STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145607	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Palos Heights	7850 West College Drive Palos Heights, IL 60463

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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 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** Based on observation, interview, and record review the facility failed to follow policy procedures and failed to review/revise a comprehensive care plan for one of 53 residents (R64) in the sample reviewed for restorative care. Findings include:R64 was admitted to the facility on [DATE] (almost 2 years ago). The (undated) facility splints/brace/prosthetic log includes R64's name. However R64's comprehensive care plan (received 9/16/25) excludes splints, brace and/or prosthetics. On 9/15/25 at 12:02pm, R64's hands were noted to be severely contracted however splints were not in use. Surveyor inquired if R64 uses hand splints R64 affirmed that she does. On 9/17/25 at 12:27pm, surveyor inquired if R64 uses a restorative device V4 (Restorative Nurse) stated, She (R64) has a left palm protector. Surveyor inquired why R64's restorative device was excluded from the comprehensive care plan (received 9/16/25). V4 responded, It's in there. V4 accessed R64's care plan (via EMR/Electronic Medical Records) which states, I am on a splint program. However, this was not included in the care plan received. Surveyor inquired when R64's splint program was added to the care plan. V4 accessed the history on the EMR (as requested) which affirms this was not initiated until 9/16/25. The care plan policy (revised 6/30/25) states the baseline care plan at minimum should include initial goals based on admission orders, physician orders, dietary orders, and therapy services. After the comprehensive assessment (state/federal required MDS) is completed, the facility will put in place person-centered care plans outlining care for the resident within 7 days. These will be periodically reviewed and revised by a team of qualified person after each assessment.

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

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure staff were aware they cannot borrow resident medications to give to other residents, failed to ensure residents were made aware when prescribed medications were not administered, failed to ensure that (over the counter) prescribed medication was purchased/available, and/or failed to ensure that medications were administered within regulatory requirements for four of 53 residents (R61, R85, R119, R154) in the sample. Findings include:R119's (9/16/25) Physician Orders include Guaifenesin-DM (Dextromethorphan) every 6 hours for cough/congestion for 2 days. On 9/15/25 at 8:49am, V15 (Registered Nurse) dispensed R119's medications however Guaifenesin (house stock) was dispensed. Surveyor inquired if Guaifenesin-DM (prescribed medication) was available. V15 searched the medication cart to no avail and replied, No. On 9/16/25 at approximately 11:00am, V2 (Director of Nursing) affirmed that the facility does not have Guaifenesin (expectorant) with DM (cough suppressant) so the Physician was contacted and changed R119's orders to Guaifenesin which is available [The DM was prescribed for R119's cough - per order].__On 9/15/25 at 10:15am, V3 (LPN/Licensed Practical Nurse) reviewed R154's EMAR (Electronic Medication Administration Record) as requested and stated, I haven't given her (R154) meds yet. Surveyor inquired when R154's am medications are scheduled. V3 responded, We do early morning passes at 7:30am and then the window closes at 10:30am (3 hours later). It gives us (staff) until 10:30 before it turns red, that's something new that we (facility) started about a week ago. Surveyor inquired about regulatory requirements for medication administration. V3 replied, We (staff) have the 3-hour gap, they (facility) changed the (EMAR), we have until 10:30am for them (resident's) to receive the medications. Surveyor inquired about the regulatory requirement for medications scheduled for 7:30am administration, V3 stated, Usually it's an hour before and an hour after. Surveyor subsequently requested to see the EMAR for all of V3's assigned residents R61 and R85 were noted to be highlighted red (indicating late administration). Surveyor inquired if R61's medications (scheduled for 7:30am administration) were administered. V3 responded, She (R61) got her blood sugar but not her medication. Surveyor inquired if R85 received medications (scheduled for 7:30am administration). V3 replied, She (R85) got all her medications except the Allopurinol, I have to check the (Electronic Medication Dispenser) for that one. On 9/15/25 at approximately 10:20am, surveyor inquired about the regulatory requirement for medication administration. V4 (Nurse Supervisor) stated, Hour before, hour after. On 9/15/25 at 10:50am, surveyor inquired if medications were administered this morning. R85 stated, Yes, I just take whatever they give me. Surveyor inquired if R85 was told that she did not receive Allopurinol this morning (as prescribed). R85 responded, No. On 9/16/25 at 10:57am, surveyor inquired about the regulatory requirement for medication administration. V2 (Director of Nursing) stated, It's within the hour. The medication pass policy (revised 7/2/25) states it is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. The (undated) medication administration general guidelines states 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. Medications are administered in accordance with written orders of the prescriber. Medications are administered within 1 hour before or after scheduled time, except before, with or after meal orders, which are administered based on mealtimes unless specified by the prescriber.The (undated) medication administration general guidelines state medications supplied for one resident are never administered to another resident. If a medication cannot be located, the pharmacy is contacted.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview, and record review the facility failed to follow policy procedures, failed to implement care plan interventions, failed to ensure that staff were aware of resident required LALM (Low Air Loss Mattress) settings, failed to ensure that LALM settings were correct while in use, failed to ensure that the LALM device was clean and free of debris, failed to provide a pressure reducing cushion on the wheelchair, failed to ensure that layers of linen were not beneath residents during LALM use, failed to ensure that soiled dressings were changed timely, and failed to ensure that open wounds were covered with a dressing for five of 53 residents (R3, R11, R12, R115, R117) in the sample reviewed for pressure ulcer prevention. Findings include: 1.R11's diagnoses include type II diabetes mellitus, chronic kidney disease/stage 3, and cachexia (muscle wasting). R11's (3/7/25) care plan states resident has unstageable pressure injury to sacrum; intervention apply wound treatment as ordered by the physician. R11's (8/7/25) Physician orders include sacrum: clean with normal saline solution, pat dry, apply collage, and cover with dry dressing daily and as needed. R11's (9/10/25) wound note affirms a (stage 3) sacrum pressure ulcer/injury is present. R11's (9/21/25) functional assessment affirms resident is dependent on staff for toileting hygiene. On 9/15/25 at 11:05am, R11 was wearing an incontinence brief and lying atop of a LALM however a fitted sheet was on the mattress, and a folded sheet (4 additional layers) were beneath the resident. Surveyor inquired what's allowed on the LALM while in use. V4 (Nurse