STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145639	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chicago Ridge Snf	10602 Southwest Highway Chicago Ridge, IL 60415

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51084 Based on interview and record review, the facility failed to prevent and protect a resident (R2) from resident-to-resident physical abuse. This failure affected one (R2) of four residents reviewed for abuse. Findings include: R2's face sheet dated 01/12/2023, initial admitted [DATE] documents that R2 is a [AGE] year-old male with diagnoses including but not limited to: unspecified focal traumatic brain injury with loss of consciousness of unspecified duration, anxiety disorder due to know physiological condition, bipolar disorder, major depressive disorder, unspecified dementia. R2's Minimum Data Set (MDS) dated [DATE] documents: Brief Interview for Mental Status (BIMS) score of 00/15, which suggests severe cognitive impairment. Minimum data set (MDS) section GG dated 10/22/2024, R2 is dependent for toileting, shower/bathe, lower body dressing, putting/taking off footwear, personal hygiene. R2 requires partial/moderate assistance for eating and oral hygiene. Walk 10 feet - Not attempted due to medical condition or safety concerns. On 12/30/2024 at 10:10 AM, R2 stated, my roommate punched me in the chest, 4 punches. I had to go to the hospital, by an ambulance. I don't know his name. He punched me because of hurt feelings. I didn't do anything to him. I told the nurse. Resident was clean and well groomed. No foul odors. Resident was sitting in wheelchair. On 12/31/2024 at 11:51 AM, R2 stated, I'm doing good today. R3 punched me. It happened last week, at 2 o'clock in the morning. I did not tell anyone. When I came back from the hospital, I told them that he (R3) punched me. No, I did not tell them I bumped my chest. No, I did not bump my chest against the sink. R2's nurses' progress note dated 12/23/2024 at 07:21 documents: Note Text: CNA (Certified Nursing Assistant) notified the writer that the resident has discoloration on the left side of the chest. the Writer and CNA intervened and separated both parties. Writer assessed the resident from head to toe. Discoloration is noted on the left side of the chest. NP (Nurse Practitioner) was called, awaiting callback. family was left a message to give the facility a callback. all departments made aware. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R2's nurses' progress note dated 12/23/2024 at 17:56 documents: Note Text: Resident was involved in an inappropriate interaction with roommate earlier today. He has redness/bruising to the left side of his chest. Resident c/o of no pain, vitals are stable and he is calm. Physician is made aware and orders to be sent to (Local) hospital have been carried out. ADON (Assistant Director of Nursing) and DON (Director of Nursing) made aware. Phone call to family made around 6pm. (Transportation) to pick resident in 60-90 minutes. R2's social service note dated 12/23/2024 documents: Late Entry: Note Text: Resident with the psych diagnosis of Unspecified Dementia, unspecified Severity, With Other Behavioral Disturbance, Anxiety Disorder Due to Known Physiological Condition, Dipolar Disorder, Unspecified, Post-Traumatic Stress Disorder, Unspecified, Other Psychoactive Substance Abuse with Psychoactive Substance-Induce Psychotic Disorder, Unspecified, Unspecified Psychosis Not Due To A Substance or Known Physiological Condition, Major Depressive Disorder, Recurrent, Unspecified, with other medical diagnosis. Resident alert, responsive and able to make needs known at this time. Resident BIMs 0 at this time. It was reported to writer that resident allegedly had a disagreement with peer. Both peers were separated immediately. Resident was taken to a quiet place to vent and was reminded he lives in a safe facility. Resident did verbalize feeling safe in the facility at this time. Resident was counseled on conflict resolution skills. Resident was encouraged to utilize appropriate language and communication. Resident was educated to utilize coping strategies for managing heightened anxiety. Resident was encouraged to report all discourteous behavior to staff immediately. Resident was receptive to counseling at this time. DON, MD (Medical Doctor), Admin, Family and (Local Police Department) notified. Care plan and assessment updated accordingly. SS (Social Services) will continue to monitor and assist. R2's care plan dated 7/20/2023 documents (in part): Focus: The resident demonstrates behavior symptoms concerning inappropriate personal boundaries due to: A diagnosis of severe mental illness., A personality disorder diagnosis., A substance abuse disorder., Cognitive impairment secondary to Alzheimer's disease or a related dementia., These symptoms are manifested by: inappropriate touching (i.e., attempting to rub another person's back, reaching for a leg), shoulder