursing and rehabilitation health centers. (Facility) will comply with current nursing standards, as well as state and federal guidelines related to the identification, treatment, and documentation of alterations in the skin integrity of our residents.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. 35119 Based on interview and record review the facility failed to ensure their facility assessment was reviewed annually. This applies to all 35 residents residing in the facility. The findings include: The facility's Resident Census and Condition (CMS 671) dated 6/10/24 shows a resident census of 35. The facility's Facility Assessment Tool is dated 02/2023. On 6/12/24 at 1:43 PM, V1 (Administrator) said he is in process of reviewing the facility assessment. V1 said he came at end of January and few things slipped by, but are in the process of getting current. The facility's Facility Assessment Tool Policy dated 9/8/2017 shows Nursing facilities will conduct, document, and annually review a facility-wide assessment, which includes both their resident population and the resources the facility needs to care for their residents.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on interview and record review the facility failed to maintain and follow the facility's Water Management plan to detect and prevent waterborne pathogens. The facility failed to ensure staff donned the necessary personal protection equipment (PPE) for a resident on Enhanced Barrier Precautions. These failures have the potential to affect all 35 residents in the facility. The findings include: 1. The facility's Long-Term Care Facility Application for Medicare and Medicaid form dated 6/10/2024 showed a resident census of 35. On 6/12/24 at 10:46 AM, the facility's Health Center Prevention and Control of Legionella policy dated 12/21/2017 was reviewed with V7 (Director of Plant Operations). The policy showed no facility water flow diagrams or assessments identifying where Legionella and/or other waterborne pathogens could potentially grow and spread. The policy showed the facility will implement procedures that inhibit microbial growth in building water systems that reduce the growth and spread of legionella and other opportunistic pathogens in water . The environmental services department will be responsible for maintenance of the (facility's) water sources. They will also complete random testing of at least three water supply sources within the health centers and communities twice per year unless more frequent testing is mandated by applicable law . V7 stated he was new to the role as Plant Director as he had only been in the role for six months. V7 stated he was unable to find a facility water flow diagram or assessment that showed a description of the facility's water systems. V7 stated, I have no water flow diagram. I am not aware of the facility having any measures in place to prevent Legionella. Per policy, we are supposed to have a company come out and test our water at least twice a year. We didn't have the testing done at all in 2023. The last time our water was tested for anything was in 2022. A facility water analysis report showed the last time the facility's water was tested for Legionella was 8/23/22 which showed no Legionella isolated. 34506 2. R12's Admission Record shows he was admitted to the facility on [DATE] with diagnoses including sepsis due to methicillin resistant staphylococcus aureus, urinary tract infection, need for assistance with personal care, urinary retention, and colostomy status. On June 10, 2024 at 11:47 AM, there was a sign on R12's door that showed enhanced barrier precautions. R12 has a urinary drainage device, colostomy bag, peripherally inserted central catheter (PICC), and a wound to his left heel. V10 CNA (certified nursing assistant) emptied R12's urinary drainage bag. V9 (restorative CNA) and V10 performed peri care to R12 and transferred R12 out of bed. V9 and V10 only had gloves on and did not have any gowns on. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R12's Care Plan revised on May 20, 2024 shows, R12 is under enhanced barrier precaution due to colostomy status, PICC to right upper arm, and presence of urinary catheter. Gown and gloves should be worn while providing high-contact resident care. On June 11, 2024 at 12:44 PM, V5 (Infection Control Nurse) said staff should wear gowns and gloves when providing cares, toileting residents, and handling indwelling devices when residents are on enhanced barrier precautions. V5 said enhanced barrier precautions are to protect from transmitting infections. The facility's Enhanced Barrier Precautions policy dated August 2022 shows, Enhanced barrier precautions (EBPs) are used as an infection prevention and control intervention to reduce the spread of multi-drug resistant organisms (MDROs) to residents. EBPs employ targeted gown and glove use during high contact resident care activities when contact precaution do not otherwise apply.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on interview and record review the facility failed to ensure residents were screened for and received all recommended doses of the pneumonia (pneumococcal) vaccine for 2 of 5 residents (R31, R17) reviewed for the pneumonia vaccine in the sample of 14. The findings include: R31's Admission Record showed R31 was admitted to the facility on [DATE]. R31's immunization report dated 6/5/24 showed no documentation of R31 receiving any pneumonia vaccines. R31's medical records dated 4/18/24-6/11/24 were reviewed. The records showed no documentation R31 was screened for or offered a pneumonia vaccine in the facility. R17's Admission Record showed R17 was admitted to the facility on [DATE]. R17's immunization report dated 4/11/24 showed no documentation of R17 receiving any pneumonia vaccines. R17's medical records dated 4/11/24-6/11/24 were reviewed. The records showed no documentation R17 was screened for or offered a pneumonia vaccine in the facility. On 6/11/24 at 12:30 PM, V5 Infection Preventionist (IP) stated residents should be screened for and offered the pneumococcal vaccine upon admission to the facility. V5 stated the IP responsible for screening residents and administering the vaccine as needed/desired. 06/11/24 02:07 PM, V5 (IP) stated neither R31 nor R17 had not been screened for or offered the pneumococcal vaccine in the facility. V5 stated R31 and R17 should have at least been screened for the vaccine while in the facility. The facility's Pneumococcal Vaccine policy (undated) showed, All residents will be offered pneumococcal vaccines to aid in preventing pneumonia/pneumococcal infections . Prior to admission, residents will be assessed for eligibility to receive the pneumococcal vaccine series and when indicated, will be offered the vaccine series within thirty days of admission . Assessments of pneumococcal vaccination status will be conducted within five (5) working days of the resident's admission if not conducted prior to admission .

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35541 Based on interview and record review the facility failed to ensure residents were screened for and received all recommended doses of the COVID-19 vaccine for 2 of 5 residents (R31, R47) reviewed for the COVID-19 vaccine in the sample of 14. The findings include: R31's Admission Record showed R31 was admitted to the facility on [DATE]. R31's immunization report dated 6/5/24 showed no documentation of R31 receiving any COVID-19 vaccines. R31's medical records dated 4/18/24-4/26/24 were reviewed. The records showed no documentation R31 was screened for or offered a COVID-19 vaccine in the facility. A facility COVID-19 resident list showed a COVID-19 outbreak began in the facility on 4/1/24. The list showed R31 tested positive for COVID-19 on 4/27/24 during facility outbreak testing. R31 was asymptomatic. R47's Admission Record showed R47 was admitted to the facility on [DATE]. R47's medical records dated 5/10/24-6/11/24 were reviewed. The records showed no documentation R47 was screened for or offered a COVID-19 vaccine/booster in the facility. On 6/11/24 at 12:30 PM, V5 Infection Preventionist (IP) stated residents should be screened for and offered the COVID-19 vaccine/booster upon admission. V5 stated the IP is responsible for screening and administering the COVID-19 vaccine to new admissions. V5 stated the facility's last COVID outbreak was April 2024. 06/11/24 02:07 PM, V5 IP stated neither R31 nor R47 had not been screened for or offered the COVID vaccine in the facility. V5 IP stated R31 and R47 should have at least been screened for the vaccine while in the facility. When V5 IP was asked about R31 testing positive for COVID in April 2024, during a facility outbreak, V5 stated, R31 was also in and out of the hospital a couple of times so we can't really say where he got it from. The facility's COVID-19 Vaccination for Team Members and Residents policy dated 11/17/23 showed, Residents who are eligible to receive the COVID-19 vaccine are strongly encouraged to do so .COVID-19 vaccine education, documentation and reporting are overseen by the infection preventionist and coordinated by his or her designee .