STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145591	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Wesley	1415 West Foster Avenue 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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45346 Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for 1 resident (R63) and ensure the call light was working properly for 1 resident (R229) out of 49 residents reviewed for call lights. Findings include: On 01/13/2025 at 11:00am observed R63 lying on her right side in the bed, alert and oriented. Surveyor asked R63 Where is your call light cord/button located? R63 stated, It is somewhere in the bed with me. On 01/13/2025 at 11:02am observed R63's call light cord hanging off the left side of R63's bed towards the floor. On 01/13/2025 at 11:05am surveyor asked V6(CNA/Certified Nursing Assistant) to come into R63's room. V6 was asked, Where is R63's call light string? V6 stated R63's call light cord is located on the left side of the bed hanging towards the floor. V6 stated the call light should be attached to the resident and within close reach of the resident. On 01/13/2025 at 11:06am surveyor observed V6(CNA/Certified Nursing Assistant) move the call light cord from hanging off the left side of the bed and place the call light cord on the bed close to R63's right hand. On 1/13/2025 at 12:28pm V5(RN/Registered Nurse) stated the call light should be within reach of the patient. V5 stated the purpose of the call light is so that the patient will be able to request assistance from the certified nursing assistant or the nurse and let us know that they need help. On 1/15/2025 at 10:43am V2(DON/Director of Nursing) stated the purpose of the call light is to make staff aware of the resident's needs. V2 stated the call light should be placed within reach of the resident. R63's diagnosis includes, but are not limited to, dysphagia, oropharyngeal phase, multiple sclerosis, acute respiratory failure with hypoxia, paraplegia, unspecified, other acute osteomyelitis, left ankle and foot, and arthritis due to other bacteria, left ankle and foot. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145591	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Aperion Care Wesley		STREET ADDRESS, CITY, STATE, ZIP CODE: 1415 West Foster Avenue Chicago, IL 60640	

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R63 has a Brief Interview for Mental Status (BIMS) dated 11/08/2024 which documents that R63 has a BIMS score of 12, indicating R63's cognition is moderately impaired. R63's care plan documents in part, Focus: I am at risk for falls r/t (related to) paraplegia. Goal: I will not sustain serious injury through the review date. Intervention: Be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Received the facility's policy titled Call Light via email from V1(Administrator) on 1/15/2025. Call light policy dated 11/28/2012 with a revision date of 2/2/18. Call light policy documents in part, 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable location . 6. Call bell system defects will be reported promptly to the Maintenance Department for servicing. Check room frequently until system is repaired. Reviewed the Certified Nursing Assistant job description with a creation date of 05/02/2017, which documents in part, The Certified Nursing Assistant (CNA) is responsible for providing resident care and support in all activities of daily living and ensure the health, welfare and safety of all residents. 49572 On 1/13/25 at 10:25am, this surveyor observed R229's call light on. On 1/13/25 at 11:01am, this surveyor observed R229's call light still on. On 1/13/25 at 11:02am, this surveyor notified V3 (Registered Nurse/RN) and V3 said, (R229's) call light is broken. They're aware and working on fixing it. When asked what interventions and alternatives are in place for R229 due to the call light being broken, V3 replied, Whenever I pass the room I just pop in there and see if she (R229) needs anything. When asked the importance of the call light, V3 replied, So they (residents) can get help from us (staff). On 1/13/25 at 12:43pm, this surveyor observed R229's call light still on. On 1/14/25 at 11:22am, R229 said, I need some help. I need the call light so the nurse can help me get up and help me with the bathroom. R229's face sheet documents, in part, diagnosis that include but are not limited to abnormal posture; age-related osteoporosis without current pathological fracture; difficulty in walking; and history of falling. R229's Minimum Data Set (MDS), dated [DATE], documents, in part, a brief interview of mental status (BIMS) score of 12 which indicates R229's cognition is moderately impaired. R229's Care Plan, date 1/6/25, documents, in part (R229) have an ADL (activities of daily living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day r/t (related to) confusion and weakness. (R229) have lupus with interventions, dated 12/30/24, that document, in part, Encourage the resident to use bell to call for assistance. R229's Care Plan, date 1/6/25, documents, in part (R229) am at risk for falls r/t previous fall with fracture in Dec (December) prior to admission. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/14/2025 at 12:28pm, V19 (Maintenance Director) said that R229's call light cord was wrapped around R229's bedrail and when staff put the bed rail down, not only did the bed rail pull the cord but it also pulls the call light out of the wall. On 1/14/25 at 1:01pm, V2 (Director of Nursing/DON) said, If a resident's call light is not working then we're supposed to give them (the residents) one of those . you know . those doorman hand bells. I'll (V2) get her (R229) one. When asked the importance of the call light, V2 replied, So the residents can get assistance. Facility policy titled, Call Light, revised date 2/2/18, documents, in part, 1. All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location . 5. Hand bells will be provided for alert dependent residents when positioned out of reach of permanent call light when needed . Facility job description titled, Registered Nurse/RN, dated 5/2/17, documents, in part, The RN is responsible for providing direct nursing care to the residents, and to supervise the day-to-day nursing activities performed by nursing assistants. Such supervision must be in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility, to ensure that the highest degree of quality care is maintained at all times . ensure that nursing services and activities can be adequately maintained to meet the needs of the residents. Facility job description titled, Maintenance Director, dated 5/2/17, documents, in part, The primary purpose of the Maintenance Director is to plan, organize, develop, and direct the overall operation of the Maintenance Department in accordance with current federal, state and local guidelines, standards, and regulations that governing our facility, to assure that our facility is maintained in a safe and comfortable manner . Ensure that supplies, equipment, etc., are maintained to provide a safe and comfortable environment . Make periodic rounds to check equipment and to assure that necessary equipment is available and working properly.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to organize and participate in resident/family groups in the facility. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50662 Based on observation, interview and record review the facility failed to develop and implement a resident council that allows residents to meet regularly to discuss facility policies and procedures, care, treatment and quality of life. This failure affected four residents (R8, R37, R51 and R74) out of a total sample size of 49 and has the potential to affect all 87 residents residing in the facility. Findings include: R8's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 9, which indicates that R8's cognition is moderately impaired. R37's MDS dated [DATE] has a BIMS score of 15, which indicated R37's cognition is intact. R51's MDS dated [DATE] has a BIMS score of 15, which indicates R51's cognition is intact. R74's MDS dated [DATE] has a BIMS score of 14, which indicates R74s cognition is intact. On 01/15/25 at 10:30am surveyor attended resident council meeting with 2 residents (R8 and R51) who were able to verbally answer questions and respond appropriately. 8 residents in attendance were nonverbal and inattentive. On 01/15/25 at 10:37am R51 stated that she had not been informed of or attended a resident council meeting before that day. R51 stated that she had not been informed of resident council meetings when she was a resident on a different floor. R51 stated that on the morning of 01/15/25 V24 (Activity Director) had asked R51 twice to be the Resident Council President. R51 stated that she accepted the offer the second time she was asked and was then brought to the resident council meeting. On 01/15/25 at 10:40am R8 stated that she had not been informed of previous resident council meetings. On 01/15/24 at 11:25am R74 stated that no one in the facility had ever mentioned to her anything about a meeting for residents and had not been invited to the resident council meeting held on 01/15/25 at 10:30am. On 01/15/25 at 11:30am R37 stated that he used to attend resident council meetings when the meetings were run by social service. R37 stated that he has not heard anything about the facility having resident council meetings in a long time. R37 stated that he would like to attend the resident council meetings to listen to what other residents have to say and to see what is going on in the facility. R37 stated that if he was given the option to attend the resident council meeting, he would say a few words. (continued on next page)

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 01/15/25 at 11:43am V24 (Activity Director) stated that she asked R51 on the morning of 01/15/25 to be the resident council president. V24 stated that she is aware that the residents are supposed to vote for the resident council president. V24 stated that the resident council meeting held on 01/15/25 was the first resident council meeting that was hosted and organized by her. V24 stated that before 01/15/25, all resident council meetings were done by V28 (Social Services). On 01/15/25 at 11:58am V18 (Human Resource Director) stated that V28's employment with the facility ended on 11/14/24. On 01/15/25 at 1:51pm V2 (Director of Nursing/DON) stated that the facility's old ownership required the social service department to organize and assist the residents with resident council meetings. V2 stated that when the facility changed ownership in 03/2024, resident council was given the responsibility of organizing and hosting resident council meetings. V2 stated that it is important for residents to have resident council meetings to allow residents to voice their concerns. V2 stated that the Activity Director is responsible for informing the residents about the resident council meetings. On 01/15/25 at 12:00pm V17 (Social Service Director/SSD) stated that the social service department does not host the resident council meetings. V17 stated that they have always been ran by the activity department. Facility's policy dated 09/2015 titled Resident Council Policy documents in part, Purpose: To establish guidelines for assisting residents with the development and facilitation of a Resident Council in order to voice concerns, make recommendations, and participate in resolution of concerns .Responsibility: 1. The facility will provide residents with an appropriate meeting place and privacy will be afforded during meetings .2. The Resident Council is to be formed by all residents who wish to participate on a voluntary basis .3. The Activity Director will be responsible to coordinate the establishment of the Resident Council and be available to render assistance as needed. Council format, procedures and agenda will be developed by the council members with the assistance of the activity director .4. The council shall determine the leadership structure if any and/or officers in accordance with the by-laws. These persons shall preside at the meetings of the council, assisted by the Activity Director .5. All Resident Council meetings shall be open to participation by all residents and their invited guests .6. New residents will be informed of the Resident Council by the Activity Director .9. The Council will also be encouraged to discuss and offer suggestions about facility policies and procedures affecting residents' care treatment, and quality of life. Facility's policy dated 01/04/19 titled Resident Rights documents in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability .Guidelines: .Exercise his or her rights .Be informed about what rights and responsibilities he or she has.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 49572 Based on observation, interview and record review, the facility failed to ensure that residents have a clean, home like environment by providing clean linen for 2 residents (R1 and R54) and clean, home like room for 1 resident (R1). This failure affected 2 residents (R1 and R54), reviewed for resident's rights to enjoy a clean, comfortable, homelike environment, in a total sample of 49 residents. Findings include: On 1/13/25 at 10:27am, surveyor observed R1 lying in bed, on her back, with 2 areas of a brown substance on R1's bottom sheet of her bed. Also observed was multiple areas of a tan/beige substance on R1's floor and bed side dresser. When asked about the brown substance and tan/beige substance, R1 replied, I know the stuff on the floor and dresser is what they (staff) give me through my tube (tube feeding). I don't know what the brown stuff is. It's probable poo. They (staff) never clean in here. They (staff) don't care. Makes me wonder how their own houses look. R1's Face Sheet, documents medical diagnosis that include but are not limited to other abnormalities of gait and mobility; cerebral infarction; dislocation of internal left hip prosthesis; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side; need for assistance with personal care; dysphagia, oropharyngeal phase; gastro-esophageal reflux disease without esophagitis; gastrostomy status; and dysphagia following cerebral infarction. R1's BIMS (Brief Interview for Mental Status) Summary Score: 10, dated 10/11/24, suggests moderate cognitive impairment. R1's Care plan, revised date 5/22/24, documents, in part, (R1) has an ADL (activities of daily living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day r/t (related to) Activity Intolerance, Fatigue, Limited Mobility, abnormal gait, Dysphagia, weakness, CVA (cerebral vascular accident) with residual hemiplegia, with interventions that document, in part, (R1) receive nutrition per tube feedings or parenteral feeding; Shower/Bathe self: (R1) take a shower/bath/bath at sink/bed bath my usual performance is dependent. R1's Care Plan, revised date 11/27/24, documents, in part, (R1) requires tube feeding GT (gastrostomy tube) r/t (related to) gastrostomy status secondary to cva (cerebral vascular accident) W/(with) dysphagia . On 1/13/25 at 10:53am, surveyor observed R54 sitting on the side of his bed, in and adult brief, with 3 areas of a brown substance on his bottom linen of his bed. When asked about the brown substance, R54 replied, If something looks like shit and smells like shit it's probably shit. The nurse knows about it (brown substance). She (nurse) said she'll be back. I don't know how long ago she said that she would be back. R54's Face Sheet, documents medical diagnosis that include but are not limited to need for assistance with personal care; history of falling; difficulty in walking; and other abnormalities of gait and mobility. R54's BIMS (Brief Interview for Mental Status) Summary Score: 14, dated 12/02/24, suggests R54 is cognitively intact. (continued on next page)