rubbing or bump, These symptoms are manifested by: other: Goals: The resident will: ask appropriate questions. The resident will: not pry into another's persons situation. The resident will demonstrate respect for personal boundaries during interaction w/ staff & peers through the next review. The resident will: behave with respect towards staff & peers. Interventions: Staff need to be assertive when interacting with persons who do not respect boundaries. It is important to: (A) establish clear boundaries, (B) reinforce the boundaries, do not waiver, do not show flexibility; enforce strict limits, (C) communicate how to set these limits with fell ow staff members & (D) communicate how to handle this behavior to residents who are approached by peers who do not respect boundaries. Document, as appropriate, behavior symptoms such as disrespecting boundaries & assertively communicate to the resident that each person is expected to behave with dignity & respect. Use phrases to clearly communicate what behavior is unacceptable & inappropriate, for example: You & I have a professional relationship. We do not have a romantic relationship. Use phrases to clearly communicate what behavior is unacceptable & inappropriate, for example: I do not discuss my personal life at work. Use phrases to clearly communicate what behavior is unacceptable & inappropriate, for example: Use phrases to clearly communicate what behavior is unacceptable & inappropriate, for example: I am concerned about your well being & I will help you function your best. R2's hospital records dated 12/24/2024 documents diagnoses as: Contusion of left chest wall and possible assault. Police Incident report dated 12/23/2024 stated, R2 alleged that his roommate, R3, struck him in the chest. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's face sheet dated 11/20/2024 documents that R3 has a diagnoses including but not limited to: unspecified systolic heart failure, opioid dependence, chronic kidney disease. R3's Minimum Data Set (MDS) dated [DATE] documents: BIMS score of 15/15, which suggests that cognition is intact. R3's nursing progress note dated 12/232024 at 7:51 am, documents: Note Text: the writer observed the resident lying in bed resting. the writer asked the resident what happened and he stated, he didn't see anything. the Writer and CNA intervened and separated both parties. The writer assessed the resident from head to toe w/ no injuries noted. the resident was put on a 1 on 1 supervision and the (local police department) was called. the resident is his own responsible party. MD and all department heads notified. R3's social service progress note dated 12/23/2024 documents: Late Entry: .It was reported to writer that resident allegedly had a disagreement with peer. Both peers were separated immediately. Resident was taken to a quiet place to vent and was reminded he lives in a safe facility. Resident did verbalize feeling safe in the facility at this time. Resident was counseled on conflict resolution skills. Resident was encouraged to utilize appropriate language and communication. Resident was educated to utilize coping strategies for managing heightened anxiety. Resident was encouraged to report all discourteous behavior to staff immediately. Resident was receptive to counseling at this time. DON, MD, Admin, Family and (Local Police Department) notified. Care plan and assessment updated accordingly. SS will continue to monitor and assist. R3's nursing progress note dated 12/23/2024 at 12:10 pm, documents: Note Text: transportation arrived X2 via stretcher for Resident who is AOX4 (Alert and Oriented). Face sheet, medication list and petition all sent with resident. Morning and all afternoon medication was given. R3's petition for involuntary/judicial admitted d 12/23/2024 documents: Resident presents with social inappropriate encounter with peer. Care Plan dated 11/27/2024 documents: Focus: I demonstrates mood distress & anxiety related to: A diagnosis &/or h/o (history of) depressive illness., Problems/needs are manifested by: voicing repetitive health complaints-e.g., persistently seeks medical attention, obsessive concern with body function, Problems/needs are manifested by: voicing repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/reassurance, Problems/needs are manifested by: voicing distressful complaints r/t (related to) exaggerated demands/expectations that do not afford an easy solution. Goals: I will work cooperatively with staff to resolve my complaints in a fair/reasonable manner by the next review. Interventions: o Listen carefully to the resident's description of his/her concerns. Assure the resident that his/her satisfaction is important. Work cooperatively w/ the individual to resolve the complaint. Inform the resident of the steps being taken to improve satisfaction. Evaluate/assess whether other factors underlie frequent complaints. For example, complaints about food may be legitimate