Supervisor) stated, It should be just a sheet. Surveyor inquired how many layers were beneath R11. V4 responded, We (staff) got 5 layers on the low air loss and instructed V5 (Certified Nursing Assistant) to remove the folded sheet. Surveyor inquired about R11's LALM settings (#4). V4 replied, It's on 4 surveyor inquired what 4 indicates. V4 stated, I (V4) would have to talk to the wound care nurse in regard to the setting on the pump and affirmed he was unsure. Surveyor inquired about the dried brown substance observed on R11's LALM device. V4 responded, I can tell you what I see on there, it looks like chocolate pudding to me or maybe a melted candy bar. Surveyor inquired about R11's incontinence care. V5 replied, I (V5) just changed him (R11). Surveyor inquired if R11 has a wound. V5 stated, Yes, his (R11) dressing hasn't been changed yet but I cleaned him and put cream down there. R11's sacrum dressing was soiled with a brown substance and part of the wound was exposed. Surveyor inquired about R11's wound. V4 responded, I see an old opening on his (R11) bottom, it's not covered with a dressing. On 9/17/25 at 9:07am, surveyor inquired what the #4 setting on R11's LALM indicates. V24 (Wound Care Nurse) responded, I'm (V24) really not sure because some of the boxes be different but it should match his (R11) weight. Surveyor inquired who's responsible for setting up the LALM. V24 responded, Maintenance brings the mattress and I wanna say we (Nurses) put the settings on. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/17/25 at 10:16am, surveyor inquired what the #4 setting indicates on the LALM. V25 (Certified Wound Care Nurse) stated, We have 2 types one goes off of the weight, and the other is based on the comfort level. I would have to get the manufacturer guidelines that's all I can tell you at the moment. The specialized mattress and appropriate layers of padding policy (revised 7/3/25) states for low air loss mattress, consider 1 fitted or flat sheet on top of the bed, 1 cloth incontinence pad, and/or 1 absorbent brief to absorb fecal and/or urinary incontinence and help with repositioning. The skin care regimen policy (revised 7/3/25) states it is the policy of this facility to ensure prompt identification, documentation, and to obtain appropriate treatment for residents with skin breakdown. On 9/15/25 at 10:25am during observation of residents in the Activity Room, the following were observed: 2. R117 was observed sitting in the wheelchair without pressure relieving cushion/devices. Again at 11:45am, R117 was still in the wheelchair without cushion. At this time, V19 (RN/Registered Nurse/Agency) was notified and stated that she (V19) is the nurse for R117 and would find a cushion for the resident. V19 added the residents should have cushions on the wheelchair to prevent pressure ulcers. 3. R3 was observed on a Low Air Loss Mattress with a weight setting of 280 pounds. R3's weight records dated 9/11/25 shows 172 pounds. 4. R12 was observed on a Low Air Loss Mattress with a weight setting of 140 pounds. R12's weight records dated 9/6/25 shows 92 pounds. 5. R115 was observed on a Low Air Loss Mattress (LALM) with a weight setting of 160 pounds. R115's weight records dated 9/15/25 shows 104 pounds. On 9/15/25 at 11:55am, all 3 residents' LALMs were observed to still be at the same wrong settings. At this time, V18 (Assistant Director of Nursing) was notified. V18 stated that the weight settings of the LALM should be as close to the resident's weight as possible to function properly to prevent pressure ulcers. V18 called V20 (Wound Care Aide) and V20 went in and changed the settings. V18 later presented the facility's document for staff in-service. This document (with several nursing staff signatures) states Check the weight settings on Low Air Loss Mattress; If unsure, ask Manager or Wound Care. R3's Records show the following: Face sheet shows diagnoses which include but are not limited to Multiple Fractures of Right-Side Ribs. POS (Physician Order Sheet) dated 6/11/25 has an order for Low Air Loss Mattress. Pressure Ulcer Risk assessment dated [DATE] shows that R3 is at risk for pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS (Minimum Data Status) section M dated 6/10/25 states that R3 is at risk of developing pressure ulcers/injuries and should have pressure-reducing device for wheelchair and bed. Care plan dated 3/19/25 states in part: R3 has an actual impairment to skin integrity. Intervention states to use Low Air Loss Mattress and apply Gel Chair Cushion to wheelchair. R12's records show the following: Face sheet shows diagnoses which include but are not limited to Age-Related Osteoporosis and Fracture of Left Femur. POS dated 9/17/25 has an order for Low Air Loss Mattress. Pressure Ulcer Risk assessment dated [DATE] shows that R12 is at risk for pressure ulcer. MDS section M dated 8/31/25 states that R12 is at risk of developing pressure ulcers/injuries and should have pressure-reducing device for wheelchair and bed.Care plan dated 8/28/25 states in part: R12 has an actual impairment to skin integrity. Intervention states to use Low Air Loss Mattress and apply Gel Chair Cushion to wheelchair. R115's records show the following: Face sheet shows diagnoses which include but are not limited to Right Hip Contusion, and Spina Stenosis. POS (Physician Order Sheet) dated 9/17/25 has an order for Low Air Loss Mattress. Pressure Ulcer Risk assessment dated [DATE] shows that R115 is at risk for pressure ulcer. MDS section M dated 7/6/25 states that R115 at risk of developing pressure ulcers/injuries and should have pressure-reducing device for wheelchair and bed. Care plan dated 9/15/25 states in part: R115 is at risk for impaired skin integrity. Intervention states in part: Apply Gel Chair Cushion to wheelchair. R117's records show the following: Face sheet shows diagnoses which include but are not limited to Gout, Osteoarthritis, Left Heel Pressure Ulcer, and Morbid Obesity. Pressure Ulcer Risk assessment dated [DATE] shows that R117 is at risk for pressure ulcer and has a pressure injury to the left heel. MDS section M dated 8/26/25 states that R117 is at risk of developing pressure ulcers/injuries and should have pressure-reducing device for wheelchair and bed. Care plan dated 1/15/25 states in part: Apply Gel Chair Cushion to wheelchair. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's policy titled Skin Care Regimen and Treatment Formulary dated 7/3/25 states in part: It is the policy of this facility to ensure prompt identification, documentation, and to obtain appropriate treatments for residents with skin breakdown. #10C – Prevention: Use of pressure redistribution mattress. Operation Manual for Low Air Loss Mattress machine states that the control knob should be set at the weight of the patient.