

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145630	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/18/2025
NAME OF PROVIDER OR SUPPLIER Elevate Care North Branch		STREET ADDRESS, CITY, STATE, ZIP CODE 6840 West Touhy Avenue Niles, IL 60714	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to promote and respect resident's dignity during mealtime. This deficiency affects one (R47) of three residents in the sample of 28 reviewed for Resident Rights.</p> <p>Findings include:</p> <p>R47 was admitted on [DATE] with diagnosis listed, in part, but not limited to Hypertensive heart and chronic kidney disease with heart failure ad with stage 5 chronic kidney disease or end stage renal disease, Monoplegia of upper limb following non-traumatic intracerebral hemorrhage affecting right dominant side. Admission MDS/Resident assessment done on 4/11/25 indicated: Section GG Functional abilities. GG0130 Self Care Coded 3 Requires partial moderate assistance in eating. Comprehensive care plan indicated that she has an ADL self-care performance deficit.</p> <p>On 4/15/25 at 12:18PM, R47 is alert, responsive and pleasantly confused. Observed R47 in her room, sitting in wheelchair with pillow place on her lap creating space between lunch tray placed on bedside tray table in front of her. She is eating by herself, with food all over her chest and her lap. She is using spoon and her hands to eat. The pillow is soiled with food. She has her cellphone connected to outlet which is wet/soiled with food. Observed long and dirty fingernails on both hands, with black matter inside the nails. Called V23 LPN (Licensed Practical Nurse), showed and informed observation made. V23 said that sometimes she needs assistance and supervision when eating. V23 said that the CNA (Certified Nurse Assistant) distributed and set up the tray to R47. V23 said that nail care is a CNA responsibility during daily ADLs care. V23 called V26 CNA. V26 said that she is the CNA assigned for R47, but she did not set up the lunch tray for R47. V26 said that lunch tray should be placed closer and accessible to resident.</p> <p>On 4/15/25 at 2:30PM, Informed V2 DON (Director of Nursing) of above observation. R47 soiling her clothes while eating. R47 needs assistance during meals. V2 said, CNA should ensure proper tray set up to resident regarding proper proximity of their tray during meal. V2 said that they don't place food protector to R47 during meals.</p> <p>On 4/16/25 at 12:26 PM, Informed both V1 Administrator and V2 DON that R47 needs partial/moderate assistance in eating as indicated in her MDS/Resident assessment. R47 was observed yesterday eating by herself without assistance, food all over her chest and lap and soiling her clothes from food.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's policy on Resident Right's reviewed 1/4/19 indicated:</p> <p>Purpose: To promote the exercise of rights for each resident, including any two face barriers (such as communication problems, hearing problems and cognition) 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.</p> <p>Facility's policy on Dignity reviewed 4/23/28 indicated:</p> <p>Guidelines:</p> <p>The facility shall promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. The facility shall consider the resident's lifestyle and personal choices identified through the assessment processes to obtain a picture of his or her individual needs and preferences.</p> <p>Staff shall carry out activities in a manner which assists the resident to maintain and enhance his/her self-esteem and self-worth.</p> <p>Facility's policy on Feeding and assisting residents to eat indicated:</p> <p>Purpose: To assist the resident to obtain nutrient and hydration. To provide a socializing experience for the resident</p> <p>Procedure:</p> <p>4. Tuck the napkin under the chin or place on clothing protector. Only necessary to prevent soiling of clothing.</p>

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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50469</p> <p>Based on observation, interview, and record review the facility failed to ensure resident call light is within reach. This deficiency affects one (R191) of three residents in the sample for 28 reviewed for accommodation of needs.</p> <p>Findings include:</p> <p>R191 is admitted on [DATE] with diagnosis, in part, but not limited to history of falls, hypertensive heart disease with chronic diastolic congestive heart failure, type 2 diabetes, hyperlipidemia, right femur fracture. A focused care plan for alteration in cardiovascular functioning related to congested heart failure, indicated intervention keep call light within reach dated 4/9/25.</p> <p>On 04/15/25 at 11:13 AM, R191 observed in bed with call light behind bed, R191 said she does not know where her call light is at.