but may also be a person's way of saying, I am upset about living in this type of environment & facing multiple health issues. On 12/30/2024 at 10:35 AM, R3 stated, I have lived here for about a month. Nothing happened between me and R2. I used to be his roommate. I didn't punch him. I barely spoke to him. I was moved out of the room. They said because I got into it with him (R3). They sent me to the hospital and the hospital sent me right back. I had no physical interaction. The guy doesn't talk. He doesn't talk, period. I was in the middle bed. Resident appeared well groomed. Items in room well organized. No foul odors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/30/2024 at 2:35 PM V12, CNA (Certified Nurse Assistant) stated, I have worked here about 9 years. I just know what R2 told me. No, I did not witness the incident. It was Monday morning, when I went about in about 5:00AM to do AM care. I was going to change his clothes. AM care involves bed bath, change clothes get them dressed. When I was going to remove his gown, I noticed a bruise mark on his chest, right over his breast, it covered his breast. I asked him what happened, and he just said punch, punch, punch and he pointed to his roommate in the middle. His roommate was in bed, sleeping. I did not wake up the roommate. When I performed Sunday morning care, I did not see that bruise. The roommate was sleeping when I did the assessment. He did complain of pain. He said it hurts; it hurts. I went to the nurses' station to let the nurse know. When I let her know, she said she was going to go look at the bruise. I stayed in front. When the nurse came back, I went in to finish the AM care. I have not noticed any previous incidences like that. On 12/30/2024 at 3:16 PM V6 (DON) stated, I have been the DON since 12/4/2024. I saw R3 on the way out and he said he had no interaction with his roommate. The typical head to toe assessment, pain assessment was done; they notified the physician and family member. The altercation was not noticed by any staff. They were separated by putting them into separate rooms. R3 was sent out. Safety precautions are: When they return to the facility they go to separate rooms. Social Service also intervenes, do some education on conflict resolution, groups, anger management if necessary. On 12/31/2024 at 10:47 AM V14, (Assistant Director of Social Services) stated, I was not present. The incident was reported to me the following day, I believe Christmas Eve. I don't believe R2 has ever had an altercation with anyone. Interventions implemented include reminding him that he is in a safe environment and counseling. He reported he felt safe. On 12/31/2024 at 1:12 PM, V1, (Administrator) stated, I was informed of the incident. R2 was found with bruise on chest. He said he was punched on the chest by R3. He said the roommate hit him in the chest. We sent them both to the hospital. R3 said he never put his hands on him. On 1/2/2025 at 1:15 PM, V1 stated, I (V1) am the abuse coordinator. V1 stated, R3 was sent out for psych evaluation because that is who R2 said hit him. On 12/31/2024 at 1:53 PM V16, LPN (Licensed Practice Nurse) stated, I have worked here for 2 months. I had gotten report from the CNA that the R2 had bruise on his chest. So, I went to check on the bruise. The bruise covered the whole left side of his chest. Dark red mark, no imprints. So, when I saw it, I asked him what happened and R2 said: he (R3) hit me, several times and he pointed to his roommate on bed 2. I asked the CNA to help me move R2 out of the room to the nurses' station and I did a set of vitals. He didn't complain of pain to the site. R2 didn't put a call light to report the incident. I do not know if he pushes himself to the bathroom. He receives incontinence care. R3 denied any encounter with R2. He was calm. The second time I questioned R3 he said R2 told him that another resident came in and punched him. R2 was consistent with his story that he was punched by his roommate. After his vitals were done, I notified V1, V6 and Nurse consultant, his doctor and left message for his family member. They told me to call 911. Abuse Prevention Program/Facility Policy and Procedure - (State) Policy dated 11/18/2016 and review dated 01/04/2019 documents (in part): Abuse is defined as the willful infection of injury, resulting physical harm, pain, or metal anguish. Willful, as used in this definition of abuse, means the individual must have acted deliberately, to inflict injury or harm. Relevant Regulatory Standards (revised November 28, 2017) F600 Free from abuse and neglect.