STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145532	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Plaza	1426 West Birchwood Chicago, IL 60626

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 40067 Based on observation, interview and record review, the facility failed to ensure that staff are feeding residents from a seated position during dining service which affected R7, R62, R73, and R77 in the total sample of 75 when reviewed for resident rights. Findings include: On 3/31/25 at 11:41 am, V13 (Certified Nursing Assistant, CNA) observed positioning R77 upright in R77's reclining wheelchair and provided R77 the lunch meal tray on top of the table over R77's lap. V13 opened up R77's plate cover to reveal a puree diet, set up food items close to R77 and utensils within reach. R77 began slowly touching a bowl on R77's tray. On 3/31/25 at 11:47 am, R77 is observed trying to eat the puree diet meal tray in front of R77 without R77 actively spooning food into R77's mouth. On 3/31/25 at 11:53 a.m., V13 (CNA) was observed standing next to R77, looking down at R77 in the reclining wheelchair. While in a standing position, V13 took R77's utensil and fed R77 three bites of food from R77's lunch meal tray. V13 then sat down on a stool chair next to R77. On 3/31/25 at 11:57 a.m., V13 was observed standing up from the stool chair and walking out of the dining room. On 3/31/25 at 11:58 am, V13 walks back into the dining room holding a plastic clear cup of water. V13 walks up to R77, and while in a standing position, feeds R77 one bite of food from the lunch meal tray. On 3/31/25 at 12:09 pm, V14 (CNA) observed in a standing position next to R7 who is seated in R7's wheelchair at the table. V14 observed feeding R7 food from the white bowl from R7's meal tray. On 3/31/25 at 12:14 pm, V12 (Licensed Practical Nurse, LPN) was observed in a standing position next to R73, who was sitting in a high-back wheelchair at the table. While standing, V12 was observed feeding R73 five bites of diced fruit from the white bowl and then sitting down in a chair next to R73. (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 - Some	On 3/31/25 at 12:16 pm, V2 (Director of Nursing, DON) was observed in a standing position next to R62, who was sitting in a reclining wheelchair. While standing, V2 observed feeding R62 the lunch meal tray of liquids with a spoon. R62's diet card clearly posted on R62's lunch meal tray indicates clear liquid diet. R7's Admission Record documents, in part, diagnoses of vascular dementia, reduced mobility, chronic obstructive pulmonary disease, chronic ischemic heart disease, diastolic (congestive) heart failure, chronic kidney disease stage 3A, venous insuffiency (chronic, peripheral), iron deficiency anemia, schizoaffective disorder, generalized anxiety disorder, cataract, hearing loss, lack of coordination, difficulty in walking, and abnormal posture. R7's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview for Mental Status (BIMS) score of 5 which indicates that R7 has severe cognitive impairment. R7's Functional Abilities for Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident is scored as Partial/moderate assistance-Helper does less than half the effort. R7's Care Plan, date initiated 12/23/23, documents, in part, a focus of (R7) may be at risk for weight loss related to mental status changes, confusion and disorientation. (R7) receives a Regular diet NAS (no added salt) regular Thin and requires partial moderate assistance with meals. R62's Admission Record documents, in part, diagnoses of dementia, dysphagia oropharyngeal phase, anorexia, abnormal weight loss, moderate protein-calorie malnutrition, absolute glaucoma, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, presence of cardiac implant and grafts, atrial fibrillation, pulmonary hypertension, iron deficiency anemia, hypertension, hyperlipidemia, major depressive disorder, cognitive communication deficit, osteoarthritis, adhesive capsulitis of right shoulder, abnormal posture, and lack of coordination. R62's MDS, dated [DATE], documents, in part, a BIMS score of 9 which indicates that R62 has moderate cognitive impairment. R62's Functional Abilities for Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident is scored as Substantial/maximal assistance-Helper does more than half the effort. R62's Care Plan, date initiated 11/1/24 and revised on 2/21/25, documents, in part, a focus of (R62) may be at risk for weight loss related to diagnoses of mild cognitive impairment resulting in mental status changes, confusion and disorientation, poor PO (oral) intake and diuretic use daily . and requires extensive assistance with meals. Appetite is poor to fair. R73's Admission Record documents, in part, diagnoses of multiple sclerosis, dysphagia oropharyngeal phase, severe protein-calorie malnutrition, arterial fibromuscular dysplasia, metabolic encephalopathy, chronic obstructive pulmonary disease, iron deficiency anemia, lack of coordination, aphasia, peripheral vascular disease, hyperlipidemia, major depressive disorder, and cramp and spasm. R73's MDS, dated [DATE], documents, in part, a BIMS score of 13 which indicates that R73 is cognitively intact. R73's Functional Abilities for Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident is scored as Dependent-Helper does all of the effort. Resident does none of the effort to complete the activity. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R73's Care Plan, dated 11/5/24, documents, in part, a focus of Self-care deficit, require assist with ADLs with an intervention of Eating: (R73) is a feeder and requires partial staff assist to eat. Able to feed self when up in chair - staff assist to complete meals (revision on 1/3/25). R77's Admission Record documents, in part, diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dementia, moderate protein-calorie nutrition, dysphagia oropharyngeal phase, polyosteoarthritis, kyphsois, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, pulmonary embolism, hypertension, cardiac murmur, anemia, irritable bowel syndrome, nuclear cataract bilateral, lack of coordination, difficulty in walking, and unsteadiness on feet. R77's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview for Mental Status (BIMS) score of 5 which indicates that R77 has severe cognitive impairment. R77's Functional Abilities for Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident is scored as Dependent-Helper does all of the effort. Resident does none of the effort to complete the activity. R77's Care Plan, dated 6/6/24, documents, in part, a focus of Self-care deficit, require assist with ADLs with an intervention of Eating: (R77) is a feeder and requires substantial/max staff assist to eat (revision on 3/18/25). On 4/2/25 at 1:47 pm, when asked the process of nursing staff feeding a resident, V2 (DON) stated that for residents who need physical assistance, who have a short attention spans or who have a puree or mechanical soft diet, the nursing staff will feed the residents. V2 stated that all staff will prepare the meal trays by cutting large food items and preparing the resident's tray. When asked for specifics about the procedure for nursing staff feeding a resident, V2 stated that the nursing staff would place chest protector on the resident's chest to protect the clothes from spillage. V2 stated, The staff needs to be sitting down to feed a resident. When asked the purpose of a nursing staff member sitting down to feed a resident, V2 stated, If you are sitting, then it's not authoritative to the resident by standing over them. You need to be sitting to feed each resident. It's a dignity issue. This surveyor informed V2 of this surveyor's observations during the lunch meal on 3/31/25, which included V2 standing while feeding a resident. V2 acknowledges that V2 was standing while feeding R62 and that V2 should have retrieved the stool chair to sit while feeding R62. On 4/3/25 at 1:05 pm, V2 stated that R62 was ordered and was receiving a clear liquid diet on 3/31/25 due to preparation for a colonoscopy procedure on 4/2/25. Facility policy dated January 2023 and titled Feeding Policy documents, in part, Purpose: To provide adequate nourishment for the resident . Procedure: . 