</p> <p>On 04/15/25 at 11:23 AM, V29 (Licensed Practical Nurse) made aware of above and said that call light should be within reach and not behind the bed.</p> <p>On 04/17/25 at 02:05 PM, V2 (Director of Nursing) said that all call lights should be within reach of resident, said that call lights are not to be behind the bed.</p> <p>Facility's policy on Call light revisions 2/2/18.</p> <p>Purpose: To respond to residents requests and needs in a timely and courteous manner.</p> <p>Guidelines:</p> <p>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.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation interview and record review the facility failed to provide nail care and assistance during meal to resident who needs assistance with Activity of daily living (ADL). This deficiency affects one (R47) of three residents in the sample of 28 reviewed for ADL care.</p> <p>Findings include:</p> <p>R47 was admitted on [DATE] with diagnosis listed, in part, but not limited to Hypertensive heart and chronic kidney disease with heart failure ad with stage 5 chronic kidney disease or end stage renal disease, Monoplegia of upper limb following non-traumatic intracerebral hemorrhage affecting right dominant side. Admission MDS/Resident assessment done on 4/11/25 indicated: Section GG Functional abilities. GG0130 Self Care Coded 3 Requires partial moderate assistance in eating. Comprehensive care plan indicated that she has an ADL self-care performance deficit.</p> <p>On 4/15/25 at 12:18PM, R47 is alert, responsive and pleasantly confused. Observed R47 in her room, sitting in wheelchair with pillow place on her lap creating space between lunch tray placed on bedside tray table in front of her. She is eating by herself, with food all over her chest and her lap. She is using spoon and her hands to eat. The pillow is soiled with food. She has her cellphone connected to outlet wet/soiled with food. Observed long and dirty fingernails on both hands, with black matter inside the nails. Called V23 LPN, showed and informed observation made. V23 said that sometimes she needs assistance and supervision when eating. V23 said that the CNA distributed and set up the tray to R47. V23 said that nail care is a CNA responsibility during daily ADLs care. V23 called V26 CNA. V26 said that she is the CNA assigned for R47, but she did not set up the lunch tray for R47. V26 said that lunch tray should be placed closer and accessible to resident.</p> <p>On 4/15/25 at 2:30PM, Informed V2 DON (Director of Nursing) of above observation. V2 said that CNA is responsible to provide nail care to resident during ADLs. CNA should ensure proper tray set up to resident regarding proper proximity of their tray during meal. V2 said that they don't place food protector to R47 during meals.</p> <p>On 4/16/25 at 12:26 PM, Informed both V1 Administrator and V2 DON that R47 needs partial/moderate assistance in eating as indicated in her MDS/Resident assessment. Informed both that R47 was observed yesterday eating lunch in her room without assistance. The food all over her chest, lap and soiling her clothes.</p> <p>Facility's policy on Feeding and assisting residents to eat indicated:</p> <p>Purpose: To assist the resident to obtain nutrient and hydration. To provide a socializing experience for the resident</p> <p>Procedure:</p> <p>4. Tuck the napkin under the chin or place on clothing protector. Only necessary to prevent soiling of clothing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility's policy in Nail care revision date 1/25/28 indicated:</p> <p>1. Observed condition of resident nails during each time of bathing. Note cleanliness, length uneven edges, hypertrophied nails.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to ensure ongoing assessment and monitoring are implemented to identify new skin impairment, worsening of skin disorder and to notify physician for appropriate wound /skin treatment. The facility also failed to update the Skin/wound care plan on a timely manner. This deficiency affects one (R47) of three residents in the sample of 28 reviewed for Quality of Care in Skin/ wound management.</p> <p>Findings include:</p> <p>R47 was admitted on [DATE] with diagnosis listed in part but not limited to Hypertensive heart and chronic kidney disease with heart failure ad with stage 5 chronic kidney disease or end stage renal disease, Monoplegia of upper limb following non-traumatic intracerebral hemorrhage affecting right dominant side. Admission Braden/skin assessment done on 4/6/25 indicated that she is at risk for skin impairment. Physician order sheet indicated: Triamcinolone acetonide external cream 0.1% apply to affected areas topically two times a day for rashes. Moisture barrier after each peri care (CNA may apply, may keep at bedside) every shift for skin. Weekly shower/skin assessment. Acknowledgement of shower and skin assessment completed. If new skin issue: notify physician for order, notify family and complete nursing skin assessment form. Wound care: right anterior arm-cleanse with normal saline, pat dry and cover with dry dressing every MWF and PRN. Comprehensive care plan indicated she has skin impairment related to skin tear, blister and potential skin integrity impairment related to reduced mobility and current diagnosis. Admission skin assessment quick shot dated 4/5/25 indicated: Right anterior arm- rashes; Right hand-fungal; Neck- rashes; Left hand- fungal. R47 is on restorative program for Active ROM (range of motion) to bilateral upper and lower extremities.