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that staff were aware of resident required restorative devices, failed to include restorative devices in the care plan, failed to ensure that required devices were included in facility tasks, and failed to ensure that restorative devices were applied as directed for one of 53 residents (R64) in the sample reviewed for restorative care. Findings include:The (undated) facility splints/brace/prosthetic log (received 9/16/25) includes R64's name however which required restorative device - was excluded.R64's comprehensive care plan (received 9/16/25) excludes splints, brace and/or prosthetics. On 9/15/25 at 12:02pm, R64's hands were noted to be severely contracted however splints were not in use. Surveyor inquired if R64 can move her left fingers (which were in a fixed position - almost touching the palm of her hand), however R64 was unable to do so. Surveyor inquired if R64 can move her right fingers (which were angled towards the lateral side of her hand) she was to move the fingers, however unable to bend the knuckles. Surveyor inquired if R64 receives restorative therapy to maintain range of motion for both hands. R64 stated, I (R64) try to do this myself but lately its (referring to her left fingers) bending down. Surveyor inquired if R64 uses hand splints. R64 responded, I thought I would order another one because I can't find the one, I had. Surveyor inquired if R64 requires hand splints. V3/Licensed Practical Nurse (assigned to R64) responded, I would have to check. On 9/15/25 at 2:13pm, surveyor inquired if R64 requires hand splints. V2 (Director of Nursing) stated, I will have to check, I don't remember. The (9/17/25) Nursing Rehab: assistance with splint or brace removal log (also) excludes R64's name. On 9/17/25 at 12:27pm, surveyor inquired if R64 uses a restorative device. V4 (Restorative Nurse) stated, She (R64) has a left palm protector, we (staff) keep that on and monitor for redness. Surveyor inquired how staff are aware of which residents require restorative devices. V4 responded, It's in the tasks (referring to the EMR/Electronic Medical Records). Surveyor inquired if V4's required restorative device was in the tasks. V4 reviewed R64's EMR and replied, I didn't see it in the tasks. Surveyor inquired why R64's restorative device was also excluded from the comprehensive care plan (received 9/16/25). V4 stated, 'It's in there. V4 accessed R64's care plan (via EMR) which states, I am on a splint program however this was not included in the care plan received. Surveyor inquired when R64's splint program was added to the care plan. V4 accessed the history on the EMR (as requested) which affirms this was not initiated until 9/16/25. R64 was admitted to the facility on [DATE] (almost 2 years ago). The restorative nursing program (revised 7/3/25) states it is the policy of this facility to assess for comprehensive nursing and restorative needs upon admission. Nursing and restorative services may include the following: splint/orthotic management. Nursing and restorative services shall be reflected in the resident's individualized care plan. Restorative programs shall be reflected and indicated in the resident's electronic restorative log in order to document the provision of services and the frequency by the nurses, CNAs (certified nursing assistants), and/or restorative aides.

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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** Based on interview and record review, the facility failed to implement fall prevention measures as indicated on the care plan, failed to ensure bed alarms were in use, and failed to ensure residents received adequate supervision to prevent falls and prevent repeated falls. This failure affected 3 residents (R2, R4, R10) reviewed for falls in a sample of 53 residents. This failure resulted in R2 sustaining radial, ulnar, and femoral fractures due to an unwitnessed fall.1. R4's records show the following: R4 had unwitnessed falls on 9/2/25 and on 9/4/25 and was sent to the hospital for each fall. Face sheet shows diagnoses which include but are not limited to Dementia, History of Falling, Anxiety Disorder, Obesity, Encephalopathy, Gout, Polyosteoarthritis, and Leg Pain. MDS section GG dated 8/13/25 states R4 needs assistance for mobility/functional ability. Care plan dated 9/1/25 states R4 is at risk for falls. Intervention states in part to use bed/chair alarm to alert staff when residents attempt to get out of bed unassisted so staff can assist residents and prevent falls. On 9/17/25 at 12:00pm, V8 (Fall Nurse) was asked why resident's falls were unwitnessed if they have bed/chair alarms and staff were alerted when resident attempts to get out of bed. V8 stated staff try to monitor residents more frequently by constantly rounding, especially for residents with Dementia. 2. R10's diagnoses include fracture of right femur (5/3/25) and right artificial hip joint. R10's (8/27/25) BIMS (Brief Interview Mental Status) states resident is rarely/never understood, inattention and disorganized thinking are present/fluctuate. R10's (8/27/25) functional assessment affirms resident requires substantial/maximal assistance with bed to chair transfers. R10's (5/3/25) care plan states resident is at high risk for falls, interventions bed alarm to alert staff when resident attempts to get out of bed unassisted, so staff can assist resident and prevent falls. (9/2/25) Morning shift staff to get resident up early before breakfast. R10's (9/2/25) fall risk evaluation (post fall) determined a score of 16 (high risk). On 9/15/25 at approximately 11:32am, R10 was lying in bed atop of a bed alarm. Surveyor inquired if R10's bed alarm was working. V3 (Licensed Practical Nurse) responded, It works because its constantly beeping. Surveyor requested V3 remove the bed alarm from beneath R10 to determine if it was working. V3 removed R10's bed alarm (as requested) however it was not sounding - as warranted. V3 stated, It's not beeping then inspected R10's bed alarm device and affirmed It's actually off. On 9/16/25 at approximately 2:30pm, V2 (Director of Nursing) affirmed the facility does not have a policy for bed alarms. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/25 at 11:50am, surveyor inquired about R10's fall prevention interventions. V8 (Fall Risk Nurse) stated, He does have a bed/chair alarm, he has a visual prompt in his room to use the call light. I know he's like confused and has intellectual disability. Surveyor inquired about R10's (9/2/25) fall. V8 responded, This happened at 7:30am, the Nurse on Duty was doing rounds after report and observed the resident walking towards the foot of the bed and suddenly fell to his knees on top of the bedside floor mat. (R10) stated he was trying to go to the bathroom, but the CNA (Certified Nursing Assistant) just took him to the bathroom at 7:20am. The doctor ordered x-rays for the bilateral knees and the results came back with no fractures. Surveyor inquired what fall prevention interventions were added to R10's care plan (post fall) to prevent additional falls. V8 replied, We (facility) added for the morning staff to get the resident up in the wheelchair and in the dining room to be monitored however on 9/15/25 at 11:32am R10 was observed lying in bed and R10's care plan excludes monitoring in the dining room – as stated. The fall occurrence policy (revised 6/30/25) states it is the policy of the facility to ensure residents are assessed for risk for falls, interventions are put in place, and interventions are reevaluated and revised as necessary. Those identified as high risk for falls will be provided fall interventions. The interventions will be reevaluated and revised as necessary. 