3. Sit beside the resident and him/her put the clothing protector in place. 4. Feed the resident slowly, offering a variety of food. Fill the fork or spoon no more than half full. Make sure that the resident chews and swallow the food before giving more. Facility policy dated November 2018 and titled Residents' Rights for People in Long-Term Care Facilities documents, in part, Your rights to dignity and respect: . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility Job description (undated) and titled Certified Nursing Assistant Job Description documents, in part, General Purpose: To perform non-professional direct patient care duties under the supervision of nursing personnel and to assist in maintaining a positive physical, social and psychological environment for the residents . Essential Job Functions (With or Without Reasonable Accommodation): . C. Food Service Functions: Duties: Prepare residents for meal and snacks; identify food arrangement and assist in feeding residents as needed . D. Resident's Rights Functions: Duties: Maintain resident confidentiality; treat residents with kindness, dignity and respect; know and comply with Resident's Rights rules.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 41611 Based on observation, interview and record review the facility failed to ensure the call light device was within reach for two residents (R103, R301) out of a sample size of 75. Findings included: R103 has a diagnosis of but not limited to Alzheimer's Disease, Type 2 Diabetes Mellitus, Hypertension, Abnormalities of Gait and Mobility and Muscle Weakness. R103 has a Brief Interview of Mental Status score of 04. R103's care plan focus for ADLs (Activities of Daily Living) dated 7/13/2023 documents, in part, Encourage R103 to use the call light for assistance. R301 has a diagnosis of but not limited to Metabolic Encephalopathy, Pyothorax, Sepsis, Retention of Urine, and Hypertension. R301 has a Brief Interview of Mental Status score of 08. R301's care plan focus for ADL's (Activities of Daily Living) dated 1/15/2025 documents, in part, Encourage R301 to use the call light for assistance. On 3/31/2025 at 11:41am surveyor observed R103's call light cord hanging from the wall on the floor and not within reach of the resident. On 3/31/2025 at 12:19pm V26 (Registered Nurse-RN) stated it (call light cord) should be close and within reach of the resident. On 3/31/2025 at 12:26pm surveyor observed R301's call light hanging from the wall behind the bed and not within reach of the resident. On 3/31/2025 at 12:27pm R301 stated he does not know where his call light is and said that he can be shown how to use the call light. On 3/31/2025 at 12:37pm V9 (Certified Nursing Assistant) stated it (call light cord) is hanging from the wall and is supposed to be within reach of the resident. On 4/02/2025 at 1:59pm V2 (Director of Nursing-DON) stated the call light device should be clipped to the resident and within reach. Call lights policy with a revised date of 1/2019 documents, in part, residents' capable of using the call light appropriately will have their call lights accessible within reach.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52232 Based on observations, interviews and records review, the facility failed to coordinate assessments with the pre-admission screening and resident review (PASARR) program and failed to refer level II residents and residents with possible serious mental disorder and/or intellectual/developmental disability, for level II resident review upon a significant change in a mental status assessment. These failures affected three residents (R22, R34, R76) and have the potential to affect additional 34 residents with diagnosis of mental disorder and/or intellectual/developmental disability in the whole facility in a sample of 75. Findings include: On 3/31/2025 at 2PM, Review of facility's Admission Record, shows R22 admitted to facility on 3/27/2012, with diagnosis included but not limited to: Unspecified Dementia (Unspecified Severity), Major Depressive Disorder (Recurrent), bipolar disorder (Unspecified), Hemiplegia and Hemiparesis following nontraumatic intracerebral Hemorrhage. On 04/01/25 at 12:55 PM, facility presented a copy of most recent Preadmission and Resident Review (PASARR) form for R22., dated 3/24/2024. Review of the document shows in part, mental health diagnosis of Major Depressive Disorder and Dementia. No other mental health diagnosis is observed on the form. No bipolar disorder diagnosis is listed on the PASARR form. R22's PASARR also shows in part, that no Level II is required after review of the assessment. Detailed Record review of Illinois Preadmission Screening and Resident Review (PASARR) Level I Form for R22 dated 3/25/2024, shows that Level I screen does not show presence of serious mental illness or an intellectual/developmental disability (IDD). Page two of the PASARR form also shows that no more screening is needed unless presence of serious mental illness or IDD or a significant change in treatment needs arises. Last page of the form shows in part name and date of completion by V28, on 3/25/2024. On 4/2/2025 at 2:30 PM, Admission record review for R34, dated 11/21/2022, shows in part diagnosis including but not limited to: Alzheimer's Disease; Lack of Coordination; Major Depressive Disorder; Dementia, Psychotic Disturbance, Mood Disturbance and Anxiety, Schizoaffective Disorder (Bipolar Type) and Paranoid Personality Disorder. On 4/2/25 at 2:30 PM, R34's Current Order Summary Report Review dated 4/2/2025, shows in part, active orders for following: Anti-depressant Medication use and Anti-psychotic Medication use; Psychiatrist consult as needed, and Psychologist consult as needed. Pharmacy portion of the same order summary report shows in part current medications included but not limited to: Mirtazapine Tablet 15mg at bedtime for Major Depressive Disorder; Olanzapine 2.5mg at bedtime for schizoaffective disorder (Bipolar Type); Valproate Sodium Oral Solution 250mg/5ml every 12 hours for bipolar disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/3/2025 at 1:15 PM, Received a copy of PASARR Level I screen documentation for residents R34, and R22 from V18 and. Also received a List of all residents with mental health diagnosis or intellectual/developmental disability in the facility, that totaled 37 residents. R22, R34 and R76 were included on the list. On 4/3/2025 at 1:15 PM, during phone interview, V28 stated that the reason for updated request for PASARR Level 1 screening dated 4/2/2025 for R22 and R34, was due to the initial PASARR Level 1 screenings (dated 3/25/2024 for R 22 and 3/27/24 for R34) were missing initial mental health diagnoses of Bipolar and Schizophrenia Disorder. 