</p> <p>On 4/15/25 at 12:18PM, R47's room has set up for contact isolation precaution. R47 is alert and pleasantly confused. Observed up in wheelchair with pillow place on her lap creating space between lunch tray placed on bedside tray table in front of her. She is eating by herself, with food all over her chest and lap. She is using spoon and her hands to eat. The pillow is soiled with food. She has her cellphone connected to outlet which is wet/soiled with food. Observed right hand fingers are reddened and swollen compared to left hand fingers. Observed long and dirty bilateral hand nails, with black matter inside the nails. Observed visible rashes on neck, chest, and bilateral hands/forearms. Called V23 LPN (Licensed Practical Nurse), showed and informed observation made. V23 said that sometimes R47 needs assistance/supervision with eating. V23 said that the CNA distributed and set up the tray to R47. V23 said that nail care is a CNA responsibility during ADL (Activity of daily living) care. V23 said that she is not aware of R47's right hand fingers reddened and swollen. V23 assessed bilateral hands. R47 said that she has eczema on her both hands. Observed right dorsal hand fingers irritated, reddened, and swollen. Observed on right hand supination-thickened, dry, hardened yellowish brown discoloration on index, middle and ring finger up to the palm area. Same observation made to the left-hand supination but more prominent on right hand. Skin disorders also observed in between fingers on both hands. V23 said that the wound care nurse is the one applying R47's skin treatment.</p> <p>On 4/15/25 at 12:27PM, Observed open wound on perianal area while V26 CNA was performing incontinence care. V26 said this is her first-time taking care of R47 and was not aware that she has open wound.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/15/25 at 12:43PM, Informed V12 DWC- Director Wound Care) of above observation. Reviewed R47's medical record with V12. V12 said R47 was admitted on [DATE] with rashes on neck and right anterior arm, fungal on right and left hand. Surveyor showed to V12 R47's worsening fungal on both hands. Observed right dorsal hand fingers irritated, reddened, and swollen. Observed on right hand supination-thickened, dry, hardened yellowish brown discoloration on index, middle and ring finger up to the palm area. Same observation made to the left-hand supination but more prominent on right hand. Skin disorders also observed in between fingers on both hands. V12 said they do not provide treatment and skin documentation for non-open wound. The floor nurse is the one applying skin treatment of triamcinolone cream to rashes and fungal areas. The floor nurse will also do the weekly documentation in the progress notes response from skin treatment for rashes and fungal. Informed V12 that no weekly documentation was found in the progress notes regarding rashes and fungal identified upon admission on bilateral hands and neck. Informed V12 of open wound observed on perianal area during incontinence care. V12 said he is not aware of this open wound. He was not notified by the floor nurse or CNA. V12 did skin assessment and measurement of R47's open wound on peri anal area. V12 said R47 has MASD (Moisture Associated Skin Disorder) on peri anal area, measures 2.5cm x 4.5cm x 0.1cm with maceration on peri wound. 40% granulation and 60% epithelial. V12 said that he will apply Vit A and D ointment for now until he gets treatment order from the physician.</p> <p>On 4/16/25 at 12:26PM, Informed V1 Administrator and V2 DON of above concerns. Informed both concerns of failure to ensure ongoing assessment and monitoring are implemented to identify new skin impairment, worsening of skin disorder and to notify physician for appropriate wound /skin treatment.