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's Care Plan, revised date 12/04/24, documents, in part, (R54) have an ADL (activities of Dily living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day r/t (related to) Right intertrochanteric femoral fracture, with interventions Toilet hygiene-My usual performance is substantial/maximal assistance. On 1/13/25 at 11:02am, while surveyor and V3 (Registered Nurse/RN) were in R1's room, V3 said that the tan/beige substance on the floor and dresser is dried tube feeding. V3 stated, I'm not sure why that wasn't cleaned up. I didn't spill it. I'll call and get it cleaned. When asked about the brown substance on R1's bottom sheet on R1's bed, V3 replied, It's probably chocolate. Yes, they (residents) should have clean linen. After leaving R1's room surveyor asked V3 if V3 could come to R54's room to inquire about the brown substance in R54's linen and V3 replied, Oh, the CNA (certified nursing assistant) is going to change that. I'll make sure R54 has his (R54) linens changed. On 1/14/25 at 1:01pm, V2 (Director of Nursing/DON) said that all resident's should have clean rooms and linen. V2 said that cleanliness is key to prevent infection and promote recovery. Facility policy titled, Housekeeping Guidelines, undated, documents, in part, To provide guidelines to maintain a safe and sanitary environment for residents, facility staff and visitors . Housekeeping personnel shall clean rooms which are occupied by residents diagnosed with infectious diseases, using precautionary measures, at the completion of the assignment. Facility policy titled, Pressure Ulcer Prevention, revised date 1/15/18, documents, in part, 3. Change bed linen per schedule and whenever soiled with urine, feces, or other material. Facility policy titled, Resident Rights, reviewed date 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to conduct care plan conferences that allow the residents to participate in the development and implementation of their plan of care and failed to develop a comprehensive care plan within the required time frame. This failure affects 2 residents (R19, R328) in a sample of 49. Findings include: 1. Record review of R19's admission record documents in part R19 has the following diagnoses including, but not limited to: spinal stenosis, chronic obstructive pulmonary disease, unspecified dementia without behavioral disturbance, major depressive disorder, and epilepsy. Record review of R19's Minimum Data Set (dated 12/5/2024) documents in part a Brief Interview of Mental Status Summary Score of 13, indicating that R19 is cognitively intact. On 1/13/2025 at 11:32 AM, R19 denied that R19 is invited to care plan meetings or invited to participate the R19's plan of care. R19 stated that if there was a meeting that discussed R19's plan of care, R19 would want to attend. Record review of R19's progress notes documents in part that R19 had a care plan meeting on 3/13/2024. No further documentation of care plan meetings for R19 or invitations to participate in R19's plan of care were provided during the survey. 2. Record review of R328's admission record documents in part R328 has the following diagnoses including, but not limited to: osteomyelitis, sepsis, paraplegia, neuromuscular dysfunction of bladder, and colitis. Record review of R328's SS (Social Services) Lookback Summary dated 12/20/2024, documents in part that R328 has a Brief Interview of Mental Status (BIMS) summary score of 15, indicating that R328 is cognitively intact. On 1/13/2025 at 11:37 AM, R328 stated that R328 has never attended a care plan meeting or has been invited to participate in developing R328's care plan. R328 affirmed that R328 would want to be involved with developing R328's plan of care. R328 stated, maybe I would be able to make better decisions about my care if I were able to have one of those meetings. I should be going home next week, but now I am not. That meeting would be a good place to discuss what's going to happen when I discharge, right? Record review of R328's electronic health record does not document that R328 has had any care plan conferences or been invited to participate in the development of R328's plan of care. Surveyor requested documentation of care plan conferences for R328, and no evidence was received during the survey. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of R328's comprehensive MDS dated [DATE] does not document a signature in section Z0500 Signature of RN Assessment Coordinator Verifying Completion. Additionally, no signatures are noted for V0200B Signature of RN Coordinator for CAA Process and Date Signed and V0200 C Signature of Person Completing Care Plan Decision and Date Signed. In section V, the MDS indicates that a care area assessment was triggered for nutritional status and was not addressed. Sections A, GG, H, I, J, K, L, M, N, O, P, S and V are incomplete. This review indicates that the MDS and care planning process is incomplete. On 1/15/2025 at 1:06 PM V27 (Regional Director of Clinical Reimbursement) reviewed R328's MDS dated [DATE] and confirmed that the assessment was late. V27 stated that the assessment should have been completed by 12/30/2024 in accordance with the resident assessment instrument (RAI) guidelines. V27 explained that the reason why the assessment was late was because the prior MDS nurse quit around that time, but the facility had secured a company to complete the MDS remotely. V27 stated that V27 is not a registered nurse, so V27 is unable to act as the registered nurse assessment coordinator on behalf of the facility. V27 stated that the primary purpose of the MDS is to identify resident conditions and needs. On 1/15/2025 at 1:50 PM, V2 (Director of Nursing) affirmed that the facility does not have a nurse that is the registered nurse assessment coordinator and is actively hiring for that position. V2 stated that the MDS drives the resident's plan of care. V2 stated that all residents should be getting a care plan meeting quarterly. V2 affirmed that residents have the right to participate in the development and implementation of their plan of care. Record review of CMS' Resident Assessment Instrument (10/2024), Chapter 5: Submission and Correction of the MDS Assessments documents in part, .For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600). - For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no later more than 13 days after the Entry Date (A1600). For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days after the ARD (A2300) . Record review of facility policy titled, Comprehensive Care Plan (Revised 11/17/17) documents in part, . Purpose: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being . The facility will develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment . A comprehensive care plan must be-Developed within 7 days after completion of the comprehensive assessment. Prepared by an interdisciplinary team, that includes but is not limited to-- .To the extent practicable, the participation of the resident and the resident's representative(s). An explanation should be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan .Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. The CAAs provide a link between the MDS and care planning. The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that the resident is receiving. The resident and/or resident representative shall be invited to review the plan of care with the interdisciplinary team either in person, via telephone or video conference (if available) at least quarterly .

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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** 50728 Based on interview and record review, the facility failed to complete and submit a comprehensive assessment within the required timeframes. This failure has the potential to affect 1 resident (R328) in a sample of 49. Findings include: Record review of R328's admission tracking minimum data set (MDS) documents in part an assessment reference date of 12/17/2024. Record review of R328's comprehensive MDS dated [DATE] documents that Sections A, GG, H, I, J, K, L, M, N, O, P, S and V of the MDS are incomplete. The MDS does not document a signature in section Z0500 Signature of RN Assessment Coordinator Verifying Completion. Additionally, no signatures are noted for V0200B Signature of RN Coordinator for CAA Process and Date Signed and V0200C Signature of Person Completing Care Plan Decision and Date Signed. This indicates that the MDS is incomplete. On 1/15/2025 at 1:06 PM V27 (Regional Director of Clinical Reimbursement) reviewed R328's MDS dated [DATE] and confirmed that the assessment was late. V27 stated that the assessment should have been completed by 12/30/2024 in accordance with the resident assessment instrument (RAI) guidelines. V27 explained that the reason why the assessment was late was because the prior MDS nurse quit around that time, but the facility had secured a company to complete the MDS remotely. V27 stated that V27 is not a registered nurse, so V27 is unable to act as the registered nurse assessment coordinator on behalf of the facility. V27 stated that the primary purpose of the MDS is to identify resident conditions and needs. On 1/15/2025 at 1:50 PM, V2 (Director of Nursing) affirmed that the facility does not have a nurse that is the registered nurse assessment coordinator and is actively hiring for that position. V2 stated that the MDS drives the resident's plan of care. Record review of CMS' Resident Assessment Instrument (10/2024), Chapter 5: Submission and Correction of the MDS Assessments documents in part, .For the Admission assessment, the MDS Completion Date (Z0500B) must be no later than 13 days after the Entry Date (A1600). - For the Admission assessment, the Care Area Assessment (CAA) Completion Date (V0200B2) must be no later more than 13 days after the Entry Date (A1600). For the Annual assessment, the CAA Completion Date (V0200B2) must be no later than 14 days after the ARD (A2300) .

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NAME OF PROVIDER OR SUPPLIER Aperion Care Wesley		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 West Foster Avenue Chicago, IL 60640	

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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 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. 49572 Based on observation, interview, and record review, the facility failed to ensure that 2 residents (R1 and R54) who depend on staff assistance for ADL (Activities of Daily Living) care and grooming receive nail care and 1 resident (R1) receive hair care. This affects 2 residents (R1 and R54) in the sample of 49 residents reviewed for accommodation of needs. Findings include: On 1/13/25 at 10:27am, R1 said, My fingernails and hair aren't any better. My hair is all matted. This surveyor observed R1 with long, discolored fingernails on both hands and brown substances underneath the nail beds and R1's hair appeared tangled, tousled, and unkempt. R1 stated, I've asked the nurses to cut my nails and fix my hair but look . I'm a mess. I doubt my hair can even be unmatted. R1's Face Sheet, documents medical diagnosis that include but are not limited to type 2 diabetes mellitus; other abnormalities of gait and mobility; cerebral infarction; dislocation of internal left hip prosthesis; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side; need for assistance with personal care; dysphagia, oropharyngeal phase; gastro-esophageal reflux disease without esophagitis; gastrostomy status; and dysphagia following cerebral infarction. R1's BIMS (Brief Interview for Mental Status) Summary Score: 10, dated 10/11/24, suggests moderate cognitive impairment. R1's Care plan, revised date 5/22/24, documents, in part, (R1) has an ADL (activities of daily living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day r/t (related to) Activity Intolerance, Fatigue, Limited Mobility, abnormal gait, Dysphagia, weakness, CVA (cerebral vascular accident) with residual hemiplegia, with interventions that document, in part, Toilet hygiene-My usual performance is Dependent; Shower/Bathe self: (R1) take a shower/bath/bath at sink/bed bath my usual performance is dependent. On 1/13/25 at 10:53am, surveyor observed R54 sitting on the side of his bed, in and adult brief, unshaven, with long fingernails on both hands and brown substances under the first, second and third fingernails on right hand. When asked about R54's fingernails, R54 responded that he would like them to cut and would also like help shaving. When asked if R54 has notified staff about his nails and wanting a shave, R54 said that he has asked a few times, but they (staff) are always busy. R54's Face Sheet, documents medical diagnosis that include but are not limited to need for assistance with personal care; history of falling; difficulty in walking; and other abnormalities of gait and mobility. R54's BIMS (Brief Interview for Mental Status) Summary Score: 14, dated 12/02/24, suggests R54 is cognitively intact. R54's Care Plan, revised date 12/04/24, documents, in part, (R54) have an ADL (activities of Dily living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day r/t (related to) Right intertrochanteric femoral fracture, with interventions Shower/Bathe self: I take a shower/bath/bath at sink/bed bath my usual performance is dependent. Toilet hygiene-My usual performance is substantial/maximal assistance. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/25 at 11:02am, while surveyor and V3 (Registered Nurse/RN) were in R1's room, V3 said, She (R1) needs her nails trimmed and hair brushed. It (nails trimmed and hair brushed) should have been done wither her last bathing. On 1/14/25 at 1:01pm, V2 (Director of Nursing/DON) said that there's a schedule for the resident's for bathing. V2 stated that staff look at the resident's nails during bathing and trim as needed. V2 said that long nails can cause self-inflicted injuries. Facility policy titled, Activities of Daily Living (ADLs), undated, documents, in part, Bathing: Washing and drying the body (excluding back and shampooing hair), including full body sponge bath, planning the task, and gathering supplies, and transfer into and out of tub/shower. Grooming: Maintaining personal hygiene, including planning the task and gathering supplies, combing and/or styling hair, face, and hands, brushing teeth, shaving, or applying makeup, oral hygiene, self-manicure (safety awareness with nail care), and/or application of deodorant or powder. Facility policy titled, Nail Care, revised date 1/25/18, 1. Observe condition of resident nails during each time of bathing. Note cleanliness, length uneven edges, hypertrophied nails . 4. After bathing, use orange stick, and clean debris from around and under finger and toenails. 5. Trim toenails carefully in a straight fashion and fingernails in an oval fashion avoiding tissue after bathing or when needed. Be sure nails are soft before trimming. Additional soaking in warm soapy water may be necessary to soften nails . 10. Document provision of care and pertinent observations. Facility policy titled, Resident Rights, reviewed date 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.