52136 Findings include: On 3/31/25 at 1:00 PM, R76's records were reviewed for PASARR 2 screening related to her MDS indicator of No PASARR with diagnosis. The PASARR 1 dated 8/8/2023 documented that resident did not require a PASARR 2 screen. On 8/14/2023 new diagnosis of schizoaffective disorder was listed on R76's Diagnosis information list sheet, no PASARR 2 screening was found in R76's chart. R76's face sheet dated April 2, 2025, shows R76 was admitted to the facility on [DATE] with multiple diagnosis: Schizoaffective disorder, multiple sclerosis, peripheral vascular disease, severe protein calorie malnutrition, dementia, quadriplegia, adult failure to thrive, acute embolism. R76's MDS (Minimum Data Set) dated February 3, 2025, shows R76 has a score of 3 which means R76 has severe cognitive impairment. On 04/01/25 at 03:11 PM, V28 (Receptionist) stated she is the person in the facility responsible for completing PASARR screening for residents and that R76 should have had a PASARR 2 completed after the new diagnosis was listed. V28 stated that the nurses should have informed her that there was a new diagnosis added on 8/14/23, and she was not sure why it wasn't completed since then .V28 stated she would complete the PASARR 2 screening request when she comes on duty the following morning. On 4/2/2025 at 9:00am, V28 presented a form with Maximus PASARR Pro-1 screen on it she stated the request for PASARR 2 has been submitted and will be done as soon as possible.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities 43351 Based on interview and record review, the facility failed to ensure a resident's psych diagnoses were included in the pre-admission screening. This failure affected 1 (R109) resident reviewed for accuracy of pre-admission screening in the total sample of 75 residents. Findings include: R109's (printed 03/31/2025) Diagnosis Report documented that R109's diagnoses: (include but not limited to) schizoaffective disorder and schizophrenia with onset date of 05/24/2022. R109's (5/24/2022) Psychotropic consent documented, in part Risperdal 0.5mg twice daily. Supporting Diagnosis: Schizophrenia. R109's (Active Order as Of: 04/03/2025) Order Summary Report documented, in part Anti-psychotic episodic medication Use: monitor and observe. Active: 02/25/2023. Behavior monitoring related to psychotic disorder with delusions due to known physiological condition, schizophrenia, schizoaffective disorder. RISPERIDONE 0.5 MG TABLET Give 1 tablet orally two times a day related to SCHIZOPHRENIA. Active. 02/25/2023. R109's (Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 12. Indicating R109's mental status as moderately impaired. Section I - Active Diagnoses. Psychiatric/Mood Disorder. I6000. Schizophrenia. R109 's (03/28/2024) Notice of PASARR (Pre-Admission Screening And Resident Review) Level I Screen Outcome documented, in part PASARR level I Determination: No level II required - NO SMI/ID/RC (serious mental illness/intellectual disability/reasonable condition). Diagnoses. Major depression. Level I Attestation and Signature. Name: (V28 -Receptionist/Office Manager). Of note, schizophrenia and schizoaffective disorder were not included as one of R109's diagnoses. On 04/02/2025 at 1:59pm, V28 (Receptionist/Office Manager) stated we sat through the webinar before the Maximus started. When I do the PASARR, I know I have to put in the psyche diagnoses of the resident like schizophrenia and schizoaffective disorder. I have no answer to why I did not include the psych diagnoses of (R109). If the schizoaffective disorder and schizophrenia diagnoses were not included in the pre-admission screening, the determination of need will be affected. It would come out as not needing a PASARR level II screening. On 04/02/2025 at 1:33pm, V18 (Associate Administrator) stated (V28) is in charge of doing the PASARR. She is sending it to Maximus via the Assessment Pro. She is non-clinical. She does not know the behavior of our residents and their medications. It should be the nurse and the social service department guiding her on what medications, diagnoses, and behavior of the residents to put in the PASARR. The PASARR screening of (R109) was not accurately completed because the diagnoses of schizophrenia and schizoaffective disorder were not included. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R109's (04/01/2025) Notice of PASARR level I Screen Outcome documented, in part Determination: Refer for Level II Onsite. Suspected or confirmed PASARR condition(s): Mental Health Disability. Your health care professional and Maximus completed PASARR level I screen for you. This screen shows that you need a face to face level II evaluation. The purpose of this evaluation is to decide whether a nursing facility is able to meet your needs. Diagnoses: Schizophrenia and Schizoaffective disorder and Major depression. The (undated) Preadmission and resident review documented, in part The purpose of a PASARR level II assessment is to determine if the person has a condition which qualifies under the PASARR program and if so, make sure that a nursing facility is necessary of if help can be received in the community.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on observation, interview and record review, the facility failed to provide timely oral care for a dependent resident (R44) and failed to provide personal hygiene shaving care for a female, dependent resident (R56) which affected 2 residents (R44, R56) in the total sample of 75 residents when reviewed for activities of daily living (ADL) care. Findings include: On 3/31/25 at 11:14 am, R56 is observed laying in bed and noted with mustache hair that is dark gray hair on upper sides of lips. R56 is observed with gray and white hair chin hair, about 1/2-3/4 inch in length, on underside of R56's chin. When asked if R56 is comfortable with the lengthy facial hair, R56 stated, I (R56) would prefer not to have it. When asked if R56 has been offered during ADL care by the CNA to shave the facial hair, R56 stated no. R56 stated, I would take care of it at home, but I am not at home and need help. R56's Admission Record documents, in part, diagnoses of chronic obstructive pulmonary disease, chronic respiratory failure with hypoxia, type 2 diabetes mellitus, shortness of breath, hypertension, obesity, hyperlipidemia, encephalopathy, major depressive disorder, anxiety disorder, and hidradenitis suppurativa. R56's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview of Mental Status (BIMS) score of 11 which indicates that R56 has moderate cognitive impairment. R56's Functional Abilities for Personal hygiene: The ability to maintain personal hygiene, including combing hair, shaving, applying makeup, washing/drying face and hands is scored as Substantial/maximal assistance-Helper does more than half the effort. R56's Care Plan, initiated on 9/20/22 and revised on 12/20/22, documents, in part, a focus of Self-care deficit, require assist with ADLs r/t (related to) weakness with an intervention of Personal Hygiene: (R56) requires extensive staff assist with personal hygiene and oral care. R56's ADL charting from 3/4/25 to 4/2/25 for Personal Hygiene documents, in part, that R56 had no resident refusals documented for personal hygiene care. On 4/2/25 at 1:47 pm, V2 (Director of Nursing, DON) stated that ADL (activities of daily living) care is provided by CNAs so residents look and feel good. V2 stated that ADL care provided by CNAs is done daily for all residents and includes washing their faces, combing hair, and shaving facial hair. V2 stated, Shaving is included and offered with the grooming from CNAs. When asked does shaving facial hair apply to female residents as well, V2 stated, Yes. The same for females. They don't want no facial hairs for a mustache or a beard and that female elderly residents can have lengthy facial hair that grows on sides of mustache and under the chin (as surveyor observed V2 demonstrating by pointing to the areas on V2's face). V2 stated that if a resident refuses to be shaved, the CNA will try at a later time. V2 stated that if the resident refuses again, it will be documented as a refusal, and the nurse will notify the resident's family member and the resident's physician. (continued on next page)