</p> <p>On 4/17/25 at 9:30AM, Reviewed with V12 DWC R47 's wound skin assessment report completed by V12 DWC on 4/15/25 indicated: Neck/chest- rashes; Left hand dorsal- rashes; Left hand supination-rashes; Right hand dorsal- rashes; Right hand supination- rashes, scab formation, small bumps. Peri anal- MASD, facility acquired, 2.5cmx4.5cmx 0.1cm, scant blood, superficial, 60% epithelial, 40% red tissues. Informed V12 that he did not document accurately description observed. V12 wrote improvement of skin condition on both hands and neck and chest instead of worsening. Informed V12 that surveyor discussed with him the concerns of worsening of skin disorder for both bilateral hands and neck/chest observed. Informed again V12 of observation made that right dorsal hand fingers irritated, reddened, and swollen. Observed on right hand supination-thickened, dry, hardened yellowish brown discoloration on index, middle and ring finger up to the palm area. Same observation made to the left-hand supination but more prominent on right hand. Skin disorders also observed in between fingers on both hands. V12 said that he has not update R47's wound/skin care plan. He should update it within 24 hours.</p> <p>Facility's facility on Skin condition assessment and monitoring-Pressure and non-pressure revision 6/18/18 indicated:</p> <p>Purpose: To establish guidelines for assessing, monitoring, and documenting the presence of skin breakdown, pressure injuries and other non-pressure skin conditions and assuring interventions are implemented.</p> <p>Guidelines:</p> <p>*Pressure and other ulcers will be assessed and measured at least weekly by licensed nurse and documented in resident's clinical record.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>*Non-pressure skin conditions will be assessed for healing progress and signs of complications or infection weekly.</p> <p>*Each resident will be observed for skin breakdown daily during care and on the assigned bath day by the CNA. Changes shall be promptly reported to the charge nurse who will perform the detailed assessment.</p> <p>*Caregivers are responsible for promptly notifying the charge nurse of skin breakdown.</p> <p>*At the earliest sign of a pressure injury or other skin problem, the resident, legal representative and attending physician will be notified. The initial observation of the ulcer or skin breakdown will also be described the nursing progress notes.</p> <p>*The licensed nurse is responsible for notifying the attending physician, Director of Nursing and legal representative for any suspected wound infection.</p> <p>*Physician ordered treatment shall be initiated by the staff on the electronic treatment administration record after each administration. Other nursing measures not involving medications shall be documented in the weekly wound assessment or nurses' notes.</p> <p>Facility's policy on Comprehensive Care Plan revised 11/17/17 indicated:</p> <p>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.</p> <p>Guidelines:</p> <p>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.</p> <p>* The care plan should be revised on an ongoing basis to reflect changes in the resident and the care that resident is receiving.</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to ensure appropriate care and service provided to resident on enteral/gastrostomy feeding tube to prevent possible complication. This deficiency affects one (R98) of three residents in the sample of 28 reviewed for Tube Feeding Management.</p> <p>Findings include:</p> <p>R98 was admitted on [DATE] with diagnosis listed in part, but not limited to Pneumonia, Chronic Respiratory failure, Pleural effusion, Anoxic brain damage, Gastrostomy, Tracheostomy. Active physician order sheet indicated: NPO (Nothing by mouth). Enteral feeding order very shift Jevity 1.5 at 55ml/hr. x21 hours or until 1155ml total volume infused. Flush and stop pump when feeding is completed. Head of bed elevated for shortness of breath while lying flat. Oral care every 8 hours and as needed. Comprehensive care plan indicated he has alteration in nutrition status related to Severe protein malnutrition, Anoxic brain damage, Tracheostomy, Gastrostomy and Respiratory failure. Intervention: Elevate head of bed as ordered.</p> <p>On 4/16/25 at 9:29AM, Surveyor and V2 DON (Director of Nursing) went to R98's room. Observed R98 lying flat on bed with GT (gastrostomy tube) connected to enteral feeding pump that is turned off. Observed large oral secretions draining to both side of his mouth to his neck. Observed whitish secretions on both side of the mouth. R98 has tracheostomy tube connected to oxygen. Informed V2 DON of R98's bed position. V2 said that R98'shis bed should be elevated. V2 then took the bed control and elevated the head of the bed. V2 called V32 RN (Registered Nurse). V32 said he forgot to turn on the machine after he administered R98's medication per GT. V32 said he administered R98's medication around 8:30AM. V32 said R98 did not vomit but has a lot of oral secretions. V32 left the room to call V18 Respiratory Therapist. V32 did not assess R98's respiratory status and did not wipe the secretions from R98's mouth. V18 said he made rounds on R98 around 8:00AM. V18 said R98 has a lot of salivary secretions. V18 did oral suctioning. V2 instructed V18 to wipe oral secretions from R98's mouth.