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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** 41611 49572 Based on observation, interview, and record review, the facility failed to ensure dressings were changed daily (as per physician order) for one resident (R24) with pressure ulcers, who is also at risk for further pressure ulcers; and failed to have the low air loss mattress at the correct weight settings for one resident (R54) with pressure ulcers, who is also at risk for further pressure ulcers. This failure has the potential to affect two residents (R24 and R54), reviewed for pressure ulcer prevention interventions, in a total sample of 49 residents. Findings include: On 1/13/25 at 10:53am, surveyor observed R54 sitting on the side of his bed, on a LAL (low air loss) mattress, with the LAL mattress weight setting set at greater than 350 pounds. When asked if R54 has any pressure wounds, R54 replied, I have one on my butt, I'm not sure when it's supposed to be changed. Every day, I think. When asked how much R54 weighs, R54 replied, I think about 150. I think I'm losing weight though. When asked if R54's mattress was comfortable, R54 replied, My mattress at home is more comfortable. This one is too firm. R54's face sheet documents, in part, diagnosis that include but are not limited to need for assistance with personal care; displaced intertrochanteric fracture of right femur, subsequent encounter for closed fracture with routine healing; and history of falling. R54's Minimum Data Set (MDS), dated [DATE], documents, in part, a brief interview of mental status (BIMS) score of 14 which indicates R54 is cognitively intact. R54's Minimum Data Set (MDS), dated [DATE], Skin Conditions (section M) documents, documents, in part, . Is this resident at risk of developing pressure ulcers/injuries? YES . Does this resident have one or more unhealed pressure ulcers/injuries? YES .Number of these Stage 3 pressure ulcers that were present upon admission/entry or reentry 1 . B. Pressure reducing device for bed YES . E. Pressure ulcer/injury care . that R54's Skin and Ulcer/Injury Treatments include a pressure reducing device for bed. R54's Admission Note, dated 11/30/2024, documents, in part, 1410 received a 77 yr. old male from (hospital) via stretcher . The writer . then proceeded to perform a head-to-toe-assessment . pressure injury on back and coccyx. R54's Braden Observation, dated 11/30/24, documents, in part, a Braden score of 17 which indicates that R54 is at risk for developing a pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R54's progress note, dated time of service 1/9/25 at 6:00am, documents, in part, Integumentary (Hair, Skin) Wound #1 status is Open. The date acquired was: 11/30/2024. The wound has been in treatment 4 weeks. The wound is currently classified as a Category/Stage IV wound with etiology of Pressure Ulcer and is located on the Coccyx. The wound measures 4.5cm length x 6cm width x 1.5cmdepth; 21.206cm^2 area and 31.809cm^3 volume. There is muscle and Fat Layer (Subcutaneous Tissue) exposed. There is a medium amount of serosanguineous drainage noted. There is medium (34-66%) granulation within the wound bed. There is a medium (34-66%) amount of necrotic tissue within the wound bed including Adherent Slough and Necrosis of Muscle. The peri wound skin appearance had no abnormalities noted for texture. The peri wound skin appearance had no abnormalities noted for moisture. The peri wound skin appearance had no abnormalities noted for color. Wound #2 status is Open. The date acquired was: 11/30/2024. The wound has been in treatment 4 weeks. The wound is currently classified as a Category/Stage III wound with etiology of Pressure Ulcer and is located on the Midline Back. The wound measures 5cm length x 11.5cm width x0.1cm depth; 45.16cm^2 area and 4.516cm^3 volume. The wound is limited to skin breakdown. There is a none (sic) present amount of drainage noted. There is no granulation within the wound bed. There is a small (1-33%) amount of necrotic tissue within the wound bed including Adherent Slough. The peri wound skin appearance had no abnormalities noted for texture. The peri wound skin appearance had no abnormalities noted for moisture. The peri wound skin appearance had no abnormalities noted for color. R54's Care Plan, revision date 12/04/24, documents, in part, (R54) require assistance with bed mobility r/t (related to) Right intertrochanteric femoral fracture, with interventions, revision date12/02/24, documents, in part, (R54) will reposition self in bed from sitting to lying and lying to sitting with partial/moderate assistance. R54's Care Plan, revision date 12/06/24, documents, in part, (R54) has pressure ulcer to the coccyx and mid back. R54's Weight Summary Sheet, dated 1/01/2025 at 3:07pm, documents, in a part, a weight of 139.2lbs. R54's Order Summary Report, dated 1/14/25, documents, in part, Coccyx: Cleanse with NSS (normal saline solution), pat dry, apply Santyl and Dakins and cover with foam dressing. one time a day for wound care . Mid Lateral back: cleanse with NSS, pat dry, apply Silvadene and cover with foam dressing. one time a day every Mon, Wed, Fri for wound care .please keep pressure off of bilateral heels, float heels with pillow or use heel boots . On 1/13/25 at 11:02am, V3 (Registered Nurse/RN) said, I'm don't know a lot about the wound mattresses. I can get the DON (Director of Nursing) to help you. On 1/15/25 at 1:49pm, V2 (Infection Preventionist/Director of Nursing/DON) said, The LAL (low air loss) mattresses should only have a flat sheet or a brief. If there's more than that the mattress may not do what it's supposed to do. The weight setting for the mattress should be set at the resident's weight or else it defeats the purpose of the low air loss mattress. If it's (LAL mattress) not set at the resident's weight it can prevent healing or cause more pressure ulcers. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In Center for Medicare and Medicaid Services article, dated 4/7/22 and titled Pressure Reducing Support Surfaces - Group 2 - Policy Article, documents, in part, that styles of Group 2 powered pressure reducing mattress (alternating pressure, low air loss, or powered flotation without low air loss) which is characterized by all of the following: an air pump or blower which provides either sequential inflation and deflation of the air cells or a low interface pressure throughout the mattress, and inflated cell height of the air cells through which air is being circulated is 5 inches or greater, and height of the air chambers, proximity of the air chambers to one another, frequency of air cycling (for alternating pressure mattresses), and air pressure provide adequate beneficiary lift, reduce pressure and prevent bottoming out, and a surface designed to reduce friction and shear, and can be placed directly on a hospital bed frame. Facility presented document titled, . Low Air Loss Mattress System with Foam Base Manual, dated 2014, documents, in part, mattress are intended to help reduce the incidence of pressure ulcers while optimizing patient comfort . 9. Turn the Pressure Adjust Knob to set a comfortable pressure level using the weight scale as a guide. Facility policy titled, Pressure Ulcer Prevention, revised date 1/15/18, documents, in part, Purpose: To prevent and treat pressure sores/ pressure injury. 3. Change bed linen per schedule and whenever soiled with urine, feces, or other material. 9 . Specialty mattresses such as low air loss, alternating pressure, etc. may be used as determined clinically appropriate. Specialty mattresses are typically used for residents who have multiple Stage 2 wounds or one or more Stage 3 or Stage 4 wounds. Facility policy titled, Resident Rights, reviewed date 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. 51772 On 01/13/25 at 10:35 AM, observed foam dressing to R24's left and right hips dated 1/8/2025. V3 (Registered Nurse) stated that R24 has a wound care order to change the foam dressings to R24's bilateral hips twice a day. V3 (RN) verified the date of 1/8/2025 written on R24's right and left foam dressings. R24 was observed with red and purple blanchable erythema wound appearances the size of a half dollar or larger to R24's bilateral hips. Wound care consult conducted by V28 (Registered Nurse- Wound Care Nurse) dated 12/11/2024 verifies 3 wounds, documents the following: R24's Wound Care Consult Note on 12/11/2024 written by V28, Wound Care Nurse documents: 1. Pressure Injury to Right Hip Deep Tissue Injury Pink; Red; Blanchable Erythema; Intact 2. Pressure Injury to Left Hip Deep Tissue Injury Pink; Red; Blanchable Erythema; Intact 3. Pressure Injury Ankle Right; Outer Deep Tissue Injury Pink; Red; Intact; Purple; Non-Blanchable Erythema (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's Treatment Administration Record documents a physician's order for wound care to R24's right and left hips that reads Bilateral hips-Foam dressing every night shift for pressure injury -Start Date- 12/13/2024 2300. Treatment Administration Record has documented signatures that wound care dressing changes were performed 1/8/2024 to 1/13/24. R24's Physicians Order Sheet (POS) contains an order dated 12/13/2024 which documents: for wound care dressing to Bilateral Hips-Foam dressing every night shift for pressure injury. On 1/15/2025 at 3:35 pm, V21 RNC (Regional Nursing Consultant) stated that R24 does not have pressure wounds. On 1/15/2025 at 3:39 pm V21 RNC returned to conference room where surveyors were present and stated that R24 has scar tissue from previous pressure injuries and his dressing is just for comfort. Requested wound care measurements and weekly assessment from 12/11/2024 but none was provided. Per face sheet R24's medical diagnosis includes other abnormalities of gait and mobility; difficulty in walking; unsteadiness on feet; infection and inflammatory reaction due to indwelling; urethral catheter, subsequent encounter; dysphagia, oropharyngeal phase; other disorders of phosphorus metabolism; other lack of coordination; hyperkalemia; acute kidney failure; obstructive and reflux uropathy.