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	145532	A. Building B. Wing	04/03/2025

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy dated 2014 and titled Shaving the Resident documents, in part, Purpose: 1. To keep the resident well groomed. 2. To refresh the resident. Equipment: 1. Electric shaver (if owned by resident). 2. If no electric shaver, then the following: A. Basin of warm water. B. Foam lather (shaving cream). C. Disposable razor. D. Face towel. E. Mirror. F. Tissues. G. After-Shave lotion. Procedure: 1. Explain nature of treatment to resident at the level of understanding. 2. Raise head of bed, If not contraindicated. 3. Place towel under chin. 4. Wet face and lather generously. 5. Hold skin taut and shave in the direction of hairs. Start under the sideburns and work downwards over the cheeks toward the chin. Work upward from the neck under the chin. 6. Use short film strokes and rinse razor frequently. 7. Use caution when shaving around lips and nose as these are very sensitive areas. 8. After beard is removed, wash face well with soap and water, dry well, apply after-shave lotion if desired. 9. Use new disposable razor for each resident. 10. Throw disposable razor in the sharps container. Facility policy dated November 2018 and titled Residents' Rights for People in Long-Term Care Facilities documents, in part, Your rights to dignity and respect: . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Facility Job description (undated) and titled Certified Nursing Assistant Job Description documents, in part, General Purpose: To perform non-professional direct patient care duties under the supervision of nursing personnel and to assist in maintaining a positive physical, social and psychological environment for the residents . Essential Job Functions (With or Without Reasonable Accommodation): A. Personal Care Functions: Duties: Assist residents with daily bath, dressing, grooming . D. Resident's Rights Functions: Duties: Maintain resident confidentiality; treat residents with kindness, dignity and respect; know and comply with Resident's Rights rules. 32338 On 3/31/25 at 11:10am and again at 11:45am, during observation of residents on the first floor, R44 was observed awake in bed with visible accumulated creamy brown substance on the teeth. The surveyor asked R44 about the last time staff assisted her(R44) with mouth care, and R44 stated that it's been a long time. V32(CNA/Certified Nurse Assistant) stated that she has not done mouth care for R44, but she would come back to do it. R44's care plan dated 9/15/23 states that R44 has a self-care deficit and requires assistance with ADLs (Activities of Daily Living). BIMS (Basic Interview for Mental Status) score dated 2/26/25 shows a score of 11(Mild Cognitive Impairment). Face sheet shows diagnoses which include but are not limited to Right Hand Contracture, Right Knee Contracture and Osteoporosis. Facility's Policy titled Patients Care All Shifts states in part: Teeth and/dentures must be kept clean with daily oral hygiene.

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	145532	A. Building B. Wing	04/03/2025

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F 0686 Level of Harm - Minimal harm or potential for 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** 32338 Based on observation, interview, and record review, the facility failed to implement pressure ulcer prevention interventions as stated in the care plan for residents with Dementia who are at risk for pressure ulcers. This failure has the potential to affect three residents (R49, R100, and R135), reviewed for wheelchair cushions as a pressure ulcer prevention intervention, in a total sample of 75 residents. Findings include: On 3/31/25 at 11:08 AM, R49, R100, and R135 were observed in the second-floor dining room during activities. R49, R100, and R135 were observed sitting in the wheelchair without cushion or any pressure-relieving device in the wheelchairs. Again, at 12:15pm, R49, R100, and R135 were still in the same position in the same wheelchairs. At this time, V25(LPN/Licensed Practical Nurse) was notified and V25 stated that sometimes, Staff send the cushions to the laundry, and that she(V25) would ensure that the residents get cushions in the wheelchairs. On 4/1/25 at 1:20pm, V8(Nursing Supervisor) stated Wheelchair cushion is a pressure-relieving device that should be in the wheelchair especially for residents who sit in the wheelchair for long. V8 added that the staff should notify the nurse or restorative aide to get the cushion from the storage room. R49's records show the following: Face sheet shows diagnoses which include but are not limited Dementia, Left Hand Contracture, and Right-Hand Contracture. Pressure Ulcer Risk assessment dated [DATE] shows that R49 is at risk for pressure ulcer. MDS (Minimum Data Status) section M dated 1/30/25 states that R49 is at risk of developing pressure ulcers/injuries and should have a pressure reducing device for chair. Care plan dated 1/24/25 states: R49 is at risk for impaired skin integrity. Intervention states to use pressure relieving/reducing cushion when up on chair. R100's records show the following: Face sheet shows diagnoses which include but are not limited Dementia. Pressure Ulcer Risk assessment dated [DATE] shows that R100 is at risk for pressure ulcer. MDS section M dated 3/17/25 states that R100 is at risk of developing pressure ulcers/injuries and should have a pressure reducing device for chair. (continued on next page)

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	145532	A. Building B. Wing	04/03/2025

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Care plan dated 3/11/25 states: R100 is at risk for impaired skin integrity. Intervention states to use pressure relieving/reducing cushion when up on chair. R135's records show the following: Face sheet shows diagnoses which include but are not limited Dementia, Overweight, and Gout. Pressure Ulcer Risk assessment dated [DATE] shows that R135 is at risk for pressure ulcer. MDS section M dated 1/8/25 states that R135 is at risk of developing pressure ulcers/injuries and should have a pressure reducing device for bed. Care plan dated 11/10/24 states: R135 is at risk for skin breakdown. Intervention states use pressure relieving/reducing cushion when up on chair. Facility's policy titled Pressure Ulcer Prevention with latest revision date 1/2023, in #3 states in part: Place at risk residents on a pressure relieving mattress/pad to chair. Consider postural alignment, distribution of weight, balance, and stability and pressure relief when positioning residents in chairs or wheelchairs.