</p> <p>On 4/16/25 at 12:36PM, Informed V2 DON of above concern identified that R98 head was not elevated after V35 administered the medication via GT which may cause possible aspiration. R98 has history of Pneumonia. V2 said that it is not necessary to keep the head elevated because the feeding tube is off. Informed V2 that per facility's policy indicates: Elevate head of bed to 30-45 degrees (Semi-fowler's or high fowler's position) and leave in this position at least for 30 minutes after administration of medications. R98's bed was not elevated after V32 administered medication from 8:30AM to 9:29AM.</p> <p>Facility's policy on Gastrostomy Tube-Feeding and care revision 8/3/20 indicated:</p> <p>Purpose: To provide nutrients, fluids, and medications, as per physician orders, to residents requiring feeding through an artificial opening into the stomach.</p> <p>Procedure:</p> <p>(continued on next page)</p>		

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<p>F 0693</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>5. Position resident on his/her back with head elevated to minimal 30 degrees and preferable 45 degrees.</p> <p>Facility's policy on Enteral tube Medication Administration effective date 10/25/14 indicated:</p> <p>Policy: The facility assures the safe and effective administration of enteral formulas and medications via enteral tubes.</p> <p>Procedures:</p> <p>Prepare medications for administration.</p> <p>7. Elevate head of bed to 30-45 degrees (Semi-fowler's or high fowler's position) and leave in this position at least for 30 minutes after administration of medications.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>49871</p> <p>Based on observation, interview, and record review the facility failed to ensure the scheduled medication was compared with the medication label prior to administration affecting 1 of 5 residents (R82) reviewed for medication administration in a total sample of 28.</p> <p>Findings Include:</p> <p>On 4/15/2025 at 11:10 AM, V21 (Registered Nurse/RN) prepared the same medication from a multi dose Insulin vial not belonging to R28. V21 proceeded to administer medication to R82.</p> <p>On 4/15/2025 at 11:11 AM, V21 stated it's okay to give or borrow medication belonging to another resident since R28 needed to go down for Dialysis.</p> <p>On 4/15/2025 at 11:45 AM, V3 (Assistant Director of Nursing) stated when a medication is not available in the med cart, the nurse should use the convenience box to retrieve the needed medication. V3 said they have insulin available in the convenience box.</p> <p>On 4/16/2025 at 8:05 AM, V2 (Director of Nursing) stated nurses should not use medication not belonging to the resident. There should not be borrowing of medication. Instead staff should use the convenience box if medication is not available in the cart.</p> <p>Review of R82's Medical Record read admitted , 3/23/2025, Diagnosis Information include Type 2 Diabetes Mellitus without complications. Order Summary Report read order date 3/23/2025, Insulin Lispro Injection Solution 100 Unit/ML (Insulin Lispro). Inject as per sliding scale. Medication Administration Record indicate on 4/15/2025 R82 received 4 units of Insulin Lispro at 1200. Care Plan Report, 2/10/2025 read Focus: R82 has Diabetes Mellitus. Intervention: Diabetes medication as ordered by doctor.</p> <p>Policy and Procedure</p> <p>Policy Title: Medication Administration, Effective date 10/25/2014</p> <p>Policy</p> <p>Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Personnel authorized to administer medications do so only after they have been properly oriented to the medication management system in the facility. The facility has sufficient staff and medication distribution system to ensure safe administration of medications without unnecessary interruptions.</p> <p>Procedures:</p> <p>A. Preparation</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>4. Five Rights - Right resident, right drug, right dose, right route and right time, are applied for each medication being administered.</p> <p>5. Prior to administration, the medication and dosage schedule on the resident's medication administration record (MAR) are compared with the medication label.</p> <p>11. If a medication with a current, active order cannot be located in the medication cart/drawer . medication removed from the night box/ emergency kit.</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident's drug regimen must be free from unnecessary drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781</p> <p>Based on observation, interview, and record review the facility failed to adequately monitor resident on antibiotics without adequate indication. This deficiency affects one (R391) of three residents in the sample of 28 reviewed for Unnecessary medication.