3. On 9/15/2025 at 10:52 AM, observed R2 sitting in a wheelchair in R2's room with V31 (Family Member) at the bedside. R2 was attempted to be interviewed but was unable to answer questioning due to cognitive deficits. V31 (Family Member) stated, You'll have to talk to me, (R2) has dementia and is very impaired mentally. R2 has lost most memories at this point and requires a lot of care and supervision. I don't think the facility has enough staff to supervise (R2), (R2) is constantly getting up if you aren't here with (R2). I spend so much time here (at the facility), this is my (family), I have to take care of (R2). So, I am here all the time trying to keep eyes on (R2) so (R2) doesn't fall again. V31 recalled about a month ago, V31 was visiting in the facility and R2 fell, sustaining a hip fracture. V31 explained V31 was visiting R2 in R2's room for a lot of the day and had left to get R2 ice from the ice machine. When V31 came back, R2 was on the ground in the bathroom and R2's wrist was swollen. The nurse came and checked R2 out and they sent R2 to the ER. The ER diagnosed R2 with wrist and hip fractures. V31 stated, See what I mean? I can't leave (R2) alone here at all; they don't have someone to sit with (R2) and supervise (R2). R2's face sheet documents in part the following diagnoses: unspecified fracture of the right femur, fracture of the left radius, fracture of the left ulna, fracture of the left femur, history of falling, unspecified dementia, polyneuropathy, chronic kidney disease, and type 2 diabetes mellitus. R2's admission assessment (6/17/2025) documents in part R2 was assessed for fall risk and has been determined to be a high risk for falls. R2's minimum data set (8/17/2025) documents in part a brief interview of mental status summary score of 7, indicating R2 has severe cognitive impairment. (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's care plan (6/5/2025) identifies R2 is a high fall risk, has a goal of preventing falls through next review, and has multiple interventions including, but not limited to, a Bed/chair alarm to alert staff if resident gets up, dining room during the day, maximizing time out of bed, visual prompts, educating R2, family/caregivers on safety measures need to be taken to reduce risk of falls, keeping needed items within reach. Additionally, the care plan identifies R2 needs extensive physical assistance with transfers, assist from staff to use the toilet, and is to only ambulate with the therapy team. R2's progress notes document in part on 8/7/2025, R2 had a fall in R2's bathroom. R2 was observed sitting in a wheelchair with a swollen left wrist and decreased range of motion. R2's POA and physician were notified and R2 was sent to the hospital for evaluation. R2 returned to the facility after hospitalization on 8/11/2025. R2's hospital records and physician notes (8/7/2025-8/11/2025) document in part R2 has a history of falls and was brought to the hospital ER on [DATE]. (Family Member) was visiting with the patient on the day of (R2's) fall. Earlier today, patient stood up from (R2's) wheelchair unsupervised and walked to the bathroom while (family member) was busy in adjacent room. By the time (family member) returned to the room (family member) found (R2) on the floor outside of the bathroom. EMS was called and patient was brought to the ED for further evaluation. In the ED, patient was afebrile and hypertensive (175/98) . XR L wrist and forearm with mildly displaced distal radius and ulnar styloid fractures. Moderate tissue swelling. XR L hip and pelvis showed acute mildly impacted subcapital fracture of the left femoral neck. Orthopedic Surgery was placed on consult, and (R2) was admitted for operative repair of new L hip fracture. Upon my interview, (R2) remembers (R2) fell but is unable to provide any further context. Per (family member), (R2) may have hit (R2's) head during the fall. Patient notes 5/10 left hip pain and 5/10 left wrist pain. Pt complains (R2's) L wrist appears swollen and mildly deformed. Pt fell at (R2's) rehab facility on 8/7. Got up from (R2's) wheelchair without supervision and fell on the way back from the bathroom. R2 underwent left femoral neck closed reduction and percutaneous pinning on 8/8/2025 to repair the femoral fracture. On 9/17/2025 at 10:39 AM, V2 (Director of Nursing) affirmed it is the expectation the facility staff follow resident care plans. V2 stated if there is a deviation from the care plan, or not implementing certain interventions, a progress note should be documented to explain why there was a deviation from the care plan. V2 affirmed V2 was familiar with R2. V2 stated R2 has dementia, poor safety awareness, and is a high fall risk. V2 affirmed V2 completed the investigation related to R2's fall on 8/7/2025. V2 recalled from the investigation the fall was unwitnessed and happened in R2's room/bathroom. V2 explained a family member was with R2 and left to go get ice and when the family member returned, R2 was on the ground. R2 was self-ambulating with no one else in the room. After, the family member picked up R2 from the ground, placed R2 in the wheelchair and called for help. The nurse assessed R2 and noted left wrist swelling/decreased range of motion so R2 was sent for evaluation. V2 reviewed R2's progress notes and affirmed R2 has a fall prevention intervention within the care plan to have R2 in the dining room during the daytime. V2 stated based on how the care plan reads, R2 should have been in the dining room during the time of the fall. V2 explained the intervention should say dining room unless if family is visiting. V2 was unsure if V31 was ever educated to not leave R2 alone in the room, educated on when to notify the nurse, or other supervisory measures. V2 affirmed if education was provided, it would be documented within the medical record. Surveyor requested this documentation related to education of V31, and no documentation was received prior to the exit of the survey. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/17/2025 at 11:58 AM, V30 (Agency Registered Nurse) affirmed V30 was the staff member assessed R2 after the fall. V30 recalled V30 received a phone call from a family member on the facility line saying R2 had fell. V30 went to the R2's room and R2 was already back in R2's wheelchair. V30 completed a head-to-toe assessment and denied there were any signs of injury to R2's hip. V30 affirmed R2's left wrist was swollen and looked displaced. V30 called V33 (Physician) and sent R2 to the ER. On 9/17/2025 at 12:25 PM, surveyor requested to interview V33 (physician) regarding the incident. V1 (Administrator) affirmed V1 asked V33 to speak with surveyor about the incident, but V33 refused to be interviewed. V1 explained V33 stated V33 cannot participate in any survey activity unless V33's risk management department allows. V33 was unable to be interviewed prior to the exit of the survey. On 9/17/25 at 2:32 pm, surveyor inquired what the potential harm to a confused resident is that has an unwitnessed fall. V29 (Medical Director) stated, You (staff) have to do a thorough evaluation if the person cannot say what's going on. There has to be a thorough assessment of the patient to see if there's any bruising, head pain, or other things. We do imaging studies as needed. If they (resident) hit their head and are on blood thinners, I (V29) would send them out for head CT (Computed Tomography) to check for a bleed. We would implement things like bed/chair alarms, look at their meds. Record review of the facility's HIGH RISK FALL IDENTIFICATION PROGRAM (undated) documents in part, . The High-Risk Fall Identification Program goes beyond the fall risk identification score and identifies the residents in the facility with the highest risk for falling. It is important to remember many residents are at risk for falling and should have care plan interventions accordingly, even if the resident is not on the high-risk identification program. To determine residents appropriate for this program, consider the following: 1. PCC risk evaluation (most recent) a. Low Risk = 7 and below b. High Risk = 8 and above. Preventing a fall may include, but is not limited to: - making sure call light, assistive device and personal items are close to the resident – reminding the resident to ask for assistance – calling for nursing to assist the resident and waiting with them until qualified staff arrive . -providing mobility, toileting and ADL assistance. – Close supervision of high risk residents.