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	145532	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 32338 Based on observation, interview, and record review, the facility failed to provide fall prevention interventions for residents who are at risk for falls and failed to ensure that residents at risk for falls do not have repeated falls. These failures affected 3 residents (R23, R43, and R58) who had repeated falls, and have the potential to affect one resident (R34), reviewed for falls and fall prevention interventions, in a total sample of 75 residents. Findings include: On 4/2/25 R23 was observed sitting at the edge of the bed with no staff nearby in the hallway. R23 had a wound dressing on the right foot and dark blue sock with smooth bottom on the left foot. The surveyor asked R23 if he(R23) needed some help. R23 stated that he's trying to exercise his legs. The surveyor called V23(RN/Registered Nurse) to assist R23. V23 stated I will get the CNA (Certified Nurse Assistant) to give him non-skid socks. Inquired from V23 if it was okay for R23 to not have proper footwear while awake and trying to exercise at the bedside, considering the fact that R23 has had several falls in the past. V23 stated that she would ensure that R23 wears a non-skid sock when not wearing his shoes to prevent R23 from falling. R23's care plan and progress notes show that R23 had repeated falls as dated below: 7/30/24; 9/4/24; 9/29/24; 10/18/24; 11/30/24; and 2/20/25. R23's records reviewed are as follows: Fall Risk Evaluation dated 3/26/25 shows that R23 is at risk for falls. Face sheet shows diagnoses which include but are not limited to History of Falls and Glaucoma. Care plan dated 10/14/22 states that R23 is at risk for falls related to poor safety awareness. Intervention states to provide proper well-maintained footwear. Basic Interview for Mental Status (BIMS) Score is 12 out of 15(Mild Cognitive Impairment). MDS (Minimum Data Status) dated 2/27/25 states that R23 uses wheelchair and walker. On 4/2/25 at 12:15pm, R43 was observed in the wheelchair in the hallway across from R43's room. R43's care plan shows that R43 had repeated falls as follows: R43's care plan and progress notes show that R43 had repeated falls as dated below: 9/23/23; 10/6/24; 10/12/24; 12/29/24; 2/13/25. R43's records reviewed are as follows: (continued on next page)

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	145532	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Fall Risk Evaluation dated 2/14/25 shows that R43 is at risk for falls. Face sheet shows diagnoses which include but are not limited to Difficulty Walking, Dementia, and Right Hip Pain. Care plan dated 10/14/22 states that R43 is at risk for falls related to poor safety awareness. Intervention states to provide proper well-maintained footwear. BIMS Score is 11 out of 15(Mild Cognitive Impairment). MDS section GG dated 3/25/25 states that R43 uses wheelchair and walker. On 4/1/25 at 10:40am, R58 was observed walking with a walker towards the dining room. R58's care plan and progress notes show that R58 had repeated falls as dated below: 11/7/24; 12/14/24; and 1/30/25. R58's records reviewed are as follows: Fall Risk Evaluation dated 3/10/25 shows that R58 is at risk for falls. Face sheet shows diagnoses which include but are not limited to Lack of Coordination, Weakness, Dementia, and Abnormal Posture. Care plan dated 1/30/24 states that R58 is at risk for falls related to poor safety awareness. Intervention states to provide proper well-maintained footwear. BIMS Score is 3 out of 15(Severe Cognitive Impairment). MDS section GG dated 3/15/25 states that R58 uses walker. On 4/2/25 at 2:10pm, V2(Director of Nursing) stated that the Restorative Nurse was not available. V2 stated all residents at risk for falls need to wear non-skid socks. V2 added that the facility has made efforts to reduce the fall incidents and still making progress and still doing in-services for staff about fall prevention interventions. Facility's Fall Precautions/Safety Interventions Policy states in part: Safety interventions tools may be implemented to provide safety to the residents and to prevent falls. Safety intervention tools include interventions such as low bed, bed/chair alarms, non-slip materials. Implementation/recommendations for special equipment such as low bed, mats or mattress on floor, nonskid socks, bed, and chair alarms. Facility's Patient Care Policy dated 2/2020 states in part: slippers or shoes and socks must be worn. If patient is ambulatory and wearing slippers, then the slippers must be of the nonskid type. 52232 (continued on next page)

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	145532	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Findings include: On 04/01/25 at 10:42AM, observed R34 in the second-floor activity room, sitting in the wheelchair during activity in progress. R34 was not wearing any shoes and was wearing gray sweat pants set and white socks with gray tips. No Non-skid bottom protection observed at this time. On 04/01/25 at 10:45AM V10 (Rehabilitation Aide), stated that R34 does not like to wear shoes and that he prefers socks. V10 also stated that during transfers and ambulation of residents, the expectation is for the residents to always wear shoes or at least non-skid socks to prevent them from falling. V10 affirmed that R34 was wearing white socks with gray tips and that those socks are not the nonskid socks. V10 also stated, that R34 is high risks for falls, and he must ambulate with help from the aides and should be wearing shoes or nonskid socks. On 04/01/25 at 3:15PM V7 (Nursing Supervisor), stated that the expectation is to make sure all high fall risk residents are wearing shoes or non-skid socks during ambulation, transfers and when in the wheelchair to prevent falls or injury. The Nursing Aides should be always using gait belts for transfers and ambulation of residents. Admission record review for R34 dated 11/21/2022, shows in part diagnosis including but not limited to: Weakness, Long term use of Anticoagulants, Abnormalities of Gait and Mobility, Chronic embolism and Thrombosis of Unspecified Deep Veins of Lower Extremity (Bilateral), Hypertensive Heart Disease without Heart Failure, Chronic Kidney Disease, Anemia, Other Specified Spondylopathies of Lumbar Region, Alzheimer's Disease, Lack of Coordination, Major Depressive Disorder, , Dementia, Psychotic Disturbance, Mood Disturbance and Anxiety, Schizoaffective Disorder, Bipolar Type, Paranoid Personality Disorder. R34's Current Order summary report dated 11/21/2022 review shows in part orders for following: Activities without contraindications as tolerated, Anti-Coagulant Medication Use, Anti-depressant Medication use, Anti-psychotic Medication use, may use bed alarm for safety, Psychiatrist consult as needed, Psychologist consult as needed. Pharmacy portion of the same order summary report shows in part current medications included but not limited to: Metoprolol Tablets 12.5 milligrams (mg) by mouth twice a day for Hypertensive Heart Disease; Ferrous Sulfate 325mg three times a day for supplement; Mirtazapine Tablet 15mg at bedtime for Major Depressive Disorder; Olanzapine 2.5mg at bedtime for schizoaffective disorder (Bipolar Type); Valproate Sodium Oral Solution 250mg/5ml every 12 hours for bipolar disorder. Review of R34's Plan of care dated 11/21/2022 shows in part that R34 is at risk for falls due to cognitive and functional impairments. The Plan of care also shows in part, that staff should always ensure that resident wears non-skid footwear, with intervention initiation date of 10/11/2023. Review of R34's Minimal Data Sheet (MDS), section GG, dated 3/6/2025, shows in part that resident is dependent in toileting hygiene and shower/bath ability. MDS also shows in part that R34 needs substantial/maximal assistance in lower body dressing and putting on/taking off footwear, and personal hygiene. R34's MDS further states that R34 needs supervision or touching assistance with most of functional abilities included, but not limited to sit to stand and sit to lying positioning, rolling left and right, toilet transfer and walking. (continued on next page)