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on interview and record review, the facility failed to ensure sufficient nursing staff were available to ensure medications were administered as ordered to 34 residents (R1, R4, and R6-R37). This failure has the potential to affect 34 residents ordered to received medication from third floor front cart. Findings include: The 3rd floor (12/25/2024) census of 72 residents was provided to surveyor by V1 administrator. R1's face sheet dated 12/30/2024 documents that R1 is a [AGE] year-old resident with diagnoses including but not limited to: unspecified dementia, unspecified psychosis, seizures, depression, encephalopathy, essential hypertension, and chronic obstructive pulmonary disease. R1's Minimum Data Set (MDS) dated [DATE] documents R1 has a Brief Interview for Mental Status (BIMS) score of 12, which suggests that R1 is moderately cognitively impaired. Medication Administration Records (MAR) for December 2024 for (R1, R4, and R6- R37) all document that medications were not given 12/25/2024, day shift. On 12/30/2024, at 10:06 am, R4 stated we always have a nurse on shift to give medications except on Christmas Eve or Christmas Day that morning I did not get my medications. On 12/30/2024, at 10:30 AM V7, Licensed Practical Nurse (LPN), stated, we are supposed to have two nurses on each floor for day (7am - 3:30pm) and evening (3:00pm - 11:30pm) and just one for nights (11:00pm-7:30am). Two nurses on nights on second floor only and one nurse on nights for 1st and 3rd floors. On 12/30/2024, at 11:03 AM, R1 stated, we did not have a nurse on the 3rd floor day of Christmas on day shift. So, we did not get medications for the day. Someone came up from another floor about 5:00 pm and gave medications then, just the evening medications. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/31/2024, at 9:35 AM, V7 (LPN) stated, I worked Christmas Day (12/25/2024) by myself up on third floor. I did not give medications to the whole floor. I just gave medications to my side which was the back hall 312-325. The other cart covers rooms 301-311 and 326-334. Management knew I was not giving medication to the whole floor. V6 DON (Director of Nursing) knew that I wasn't going to be giving medication to the whole floor because she was looking for a nurse. She said, they were missing a nurse on first floor as well and the nurse down there was getting a bonus to pass meds for the whole floor. I told her I would not pass meds for the whole floor bonus or not. The other residents on the floor did not get their medications. V6 did not come up and pass meds for the other residents. There are 77 residents on this floor right now. I did not accept keys for that cart or anything. I came in and did my residents, passed medications, and did make sure everyone was safe and taken care of but did not pass medications for the other half of residents. This was the only time this happened that I am aware of. V6 was well aware that I was not passing medications on the other cart. ADON (Assistant Director of Nursing) is on vacation and was on vacation at that time. On 12/30/2024, at 12:27 PM, Surveyor Reviewed Daily Staffing sheets from 11/6/2024 - 12/30/2024. Date of 12/25/2024 is missing. All other dates show 2 nurses on dayshift per floor, 2 on pm shift per floor and 1 nurse on night shift for 1st and 3rd floor and 2 on 2nd floor except for the following dates: 11/8/2024 only 1 nurse on nights on 2nd floor 12/6/2024 only 1 nurse on nights on 2nd floor 12/20/2024 only 1 nurse on pms on 2nd floor 12/29/2024 only 1 nurse on nights on 2nd floor 12/30/2024 only 1 nurse on pms on 2nd and 3rd floor and 1 nurse on nights on 2nd floor. On 12/31/2024, at 11:36 AM, Schedule was provided to surveyor for 12/25/2024. Schedule documents only one nurse assigned to day shift on 3rd floor and only one nurse assigned to 1st and 3rd floor on second shift. On 12/30/2024, at 3:20 PM V6 (DON) stated I have been the DON since December 4th, 2024. I am not aware of any issues with medications not being delivered by pharmacy or residents not getting medications. R1 has not complained to me about not getting his medication. My expectation of my staff is that residents get their medications as ordered. If they run into any issues, to please let me know. I am aware of not having a second nurse up on 3rd floor on Christmas day. There was a call off. I have not had anyone come to me to say they did not receive their medications on that day. I did only have one nurse up on 3rd floor. I have worked this floor by myself and that is not how we typically want it, but it can be done. I have not been made aware of anyone missing medications. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/31/2024, at 11:52 AM surveyor interviewed V6 and V7 together. V6 stated, I would come in if we do not have enough nurses on the floor. Wound nurse, restorative nurse, IP (Infection Preventionist) nurse, ADON, MDS nurses and I can all fill in on the floor. Other nurses have come up on different occasions to help pass medications. I was trying to get help to get some nurse to come in to help pass medications. It was a holiday. (ADON) was on vacation. I was given schedules as if it was staffed. Someone quit on me. I was working at another job and could not get a replacement for myself. I was under the impression that V7 was going to pass medications for the whole floor. A resident called the administrator and said V7 told resident she wouldn't give her medications. V6 stated, I called (V7) and (V7) stated she was in process of passing medications and did not say that. V7 stated, I did not accept the keys for the other cart and made it clear I would not pass medications for whole floor. V6 stated, (V7) did say she would not accept a bonus to do the medications on the other half of the floor. V7 stated, I did not say I was passing medication all morning on the other side of the floor. V7 stated, I passed my medications to my residents, on my cart, made sure people were safe and cared for. V6 stated, I understand it is a lot, I am new, and I am accepting responsibility for this. I understand approximately 77 residents is a lot and I was continuing to look for another nurse. This was an isolated incident. These are routine residents that the nurses are used to working with. I am not an office DON. I come in here in uniforms and I work the floors. The conversation was different, I take responsibility for the situation. Not one time did (V7) say she would not pass the medications for the other residents. I still pick up at my other job. My administrator is aware that I have another job and I just pick up as needed. I have not picked up anymore because my ADON is on vacation. I had promised to work at the other job months ago prior to taking this job. We staff two nurses on day shift and pm shift for all three floors. On nights it is only one nurse for first and third floors and two nurses on second floor. On 1/2/2025, at 9:33 AM, V7 (LPN) stated I did not call the doctors for the residents that I did not pass medications to on 12/25/2024 and let them know that the residents did not get their medications. I was not the nurse for that med cart. I did not accept keys for that cart. Management knew I was not passing medications on that cart. On 12/30/2024, at 1:18 PM, V3 (Nurse Practitioner) stated, I did not get a call regarding Christmas Day or any residents not receiving their medications that morning. I am a contractor here. I do see the residents here. I was not here Christmas day. On 12/31/2024, at 1:19 PM V1 (Administrator) stated, my expectation of staff is that staff completes medication pass and documents it. I do not know the answer to if V6 is allowed to have another job. We are going to have to try to create a holiday rotation. We do not have a holiday rotation set right now. The impression I was under was that V7 (LPN) was going to pass the medications for the whole floor of about 77 patients. I did not know anything about the bonus until after the fact. I do not have to approve the bonuses. We don't give too many out. If it got crazy, yes but not in this case. We will have to come up with a holiday plan and whoever is on call for the holiday is going to have to come in and cover any call offs. My expectation is that medications are given as ordered to the residents. It could have been not so good of turnout as a lot of residents are on seizure medications, psych medications, etc. Thank God it wasn't. I am not aware of any other complaints of medications not being given as ordered except for now the issue with Christmas day on day shift. On 12/31/2024, at 11:36 AM, nursing schedule provided to surveyor for 12/25/2024. Schedule documents only one nurse assigned to day shift on 3rd floor and only one nurse assigned to 1st and 3rd floor on second shift. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on interview and record review, the facility failed to provide medications to 34 residents (R1, R4, and R6-R37) as ordered by the prescriber to meet the needs of each resident. This failure has the potential to affect thirty-four residents receiving medication from third floor front cart. Findings include: R1's face sheet dated 12/30/2024 documents that R1 has a diagnoses including but not limited to: unspecified dementia, unspecified psychosis, seizures, depression, encephalopathy, essential hypertension, and chronic obstructive pulmonary disease. R1's Minimum Data Set (MDS) dated [DATE] documents that R1 has a Brief Interview for Mental Status (BIMS) score of 12, which suggests that R1 is moderately cognitively impaired. Medication Administration Records (MAR) for December 2024 for (R1, R4, and R6- R37) all document that medications were not given 12/25/2024, day shift. On 12/30/2024, at 10:06 am, R4 stated, we always have a nurse on shift to give medications except on Christmas Eve or Christmas Day that morning I did not get my medications. On 12/30/2024, at 11:03 AM, R1 stated (in part), we did not have a nurse on the third floor day of Christmas on day shift. So, we did not get medications for the day. Someone came up from another floor about 5:00 pm and gave medications then, just the evening medications. On 12/31/2024, at 9:35 AM, V7, Licensed