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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. Based on observation, interview, and record review the facility failed to ensure that the enteral feeding pump was functioning properly, failed to follow physician orders, failed to provide enteral nutrition as directed, and failed to prevent weight loss for one of 53 residents (R10) in the sample reviewed for tube feeding management. Findings include:R10's diagnoses include severe protein-calorie malnutrition and gastrostomy status.R10's (5/5/25) care plan includes risk for alteration in nutritional status related to dysphagia, intervention g (gastrostomy) tube feeding as ordered.R10's physician orders include (7/30/25) NPO (nothing by mouth) diet. (8/5/25) Enteral feed order: Jevity 1.2 rate: 75ml (milliliters)/hr (hour) start at 2pm and infuse until 1,500ml formula total volume is reached per day. On 9/15/25 at 11:18am, R10 appeared frail and notably thin. R10's Jevity 1.2cal hung on 9/15 at 9:30am (per container) was set to be infused at 75cc/hr (cubic centimeters/per hour) via pump however the pump was noted to be alarming and 1,000ml (milliliters) remained in the (1,000ml) container. Upon further inspection R10's enteral feeding pump stated, pump has been idle for 10 minutes. Surveyor inquired why R10's enteral feeding was not infusing. V3 (Licensed Practical Nurse) stated, The pump has been having an error we (staff) let the lady in charge of ordering know. I'm (V3) not sure if this pump is new but it keeps beeping and stops, stating it kinks. Surveyor inquired how much Jevity R10 received within in the past hour. V3 accessed the pump and affirmed 0 milliliters was infused. 96ml was infused over 2 hours, 110ml was infused over 3 hours and 182ml was infused over 4 hours - therefore not 75 ml/hr as ordered. Surveyor inquired how much Jevity R10 received over the last 24 hours. V3 affirmed, 1,029ml was infused over 20 hours therefore R10 will not receive 1,500ml within 24 hours - as prescribed. Surveyor inquired if R10 receives oral nutrition. V3 responded, No, he's (R1) NPO.On 08/06/2025, R10 weighed 114.2 pounds. On 09/03/2025, R10 weighed 112.2 pounds which is a -1.75% loss in 1 month. On 06/29/2025, R10 weighed 118.3 pounds. On 09/03/2025, R10 weighed 112.2 pounds which is a -5.16% loss in roughly 2 months. On 9/17/25 at 2:20pm, surveyor inquired if a resident is NPO and receives enteral feedings what may be the cause of weight loss. V29 stated, It depends, we can't just pinpoint one thing, the dietician should have looked at the diet goal and how many calories he (resident) needs in a day to meet the calorie needs. The enteral tube feeding policy (revised 6/30/25) states enteral tube is an avenue of feeding and hydration nutritional support via gastrostomy route. Procedure: Nurse to check in the POS (Physician Order Sheet) / MAR (Medication Administration Record) the order for enteral feeding interventions: feeding formula, type; bolus, continuous, rate, duration.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review the facility failed to follow policy procedures, failed to follow physician orders, failed to ensure that humidification was provided when administering high flow oxygen, failed to date respiratory equipment, and failed to contain respiratory equipment in a bag after use for four of 53 residents (R10, R18, R38, R85) in the sample. Findings include: 1. R85's diagnoses include COPD (Chronic Obstructive Pulmonary Disease). R85's (6/10/25) physician orders include oxygen 3 liters nasal cannula. R85's (7/4/25) BIMS (Brief Interview Mental Status) determined a score of 15 (cognition intact). On 9/15/25 at 10:50am, R85 was wearing a nasal cannula with oxygen set at 4 liters. R85 affirmed she uses 3 liters. R85's oxygen humidifier was empty. R85's nebulizer mask and CPAP (Continuous Positive Airway Pressure) mask were observed sitting on the dresser (uncontained). On 9/15/25 at 11:00am, surveyor inquired about R85's oxygen setting. V3 (Licensed Practical Nurse) inspected the concentrator and stated, She's (R85) up to 4 liters and the bubbler (referring to humidifier) is empty this needs to be changed it's from the 11th. Surveyor inquired if R85's CPAP mask was dated. V3 responded, There's no date on it. Surveyor inquired if R85's nebulizer mask was dated. V3 replied, The neb is dated 9/4 (11 days ago – therefore not discarded within 7 days). Surveyor inquired when nebulizer masks are supposed to be changed. V3 replied, I think weekly. Surveyor inquired if R85's nebulizer mask and/or CPAP mask were contained. V3 stated, No, it should be inside a bag, and they should both be put up. On 9/15/25 at 12:03pm, R85's oxygen humidifier remained empty. Surveyor inquired if R85's bubbler was changed. V3 responded, No, I (V3) haven't had a chance to change it. The respiratory therapy equipment use policy (revised 7/3/25) states it is the facility's policy to ensure that oxygen and nebulizer equipment use is compliant with the acceptable standards of practice. All oxygen equipment including nasal cannula, humidifier, and nebulizer mask will not be reused. Once opened, this equipment will be dated and discarded after 7 days of use, whether used continuously or on a prn (as needed) basis. 2. R10's diagnoses includes but are not limited to morbid obesity and diabetes 2 mellitus. R10's Order Summary Report, dated 9/17/25, documents, in part, Supplemental O2 = 2l by nasal cannula titrate to SPO2 over 94% every 8 hours as needed. On 9/15/25 at 10:53am, R10's oxygen face mask and tubing were observed lying on a white table, unlabeled with a date and not properly contained. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R38's diagnoses includes but are not limited to heart failure and chronic kidney disease. R38's care plan, date initiated 1/03/23, documents, in part, Prefers (not to attend group activities/limited group activities) due to: covid 19 restrictions. O2 (oxygen) Need for individualized visit program for stimulation of patient senses and for social contact. with interventions that document, in part, Monitor for sob and the need for O2 (oxygen) notify nurse if in distress and encourage deep breathing exercises, monitor for side effects of psychotropics and for depression and agitation notify nurse if any changes. R38's Order Summary Report, dated 9/17/25, documents, in part, Apply oxygen to keep O2 sat greater than or equal to 90% as needed for hypoxia or SOB (shortness of breath). On 9/15/25 at 10:57am, R38's oxygen nasal cannula and tubing, connected to an oxygen humidifier bottle, were observed lying on the bedside table, not properly contained and lacking a date label. 4. R18's diagnoses includes but are not limited to chronic obstructive pulmonary disease and pneumonia. R18's care plan, date initiated 1/01/25, documents, in part, R18 is at risk for alteration in respiratory functioning related to: COPD (chronic obstructive pulmonary disease) with interventions that document, in part, Administer oxygen and other medications and respiratory treatments as ordered. R18's Order Summary Report, dated 9/17/25, documents, in part, O2 (oxygen) at 2-6L/NC PRN for O2 sat <92%. On 9/15/25 at 10:58am, R18's oxygen face mask and tubing were observed lying on a table, unlabeled with a date and not properly contained. On 9/15/25 at 11:20am, while in R38's room with V2 (Director of Nursing/DON), V2 said, R38's oxygen tubing should be in a bag. I'll (V2) throw it out. Oxygen masks and tubing should be changed weekly. When it (oxygen equipment) is changed the nurse puts a date on it (oxygen equipment), so they (nursing staff) know when to change it (oxygen equipment). When the oxygen masks and tubing aren't in use, they (oxygen equipment) should be kept in a bag. It's (oxygen equipment in a bag when not in use) done for infection control and to prevent cross contamination. Facility policy titled, Oxygen Therapy and Administration, revised date 7/02/25, documents, in part, Oxygen setups should be changed every seven days and as needed if heavy soiling is present. Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based upon observation, interview, and record review the facility failed to follow policy procedures and failed to ensure that prescribed medications were available for one of 5 residents (R119) reviewed for medication administration. Findings include:R119's Physician Order Sheets include (9/16/25) Benzonatate 100mg three times daily for 5 days and Guaifenesin -DM (Dextromethorphan) 100mg/10ml (milliliters) give 10 ml every 6 hours for 2 days.On 9/15/25 at 8:49am, V15 (Registered Nurse) dispensed R119's medications (scheduled for 7:30am administration - per EMAR/Electronic Medical Administration Record) however the prescribed Benzonatate was unavailable. V15 stated, The Benzonatate, that's a new order so I have to call the pharmacy for that. V15 then affirmed that she was prepared to administer the medications however Guaifenesin (house stock) was dispensed. Surveyor inquired if Guaifenesin - DM (prescribed medication) was available V15 searched the medication cart to no avail and replied, No.On 9/17/25 at 9:16am, surveyor inquired who places the order for facility house stock medications. V2 (Director of Nursing) stated, We (Facility) have an ancillary person (V23/Central Supply). Surveyor inquired how V23 knows which medications need to be ordered. V2 responded, They (V23) follow the list. The (undated) central supply list (received 9/17/25) excludes Guaifenesin DM.On 9/17/25 at 9:53am, surveyor inspected the 1st floor (east) medication cart with V15 (Registered Nurse). V15 opened the top drawer, and a yellow gel capsule was observed in a medication cup. Surveyor inquired why the medication was dispensed V15 stated, Its benzonatate, I (V15) wanted to see if I can give it to another patient (R119) to see if I can use it. V15 affirmed the benzonatate was dispensed from R25's medications due to R119's benzonatate not received from the pharmacy. The (undated) medication administration general guidelines state medications supplied for one resident are never administered to another resident. If a medication cannot be located, the pharmacy is contacted.

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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. Based on observation, interview, and record review, the facility failed to follow policy procedures, failed to ensure that prescribed medications were available, failed to ensure that the correct medication was dispensed, and failed to ensure that unauthorized medications were not administered. There were three medication errors out of 25 opportunities, resulting in a 12% medication error rate. Two of five residents (R25, R119) in the medication administration sample were affected. Findings include:R25's (9/8/25) POS (Physician Order Sheets) include Hydrocodone 7.5/325mg (milligrams) tablet every 6 hours as needed for severe pain 7-10.On 9/16/25 at approximately 8:35am, R25 requested pain medication. V15 (RN/Registered Nurse) dispensed Hydrocodone 7.5/325mg then requested R25's pain level. R25 rated current pain level a 4. V15 responded the Hydrocodone is prescribed for pain above 7 (which affirmed V15 was aware), however administered Hydrocodone to R25 (unauthorized). R119's POS includes (9/16/25) Benzonatate 100mg three times daily for cough for 5 days and Guaifenesin -DM (Dextromethorphan) 100mg/10ml (milliliters) give 10 ml every 6 hours for cough/congestion for 2 days.On 9/15/25 at 8:49am, V15 (RN) dispensed R119's medications (scheduled for 7:30am administration - per EMAR/Electronic Medical Administration Record), however the prescribed Benzonatate was unavailable. V15 stated, The Benzonatate, that's a new order so I have to call the pharmacy for that. V15 then affirmed that she was prepared to administer the medications however Guaifenesin was dispensed (incorrect medication). Surveyor inquired about R119's Guaifenesin discrepancy V15 reviewed the EMAR and responded Oh, the combination Dextro? Surveyor inquired if Guaifenesin DM was available. V15 searched the medication cart to no avail and replied, No.The medication pass policy (revised 7/2/25) states it is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. The (undated) medication administration general guidelines state: 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. Medications are administered in accordance with written orders of the prescriber. If a medication with a current active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (other units) are searched, if possible. If medication cannot be located after further investigation, the pharmacy is contacted, or medication removed from the emergency kit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, interview, and record review the facility failed to follow policy procedures and failed to ensure that one of five residents (R25) reviewed for medication administration remained free from significant medication errors. Findings include: R25's (9/8/25) Physician Order Sheet includes Hydrocodone 7.5/325mg tablet every 6 hours as needed (for severe pain 7-10). On 9/16/25 at approximately 8:35am, R25 requested pain medication. V15 (RN/Registered Nurse) dispensed Hydrocodone 7.5/325mg then requested R25's pain level. R25 rated current pain level a 4. V15 responded the Hydrocodone is prescribed for pain above 7 (which affirmed V15 was aware) however administered Hydrocodone to R25 (unauthorized). R25's (September 2025) Medication Administration Record affirms Hydrocodone 7.5/325mg was also administered on 9/9 for pain level 4, on 9/13 for pain level 6, on 9/14 for pain level 5 and on 9/15 for pain level 5 therefore administered 4 additional times - unauthorized. The medication pass policy (revised 7/2/25) states it is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. The (undated) medication administration general guidelines state medications are administered in accordance with written orders of the prescriber.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that medication was not left at bedside, failed to ensure that medications were not accessible to unauthorized individuals, failed to maintain the medication refrigerator temperature within range, failed to ensure that multidose medication was dated when opened, and failed to discard multi-dose medications as directed for three of 53 residents (R85, R138, R154) in the sample. The facility failed to ensure that (3rd floor) refrigerated medications were stored at the appropriate temperature. This failure has the potential to affect 54 (3rd floor) residents. Findings include: The 9/14/25 (3rd floor) census includes 54 residents. On 9/15/25 at 10:13am, Fluticasone Propionate nasal spray was observed on R154's bedside table. Surveyor inquired if staff keep the nasal spray on the medication cart. R154 responded, They (staff) leave it here. On 9/15/25 at 10:15am, surveyor inquired why R154's nasal spray was left at the bedside. V3 (LPN/Licensed Practical Nurse) stated, It should not be there, usually it's on the cart. On 9/16/25 at approximately 8:55am, a bottle of Aspirin EC (Enteric Coated) 81mg was observed on V15's (Registered Nurse) medication cart which was unattended. V15 returned to the medication cart approximately one minute later. Surveyor inquired why the Aspirin was left on the cart and unattended. V15 responded, I just saw it and affirmed she was