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F 0687 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate foot care. 49572 Based on observations, interviews, and record reviews, the facility failed to ensure foot care was provided for 1 resident (R1) and failed to assist the resident in making appointments with a qualified person to receive appropriate foot care, demonstrating inadequate care. This failure resulted in R1 suffering physical harm stating symptoms of unbearable foot pain and also suffering psychosocial harm stating feelings of depression, irritability and difficulty sleeping. Findings include: On 1/13/25 at 10:27am, surveyor observed R1 displaying facial grimacing and when surveyor inquired about the facial grimacing, R1 replied, It's my feet. Look at my feet. The pain is unbearable sometimes. I am so depressed and mad. The pain makes it impossible to sleep. Surveyor observed R1's feet, which were red, very dry, and scaly. R1's toenails were long, and discolored. A maroon colored substance was observed between the 1st and 2nd toe and the 4th and 5th toe on R1's right foot. A brown substance was observed between the 1st and 2nd toe on R1's left foot. Surveyor asked when the last time R1 received nail care and R1 replied, I went to the podiatrist once. The staff will not touch my nails because they said I have to see podiatry. It was years ago since I seen the podiatrist. My fingernails and hair aren't any better. My hair is all matted. R1's Face Sheet, documents medical diagnosis that include but are not limited to type 2 diabetes mellitus; other abnormalities of gait and mobility; cerebral infarction; dislocation of internal left hip prosthesis; hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side; need for assistance with personal care; dysphagia, oropharyngeal phase; gastro-esophageal reflux disease without esophagitis; gastrostomy status; and dysphagia following cerebral infarction. R1's BIMS (Brief Interview for Mental Status) Summary Score: 10, dated 10/11/24, suggests moderate cognitive impairment. R1's Care Plan, revised date 4/24/24, documents, in part, (R1) has Diabetes Mellitus, with interventions, Check all of body for breaks in skin and treat promptly as ordered by doctor. R1's Care plan, revised date 5/22/24, documents, in part, (R1) has an ADL (activities of daily living) self-care/mobility performance (functional abilities) deficit that may fluctuate with activity throughout the day r/t (related to) Activity Intolerance, Fatigue, Limited Mobility, abnormal gait, Dysphagia, weakness, CVA (cerebral vascular accident) with residual hemiplegia, with interventions that document, in part, Toilet hygiene-My usual performance is Dependent; Shower/Bathe self: (R1) take a shower/bath/bath at sink/bed bath my usual performance is dependent. R1's Order Summary Report, dated 1/14/25, documents, in part, Order date 9/16/25 Podiatry consult for toenail trimming. On 1/13/25 at 11:02am, while surveyor and V3 (Registered Nurse/RN) were in R1's room, V3 said, I'm not sure when (R1) went to the podiatrist last. Yes, they (toenails) are overgrown. Let me check when her next appointment is. (continued on next page)

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F 0687 Level of Harm - Actual harm Residents Affected - Few	On 1/15/25 at 11:06am, V17 (Social Services Director) said, I schedule the residents for the podiatry clinic. I don't know when (R1) was last seen by podiatry. I contacted the podiatry office and they said that she (R1) was last seen in 2017. She is now set up to go January 30th (1/30/25). I cannot find any other records. Facility presented document from the podiatry office, undated, that documents, in part, (R1) (11/15/1951) was seen in March 2017 . Our office has received a request to reinstate (R1) for podiatry services. She has been added to the visit list and scheduled to be seen . 1/30/25 when (Podiatrist) is next on the building. On 1/15/25 at 1:18pm, V23 (Medical Director) said, I know of her (R1), but I am not her attending. My colleague is her attending and would know more but and I can try to answer your questions. When asked about R1's feet care and podiatry V23 replied, I am not aware of any issues with her (R1). V23 stated that Diabetes can cause poor circulation in the feet and pain. V23 said that she will try to reach R1's attending physician and have R1's attending physician call this surveyor. R1's attending physician never called this surveyor. Evidence shows that R1 has Type 2 Diabetes Mellitus which poses a risk to foot health. R1 has an active order for a Podiatry consult that was ordered on 9/16/25 and the facility was not able to provide evidence that R1 has seen the podiatrist recently. The facility was only able to provide documentation that R1 saw the podiatrist in March of 2017 (almost 8 years ago). Facility policy titled, Activities of Daily Living (ADLS), undated, documents, in part, Bathing: Washing and drying the body (excluding back and shampooing hair), including full body sponge bath, planning the task, and gathering supplies, and transfer into and out of tub/shower. Grooming: Maintaining personal hygiene, including planning the task and gathering supplies, combing and/or styling hair, face, and hands, brushing teeth, shaving, or applying makeup, oral hygiene, self-manicure (safety awareness with nail care), and/or application of deodorant or powder. Facility policy titled, Nail Care, revised date 1/25/18, 1. Observe condition of resident nails during each time of bathing. Note cleanliness, length uneven edges, hypertrophied nails. 4. After bathing, use orange stick, and clean debris from around and under finger and toenails. 5. Trim toenails carefully in a straight fashion and fingernails in an oval fashion avoiding tissue after bathing or when needed. Be sure nails are soft before trimming. Additional soaking in warm soapy water may be necessary to soften nails. 10. Document provision of care and pertinent observations. Facility policy titled, Resident Rights, reviewed date 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on interview and record review, the facility failed to ensure that oxygen cylinders were secured and that personal heaters were not in use. This failure has the potential to affect all 87 residents that reside within the facility. Findings include: Record review of facility census documents in part that 87 residents reside in facility. Record review of R3's admission record documents in part that R3 has the following diagnoses including but not limited to: chronic obstructive pulmonary disease, pulmonary fibrosis, depression, anxiety and dependence on supplemental oxygen. Record review of R3's Minimum Data Set (dated 11/04/2024) documents in part a Brief Interview of Mental Status score of 15, indicating that R3 is cognitively intact. On 1/13/2025 at 11:02 AM, observed an oxygen cylinder freestanding, unsecured next to R3's bed. R3 stated that the oxygen cylinder used to be in a holder, but the facility took the holder away a couple of months ago. On 1/13/2025 at 11:32 AM, V10 (Agency Licensed Practical Nurse) observed the oxygen cylinder in the room. V10 stated that oxygen cylinders should be secured to a holder to prevent the tank from tipping over. V10 affirmed that oxygen cylinders are combustible and removed the cylinder from R3's room. On 1/15/2024 at 1:50 PM, V2 (Director of Nursing) stated that the facility secures oxygen tanks in a holder. V2 stated that oxygen cylinders need to be secured because oxygen cylinders are a fire hazard. Facility policy titled Oxygen Safety and Training Policy reviewed 11/2024, documents in part, .7. Compressed gas cylinders shall be stored in an upright position with the valve end up, the valve cap in place and the cylinder chained to the wall or otherwise secured. This protects the vulnerable cylinder valve and prevents the cylinder from falling and becoming a dangerous projectile. 50662 On 01/13/25 at 11:23am R57 observed with electric space heater at bedside. R57 stated that the facility was aware of her having the space heater. R57 stated that the facility has been having heating issues and R57 uses the heater to stay warm. R57's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 15 which indicates that R57's cognition is intact. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145591	A. Building B. Wing	01/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aperion Care Wesley	1415 West Foster Avenue Chicago, IL 60640

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/15/25 at 1:51pm V2 (Director of Nursing/DON) stated that residents should not have space heaters but because of the climate, the facility allowed the residents to have space heaters. V2 stated that the facility just had repairs done to the boilers. V2 stated that space heaters are a fire hazards and that someone could die in a fire. On 01/15/25 a 2:13pm V19 (Maintenance Director) stated that the facility shouldn't have space heaters in resident rooms and that space heaters are a safety hazard. On 010/14/25 at 1:38pm V1 (Administrator) stated that he was unable to locate the facility's policy on safety and hazards regarding space heaters.