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	145532	A. Building B. Wing	04/03/2025

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of facility's Fall Precautions/Safety Intervention policy dated 12/2023, shows in part, that fall risk assessment and functional Ability Assessment should be completed upon admission, readmission, quarterly and if significant change or decline in condition occurs. The policy also shows in part, that safety intervention Tools include, but are not limited to non-slip materials. Policy further shows the implementation/recommendations for special equipment fall prevention aids which include but are not limited to non-skid socks.

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	145532	A. Building B. Wing	04/03/2025

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52136 Based on observation, interview, and record review, the facility failed to ensure that a resident ordered for Enteral g-tube (gastrostomy tube) feeding received the correct amount of Enteral feeding. This failure affected one resident (R76) out of one resident reviewed for Enteral/G-tube feeding in a sample of 75 residents. Findings include: On 3/31/25 at 10:35 AM, R76 was observed laying in her bed resting. R76 is alert and talkative, denies pain or discomfort when asked on interview. R76's Enteral g-tube feeding bottle was observed with a date of 3/31/25 but the Enteral g-tube feeding machine was off and not connected to the resident at that time. R76's Enteral g-tube bottle was observed by this surveyor with 1/3 of the Enteral g-tube feeding amount gone from the bottle. On 3/31/25 at 10:40 AM, V12(Licensed Practical Nurse, LPN) stated she did not turn the g-tube feeding off and doesn't know who turned it off or how long it was off. On 04/01/25 at 11:00 AM, V12(LPN) stated she is the nurse in charge of R76 and that she started her shift this am at 7:00am. V12 stated she has not turned g-tube feeding off since the start of her shift, and that the night nurse hung the Enteral g-tube feeding at 6am before she came on shift. This surveyor observed Jevity 1.2 Enteral g-tube feeding bottle dated and labeled with 4/1 at 6am and R76's name. V12 came into the room and observed the Enteral g-tube feeding and stated 100ml (milliliters) has infused at this time. She stated 4 hours have passed and R76 should have received at least 280 milliliters of feeding by now. V12 stated if R76 doesn't receive her appropriate amount of feeding, R76 can lose weight or get a disease if she doesn't receive her total volume. R76's face sheet dated April 2, 2025, shows R76 was admitted to the facility on [DATE] with multiple diagnosis: Schizoaffective disorder, multiple sclerosis, peripheral vascular disease, severe protein calorie malnutrition, dementia, quadriplegia, adult failure to thrive, acute embolism. R76's MDS (Minimum Data Set) dated February 3, 2025, shows R76 has a score of 3 which means R76 is severe cognitive impairment and that R76 receives her nutrition from feeding tube. R76's Physician Order Summary Report dated 8/9/23 documents that R76 is NPO which means (Nothing by mouth), and Enteral Feed Order dated 11/18/24 documents Jevity 1.5 via g-tube at 70 ml/hr for 20 hours (on at 4pm off at 12pm). R76's Care plan dated 3/23/25 states Jevity 1.5 at 70 ml/hr over 20 hours, [staff to provide total assistance with tube feeding and water flushes]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145532	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Plaza	1426 West Birchwood Chicago, IL 60626

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/25 at 02:12 PM, V2 (Director of Nursing) stated her expectations of the nurse who is administering Enteral g-tube feeding to a resident is that they make sure feeding is running according to physicians' orders start and stop time, that the resident is laying in upright position to decrease risk for aspiration. When asked if a resident is scheduled to receive 70ml Enteral g-tube feeding hourly and four hours have past how much Enteral g-tube feeding do you expect the resident to have received, V2 stated she would expect the g-tube feeding to have infused 280ml of g-tube feeding and if the resident receives 100 ml within 4 hours the resident has not received their adequate amount of caloric intake; they should have received according to how the dietician calculates the calorie intake for each patient. Facility policy dated January 2023 and titled Tube Feeding documents, in part, To maintain proper nutrition and hydration. To prevent complications from tube feeding. Procedure: Fill in information on label (i.e. residents name, start time, and rate) .When a Physician orders a tube feeding to run either continuous or over 24 hours, the Consulting Dietician will assess the resident's nutritional needs. Once the calorie and protein needs are calculated, the total amount of formula required will be divided between each shift allowing time for the feeding to be off for care. Facility job description dated 9/2001, titled Job duties RN/LPN, Nursing care functions and Drug and Treatment functions: Prepare and administer medication and treatments as ordered by the physician.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145532	A. Building B. Wing	04/03/2025