</p> <p>Findings include:</p> <p>On 4/15/25 at 10:54AM, Observed R391 lying in bed with oxygen via nasal cannula. He is alert and oriented, able to express self and needs to staff. He said that he was admitted 2 weeks ago. He said that he did not have any sign and symptoms of infection.</p> <p>R391 was admitted on [DATE] with diagnosis listed in part, but not limited to Acute and chronic respiratory failure, Chronic obstructive pulmonary disease, Hypertensive heart, and chronic kidney disease with heart failure. Active physician progress notes indicated Azithromycin oral table 500mg give 1 by mouth one time every Monday, Wednesday and Friday for infection dated 4/3/25. No clinical usage indication for specific infection. Comprehensive care plan indicated usage of antibiotic therapy for infection, no indicated of specific infection. No antibiotic/Mc Geer infection monitoring form completed in chart. Hematology test dated 4/4/25 ad 4/9/25 indicated normal WBC (White blood test). Daily body temperature taken since admission indicated no fever, normal body temperature.</p> <p>On 4/16/25 at 9:58AM, V7 Infection Preventionist (IP) said they have antibiotic stewardship program to reduce unnecessary use of antibiotics. They monitor resident on antibiotics using McGeer/Antibiotic monitoring form completed within 48 to 72 hours upon starting on antibiotics. Review R391's medical records with V7 IP. Informed V7 that R391 is on Azithromycin oral antibiotics but no specific indication for specific infection/diagnosis, no specific duration of antibiotics and no infectious disease consults for usage of antibiotics. V7 said he oversees completing McGeer/Antibiotic monitoring form for R391 usage of Azithromycin upon admission. V7 does not know why R391 was on antibiotics.</p> <p>On 4/16/25 at 1:30PM, V7 Infection Preventionist presented completed McGeer/antibiotic monitoring form dated 4/4/25 but no electronic signature and date indicated: #3. Verification of infection status: d. Does not meet criteria for infection.</p> <p>On 4/17/25 at 10:00AM, Informed V2 DON (Director of Nursing) of above concern.</p> <p>On 4/18/25 at 10:47AM, Informed V1 Administrator of above concern.</p> <p>Facility's policy on Antibiotic/Antimicrobial Stewardship Program-Mission Statement and Guidelines effective date 11/28/17 indicated:</p> <p>Mission Statement:</p> <p>(continued on next page)</p>		

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<p>F 0757</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>This facility is dedicated to implement an Antibiotic/Antimicrobial Stewardship program to reduce the unnecessary use of antibiotics. This program help ensure that our resident get the right antibiotics at the right time for the right duration, and can improve individual patient outcomes, prevent deaths from resistant infections, slow antibiotic resistance, decrease Clostridium Difficile infections and reduce healthcare costs.</p> <p>The facility will strive to incorporate the core elements of antibiotic/antimicrobial stewardship into the daily activities and culture of the facility, creating awareness and work toward long term goals of reducing the unnecessary use of antibiotics.</p> <p>Guidelines:</p> <p>These core elements include the following:</p> <p>5. Tracking-Monitor at least one process measure of antibiotic use and at least one outcome from antibiotic use</p> <p>6. Reporting-Provide regular feedback and data on antibiotic use and resistance to prescribing clinicians, nursing staff and other relevant staff to increase awareness.</p> <p>* Medical Director will set standards for antibiotic prescribing practices for all physician providing care in the facility, review antibiotics use data gathered by tracking monitoring and provide feedback and recommendation to ensure that best practices are followed in the medical care or residents in the facility.</p> <p>*The DON will be responsible for providing ongoing education and feedback to staff regarding infection control and appropriate antibiotic prescribing practices through observations, monitoring, and tracking antibiotic use and report findings to the QAA committee.</p> <p>*The Consultant Pharmacist will review the use of antibiotics be performing medication regiment review, reviewing the clinical records and laboratory results, and making recommendations regarding antibiotic use. The Consultant Pharmacist may also provide education and or education materials to nursing staff to assist its increasing awareness and knowledge of appropriate antibiotic use.</p> <p>*The facility will utilize the McGeer's Criteria for determining if the infection meets criteria for treatment with an antibiotic.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49871</p> <p>Based on observation, interview, and record review the facility failed to ensure outdated/expired medication was removed from resident medication supply affecting 1 of 5 (R20) residents reviewed for medication storage and labeling in a total sample of 28.