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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. 49572 Based on observations, interviews, and record reviews, the facility failed to ensure a tube feeding syringe was changed daily on 1 resident (R1). These failures have the potential to affect 1 resident (R1) reviewed for tube feeding management in the total sample of 49 residents. Findings include: On 1/13/25 at 10:27am, surveyor observed R1's tube feeing syringe with an open date of 1/9/25. When asked if R1 noticed staff changing the tube feeding syringe recently, R1 replied, Doubt it. I can't even get my hair washed or brushed. Look, my hair is all matted. R1's Face Sheet, documents medical diagnosis that include but are not limited to dysphagia, oropharyngeal phase; gastro-esophageal reflux disease without esophagitis; gastrostomy status; and dysphagia following cerebral infarction. R1's BIMS (Brief Interview for Mental Status) Summary Score: 10, dated 10/11/24, suggests moderate cognitive impairment. R1's Care Plan, revised date 11/27/24, documents, in part, (R1) requires tube feeding GT (gastrostomy tube) r/t (related to) gastrostomy status secondary to CVA (cerebral vascular accident) W/(with) dysphagia . R1's Order Summary Report,, dated 1/14/25, documents, in part, Enteral Feed Order one time a day (Tube feeding) @ 70mL/hr (hour) x 14 hours. On 1/13/25 at 11:02am, V3 (Registered Nurse/RN) said, Tube feeding syringes should be changed every 5 days, but I (V3) change them every other day. On 1/14/25, surveyor observed R1's tube feeing syringe, again, with an open date of 1/9/25. On 1/15/25 at 1:49pm, V2 (Director of Nursing/DON/Infection Preventionist) said, (Tube Feeding) syringes are to be changed every 24 hours. When asked the purpose of changing tube feeding syringes every 24 hours, V2 replied, Infection. Not changing can cause an infection. Facility policy titled, Gastrostomy Tube- Feeding and Care, revised date 8/3/20, documents, in part, 13. Feeding tube syringes and irrigation containers are to be changed every 24 hours. Facility policy titled, Resident Rights, reviewed date 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45346 Based on observation, interview, and record review the facility staff failed to secure in a bag the oxygen tubing and nasal cannula when not in use for one resident (R21) and failed to properly date the oxygen tubing, humidifier bottle, and nebulizer tubing for one resident (R11). Findings include: R21's diagnosis includes, but are not limited to, chronic obstructive pulmonary disease with (acute) exacerbation, chronic respiratory failure with hypoxia, muscle weakness (generalized), unspecified dementia, unspecified severity, with other behavioral disturbance, chronic systolic (congestive) heart failure, hypertensive heart disease with heart failure, and atherosclerotic heart disease of native coronary artery without angina pectoris. R21 has a Brief Interview for Mental Status (BIMS) dated 11/13/2024 which documents that R21 has a BIMS score of 07, indicating R21's cognition is severely impaired. R21's Physician Order Summary Report dated 01/14/2025 documents, in part, Continuous oxygen at 2-3 LPM (liters per minute) via nasal cannula. On 01/13/2025 at 2:00pm observed R21's oxygen tubing and nasal cannula hanging on the oxygen concentrator machine, not contained in a bag. On 01/13/2025 at 2:15pm V11(LPN/Licensed Practical Nurse) stated the oxygen tubing and nasal cannula should be put up, covered up. V11 stated the tubing should not be hanging over the machine. V11 stated the purpose of having the tubing covered is to prevent germs from getting on the tubing. On 1/15/2025 at 10:43am V2 (DON/Director of Nursing) stated when the nasal cannula and oxygen tubing are not in use by the resident the tubing should be placed in a plastic bag. V2 stated placing the tubing in the plastic bag prevents issues with infection control. 50662 On 01/13/25 at 11:37am R11 observed receiving nebulizer treatment. No date observed on R11's nebulizer treatment face mask, oxygen tubing or humidifier bottle. On 01/13/25 at 11:43am V10 (Licensed Practical Nurse/LPN) stated that she did not see a date on R11's oxygen tubing, humidifier bottle, or nebulizer treatment. On 01/15/25 at 1:51pm V2 (Director of Nursing/DON) stated that oxygen tubing is changed every seven days and as needed and should be dated. V2 stated that oxygen tubing is changed for infection control reasons. R11's diagnoses include but are not limited to chronic diastolic congestive heart failure, hypertensive heart disease with heart failure, cardiomegaly, type 2 diabetes mellitus without complications, major depressive disorder, generalized anxiety. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R11's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 15, which indicated R11's cognition is intact. R11's active order dated 09/25/22 documents in part, Oxygen nasal cannula at 2 liters per minute as needed to keep oxygen saturation above ninety two percent. R11's active order dated 09/25/22 documents in part, Nebulizer every four hours as needed for shortness of breath. R11's care plan dated 09/27/24 documents in part, R11 is at risk for cardiac distress related to multiple cardiac conditions affecting functions diagnosis with the following chronic diastolic CHF (congestive heart failure) .Apply oxygen at two liters as needed through nasal canula to keep oxygen saturation above 92 percent. Facility's policy dated 01/07/19 titled Oxygen and Respiratory Equipment - Changing/Cleaning documents in part, Purpose: 1. To provide guideline to employees for changing all disposable respiratory supplies. 2. To ensure the safety of residents by providing maintenance of all disposable respiratory supplies. 3. To minimize the risk of infection transmission .Procedure: 1. Hand Held Nebulizer and mask .The handheld nebulizer should be changed weekly and PRN (as needed) .2. Nasal cannula .a. Nasal cannulas are to be changed once a week and PRN .4. Oxygen Humidifiers. a. Oxygen humidifiers should be changed weekly or as needed and will be dated when changed.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on observation, interview and record review, the facility failed to ensure there were sufficient staff to meet the resident's needs. This failure caused R328 to not have an intravenous antibiotic administered; failed to have an intravenous antibiotic administered timely; failed to have R328's comprehensive assessment completed timely; failed to have R328's plan of care to be developed within the required timeframe. This failure affects 1 (R328) resident in a sample of 49. Findings include: Record review of the facility's staffing schedule/assignment for 1/13/2025 documents in part that an agency nurse was supposed to begin at 9:30 AM. The staffing records do not indicate the agency nursing staff's names or titles (registered nurse vs licensed practical nurse). Record review of R328's admission record documents in part R328 has the following diagnoses including, but not limited to: osteomyelitis, sepsis, paraplegia, neuromuscular dysfunction of bladder, and colitis. Record review of R328's Brief Interview of Mental Status (BIMS) assessment dated [DATE], documents in part that R328 has a BIMS summary score of 15, indicating that R328 is cognitively intact. Record review of R328's medication administration record documents in part that R328 has active orders for Ampicillin 12 g in 0.9% normal saline Use 12 gram intravenously one time a day for sepsis until 01/20/2025 23:59 ampicillin 12g in 0.9% NSS 500ml daily in continuous pump, and Vancomycin HCl Intravenous Solution 1500 MG/300ML (Vancomycin HCl) Use 1500 mg intravenously every 8 hours for Osteomyelitis until 01/20/2025 23:00. Additionally, the record documents that Vancomycin should be administered at 01:00 AM, 9:00 AM and 5:00 PM. On 1/13/2025 at 11:37 AM, observed R328 sitting upright in a wheelchair with a double lumen peripherally inserted central catheter (PICC) line to R328's right upper arm. An IV (intravenous) pole with a bag containing approximately 500 milliliters (mL) labeled Ampicillin 12 grams in 500 mL of 0.9% sodium chloride (normal saline) was observed to the right of R328 with the IV line disconnected from R328. The directions on the bag of Ampicillin stated, infuse intravenously at 41.7 ml/hr (hour) over 24 hours. R328 stated that the medication on the IV pole was antibiotics and explained that R328 has multiple pressure ulcers that became infected, causing R328 to become septic and needing nursing home level of care. R328 stated that R328 does not get prescribed antibiotics regularly because the facility does not have enough nursing staff to run R328's IV medication. R328 stated that R328 feels that R328's wounds have had delayed healing because R328 does not get antibiotics regularly. R328 stated, the staff here are good, they just don't have enough of them. They (the staff) are too stretched thin, overworked and underpaid. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/2025 at 11:50 AM, V2 (Director of Nursing) entered the room and observed the ampicillin not connected or being administered to R328. V2 affirmed that the ampicillin should be running and the ampicillin gets stopped when (R328) gets vancomycin. When V2 was asked why the ampicillin wasn't running V2 stated, we had some staffing issues this morning and a nurse called off. V2 explained that the ampicillin and vancomycin were being given for R328's osteomyelitis and V2 would check the medication administration record and administer the ampicillin. V2 left the room without administering the ampicillin. On 1/14/2024, documentation of the working schedule that reflects the nurse call-in was requested. This was not provided prior to the exit of the survey. On 1/14/2025 at 1:37 PM, V14 (Regional [NAME] President of Operations) reviewed the facility assessment and affirmed that the staffing needs are not broken down by unit. V14 stated that the facility has identified that there are staffing needs for nurses, an MDS nurse, a wound care nurse and an assistant director of nursing. V14 stated that the facility does have a formal contingency plan to ensure resident needs are met should there be a staffing crisis. V14 explained that the plan is only if there is a large number of staff unable to work (beginning with 75% of the workforce), not if there is a call in. V14 stated after a call-in, other staff/agency would be called in to cover the shift. Record review of R328's comprehensive MDS dated [DATE] does not document a signature in section Z0500 Signature of RN Assessment Coordinator Verifying Completion. Additionally, no signatures are noted for V0200B Signature of RN Coordinator for CAA Process and Date Signed and V0200 C Signature of Person Completing Care Plan Decision and Date Signed. In section V, the MDS indicates that a care area assessment was triggered for nutritional status and was not addressed. Sections A, GG, H, I, J, K, L, M, N, O, P, S and V are incomplete. This review indicates that the MDS and care planning process is incomplete. On 1/15/2025 at 1:06 PM V27 (Regional Director of Clinical Reimbursement) reviewed R328's MDS dated [DATE] and confirmed that the assessment was late. V27 stated that the assessment should have been completed by 12/30/2024 in accordance with the resident assessment instrument (RAI) guidelines. V27 explained that the reason why the assessment was late was because the prior MDS nurse quit around that time, but the facility had secured a company to complete the MDS remotely. V27 stated that V27 is not a registered nurse, so V27 is unable to act as the registered nurse assessment coordinator on behalf of the facility. V27 stated that the primary purpose of the MDS is to identify resident conditions and needs. On 1/15/2025 at 1:50 PM, V2 (Director of Nursing) affirmed that the facility does not have a nurse that is the registered nurse assessment coordinator and is actively hiring for that position. V2 stated that the MDS drives the resident's plan of care. V2 stated that the facility has active positions for registered and licensed practical nurses, a wound care nurse and an MDS nurse. V2 affirmed that V2 is the only nurse in a supervisory role for the facility. V2 stated that if a facility does not have enough staff, the residents may not be delivered the care they need. Facility policy titled, Staffing undated, documents in part, .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment . (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of facility assessment (reviewed 10/23/2024) staffing plan documents in part that on average, 5 licensed nurses are needed on every shift, on average 11 certified nursing assistants are needed on day shift and evening shift, and Other department heads, quality assurance nurse, ancillary staff in maintenance, housekeeping, dietary, laundry, etc. Customize to the staffing of your facility 1 Director of Nursing, 1 Night weekend supervisor, 1 MDS coordinators, 1 Restorative Nurse. The facility assessment also indicates that the facility has 2 specialty units, a memory care unit and a short stay unit. The facility assessment does not indicate the following: the average daily census, the amount of nursing and ancillary staff needed per unit per shift. The facility assessment documents that this was reviewed with V1 (Administrator). The facility assessment also does not identify that the facility needs a wound care nurse or an assistant director of nursing and does not list any recruitment/retention strategies being used by the facility.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 50728 Based on observation, interview and record review, the facility failed to ensure that agency staff received sufficient competency prior to starting the scheduled shift and failed to ensure a system is in place to ensure agency staff are competent in the facility's policies and procedures. This failure has the potential to affect all 87 residents that reside within the facility. Findings include: Record review of facility census documents in part that 87 residents reside within the facility. On 1/13/2024 at 11:28 AM, V10 (Agency Licensed Practical Nurse) was observed unable to access the electronic health record. V10 stated that V10 works for an agency but has picked up shifts in the past. V10 stated that V10 picked up today and was having issues accessing the electronic health record, so V10 was unable to administer medications. V10 stated that V10 needed to start R358's IV medication and had a bag of vancomycin in V10's hands. V10 was unsure if it was within V10's scope of practice as a licensed practical nurse to access and administer IV medications through a peripherally inserted central catheter (PICC) line. V10 stated that V10 did not receive any training, orientation or competency checks from the facility including but not limited to, abuse, skills training, emergency preparedness. V10 affirmed that V10 has worked on multiple units when V10 has picked up shifts at the facility, usually on night shift. V10 could not give the code to disengage the alarm to the stairwell or elevators. On 1/14/2024 at 11:18 AM, surveyor requested all documentation of V10 and V12 (Agency Registered Nurse) orientation and training documents. These documents were not received by the end of the survey. On 1/14/2025 at 1:37 PM, V14 (Regional [NAME] President of Operations) stated that when agency staff pick up shifts at the facility, they are given a verbal orientation of the unit and report. V14 stated that there is not a formal orientation process or competency process that agency staff are given. V14 affirmed that there is no documentation that agency staff are oriented or checked for competency prior to working on the units. V14 stated, this (agency staff orientation and competencies) process is something we need to evaluate for the facility. On 1/15/2025 at 1:50 PM, V2 (Director of Nursing) affirmed that the facility has no documentation of agency staff competency or formal system to ensure agency staff are trained to meet the resident's needs. V2 stated that if agency staff are not trained or competent, they may not provide care at a level that the residents need. Facility policy titled, Staffing undated, documents in part, .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment . (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility assessment (reviewed 10/23/2024) identifies in part that staff need the following competencies to meet the resident's needs, including but not limited to: communication, resident rights, abuse/neglect/exploitation, infection control, antibiotic stewardship, person-centered care, identification of changes in condition, cultural competency, first aid/cardiopulmonary resuscitation, pressure ulcer prevention/treatment, fall prevention and interventions, emergency preparedness, and QAPI.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 45346 Based on observation, interview, and record review the facility failed to ensure two licensed personnel conducted a physical inventory of controlled substances at each change of shift. This failure has the potential to affect 8 residents who are prescribed controlled substances from the 3rd floor medication cart and 6 residents who are prescribed controlled substances from the 4th floor medication cart. Findings include: On 01/14/2025 at 12:10 pm, review of the 3rd Floor medication cart with V15 (RN/Registered Nurse) surveyor observed the controlled substances count verification form for January 2025. The Nurse's Initials Off box was left blank for January 10, 2025 (night shift). The Nurse's Initials On box was left blank for January 13, 2025 (day shift). The Nurse's Initials Off box was left blank for January 13, 2025 (evening shift). On 01/14/2025 at 12:40pm, review of the 4th Floor medication cart with V11(LPN/Licensed Practical Nurse) surveyor observed the controlled substances count verification form for January 2025. The Nurse's Initials Off box was left blank for January 04, 2025 (day shift). The blank spaces on the facility's-controlled substances count verification form indicate the controlled substances were not reconciled at the end and beginning of the shift on the specified days. On 01/14/2025 at 12:15pm V15 (RN/Registered Nurse) stated when the nurse comes on the shift, this nurse counts the number of controlled substances in the medication packs and initials the controlled substances count verification form. V15 stated the nurse going off shift also verifies the count of the controlled substances in the medication packs and initials the controlled substances count verification form indicating the count of controlled substances is correct. On 1/15/2025 at 10:43am V2 (DON/Director of Nursing) stated the controlled substances count verification sheet is used by the nurses to keep track of the narcotics. V2 stated the nurse coming onto the shift is to count the narcotics with the nurse leaving the shift. V2 stated the nurse beginning the shift signs in the nurse initials on box and the nurse ending the shift signs in the nurse initials off box. V2 stated it is my expectation that the nurses are initialing the controlled substances count verification sheets to indicate that the count is correct. Received the facility's undated policy titled Counting Controlled Substances and responding to errors in a controlled substance count via email from V1(Administrator) on 1/15/2025, which documents in part, General Guidelines: Always participate in the counting of controlled substances at the beginning and ending of your shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/15/2025 reviewed the facility's Registered Nurse job description dated 05/02/2017 which documents in part, underneath Essential Duties and Responsibilities: Perform routine charting duties as required & in accordance with established charting & documentation policies & procedures. On 01/15/2025 reviewed the facility's Licensed Practical Nurse job description dated 05/02/2017 which documents in part, underneath Essential Duties and Responsibilities: Perform routine charting duties as required & in accordance with established charting & documentation policies & procedures.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 51772 Based on observation, interview, and record review, the facility failed to administer medications per physician's order for 2 residents (R63 and R379.) The Facility had 2 medication errors out of 25 opportunities resulting in an 8% medication error rate. Findings include: On 1/14/2025 at 9:12 am, observed V2 (Director of Nursing-DON), administer prefilled syringe Enoxaparin Sodium 30 mg/0.3 ml injection to R63's Left Thigh instead of the 20 mg/0.2 ml dosage per physician's order. V2 did not discard 0.1 ml before administering Enoxaparin Sodium injection and administered Enoxaparin 30mg/0.3 ml to Left Thigh. On 1/14/2025 at 1:54 pm, V2 (DON), stated that she believes R63's medication dosage for Enoxaparin Sodium is 30mg or 20mg and that she administered 30 mg of the medication. V2 was asked if she discarded 0.1 ml before administering Enoxaparin Sodium and V2 stated No, I don't think so. V2 stated that administering more than the prescribed dosage of the medication can cause excessive bleeding. V2 stated that when a medication error occurs it must be reported to the DON and Physician and an incident report is written. R63's Physician Order Sheet (POS) documents an order dated 12/13/2024: Enoxaparin Sodium Injection Solution Prefilled Syringe 30MG/0.3ML (Enoxaparin Sodium) Inject 20 mg subcutaneously one time a day for anticoagulant dispose 0.1 ml and administer 20 mg. On 1/14/2025 at 9:26 am, observed V3 (Registered Nurse-RN) preparing 1 tablet of Acetaminophen 500 mg to be administered to R379. V3 (RN) showed a house stock of Acetaminophen 500 mg tablets and stated that R379's order is actually 325 mg of Acetaminophen for pain. V3 administered 325 mg 1 tab by mouth to R379. On 1/14/2025 at 1:41 pm, V3 (RN) stated R379 has an order for Acetaminophen 325 mg. V3 provided R379's POS which excludes an order for Acetaminophen 325mg. V3 (RN) stated that R379 had an order for Acetaminophen yesterday, so he was just following the order from yesterday. V3 stated that all orders for Acetaminophen had been discontinued and there were no standing orders for Acetaminophen at the time of administration of the medication to R379. Facility presented a policy titled Medication Administration General Guidelines undated which documents: FIVE RIGHTS - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered. A triple check of these 5 Rights is recommended at three steps in the process of preparation of a medication for administration: (1) when the medication is selected, (2) when the dose is removed from the container, and finally (3) just after the dose is prepared and the medication put away. a) Check #1: Select the Medication - label, container and contents are checked for integrity, and compared against the medication administration record (MAR) by reviewing the 5 Rights. b) Check #2: Prepare the dose - the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. c) Check #3: Complete the preparation of the dose and re-verify the label against the MAR (Medication Administration Record) by reviewing the 5 Rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145591	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/16/2025
NAME OF PROVIDER OR SUPPLIER: Aperion Care Wesley		STREET ADDRESS, CITY, STATE, ZIP CODE: 1415 West Foster Avenue Chicago, IL 60640	