Practical Nurse (LPN), stated I worked Christmas Day by myself up on 3rd floor. I did not give medications to the whole floor. I just gave medications to my side which was the back hall (third floor). The other cart (front) covers residents (R1, R4, and R6-R37). Management knew I was not giving medication to the whole floor. V6 Director of Nursing (DON) knew that I wasn't going to be giving medication to the whole floor because she was looking for a nurse. She said that they were missing nurse on 1st floor as well and the nurse down there was getting a bonus to pass meds for the whole floor. I told her I would not pass meds for the whole floor bonus or not. The other residents on the floor did not get their medications. The DON did not come up and pass meds for the other residents. There are 77 residents on this floor right now. I did not accept keys for that cart or anything. I came in and did my residents, passed medications, and did make sure everyone was safe and taken care of but did not pass medications for the other half of residents. This was the only time this happened that I am aware of. The DON was well aware that I was not passing medications on the other cart. The ADON (Assistant Director of Nursing) is on vacation and was on vacation at that time. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145639	A. Building B. Wing	01/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chicago Ridge Snf	10602 Southwest Highway Chicago Ridge, IL 60415

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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/30/2024, at 3:20 PM V6 (DON) stated (in part), I have been the DON since December 4th, 2024. I am not aware of any issues with medications not being delivered by pharmacy or residents not getting medications. R1 has not complained to me about not getting his medication. My expectation of my staff is that residents get their medications as ordered. If they run into any issues, to please let me know. There was a call off. I have not had anyone come to me to say they did not receive their medications on that day. I did only have one nurse up on 3rd floor. I have not been made aware of anyone missing medications. On 12/31/2024, at 11:52 AM, surveyor interviewed both V6 (DON) and V7 (LPN) together. I (V6) was trying to get help to get some nurse to come in to help pass medications. It was a holiday. I was under the impression that (V7) was going to pass medications for the whole floor. Another (resident) called administrator and said (V7) told resident she wouldn't give her medications. I called (V7) and (V7) stated she was in process of passing medications and did not say that. V7 stated she did not accept the keys for the other cart and made it clear she would not pass medications for whole floor. V6 stated, V7 did say she would not accept a bonus to do the medications on the other half of the floor. V7 stated she did not say she was passing medication all morning on the other side of the floor. V7 stated I passed my medications to my residents, on my cart, made sure people were safe and cared for. V6 stated Not one time did (V7) say she would not pass the medications for the other residents. On 1/2/2025, at 9:33 AM, V7 (LPN) stated, I did not call the doctors for the residents that I did not pass medications to on 12/25/2024 and let them know that the residents did not get their medications. I was not the nurse for that med cart. I did not accept keys for that cart. Management knew I was not passing medications on that cart. On 12/30/2024, at 1:18 PM, V3 (Nurse Practitioner) stated, I did not get a call regarding Christmas Day or any residents not receiving their medications that morning. I am a contractor here. I do see the residents here. I was not here Christmas day. On 12/31/2024, at 1:19 PM V1 (Administrator) stated, the impression I was under was that V7 (LPN) was going to pass the medications for the whole floor of about 77 patients. Administering Medications Policy & Procedure dated 1/1/2020 documents (in part): Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. 2. The Director of Nursing Services is responsible for the supervision and direction of all personnel with medication administration duties and functions. 3. Medications shall be administered in physicians written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the residents identity when no contraindications are identified and the medication is labeled according to accepted standards. 8. The individual administering the medication shall initial the resident's medication administration record (MAR) on the appropriate line and date for that specific day before administering the medication. 10. If it is discovered the person administering medications has forgot to initial in the appropriate space, the supervisor shall notify that person to investigate if the medication/treatment has been administered/performed. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	If the response indicates the medication/treatment was administered the staff member shall return to the facility, initial and circle the MAR to indicate a late entry. A late entry note will be documented indicating the administrateion of the medication. If the medication was not administered the missed dose/medication error protocol shall be followed.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on interview and record review, the facility failed to provide significant medications to five residents (R1, R16, R26, R33 and R37) on 12/25/2024 on day shift. This failure affected five of thirty-four residents reviewed for significant medication. Findings include: Complaint dated 12/25/2024 alleges R1 is missing medications, given wrong medications and at times not all the medications due to no nurse. R1's face sheet dated 12/30/2024 documents that R1 is a [AGE] year-old resident with diagnoses including but not limited to: unspecified dementia, unspecified psychosis, seizures, depression, encephalopathy, essential hypertension, and chronic obstructive pulmonary disease. R1's Minimum Data Set (MDS) dated [DATE] documents that R1 has a Brief Interview for Mental Status (BIMS) score of 12, which suggests that R1 is moderately cognitively impaired. Medication Administration Records (MAR) for December 2024 for (R1, R16, R26, R33 and R37) all document that seizure medication were not given on on 12/25/2024, day shift. On 12/25/2024 R1's December MAR documents (in part) Divalproex Sodium Oral Tablet Delayed Release 250 mg - Give 1 tablet by mouth two times a day for treat seizures was not given on at 8:00 AM. and Levetiracetam Oral Tablet 250 mg - give 3 tablets by mouth two times a day for seizures was not given at 8:00 AM On 12/25/2024 R16's December MAR documents (in part) Keppra Oral Tablet 250 mg (milligram) - give 5 tablet by mouth two times a day for seizure was not given on at 8:00 AM and Lacosamide Oral Tablet 100 mg - give 1 tablet by mouth every 12 hours for seizures was not given at 8:00 AM. On 12/25/2024 R26's December MAR documents (in part) Depakote Tablet Delayed Release 500mg - give 1 tablet by mouth two times a day for anticonvulsant was not given at 8:00 AM. On 12/25/2024 R33's December MAR documents (in part) Depakote Tablet Delayed Release 500 mg - give 1 tablet by mouth three times a day for prevent seizures was not given at 8:00 AM nor at 12:00 PM. On 12/25/2024 R37's December MAR documents (in part) Keppra Oral Tablet 1000 mg - give 1 tablet by mouth one time a day related to other generalized epilepsy and epileptic syndromes was not given at 8:00 AM. On 12/30/2024, at 10:06 am, R4 stated, we always have a nurse on shift to give medications except on Christmas Eve or Christmas Day that morning I did not get my medications. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/30/2024, at 11:03 AM, R1 stated, I have not had my seizure medicine for about 4 days. I take Keppra twice a day 750 mg. The facility ran out. I think it is an insurance issue. I had an issue when I was not here of not taking my medications when I was supposed to. I should have 90-day supply of Keppra here that I came in with, but because I came in with it, I don't think the facility will give it to me because they can't verify what the pills are. They were giving me Depakote from a previous facility and this facility continued it here until I refused to take it. We did not have a nurse on the 3rd floor day of Christmas on day shift. So, we did not get medications for the day. Someone came up from another floor about 5 pm and gave medications then, just the evening medications. On 12/30/2024, at 2:27 PM, surveyor asked V8 (Licensed Practical Nurse/LPN) to see R1 medication cards for Keppra. V8 stated, he took his last dose on the card this morning. I already reordered it. When he needs it, we can get it out of the (Medication Storage System) downstairs. Electronic medical record shows it was reordered 12/29/2024. V8 stated, she is going to call pharmacy right now to see when it is coming in. Surveyor stayed and V8 put phone on speaker. Pharmacy stated, there is an issue with insurance. The last time we sent was November 20th for 30 days. It was a 750 mg tablet and then it changed to 250 mg tablets x 3 tabs. That may be the issue. They are stating that they can send 500 mg tablet and a 250 mg and will send it tonight and update the (Medication Storage System) for it to be pulled with new order this evening. Pharmacy needs new order sent over. On 12/30/2024, at 4:05 PM, V8 (LPN) showed surveyor 3 tabs of Keppra 250 mg pulled from (Medication Storage System) for evening dose for R1. She stated, the order was approved by pharmacy for the 750 mg oral tablet twice a day and will be delivered tonight. On 12/31/2024, at 9:32 AM, V9 (LPN) showed surveyor the two medication cards for R1 that came in of Keppra 750 mg of 30 pills each. She also showed surveyor the bottle of Keppra 750mg