</p> <p>Findings Include:</p> <p>On 4/15/2025 at 12PM, observed V22 (Licensed Practical Nurse/LPN) medication cart with an opened expired multi dose insulin vial belonging to R20. Insulin vial read Insulin Lispro, open date was not readable and expiration date of 4/11/2025.</p> <p>On 4/15/2025 at 12PM, V22 stated the expired insulin vial should be discarded and re-order from pharmacy.</p> <p>On 4/17/2025 at 1:30PM, V2 (Director of Nursing) stated expired medication should be removed, discarded and re-order from pharmacy.</p> <p>Review of R20's Admission Record read admitted [DATE]. Diagnosis Information include Type 2 Diabetes Mellitus with Diabetic Peripheral Angiopathy without Gangrene; Order Summary, order date 8/3/2024 read: HumaLOG Injection Solution 100 UNIT/ML (Insulin Lispro) Inject subcutaneously before meals for diabetic. Care Plan Report, revision date 8/7/2021 read, Focus: R20 has Diabetes Mellitus. Interventions: Diabetes medication as ordered by doctor.</p> <p>Policy and Procedure:</p> <p>Policy Title: Storage of Medications, Effective date 10/25/2014</p> <p>Policy: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications.</p> <p>Procedures:</p> <p>H. Outdated, contaminated, or deteriorated medications .disposed of according to procedures for medication disposal.</p> <p>Expiration Dating</p> <p>A. Expiration dates of dispensed medications shall be determined by pharmacist at the time of dispensing.</p> <p>(continued on next page)</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>E. 1 The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration.</p> <p>H. All expired medications will be removed from the active supply.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45316</p> <p>Based on observation, interview and record review, the facility failed to ensure that dining service staff are wearing hair restraints (e.g. hairnet, hat and/or beard restraint) to prevent hair from contacting exposed food. This deficiency has the potential to affect 121 residents who consumes food from the kitchen.</p> <p>Finding includes:</p> <p>On 4/16/2025 at 11:30 AM, during subsequent visit to the kitchen to monitor food temperature, V25 (Dietary Aide) was observed in the kitchen without wearing a hair net. V25 said that he should have cover his hair with a hair net.</p> <p>On 4/16/2025 at 11:32 AM, V8 (Dietary Manager) said that V25 should have a hair net on.</p> <p>On 4/17/2025 at 1:32 PM, V1 (Administrator) said that he expects the dining service staff to wear the hair restraints.</p> <p>Facility Policy:</p> <p>Guideline & Procedure Manual</p> <p>Hair Restraints</p> <p>Guideline: The restraints shall be worn by all Dining Services staff when in food production areas, dishwashing areas, or when serving food.</p> <p>Procedure:</p> <ol style="list-style-type: none"> Staff shall wear hair restraints in all food production, dishwashing, and serving areas. Hair restraints, hats, and/or beard guards shall be used to prevent hair from contacting exposed food. 		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39781</p> <p>Based on observation, interview, and record review the facility failed to use appropriate infection control practices during resident care on contact isolation precaution. The facility also failed to educate visitor on donning appropriate PPE (Personal Protective Equipment) when entering resident on contact isolation. This deficiency affects one (R47) of three residents in the sample of 28 reviewed for infection control.</p> <p>Findings include:</p> <p>On 4/15/25 at 12:18PM, R47's room was set up for contact isolation precaution. R47 is alert and pleasantly confused. Observed up in wheelchair with pillow place on her lap creating space between lunch tray placed on bedside tray table in front of her. She is eating by herself, with food all over her chest and lap. She is using spoon and her hands to eat. The pillow is soiled with food. She has her cellphone connected to outlet which is wet/soiled with food. Observed right hand fingers are reddened and swollen compared to left hand fingers. Observed long and dirty bilateral hand nails, with black matter inside the nails. Observed visible rashes on neck, chest, and bilateral hands/forearms. Called V23 LPN (Licensed Practical Nurse), showed and informed observation made. V23 called V26 CNA (Certified Nurse Assistant). V26 entered the room with proper PPE, then she realized and came out to wear gown and gloves. V23 LPN removed the food particles, on R47's chest, face, and hands. V23 cleaned R47's cellphone placed on her lap, and removed the soiled pillow covered. V23 removed her gown and gloves then performed hand sanitizing outside the door. Surveyor asked V23 why R47 is on contact isolation. V23 said that R47 is on contact isolation for Clostridium Difficile infection. Surveyor asked V23 if she needs to perform hand washing, she said using hand sanitizing is okay.