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on observation, interview and record review, the facility failed to ensure that residents were free of serious medication errors. This failure affects 1 resident (R328) in a sample of 49. Findings include: Record review of R328's admission record documents in part R328 has the following diagnoses including, but not limited to: osteomyelitis, sepsis, paraplegia, neuromuscular dysfunction of bladder, and colitis. Record review of R328's Brief Interview of Mental Status (BIMS) assessment dated [DATE], documents in part that R328 has a BIMS summary score of 15, indicating that R328 is cognitively intact. Record review of R328's medication administration record documents in part that R328 has active orders for Ampicillin 12 g in 0.9% normal saline Use 12 gram intravenously one time a day for sepsis until 01/20/2025 23:59 ampicillin 12g in 0.9% NSS 500ml daily in continuous pump, and Vancomycin HCl Intravenous Solution 1500 MG/300ML (Vancomycin HCl) Use 1500 mg intravenously every 8 hours for Osteomyelitis until 01/20/2025 23:00. Additionally, the record documents that Vancomycin should be administered at 01:00 AM, 9:00 AM and 5:00 PM. On 1/13/2025 at 11:37 AM, observed R328 sitting upright in a wheelchair with a double lumen peripherally inserted central catheter (PICC) line to R328's right upper arm. An IV (intravenous) pole with a bag containing approximately 500 milliliters (mL) labeled Ampicillin 12 grams in 500 mL of 0.9% sodium chloride (normal saline) was observed to the right of R328 with the IV line disconnected from R328. The directions on the bag of Ampicillin stated, infuse intravenously at 41.7 ml/hr (hour) over 24 hours. R328 stated that the medication on the IV pole was antibiotics and explained that R328 has multiple pressure ulcers that became infected, causing R328 to become septic and needing nursing home level of care. R328 stated that R328 does not get prescribed antibiotics regularly because the facility does not have enough nursing staff to run R328's IV medication. R328 stated that R328 feels that R328's wounds have had delayed healing because R328 does not get antibiotics regularly. On 1/13/2025 at 11:50 AM, V2 (Director of Nursing) entered the room and observed the ampicillin not connected or being administered to R328. V2 affirmed that the ampicillin should be running and the ampicillin gets stopped when (R328) gets vancomycin. When V2 was asked why the ampicillin wasn't running V2 stated, we had some staffing issues this morning and a nurse called off. V2 explained that the ampicillin and vancomycin were being given for R328's osteomyelitis and would check the medication administration record and administer the ampicillin. V2 left the room without administering the ampicillin. On 1/13/2025 at 12:30 AM, V2 entered R328's room and flushed both lumens of R328's PICC line with 10 mL of normal saline (indicating patency to both lumen). V2 began administering vancomycin 1500 mg mg/400 mL through R328's PICC line (administered 3 hours late). V2 affirmed that once the vancomycin was completed, that V2 would connect R328 to the ampicillin and continue the infusion. V2 left the room without infusing the ampicillin. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/13/2025 2:50 PM, observed V10 (Agency Licensed Practical Nurse) in R328's room and the bag of ampicillin at 500 mL. V10 stated that R328's Vancomycin IV had been completed and V10 was going to find a registered nurse to administer the ampicillin. V10 was unaware if the ampicillin was supposed to be continuously infusing. On 1/14/2025 at 12:10 PM, observed R328 lying in bed. A 500 mL bag (with 500 mL of fluid) labeled ampicillin 12 g was noted on R328's IV pole and not connected to R328. R328 stated that R328 had not been administered the ampicillin on 1/14/2025. On 1/15/2025 at 11:09 AM, observed R328 lying in bed. A 500 mL bag (with 500 mL of fluid) labeled ampicillin 12 g was noted on R328's IV pole and not connected to R328. An IV bag labeled for vancomycin with an unidentifiable amount of liquid (small amount) was affixed to the IV pole and infusing to R328's PICC line. R328's infusion pump was heard alarming. R328 stated that the ampicillin was disconnected while the vancomycin was running. On 1/15/2026 at 1:06 PM, V22 (Registered Pharmacist) stated that V22 had reviewed the physician's orders for R328. V22 stated that Ampicillin can be administered continuously over 24 hours for the indication of osteomyelitis/sepsis. V22 stated, As ordered, (R328's) ampicillin should be continuously infusing over 24 hours. Ampicillin and Vancomycin are compatible and can be ran through the same PICC line as long as (R328) has multiple lumens. The facility should not be stopping the ampicillin to administer the vancomycin. If medications are not given, or not given on time, a general adverse effect could be delayed healing, microbial resistance, or persistent infection. Facility policy titled Medication Administration General Guidelines (undated) documents in part, .Medications are administered as prescribed in accordance with good nursing principles and practices . 6. FIVE RIGHTS - Right resident, right drug, right dose, right route and right time are applied for each medication being administered . Medications are administered within 1 hour before or after scheduled time, except before, with or after meal orders which are administered based on mealtimes .

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 45346 Based on observation, interview and record review the facility failed to ensure: three medication carts out of the three medication carts reviewed were free of loose tablets, insulin pens that were dated with an open date and the temperature was properly logged for two of the three medication storage refrigerators reviewed. This deficient practice has the potential to affect 24 residents on the fourth floor, 23 residents on the third floor and 11 residents on the 2nd Floor [NAME] (East Wing) who receive medications from the medication carts and units. Findings include: On 01/14/ 2025 at 11:37am inspected the 3rd Floor medication cart with V15 (RN/Registered Nurse). The following was observed: V15 pulled 5 loose white tablets, 3 loose yellow tablets, and 1 loose white capsule from the second drawer of the 3rd floor medication cart. On 01/14/2025 at 12:24pm inspected the 4th Floor medication cart with V11 (LPN/Licensed Practical Nurse). The following was observed: V11 pulled 1 loose pale pink tablet, 2 loose orange tablets, 20 loose white tablets, 2 loose green tablets, 5 loose pink tablets, and 1 loose gray tablet from the second drawer of the 4th floor medication cart. On 01/14/2025 at 1:23pm inspected the 2nd Floor [NAME] East Wing medication cart with V16 (LPN/Licensed Practical Nurse). The following was observed: V16 pulled 5 loose white tablets, 1 loose orange tablet, and 1 loose green tablet from the second drawer of the 2nd floor [NAME] East wing medication cart. On 01/14/ 2025 at 11:37am inspected the 3rd Floor medication cart with V15 (RN/Registered Nurse). The following was observed: two insulin pens with no date documented indicating when the insulin pen was opened. Each insulin pen was inside a plastic bag with a label on the bag, the label documented in part, High Alert Refrigerate until opened, once opened store at room temperature for 28 days. Date opened________. Observed no date on the plastic bag containing the insulin pen or the pen itself. On 01/14/2025 at 11:40am inspected the 3rd floor medication storage refrigerator with V15(RN/Registered Nurse). The following was observed: the 3rd floor unit medicine refrigerator temperature log was missing documentation of a temperature for the following dates 1/6/25, 1/7/25, 1/8/25, 1/9/25, and 1/10/25. On 01/14/2025 at 12:30pm inspected the 4th floor medication storage refrigerator with V11(LPN/Licensed Practical Nurse). The following was observed: the 4th floor unit medicine refrigerator temperature log was missing documentation of a temperature for the following dates 1/1/25, 1/8/25, 1/8/25, and 1/11/25. On 01/14/2025 at 1:30pm V16 (LPN/Licensed Practical Nurse) stated the nurse on each shift is responsible for cleaning the medication cart. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 1/14/2025 at 12:31pm V11 (LPN/Licensed Practical Nurse) stated the nurse is responsible for obtaining and documenting a temperature for the medication storage refrigerator in the nurse's station. On 1/15/2025 at 10:43am V2 (DON/Director of Nursing) stated the nurses are responsible for checking the temperature in the refrigerators used to store medications. V2 stated the temperature is usually checked by the overnight nurse. V2 stated the temperatures in the refrigerators used to store medications should be checked once a day. V2 stated it is my expectation that the nurses document a temperature on the temperature log once the temperature in the refrigerator is checked. V2 stated the purpose of maintaining a proper temperature is because certain medications need to be at a certain temperature. V2 stated the nurses are responsible for cleaning the medication carts. V2 stated the medication carts are to be cleaned as needed. V2 stated there should not be any loose tablets in the bottom of the drawers of the medication cart. V2 stated the insulin pens are to be dated when the pen is opened. V2 stated the date the pen was opened can be placed on the pen itself or on the bag the insulin pen was contained in. On 1/15/2025 reviewed facility's undated policy titled Storage of Medications which documents in part, Underneath Procedures 8. Medication storage areas are kept clean, well-lit, and free of clutter and extreme temperatures and humidity. Underneath Temperature 3. Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 degrees Celsius and 8 degrees Celsius with a thermometer to allow temperature monitoring. 5. The facility should maintain a temperature log in the storage area to record temperature at least once a day. Underneath Expiration Dating 5. When the original seal of manufacturer's container or vial is initially broken, the container or vial will be dated. a) The nurse shall place a date opened sticker on the medication and enter the date opened.