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 43351 Based on observation, interview, and record review, the facility failed to ensure a resident nasal canula was labeled with the date it was changed and failed to ensure the humidifier bottle and oxygen tubing were changed weekly. These failures affected 2 (R11 and R79) residents reviewed for oxygen therapy in the total sample of 75 residents. Findings include: On 03/31/2025 at 11:53am, R11 was on 2 Liters of oxygen per minute via nasal cannula. The oxygen tubing was attached to the oxygen concentrator. R11's nasal canula was not dated. On 03/31/2025 at 11:54am, V6 (Registered Nurse) was instructed to check R11's nasal canula for label and stated her nasal canula is not labeled. There is no date. The night shift is supposed to label it with the date it was changed. On 04/02/2025 at 1:29pm, V2 (Director of Nursing) stated we label the humidifier bottle with the date the humidifier bottle and tubings were changed. We change them weekly on Wednesday. If there is no humidifier bottle, the expectation is to label the nasal cannula with the date it was changed. The purpose of that is to know the last time it was changed to prevent accumulation of dust and mucus and nasal discharges on the nose piece for infection control. R11's (Active Order as Of: 04/03/2025) Order Summary Report documented, in part Diagnoses: (include but not limited to) shortness of breath and chronic obstructive pulmonary disease. Oxygen at 2-3 liters per nasal cannula continuous for shortness of breath. Oxygen - Change tubing, humidifier, cannula every shift night every Wednesday and as needed. R11's (03/04/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 12. Indicating R11's mental status as moderately impaired. Section O. Special Treatment, Procedures, and Programs. Respiratory. C1. Oxygen therapy: b - While a resident. R11's (Target Date: 06/02/2025) care plan documented, in part at risk for respiratory distress. Oxygen setting: O2 (oxygen) at 3L/min. The (06/2023) Oxygen Therapy Policy documented, in part Oxygen therapy is used when there is evidence of respiratory distress. Oxygen is administered according to the Doctor's orders. It can be given by nasal cannula or mask. The following procedure is to be followed: 6. Nasal tubing/mask and humidifier must be changed weekly or as needed. [NAME] date of the replacement on the humidifier bottle. No need to date tubing as humidifier bottle, tubing, nasal cannula/mask are all discarded when changed. 41611 Findings include: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145532	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R79 has a diagnosis of but not limited to Metabolic Encephalopathy, Chronic Obstructive Pulmonary Disease, Hypertension, and Hyperlipidemia. R79 has a Brief Interview of Mental Status score of 03. R79's Order Summary Report with active orders as of 4/02/2025 documents, in part, Oxygen-change tubing, humidifier, cannula every night shift every Wednesday. R79's care plan focus for oxygen therapy dated 3/18/2025 documents, in part, change the oxygen tubing and humidifier weekly and as needed. On 3/31/2025 at 10:47am surveyor observed R79's nasal cannula not dated and the humidification bottle with a date of 3/24/2025. On 4/02/2025 at 11:41am V29 (Registered Nurse) stated oxygen tubing and humidification bottle is changed once a week on the 11:00pm-7:00am shift and both items (tubing and bottle) should be dated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145532	A. Building B. Wing	04/03/2025

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on observation, interview and record review, the facility failed to ensure that staff perform hand hygiene during resident dining service prior to feeding a resident, in between feeding separate residents, and after staff touching their personal body then feeding a resident to prevent and/or contain the possible spread of infectious microorganisms. These failures affected R28, R43 and R77 in the total sample of 75 when reviewed for infection control. Findings include: On 3/31/25 at 12:00 pm, V13 (Certified Nursing Assistant, CNA) observed sitting on the stool chair feeding R77 in the dining room. V13 is observed sitting positioned next to R77 (who is sitting on V13's right side) and also next to R43 (who is sitting on V13's left side). R43 is observed feeding R43's self while sitting in R43's reclining wheelchair. V13 observed stopping from feeding R77, and V13 reaches over to R43's tray then touches and moves R43's blue coffee cup which was in contact with the remainder of R43's brown bread crusts that were on the lunch meal tray. V13 stated to R43, It's (brown bread crusts) mushy. V13 does not perform hand hygiene, turns back to R77 and continues to feed R77. On 3/31/25 at 12:02 pm, V11 (CNA) is observed in front of R43's reclining wheelchair in the dining room and is in a seated position feeding R28. V11 stands and does not perform hand hygiene. V11 is observed walking up to R43 who has R43's lunch meal tray on a table over R43's lap, and V11 observed lifting up R43's white meal plate from the tray and then sits the food plate back down on R43's tray. On 3/31/25 at 12:04 pm, V11 observed touching R43's spoon which is in the bowl of mushroom soup on R43's lunch tray. V11 does not perform hand hygiene and walks back to R28, sits down and feeds R28 again. R43 observed touching the same spoon in the mushroom soup bowl and stirring R43's soup. R43's Admission Record documents, in part, diagnoses of severe protein-calorie malnutrition, dementia, dysphagia oropharyngeal phase, osteoarthritis, shortness of breath, chronic obstructive pulmonary disease, asthma, iron deficiency anemia, type 2 diabetes mellitus, chronic kidney disease stage 3A, diaphragmatic hernia, hypertension, bipolar disorder, malignant neoplasm of colon, difficulty in walking, unsteadiness on feet, and irritable bowel syndrome. R43's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview for Mental Status (BIMS) score of 10 which indicates that R43 has moderate cognitive impairment. R43's Functional Abilities for Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident is scored as Partial/moderate assistance-Helper does less than half the effort. R43's Care Plan, date initiated 11/11/22, documents, in part, a focus of (R43) the potential for weight changes with an intervention of Assist with meals (Feed/Set-Up) as needed (initiated 11/11/22). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145532	A. Building B. Wing	04/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Birchwood Plaza	1426 West Birchwood Chicago, IL 60626