that R1 came in with. Bottle is over half full approximately 75% full. V9 stated, I have not been made aware of him missing any medications or Keppra. That bottle has been here since he came. On 12/31/2024, at 9:35 AM, V7 (LPN) stated I worked Christmas Day by myself up on 3rd floor. I did not give medications to the whole floor. I just gave medications to my side which was the back hall. The other cart covers (R1, R4, and R6-R37). Management knew I was not giving medication to the whole floor. V6 Director of Nursing (DON) knew that I wasn't going to be giving medication to the whole floor because she was looking for a nurse. She said that they were missing nurse on 1st floor as well and the nurse down there was getting a bonus to pass meds for the whole floor. I told her I would not pass meds for the whole floor bonus or not. The other residents on the floor did not get their medications. The DON did not come up and pass meds for the other residents. There are 77 residents on this floor right now. I did not accept keys for that cart or anything. I came in and did my residents, passed medications, and did make sure everyone was safe and taken care of but did not pass medications for the other half of residents. This was the only time this happened that I am aware of. The DON was well aware that I was not passing medications on the other cart. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 12/30/2024, at 3:20 PM V6 (DON) stated (in part), I have been the DON since December 4th, 2024. I am not aware of any issues with medications not being delivered by pharmacy or residents not getting medications. R1 did have a hospitalization and was out 12/16/2024-12/20/2024. So, he could have gotten his dose for those days at the hospital prior to returning. We do have access to this medication in the (Automated Medication Storage/Dispensing System) and he will get the dose. If there is an insurance issue, we can still get out of the (Automated Medication Storage/Dispensing System), and the facility will cover cost. That is a short-term fix, but we still need to figure out how we can get this medication. Whether it be getting an order for a different medication that does the same thing, or go to a different pharmacy, we just need to figure it out for the patient. He has not complained to me about not getting his medication. My expectation of my staff is that residents get their medications as ordered. If they run into any issues, to please let me know. I have not had anyone come to me to say they did not receive their medications on that day. I did only have one nurse up on 3rd floor. I have not been made aware of anyone missing medications. On 1/2/2025, at 9:33 AM, V7 (LPN) stated I did not call the doctors for the residents that I did not pass medications to on 12/25/2024 and let them know that the residents did not get their medications. I was not the nurse for that med cart. I did not accept keys for that cart. Management knew I was not passing medications on that cart. On 12/30/2024, at 1:18 PM, V3 (Nurse Practitioner) stated, regarding R1 is on Keppra 750 mg twice a day. I did not get a call regarding Christmas Day or any residents not receiving their medications that morning. The Keppra is used for seizure. The resident is prone to having seizures. If residents do not get seizure medication that will lower the seizure threshold and make them more susceptible to having a seizure. I am a contractor here. I do see the residents here. I was not here Christmas day. Facility policy: Administering Medications Policy & Procedure dated 1/1/2020 documents: Purpose: To ensure safe and effective administration of medication in accordance with physician orders and state/federal regulations. 2. The Director of Nursing Services is responsible for the supervision and direction of all personnel with medication administration duties and functions. 3. Medications shall be administered in physicians written/verbal orders upon verification of the right medication, dose, route, time and positive verification of the residents identity when no contraindications are identified and the medication is labeled according to accepted standards. 8. The individual administering the medication shall initial the resident's medication administration record (MAR) on the appropriate line and date for that specific day before administering the medication. 10. If it is discovered the person administering medications has forgot to initial in the appropriate space, the supervisor shall notify that person to investigate if the medication/treatment has been administered/performed. If the response indicates the medication/treatment was administered the staff member shall return to the facility, initial and circle the MAR to indicate a late entry.A late entry note will be documented indicating the administration of the medication. If the medication was not administered the missed dose/medication error protocol shall be followed.