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F 0813

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Have a policy regarding use and storage of foods brought to residents by family and other visitors.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 50662

Based on observation, interview and record review, the facility failed to properly log refrigerator temperatures for resident's personal refrigerators for 6 residents (R11, R42, R49, R56, R57 and R74). This failure has the potential to affect all 6 residents reviewed for safety of personal food items, in a total sample size of 49 residents reviewed.

Findings include:

On [DATE] at 11:23am R57's refrigerator observed with no temperature log and no thermometer inside R57's refrigerator.

On [DATE] at 11:32am R11's refrigerator observed with refrigerator log dated ,d+[DATE] with missing check dates. R11 had no additional refrigerator logs for any date beyond ,d+[DATE] including ,d+[DATE].

On [DATE] at 11:37 R42's refrigerator observed with refrigerator log dated June with missing check dates. R11 had no additional refrigerator logs for any date beyond June including ,d+[DATE].

On [DATE] at 11:43am V10 (Licensed Practical Nurse/LPN) stated that R11, R42 and R57 did not have refrigerator temperature logs for [DATE].

On [DATE] at 1:51pm V2 (Director of Nursing/DON) stated that resident refrigerator temperature logs should be checked daily and that the inside of the refrigerator should be cleaned every three days. V2 stated that if the resident's refrigerators are not checked, then food could spoil, and a resident could get food poisoning.

Facility's policy dated ,d+[DATE] titled Compact Refrigerator-Resident Rooms, documents in part, Purpose: The facility will ensure that all refrigerators in resident rooms meet the appropriate safety and infection control pursuant to State and Federal regulations .Procedure: 1. Every refrigerator must have a thermometer for ancillary services to monitor proper fridge temps daily .5. Housekeeping will clean the interior and exterior of the refrigerator on a daily basis and annotate it on the log sheet .7. Housekeeping supervisor will spot check on a daily basis for thermometers, cleanliness and dates on food .8. Supervisor will check all refrigerators on a weekly basis and annotate inspection on a log sheet.

41611

On [DATE] at 11:51am surveyor observed R74's personal refrigerator without a temperature log for [DATE]; partially completed temperature log was for [DATE] was displayed. Surveyor also observed the thermostat sitting on top of the refrigerator inside of inside of the refrigerator.

On [DATE] at 11:57am surveyor observed R56's personal refrigerator with a partially completed temperature log for [DATE]; there was no temperature log for [DATE]. There was an unopened carton of 2% milk dated [DATE] in the refrigerator.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:10am V8 (Certified Nursing Assistant) said, Oh no, that (referring to the unopened 2% milk carton on the door inside of the refrigerator) says [DATE] and is expired. I will throw that out. V8 stated R56's son is responsible for documenting the date on the log and I don't see a date but it's for the month of [DATE]. On [DATE] at 12:28pm V5 (Registered Nurse) stated the nurses and CNAs are supposed to update the refrigerator log, daily, on the third shift and we (nursing staff) are responsible for changing the log and documenting the temperature from the refrigerator. V5 stated the thermostat should be inside of the fridge to regulate the temperature and make sure the refrigerator is functioning and we are to make sure there is no expired food. On [DATE] at 12:37pm surveyor observed R49's personal refrigerator with no temperature log at all, but the refrigerator was stocked with a container of french onion dip and Pepsi. On [DATE] R49 stated she did not know there was supposed to be a refrigerator log. On [DATE] at about 10:15am V4 (Registered Nurse) stated that the nurse's and CNAs on the third shift are responsible for maintaining the resident's personal refrigerator log, but other shift nurses and CNA's help also. On [DATE] at 1:55pm V2 (Director of Nursing) stated housekeeping staff is responsible for checking and maintaining resident's personal refrigerator. On [DATE] at 2:33pm V19 (Housekeeping Director) stated my staff is responsible for cleaning the resident's personal refrigerators only and does not maintain temperature logs. V19 stated the nurses are responsible to maintain the temperature logs. Undated policy titled Food Brought in By Family or Visitors Personal Refrigerators documents, in part, personal refrigerator temperatures are maintained at 41 degrees Fahrenheit or below and perishable foods are discarded on the sixth day after preparation/opening or on the expiration date. Undated policy titled Older Adults and Food Safety policy documents, in part, keep it safe, use a refrigerator/freezer thermometer to check temperatures.

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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. 50728 Based on interview and record review, the facility failed to ensure the facility's facility assessment was developed with input from the resident's family members; failed to identify staffing needs per unit within the facility; failed to update the facility assessment as new needs arise; and failed to list average daily census. These failures have the potential to affect all 87 residents that reside within the facility. Findings include: Record review of facility census documents in part that 87 residents reside in facility. Record review of facility assessment (reviewed 10/23/2024) staffing plan documents in part that on average, 5 licensed nurses are needed on every shift, on average 11 certified nursing assistants are needed on day shift and evening shift, and Other (department heads, quality assurance nurse, ancillary staff in maintenance, housekeeping, dietary, laundry, etc. Customize to the staffing of your facility 1 Director of Nursing, 1 Night weekend supervisor, 1 MDS coordinators, 1 Restorative Nurse. The facility assessment also indicates that the facility has 2 specialty units, a memory care unit and a short stay unit. The facility assessment does not indicate the following: the average daily census, the amount of nursing and ancillary staff needed per unit per shift, any input from resident family members in the development of the facility assessment, a specific member from the facility's governing body (Aperion Care Corporate Compliance). The facility assessment documents that this was reviewed with V1 (Administrator). The facility assessment also does not identify that the facility needs a wound care nurse or an assistant director of nursing. On 1/14/2025 at 1:30 PM, V1 stated that the regional team (V14, Regional Director of Operations and V21, Regional Nurse Consultant) would be able to better answer questions about the facility assessment. On 1/14/2025 at 1:37 PM, V14 stated that V14 participates in the development of the facility's assessment. V14 stated that the resident's family members were not involved in development of the facility assessment and was unsure if that was a requirement. V14 reviewed the facility assessment and affirmed that the staffing needs are not broken down by unit. V14 stated that the facility has identified and is currently hiring for an assistant director of nursing and a wound care nurse. Record review of facility assessment tool (undated) documents in part, .The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Use this assessment to make decisions about your direct care staff needs as well as your capabilities to provide services to the residents in your facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being .Guidelines for Conducting the Assessment .1 . Facilities are encouraged to seek input from residents, their representatives(s), or families, and consider that information when formulating their assessment .3. The facility must update this assessment annually or whenever there is/the facility plans for any change that would require modification to any part of this assessment .

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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** 41611 Based on observation, interview, and record review the facility failed to properly don PPE (personal protective equipment) upon entering the room of one resident (R71) on isolation precautions, failed to provide waste bins to properly dispose of PPE for 3 residents (R49, R52 and R65) on isolation precautions, and failed to monitor the measures the facility has in place to prevent the growth of Legionella and other opportunistic waterborne pathogens in the facility's water systems. These failures have the potential to affect all 87 residents residing in the facility reviewed for preventing the spread of microorganisms in the facility when reviewed for infection control. Findings include: Facility census, dated 1/13/25, documents 87 active residents. Facility's policy titled, Infection Prevention and Control Program, has a revised date 11/28/17 and the Reviewed/ Approved by: section is blank. R71 has a diagnosis of but not limited to Displaced Intertrochanteric Fracture of Left Femur, Subsequent Encounter for Closed Fracture with Routine Healing, Encounter for Other Orthopedic Aftercare, Abnormal Posture, Pressure Ulcer of Left Heel, Unstageable. R71's Brief Interview of Mental Status score is 13 whioch indicates R13 is cognitive. R71 is on Enhanced Barrier Precautions. R71's Order Summary Report with active orders as of 1/15/2025 documents, in part, Enhanced Barrier Precautions related to wounds. R49 has a diagnosis of but not limited to Acute Metabolic Acidosis, Cor Pulmonale, Influenza due to Identified Novel Influenza A Virus and Plasma-Protein Metabolism. R49's Order Summary Report with active orders as of 1/15/2025 documents, in part, Contact and Droplet Precautions due to Influenza A Positive (1/4/025). On 1/13/2025 at 11:58am surveyor observed an Enhanced Barrier Precaution sign on R71's door, but there was no PPE (Personal Protective Equipment) bin outside of the room. Surveyor also observed that there was no separate garbage specifically to doff PPE. On 1/13/2025 at 12:03pm surveyor observer Droplet and Contact Precautions signs on R49's door but there was no PPE bin outside of the room. On 1/13/2025 at 12:28pm V5 (Registered Nurse) stated the PPE is located in the container, attached to the wall, by the nurse's station and stated staff are not to walk down the halls with PPE on outside of the room. On 1/13/2025 at 12:37pm surveyor observed that R49 had no PPE disposal bin inside of her room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/14/2025 at 11:55am surveyor observed V2 (DON) and V13 (Wound Care tech/CNA) donning PPE inside of R71's room. V2 asked V13 did she bring a gown in for her too? On 1/15/2025 at 1:55pm V2 stated PPE should be donned prior to entering a resident's room because the area is considered a clean space. On 1/16/2025 at 11:01am via email V2 stated the adverse effects that can result from donning PPE inside of the resident's room before providing care is the transfer of pathogens (MDRO) which will increase the risk of infection and the purpose of enhanced barrier precautions is to reduce the transmission of (MDRO) to high-risk residents. 49572 On 1/15/25 at 1:49pm, when asked when the facility's Infection Prevention and Control Program, was last reviewed, V2 (Infection Preventionist/Director of Nursing/DON) replied, I'm not sure. I'll have to check. V2 never provided the date when the facility's Infection Prevention and Control Program was last reviewed. Email from V14 (Regional [NAME] President of Operations), dated 1/15/25 at 5:37pm, documents, in part, We do not have any recent testing. Please find our water system management - legionella . Attached was the facility's policy titled, Water Management Program for Prevention of Legionella Growth, revision date 5/17/24. Facility policy titled, Water Management Program for Prevention of Legionella Growth, revision date 5/17/24, documents, in part, Purpose: To identify and reduce the risk of Legionella growth and spread. Definition: Legionella is found naturally in [NAME] environments, like lakes and streams, but generally the low amounts in [NAME] do not lead to disease. Legionella can become a health problem in building water systems . Preventative maintenance will be performed as applicable: The following will be verified and documented at least once weekly: Thermostat indicating the temperature of water entering the circulating system at the mixing valve is 120F or above. Weekly sanitizing of medical devices such as CPAP. Email from V1 (Administrator), dated 1/16/25 at 11:23am, documents, in part, 1. Weekly thermostat readings indicating the temperature of water entering the circulating system at the mixing valve, we do not have a log for this. 2. Weekly sanitizing of medical devices such as CPAP. We do not have a log for this. On 1/15/25 at 3:53pm, when asked for the documentation regarding the facility's water management program for Legionella, V1 (Administrator) replied, I don't think the water supply has been tested for it (Legionella). It (water supply) should be tested yearly. It (Legionella) is a deadly disease. Residents can get sick and die. On 1/15/25 at 1:49pm, V2 (Infection Preventionist/Director of Nursing/DON) said, There should be bins in the rooms for residents on isolation so the staff can throw out the PPE (personal protective equipment) after use. I ordered them, but you guys are here before the order came in. It prevents infection from spreading. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Aperion Care Wesley		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 West Foster Avenue Chicago, IL 60640	