getting water for a resident. On 9/17/25 at 9:53am, the 1st floor (east) medication cart was inspected with V15 (RN/Registered Nurse). V15 opened the top drawer, and a yellow gel capsule was observed in a medication cup. Surveyor inquired why the medication was dispensed. V15 stated, Its benzonatate, I (V15) wanted to see if I can give it to another patient.On 9/17/25 at 10:04am, the 1st floor (south) medication cart was inspected with V27 (LPN/Licensed Practical Nurse). A vial of Lantus was observed in the top drawer in a bag which states refrigerate. Surveyor inquired about concerns with the Lantus on the cart. V27 stated, It says it's supposed to be refrigerated. V27 removed (house stock) Acetaminophen suspension from the cart (as requested) which was opened and undated. Surveyor inquired if the Acetaminophen container was dated. V27 responded, No, it's no open date on it. V27 removed (house stock) Multivite suspension from the cart (as requested) which was opened and undated. Surveyor inquired if the Multivite container was dated. V24 replied, It's no open date on here. On 9/17/25 at 12:11pm, the 3rd floor (west) medication cart was inspected with V32 (RN). Resident #138's Timolol ophthalmic solution was noted to be opened and undated. Surveyor inquired if an open date was on R138's Timolol. V32 stated, They (staff) did not put the date. When you open this one (referring to the Timolol), you have to put the date. On 9/17/25 at 12:18pm, the 3rd floor medication room refrigerator was inspected with V32 (RN). The refrigerator temperature log affirms inside temperature was 21 on 9/17/25. Surveyor inquired about the current temperature of the refrigerator. V32 inspected the thermometer and responded, It's 15. Surveyor also affirmed the refrigerator temperature was 15F (Fahrenheit) and within freezing range. Surveyor inquired about the ice buildup in the refrigerator freezer (approximately 4 inches thick). V32 replied, It's a lot. Numerous insulins and suspensions (nystatin, gabapentin Megace, vancomycin) were in the refrigerator at this time. On 9/17/25 at 12;49pm, the 3rd floor (east) medication cart was inspected with V3 (LPN). Surveyor inquired about R85's Dorzolamide ophthalmic solution which was opened and dated 6/17/25 (3 months ago). V3 stated, This one was opened 6/17, we have to discard it. R85's Brimonidine ophthalmic solution was opened and dated 8/9/25 per V3. R85's Latanoprost ophthalmic solution was opened and dated 8/7/25 per V3. Surveyor inquired when ophthalmic solutions should be discarded. V3 responded, Within 30 days after opening. The medication storage, labeling, and disposal policy (revised 7/2/25) states it is the facility's policy to comply with federal regulations in storage, labeling, and disposal of medications. Medications will be secured in locked storage areas. The (undated) administration procedures for all medications stated check expiration date on package/container before administering any medication. When opening a multi-dose container, place the date on the container. The (undated) storage of medication policy states medications and biologicals are stored safely, securely, and properly following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Medications requiring refrigeration are kept in a refrigerator at temperatures between 36F degrees and 46F with a thermometer to allow temperature monitoring.

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	145607	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Palos Heights	7850 West College Drive Palos Heights, IL 60463

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to comply with proper food storage and sanitation protocols; failed to ensure residents' food items were dated upon opening; failed to properly contain and cover residents' food after opening; failed to ensure the scoops for bulk food items were stored appropriately; failed to limit storage in the dry food storage room/pantry exclusively to residents' items; and failed to utilize unexpired sanitizing test strips. These deficiencies have the potential to impact the health and safety of all 144 residents residing at the facility.Findings include:Facility census, dated 9/15/2025, documents 144 residents residing at the facility.On 09/15/25 at 9:25am, with V11 (Food Service Director), during observation of the facility's walk-in freezer and refrigerator (connected) the following was observed: An uncovered food cart containing a tray of individual serving containers of applesauce that were not covered; A clear plastic bag, observed opened and lacking a date label, contained beef patties with visible freezer burn; An undated blue bag of sausage crumble was observed with an approximate 3-inch tear in the packaging; and an undated, partially cut tomato wrapped in clear plastic.On 9/15/25 at 9:28am, V11 (Food Service Director) said, No matter how many times I (V11) tell them (staff), they (staff) still don't do things right. Food should be covered and dated in the fridge and freezer to keep the food fresh and not spoiled so the residents don't get sick.On 9/15/25 at 9:32am, with V11 (Food Service Director), during observation of the facility's dry food storage/pantry the following was observed: An uncontained, soiled bulk scoop was observed resting on the shelf adjacent to a bulk item container; Another soiled bulk scoop was observed placed directly on top of a bulk item container, also uncontained; and V17's (Dietary Aide) backpack (last name of V17 observed on backpack) was observed on a wooden tote. On 9/15/25 at 9:32am, V11 said, These scoops shouldn't be left out like this. Too many germs. This (backpack) is an employees. It (V17's backpack) shouldn't be in here. This is just for the resident's food. Employees things shouldn't be with the residents' food cause it (employee's personal items) may be dirty.On 9/16/25 at 11:20am, with V11 (Food Service Director), during observation of the 3 compartment sink and cleaning buckets, the sanitary testing strips were observed to be expired with an expiration date of August 15, 2025. V11 said, I have new ones. Let me get them (sanitary testing strips). Can't use expired strips because the reading might not be right. Facility policy titled, Kitchen, revised date 6/30/25, documents, in part, The facility will comply with state and federal regulations in operating facility's kitchen. Refrigerated food should be covered, dated, labeled, and shelved to allow air circulation. Open containers or potentially hazardous food or leftover should be dated and used within 3-5 days in the refrigerator. scoop handles in bulk items stored in such a way they do not touch bulk item. If the resident rooms have refrigerators, the facility will ensure that the daily temperature is checked to ensure proper temperature.Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.Facility job description titled, Cook, updated 12/01/19, documents, in part, In keeping with our organization's goal of improving the lives of the Guests we serve, the [NAME] position is responsible for providing nourishing food to Guests, and employees under sanitary conditions as directed and in accordance with established policies and procedures. The [NAME] will help to assure that the dietary department is maintained in a clean, safe and sanitary manner by providing assistance in all dietary functions and providing supervision to all dietary aides. Assure that established sanitation policies and procedures are followed at all times in accordance with federal, state and local regulations. Assure that equipment, tools and supplies are properly stored at all times. Maintains the comfort, privacy and dignity of Guests and interacts with them in a manner that displays warmth, respect and promotes a caring environment.Facility job description titled, Dietary Aide, updated 12/01/19, documents, in part, . The Dietary Aide will help to assure that the dietary department is maintained in a clean, safe and sanitary manner by providing assistance in all dietary functions as directed and in accordance with established dietary policies and procedures. Bag and store food items as directed. Scrape, wash, and rack unclean dishes and utensils. Sort and stack clean dishes and inspect for cleanliness. Discard waste/trash into proper containers in accordance with established sanitation procedures and guidelines. Assure that equipment, tools and supplies are properly stored at all times.Facility job description titled, Director of Dietary Services, updated 12/01/19, documents, in part, In keeping with our organization's goal of improving the lives of the Guests we serve, the Director of Dietary Services position is responsible for providing nourishing food