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R43's Care Plan, dated 9/12/22, documents, in part, a focus of (R43) is at risk for COVID-19 Infection. Nursing Home Residency with an intervention of Staff to perform hand hygiene before and after each encounter with resident and others (initiated 9/12/22). R77's Admission Record documents, in part, diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, dementia, moderate protein-calorie nutrition, dysphagia oropharyngeal phase, polyosteoarthritis, kyphsois, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypoxia, pulmonary embolism, hypertension, cardiac murmur, anemia, irritable bowel syndrome, nuclear cataract bilateral, lack of coordination, difficulty in walking, and unsteadiness on feet. R77's MDS, dated [DATE], documents, in part, a BIMS score of 5 which indicates that R77 has severe cognitive impairment. R77's Functional Abilities for Eating: The ability to use suitable utensils to bring food and/or liquid to the mouth and swallow food and/or liquid once the meal is placed before the resident is scored as Dependent-Helper does all of the effort. Resident does none of the effort to complete the activity. R77's Care Plan, dated 6/6/24, documents, in part, a focus of Self-care deficit, require assist with ADLs with an intervention of Eating: (R77) is a feeder and requires substantial/max staff assist to eat (revision on 3/18/25). R77's Care Plan, dated 6/5/24, documents, in part, a focus of (R77) is at risk for COVID-19 Infection. Nursing Home Residency with an intervention of Staff to perform hand hygiene before and after each encounter with resident and others (initiated 6/5/24). On 4/2/25 at 1:47 pm, when asked within the process of CNAs feeding residents, when is hand hygiene to be performed, and V2 (Director of Nursing, DON) stated, Before they (CNAs) touch anything. They start giving food to one resident and do it before giving food to another resident. When asked the purpose of hand hygiene by staff while passing meal trays and feeding residents, V2 stated, Infection control. When asked why a staff member who is feeding one resident must perform hand hygiene before touching another resident's meal tray or feeding another resident, V2 stated, You don't know what a resident has (infection). V2 stated that if a CNA touches another resident's tray or food items then goes to feed another resident without performing hand hygiene, the CNA's hands could be contaminated. And they are handling food items on trays. V2 said that this CNA could transmit unknown bacteria to other residents. Facility policy (undated) titled Subject: Infection Control Standard Precautions documents, in part, Standard Precautions will be used in the care of all residents regardless of their diagnosis or presumed infection status. Standard Precautions apply to blood, body fluids, secretions, and excretions regardless of whether or not they contain visible blood, nonintact skin, and mucous membranes. Procedure Implementation: 1. Handwashing: a. Wash hands after touching . contaminated items, whether or not gloves are worn. b. Wash hands immediately after gloves are removed, between resident contacts and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. c. Use a plan (nonantimicrobial) soap for handwashing. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility policy dated 2014 and titled Hand Hygiene documents, in part, The purpose is to provide guidelines for the proper hand washing to prevent the spread of infection to other personnel, residents and visitors. Compliance Guidelines: All facility personnel must wash their hands for at least 20 seconds under the following conditions: . 2. Between resident contacts . Additional Considerations: . Antiseptic solution may be applied to hands after proper hand washing. If sinks are not readily available, a waterless antiseptic may be used between tasks normally requiring hand washing unless hands are visibly soiled. Hands should be washed with soap and water as soon as possible. Facility Job description (undated) and titled Certified Nursing Assistant Job Description documents, in part, General Purpose: To perform non-professional direct patient care duties under the supervision of nursing personnel and to assist in maintaining a positive physical, social and psychological environment for the residents . Essential Job Functions (With or Without Reasonable Accommodation): . C. Food Service Functions: Duties: Prepare residents for meal and snacks. 52136 Findings include: On 3/31/25 at 11:47 AM, R28 was observed in dining room sitting in recliner high back chair resting, R28 a bedside table was next to R28 in preparation for lunchtime set up by staff. On 3/31/25 at 11:47am, V11(Certified Nursing Assistant) was observed in dining room sitting next to R28, V11 did not sanitize her hands prior to cutting food and feeding R28, V11 then opened the milk carton and placed her finger inside the carton to pull open the box to pour the milk into the cup then began to feed R28 her soup. At 11:56am, V11 stood up to go get a straw, she touched the chair handles after placing the straw in the drink and she gave the drink to R28 without any hand sanitizer utilized. At 12:06pm, V11 was observed touching her face, touching her ear on left side, and touching the chair handles without utilizing hand sanitizer. At 12:08pm, V11 stood up again to check another resident then began to rub her legs while still feeding R28 no hand sanitizer utilized. At 12:12pm, V11 was observed rubbing her left eye while she was still feeding R28, and no hand sanitizer was utilized. R28's face sheet dated April 2, 2025, shows R28 was admitted to the facility on [DATE] with multiple diagnoses including Dementia, spinal stenosis, adult failure to thrive, diabetes mellitus, major depressive disorder, hypertension, anxiety. R28's MDS (Minimum Data Set) dated January 3, 2025, shows R28 has a score of 3 which means R28 is severe cognitive impairment and Selfcare performance is scored at a 2 for eating which means R28 requires Substantial/maximal assistance with eating [staff does more than half the effort for feeding R28]. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/02/25 at 02:08 PM, V2 (Director of Nursing) stated my expectations for the nurses prior to feeding a resident is to perform hand hygiene either wash their hands with soap and water or use hand sanitizer , to decrease risk for contaminating food.V2 stated that she expects staff to perform hand hygiene if they get up from feeding a resident to assist another resident and if they touch their face or any body parts, or clothing to prevent infection to decrease risk for transmitting infection from their clothing or body parts to resident.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. 43351 Based on interviews, and record reviews, the facility failed to provide the required square footage of 80 square feet per resident for multiple resident bedrooms for 19 (111, 113, 114, 115, 116, 118, 121, 122, 210, 211, 212, 214, 215, 217, 311, 313, 315, 317, 325) rooms out of 86 rooms in the facility. This failure affected 29 (R5, R14, R18, R27, R44, R46, R49, R53, R54, R58, R59, R60, R64, R72, R78, R80, R82, R83, R89, R103, R106, R110, R116, R123, R125, R126, R130, R133, R134) residents in the total sample of 75 residents. Findings include: On 03/31/2024 at 9:51am, during the entrance conference with V3 (Administrative Consultant). V3 stated we have a waiver for our room sizes. We do this waiver every year. On 04/01/2025 at 10:55am, V18 (Associate Administrator) we have rooms that have less than the required square footage for each resident. Each room has 2 certified beds. We ensure all the required furnishing and equipment for these residents are met, and these are included in our plan of correction. We did not make any repairs or construction since the last annual survey. The (04/02/2025) email correspondence with V18 documented, in part The facility has an annual Waiver for Resident bedrooms that do not measure 80 square feet per resident in multiple residents bedrooms. The (04/16/2024) Waiver of 42 CFR 483.90. Physical Environment documented, in part The State Department of Public Health reviewed your facility's request for a waiver of the federal requirement for a resident's room must afford 80square feet per bed in multi-patient rooms. CMS is granting a waiver of the federal requirement at 42 CFR483.30. The waiver is granted for rooms: 111, 113, 114, 115, 116, 118, 121, 122, 210, 211, 212, 214, 215, 217, 311, 313, 315, 317, 325 and is subject to annual review. The (undated) Policy Resident Room Waivers documented, in part The facility complies with the IDPH and CMS federal requirements for the waiver of the resident room sizes. The facility has an annual waiver for resident bedrooms that do not measure 80square feet per bed in multi-patient rooms. The rooms identified is (sic) listed below: 111, 113, 114, 115, 116, 118, 121, 122, 210, 211, 212, 214, 215, 217, 311, 313, 315, 317, 325, and 210.