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility's policy titled, Infection Prevention and Control Program, revised date 11/28/17, To comply with a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement . 1. The facility has established an Infection Control Program which addresses all phases of the organization's operation to reduce or prevent the risks of nosocomial infections in residents and health care workers . 5. All infection control policies and procedures will be reviewed annually by the Quality Assurance Committee and revised as needed. Department Heads are responsible for assuring personnel are made aware of all revisions to respective policies and procedures . Scholarly article from CDC (Center for Disease Control and Prevention) titled, Developing a Water Management Program to Reduce Legionella Growth & Spread in Buildings A PRACTICAL GUIDE TO IMPLEMENTING INDUSTRY STANDARD, dated June 24, 2021, documents, in part, Factors that might make testing for Legionella more important include: being a healthcare facility that provides inpatient services to people who are at increased risk for Legionnaires' disease . Patients with severe pneumonia, in particular those requiring intensive care . Immunocompromised patients with pneumonia . Patients at risk for Legionnaires' disease with healthcare-associated pneumonia (pneumonia with onset ?48 hours after admission) https://www.cdc.gov/control-legionella/media/pdfs/toolkit.pdf Facility policy titled, Enhanced Barrier Precautions, revised date 5/7/24, documents, in part, To reduce risk of transmitting multidrug-resistant organisms (MDRO) and targeted MDRO when contact precautions do not apply for residents identified as higher risk. Enhanced Barrier Precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. The facility should ensure PPE and alcohol-based hand rub are readily accessible to staff. Discretion may be used in the placement of supplies which may include placement near or outside the resident's room. Facility policy titled, Infection Precaution Guidelines, revised date 5/15/23, documents, in part, It is the policy of this facility to, when necessary, prevent the transmission of infections within the facility through the use of Isolation Precautions. Facility policy titled, Resident Rights, reviewed date 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability. 51772 On 1/13/2025 at 10:13 AM, surveyor observed Enhanced Barrier Precautions sign on R52 ' s door. On 1/13/2025 at 10:15 AM, observed R52's room without garbage cans to dispose of Proper Personal Equipment when exiting a positive COVID-19 resident's room. On 1/13/2025 at 10:21 AM, V3 (Registered Nurse) stated that the staff disposes the Personal Protective Equipment in the garbage can down the hall and that PPE from a positive COVID-19 patient is disposed of before we leave the resident's room. V3 stated that improper disposal of PPE can result in an outbreak of COVID-19. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 1/15/2025 at 2:39 pm, V2 (DON) provided a document dated 11/17/17 titled Medical Waste Disposal. V2 state that the facility only has a policy for medical waste and does not have a policy for disposal of COVID-19 medical waste that uses red bags. Per face sheet R52's active medical diagnosis includes COVID-19. On 01/13/2025 at 10:28 AM, surveyor observed Enhanced Barrier Precautions sign on R65 ' s door. On 1/13/2025 at 10:28 AM, observed R65's room without garbage cans to dispose of Proper Personal Equipment when exiting a positive COVID-19 resident's room. On 1/13/2025 at 10:29 AM, V3 RN stated that R65 is positive of COVID-19.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. 49572 Based on interview and record review, the facility failed to follow policies and procedures for immunization of residents against pneumococcal disease in accordance with national standards of practice. The facility failed to vaccinate eligible residents with the pneumococcal vaccine. The facility failed to document the refusal and/or the benefits and side effects in the resident's electronic medical records. This deficient practice affected 3 residents (R1, R17 and R74) reviewed for pneumococcal immunizations in a total sample size of 49 residents. Findings include: Review of records for R1, R17 and R74 from admitted to 1/14/25 and there were no findings of documentation of pneumococcal vaccine offering or education of the vaccine. Review of physician orders for R1, R17 and R74 from admission to 1/14/25 show no orders of pneumococcal vaccination. Immunization records for R1, R17 and R74 have no current pneumococcal vaccination listed. On 1/15/25 at 1:27pm, V21 (Regional Nurse Consultant) said that the facility hasn't had a pneumococcal vaccine clinic. Only Influenza vaccines have been administered. On 1/15/25 at 1:49pm, V2 (Infection Preventionist/Director of Nursing/DON) was unable to produce a list of residents that the facility had given the pneumococcal and COVID-19 vaccines to. V2 said, I do not have any documentation that (R1, R17 and R74) received or declined the pneumococcal or COVID-19 vaccine. Facility haven't had pneumonia or COVID-19 clinics since I've been here. They've (pneumonia and COVID-19 clinics) been booked. I've been here since April (April 2024). Pneumonia and COVID-19 vaccines are important to prevent infection and a facility breakout. V2 stated that the COVID-19 and pneumococcal vaccines should be offered on admission, if eligible, and the resident has the right to decline. V2 stated that if the resident declines the vaccine, the refusal should be documented in the EMR (electronic medical record) as well. When asked if vaccination education should be provided to the resident prior to offering the COVID-19 and pneumococcal vaccines, V2 replied, Yes. Facility's policy titled, Influenza and Pneumococcal Immunizations, revised date 4/21/2022, documents, in part, To minimize the risk of resident's acquiring, transmitting, or experiencing complications from influenza and pneumococcal pneumonia. The facility shall provide pertinent information about the significant risks and benefits of vaccines to residents (or resident's legal representative) . Before offering the pneumococcal immunization, each resident or the resident's representative will be provided education regarding the benefits and potential side effects of the immunization. The resident's medical record includes documentation that indicates, at a minimum, the following: The resident either received or did not receive the pneumococcal immunization due to medical contraindications or refusal. Facility policy titled, Resident Rights, reviewed date 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.

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F 0887

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Many

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.

49572

Based on interview and record review, the facility failed to follow policies and procedures for immunization of residents against COVID-19 in accordance with national standards of practice. The facility failed to vaccinate eligible residents with the COVID-19. The facility failed to document the refusal and/or the benefits and side effects in the resident's electronic medical records. This deficient practice affected 3 residents (R1, R17 and R74) reviewed for COVID-19 immunizations in a total sample size of 49 residents and has the potential to affect all eligible residents that reside at the facility. This deficient practice has the potential to affect all 87 eligible residents that reside at the facility.

Findings include:

Review of records for R1, R17 and R74 from admitted to 1/14/25 and there were no findings of documentation of COVID-19 vaccine offering or education of the vaccine. Review of physician orders for R1, R17 and R74 from admission to 1/14/25 show no orders of COVID-19 vaccination. Immunization records for R1, R17 and R74 have no current COVID-19 vaccination listed.

On 1/15/25 at 1:49pm, V2 (Infection Preventionist/Director of Nursing/DON) was unable to produce a list of residents that the facility had given the pneumococcal and COVID-19 vaccines to. V2 said, I (V2) do not have any documentation that (R1, R17 and R74) received or declined the pneumococcal or COVID-19 vaccine. (facility) hasn't had pneumonia or COVID-19 clinics since I've been here. They've (pneumonia and COVID-19 clinics) been booked. I've been here since April (April 2024). Pneumonia and COVID-19 vaccines are important to prevent infection and a facility breakout. V2 stated that the COVID-19 and pneumococcal vaccines should be offered on admission, if eligible, and the resident has the right to decline. V2 stated that if the resident declines the vaccine, the refusal should be documented in the EMR (electronic medical record) as well. When asked if vaccination education should be provided to the resident prior to offering the COVID-19 and pneumococcal vaccines, V2 replied, Yes.

Facility's policy titled, COVID-19 Vaccination Guidelines- Residents and Employees, revised date 12/09/24, documents, in part, To minimize the risk of resident's acquiring, transmitting, or experiencing complications from SARS-CoV-2 (COVID-19). The facility shall provide pertinent information about the significant risks and benefits of vaccines to residents (or resident's legal representative) . Before offering the COVID-19 vaccine, each resident or the resident's representative will be provided education regarding the benefits and risks and potential side effects of the COVID-19 vaccine. The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; Each dose of the COVID-19 vaccine administered to the resident, or If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy titled, Resident Rights, reviewed date 1/04/19, documents, in part, Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. A resident, even though determined to be incompetent, should be able to assert these rights based on his or her degree of capability.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. 49572 Based on observation, interview and record review, the facility failed to clean the dryer lint screen thoroughly to provide a safe environment for the residents. This failure has the potential to affect all 87 residents at the facility. Findings include: On 1/15/25 at 10:15 am, V1 (Administrator) said, the Laundry Manager (V19) is busy with Life Safety, but I know laundry and can answer any questions for you. On 1/15/25 at 10:45 am, this surveyor, with V1 (Administrator) observed 2 dryers in the laundry room. Dryer #1 was not in use but did have linen inside it. Dryer number 2 had just finished while V1 and this surveyor were present. This surveyor requested V1 (Administrator) to open the lint compartment dryer #1. The lint compartment floor was clean however the lint screen was fully covered with lint. This surveyor requested V1 (Administrator) to open the lint compartment dryer #2. The lint compartment floor had loose lint on the floor and the lint screen was fully covered with lint. On 1/15/25 at 10:52am, V1 (Administrator) stated the dryer lint traps should be cleaned out daily so the linen can be properly dried and to prevent the lint from catching fire. V1 said that the employees in laundry are responsible for cleaning out the lint traps. On 1/15/25 at 12:31pm, V20 (Laundry Aide) said, I clean out the lint traps. Normally, I clean them out when I come in because when I leave for the day there is usually a load in there. The purpose for cleaning out the lint traps is to not start a fire and also not to accumulate a bunch of dust and dirt. I did not clean them (lint traps) out this morning cause I was late and rushing. Facility policy titled, Section: Laundry Services/Maintenance Subject: Safety Procedures or Dryers in Laundry Department, dated 2/09/2024, documents, in part, Purpose: To Staff and equipment from possible fires. 1. Clean lint screens can be maintained at least every 3 loads or every 2 hours by the laundry personnel. (Whichever comes first) 2. Always keep the motor vents free from lint. This is the responsibility of the maintenance department to be done weekly. 2. Cleaning lint screens according to the schedule. Facility job description titled, Laundry Aide, documents, in part, Remove . lint . from equipment . Facility job description titled, Administrator, dated 5/2/17, documents, in part, The Administrator directs the day to day functions of the facility in accordance with the federal and guidelines, standards, and regulations that govern the nursing facilities to assure that the highest degree of quality care can be provided to our residents at all times . Ensure that a11 facility personnel, residents, and visitors follow established safety regulations to include fire protection/prevention, smoking regulations, infection control etc. Ensure that the facility is maintained in a clean and safe manner for resident comfort and convenience by assuring that necessary equipment and supplies are maintained to perform such duties/services.