</p> <p>On 4/15/25 at 12:27PM, Observed V26 CNA performed incontinence care with R47. After incontinence care, V26 removed soiled disposable brief and tossed in trash can. No isolation trash bin inside the room. No isolation bag for soiled linens/clothes. V26 rolled the soiled towel (that she used for incontinence care) and placed on bedside stand. She applied clean disposable brief without removing gloves and performing hand hygiene in between. Informed V26 of observation made. V26 said she should remove her gloves after touching soiled brief and linens, performed hand hygiene and wear new gloves before touching clean brief and linen. V26 then removed her gloves and applied a new pair of gloves without hand hygiene.</p> <p>On 4/15/25 at 12:39PM, V27 R47's friend came inside the room without wearing proper PPE (Personal protective equipment). V27 said that she has been visiting R47 twice a week for the past 2 weeks and no one told her that she must wear gown and gloves when entering the R47's room due to isolation.</p> <p>On 4/15/25 at 1:00PM, Called V2 DON (Director of Nursing) and informed of above observation. V2 said staff should perform hand hygiene when coming out resident with C. Diff infection because hand washing with soap and water physically removes the spores from the skin. Hand sanitizers are not effective against C. Diff spores. V2 said R47's visitor should be educated on wearing appropriate PPE and infection control practices for contact isolation when entering R47's room.</p> <p>On 4/15/25 at 2:58PM, Informed V7 Infection Preventionist of above observations and concerns.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 4/16/25 at 12:26PM, Informed both V1 Administrator and V2 DON of above concerns.</p> <p>On 4/17/25 at 9:15AM, V2 DON they for contact isolation set up for C. diff, don't have isolation bag/container for soiled clothes and garbage inside R47 room. They only use the regular trash can for the garbage. They combined R47's soiled clothes and linens to unit soiled hamper.</p> <p>On 4/17/25 at 10:00AM, V7 Infection Preventionist said that resident on contact isolation- for any infections including C. Diff only use the regular trash can inside the room for garbage disposal. The soiled clothes and linens are combined with unit soiled clothes/linens to be sent to laundry.</p> <p>Facility unable to provide policy on contact isolation set up.</p> <p>Facility's policy on Hand hygiene /Handwashing revision 1/10/18 indicated:</p> <p>Definition: Hand hygiene means cleaning your hands by using other hand washing (Washing hands with soap and water), antiseptic hand wash or antiseptic hand rub (i.e. alcohol-based hand sanitizer including foam or gel).</p> <p>Guidelines:</p> <p>When to wash hand with soap and water only (may use alcohol based hand hygiene sanitizer for all other):</p> <p>*After known or suspected exposure to Clostridium Difficile if your facility is experiencing an outbreak or higher endemic rates (alcohol based hand sanitizer should not be used)</p> <p>Examples of when to perform hand hygiene (either alcohol based hand sanitizer or hand washing)</p> <p>*After contact with blood, body fluids or excretions, mucous membranes, non-intact skin or wound dressings.</p> <p>*After gloves removal</p> <p>Facility's policy on Infection Precaution Guidelines revision date 5/15/23 indicated:</p> <p>Guidelines: it is the policy of this facility to, when necessary, prevent the transmission of infections within the facility with isolation precautions.</p> <p>B. Transmission- Based Precautions. Use the CDC Guidelines for Isolation Precautions to determine the infective materials, precaution needed, duration of precautions recommended.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Contact Precautions: In addition to standard precaution, use contact precautions for residents known or suspected to be infected with microorganism that can be easily transmitted by direct or indirect contact such as handling environmental surfaces or resident care items. In some instances, residents colonized with these organisms may also require contact precautions, for example, when a draining wound cannot be contained, when a resident exhibits noncompliant behavior with stool or other body fluids or when a resident has very poor personal hygiene, etc. The above includes epidemiologically important organisms (Multidrug-resistant organism) such as Methicillin-resistant Staphylococcus Aureus (MRSA) and Vancomycin-resistant Enterococcus (VRE), other highly transmissible infections such as Clostridium difficile and herpes (simplex or zoster), other transmissible conditions such as impetigo, pediculosis, scabies, and conditions such as rash of unknown origin, conjunctivitis, draining wounds, etc.</p>