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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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure that the outside dumpster was closed. These failures have the potential to affect all 144 residents residing at the facility. Findings include:Facility census, dated 9/15/2025, documents 144 residents residing at the facility.On 9/15/2025 at 9:34am, during observation of the external facility dumpster area, accompanied by V11 (Food Service Director), the dumpster was observed left open and contained garbage. V11 acknowledged the issue, stating, The dumpster should be closed, and subsequently closed both covers of the dumpster. V11 further emphasized, It (dumpster) should be closed all the time to keep rodents out.V1's (Administrator) e-mail, dated 9/16/25 at 10:26am, documents, in part, . We do not have a garbage disposal policy.Facility policy titled, Pest Control, revised date 7/3/25, documents, in part, It is the facility's policy to ensure that there is an effective pest control process in the building.Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.Facility job description titled, Dietary Aide, updated 12/01/19, documents, in part, . The Dietary Aide will help to assure that the dietary department is maintained in a clean, safe and sanitary manner by providing assistance in all dietary functions as directed and in accordance with established dietary policies and procedures. Discard waste/trash into proper containers in accordance with established sanitation procedures and guidelines. Facility job description titled, Cook, updated 12/01/19, documents, in part, In keeping with our organization's goal of improving the lives of the Guests we serve, the [NAME] position is responsible for providing nourishing food to Guests, and employees under sanitary conditions as directed and in accordance with established policies and procedures. The [NAME] will help to assure that the dietary department is maintained in a clean, safe and sanitary manner by providing assistance in all dietary functions and providing supervision to all dietary aides. Assure that established sanitation policies and procedures are followed at all times in accordance with federal, state and local regulations. Assure that equipment, tools and supplies are properly stored at all times. Maintains the comfort, privacy and dignity of Guests and interacts with them in a manner that displays warmth, respect and promotes a caring environment. Facility job description titled, Director of Dietary Services, updated 12/01/19, documents, in part, In keeping with our organization's goal of improving the lives of the Guests we serve, theDirector of Dietary Services position is responsible for providing nourishing food to guests and employees under sanitary conditions and in accordance with established policies and procedures. Operates the dietary department in a safe and sanitary manner by ensuring compliance with Federal, State, and local regulations and following established policies and procedures. Assure that established infection control and prevention practices and standard precautions are maintained at all times.Facility job description titled, Housekeeper, updated 12/01/19, documents, in part, . In keeping with our organization's goal of improving the lives of the Guests we serve, the Housekeeper plays a critical role in providing superior customer service and housekeeping services to all Guests in the facility. The Housekeeper is responsible maintaining environmental and infection control standards.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to conduct hand hygiene prior to passing meal trays. This failure has the potential to affect affected four residents (R67, R101, R111, and R129) reviewed for infection control on the sample of 53 residents.Findings include:On 9/15/25 from 12:46pm to 12:54pm, V9 (Activity Aide) was observed preparing and arranging beverages for the residents. On 9/15/25 at 12:54pm, V9 was observed arranging beverages and then retrieving a food tray from the food cart without performing hand hygiene. V9 served the tray to R11, making direct contact with the resident while assisting with meal setup. Without performing hand hygiene, V9 returned to the food cart, retrieved another tray, and served it to R101, again making physical contact while assisting with the meal and cutting the resident's hot dog. V9 continued this pattern by retrieving a tray from the food cart for R129 without performing hand hygiene, served R129 the food tray, cutting the hot dog in half, and placing the R129's hand on the food. V9 then walked back to the food cart, did not perform hand hygiene, retrieved another tray of food from the food cart, walked to the table R67 was at and served R67 the food tray, without hand hygiene and with direct resident contact during meal setup.On 9/17/25 at 9:19am, V2 (Director of Nursing/DON) said, Staff should wash hands or use hand sanitizer between each resident while serving food. V2 affirmed, staff should perform proper hand hygiene between each resident while serving meals to prevent the spread of infection.Facility policy titled, Hand Hygiene, revised date 6/30/25, documents, in part, Hand hygiene is important in controlling infections. Hand Hygiene consists of either hand washing or the use of alcohol gel. The facility will comply with the CDC Guidelines in regards to hand hygiene. Hand Hygiene using alcohol-based hand rub is recommended during the following situations: Before and after direct resident contact. Before and after assisting a resident with meals.Facility policy titled, Infection Prevention and Control, revised date 6/30/25, documents, in part, The facility has established a policy to Identify, Record, Investigate, Control, Test, and Prevent infections in the facility. The facility will also maintain a record of incidents and corrective actions implemented for the identified infection. Hand hygiene will be performed by staff and contracted workers before and after direct patient contact and after each situation that necessitates hand hygiene. Alcohol-based hand rubs or hand washing x 20 seconds will be used. The facility shall comply with infection control recommendations provided by the IDPH or certified local health department. Standard Precaution: . Infection prevention practices include hand hygiene.Facility policy titled, Kitchen, revised date 6/30/25, documents, in part, Staff will wash hands prior to handling food for 15-20 seconds.Pamphlet titled, Illinois Long-Term Care Ombudsman Program Residents' Rights for People in Long-Term Care Facilities, revised date 11/18, documents, in part, Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike.