STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145734	A. Building B. Wing	05/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Evergreen Park	10124 South Kedzie Evergreen Park, IL 60805

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observations, interviews, and record reviews, the facility failed to follow its electronic monitoring policy and post signage regarding electronic monitoring in use on facility entry and the resident's room, failed to obtain informed consent from residents and resident representatives before initiating video monitoring and audio monitoring for residents. This affected two of two residents (R83 and R159) reviewed for resident rights in a sample of 49. Findings include: On 5/21/25 at 3:00 PM, an electronic monitoring device was observed by this surveyor and V2 DON (director of nursing) on R159's bedside refrigerator. V2 stated that this device was monitoring the refrigerator temperature. On 5/21/25 at 3:10 PM, R83 stated that R83 was not aware that there was electronic monitoring being done in R83 and R159's room. R83 stated that R83 did not understand what this surveyor and V2 DON were talking about regarding the electronic monitoring device. On 5/22/25 at 9:15 AM, R159 stated that she was not aware there was an electronic monitoring device on her bedside refrigerator. When questioned if staff discussed electronic monitoring with her, R159 stated no. When questioned if R159 had given consent to be video and audio monitored, R159 stated no. On 5/22/25 at 9:20 AM, R83 stated that she was not aware there was an electronic monitoring device on R159's bedside refrigerator prior to 5/21/25. When questioned if staff discussed electronic monitoring with her, R83 stated no. When questioned if R83 had given consent to be video and audio monitored, R83 stated no. On 5/23/25 at 8:56 AM, V25 (R83's POA (power of attorney)) stated that a staff member from this facility called her yesterday and asked if R83's roommate, R159, could have a video and audio monitoring device so R159's family could monitor R159. V25 denied being informed of R83's roommate having a video and audio electronic monitoring device prior to now. V25 stated that it was explained to her that the audio would only be on if R159 was if need of assistance. V25 stated that she was not informed that the audio recording would be on 24/7. V25 stated that she understood that the device would be voice activated when R159 needed help. V25 stated that she was informed that the video and audio monitoring would only be recording R159 because R159 is an older resident and may need extra assistance to prevent her from falling. V25 stated that she does not consent to having R83 being audio recorded. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R159's medical record does not note a care plan for electronic monitoring was developed. The facility presented an electronic monitoring notification and consent form noting R159's family would like to have a video and audio monitoring device placed in R159's room. Page 1 does not note R159's first and last name or when the electronic monitoring device will be installed. Page 2 is dated 4/15/25. Page 5 notes V25 wants restriction in place: turn off the electronic monitoring device or block the video recording component of the electronic monitoring device for the duration of an exam or procedure by a health care professional. Page 6 does not note R83 signed the consent form. It also notes V25 gave consent on 4/19/25. Page 8 does not note the first and last name of the employee who was present when R83 was asked if R83 wants authorized electronic monitoring to be conducted. The facility was unable to provide documentation noting the electronic monitoring device was turned off during exams and provision of care for R83. The facility's authorized electronic monitoring of resident's room policy, revised 6/10/21, notes prior to another person consenting on behalf of a resident, the resident must be asked by that person, in the presence of a facility employee, if he or she wants authorized electronic monitoring to be conducted. The resident's response must be documented on the consent form. Prior to the authorized electronic monitoring, a resident must obtain the written consent of any other resident residing in the room on the consent form. Authorized electronic monitoring may begin only after the required consent form has been completed and submitted to the facility. If a person other than the resident signs the consent form, the form must document: the date the resident was asked if he or she wants authorized electronic monitoring to be conducted, who was present when the resident was asked, and an acknowledgement that the resident did not affirmatively object. If a person other than the roommate signs the consent form, the form must document: the date the roommate was asked if he or she wants authorized electronic monitoring to be conducted, who was present when the roommate was asked, and an acknowledgement that the roommate did not affirmatively object. A copy of the resident's consent form shall be placed in the resident's file. A sign shall be clearly and conspicuously posted at all building entrances accessible to visitors and at the entrance to a resident's room where authorized electronic monitoring is being conducted.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview the facility failed to ensure the call light was in reach for a dependent resident. This affected one of three residents (R146) reviewed for call light accessibility. Findings include: On 5/20/25 at 11:41am R146 was observed resting in bed, R146 observed alert to person and able to communicate. R146 call light was observed hanging down to the floor on the left-hand side of the bed. R146 said she don't know where her call was, R146 was observed to feel around for the call light but not able to reach it. At 12:27pm R146 call light remains out of reach. On 5/23/25 at 9:52am V17 (Assistant Director of Nursing) said call lights should be in reach of the resident; the residents use the call lights to call for the Nurse assistant when they need something. Facility policy titled Call Light Policy with last revised date of 7/26/2024 denotes in part, it is the policy of this facility to ensure that there is prompt response to the residents call assistance. The facility also ensures that the call system is in proper working order.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, facility staff failed to accurately code a Minimum Data Set (MDS). This affected three of three residents (R130, R81, R43) reviewed for accurate assessment. Findings include: 1. On 5/20/25 R130 observed alert to person, place and time, R130 said she has not received dialysis in over two years. R130 said she has a new kidney, and she is not receiving dialysis. R130 said she has never received dialysis at the this Nursing home. Review of R130 MDS dated [DATE], section o for special treatment, procedures and programs, J1 denotes dialysis , performed while a resident of this facility and within the last 14 days. Yes is checked with an X. Review of R130 physician orders including discontinued orders, R130 does not have any orders for dialysis treatment. On 5/22/25 at 10:49am V22 (MDS Coordinator/RN) said the MDS assessment should be coded accurately, the MDS drives the plan of care and is also used for reimbursement. V22 said R130 does not received dialysis and has never received dialysis while a resident of the facility. V22 said she has to submit a correction MDS. 2. R81 was admitted on [DATE] with a diagnosis of anemia, dementia, adult failure to thrive and malnutrition. R81's physician order dated 2/8/24 document hospice evaluate and treat. R81's hospice note dated 3/18/25 documents: Resident continues to have six months or less prognosis if disease runs its normal course. Proceed with recertification of hospice services under terminal diagnosis of cerebral atherosclerosis. On 5/22/25 at 11:59AM, V22 (MDS Coordinator) said for hospice residents they code section J related to prognosis if documentation (physician certificate) is available. V22 said that R81's Minimum data set should have been coded yes based on documentation that was uploaded into the medical record prior to the minimum data set being completed. R81's Minimum Data Set, dated [DATE] documents under section J prognosis does the resident have a condition or present illness that may result in life expectancy of less than 6 months. Coded a 0, which indicates no. 3. R43 minimal data set section O (special treatment procedure and program) dated 5/15/25 documents: Hospice Care. Response locked: Yes. Social service note dated 8/6/24 was advised that the patient's last cover date (LCD) for Hospice is July 25, 2024. On 5/22/25 at 11:20am, V17 (adon) said, R43 is not on hospice. The MDS should have be change when resident was removed from hospice. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/25 11:59am, V22 (mds coordinator) said, significant change needs to be completed with-in fourteen (14) days after being informed. R43 had a payor source change from hospice on July 26. 2024. R43's minimal data set should have been changed in July 2024.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure care plans reflect the patients care needs for safe transfer status to include mechanical lift. This affected one of eight residents (R52) reviewed for implementation of care plan interventions in the sample of 49 residents. The findings include: On 05/20/25 at 11:21 AM V9, Certified Nursing Assistant (CNA), assisted R52 into the resident bathroom in her wheelchair. V9 told R52 to stand to use the toilet. R52 hesitant and required verbal and physical cueing from V9 to stand. No gait belt was applied to R52 during the transfer onto the toilet. V9 stood and R52 assisted with removing the soiled brief. R52 turned with V9 assisting and sat on the toilet. V9 said I know how to transfer the resident with the care cards instruction. V9 said R52 is recovering from a hip fracture. On 5/21/25 at 9:48AM V5, Restorative Nurse, said transfer status for R52 prior to her fall on 5/1/25 was stand and pivot with 1 assist. V5 said currently R52 should be a mechanical lift transfer due to a diagnosis of hip fracture. On 5/21/25 at 12:46PM V7, CNA, said I was transferring R52 from her bed to wheelchair. V7 said I had transferred R52 before. V7 said I did not use any equipment to transfer her. V7 said R52 does not use a walker or cane for transfers. V7 said I don't recall using the gait belt, everything happened so fast. V7 said R52 was a stand and pivot with 1 person assist with transfers. On 5/22/25 at 12:51PM V22, MDS Nurse, said the care plan is driven by the Care Area Assessment (CAAs) medications, and acute issues. V22 said the care plan reflects the residents care needs. V22 said staff should follow the interventions on the care plan. R52's care plan dated 8/8/24 intervention dated 11/13/24 identifies she requires x2 staff participation with full body mechanical lift transfers. There is no identification that she was a 1 person with gait belt assist for transfers. MDS dated [DATE] identifies R52 uses a walker and requires partial to moderate assistance from the staff for transfers.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observations, interviews, and record reviews, this facility failed to provide incontinence care/checks at least every two hours. This affected one of three (R150) residents reviewed providing incontinence care for dependent residents in the sample of 49 residents. Findings include: On 5/20/25 from 11:45 AM until 1:45 PM, continuous observation was made by this surveyor. There was noted to be a malodor coming from R150's room. During this time period, staff did not provide incontinence care or turning/repositioning for R150. On 5/20/25 at 12:40 PM, V15 (nurse) was observed entering R150's room to provide gastrostomy tube care. V15 exited R150's room without checking if R150 needing incontinence care. On 5/20/25 at 1:45 PM, R150 was observed to have a urine saturated brief on, the flat sheet under R150 was wet from R150's upper back down to her knees with a brown discoloration outlining it. When R150 was turned towards her left side, the mattress was wet with liquid pooled where buttocks was. R150's sacral pressure ulcer dressing was saturated with urine. On 5/20/25 at 1:45 PM, V4 CNA (certified nurse aide) stated that V4 is the first resident she provides care for when she starts her shift. V4 stated that R150 is not able to assist staff with ADLs; R150 is totally dependent on staff for care. On 5/22/25 at 8:22 AM, V12 (wound care director) stated that staff are expected to turn and reposition residents every two hours. V12 stated that staff are expected to provide incontinence care for residents every two hours and as needed. V12 stated that if a resident's dressing becomes saturated with urine or stool, the nurse is expected to perform an as needed dressing change. R150'2 MDS (minimum data set), dated 1/9/25 and 4/4/25, notes R150's BIMS (brief interview of mental status) score is 3 out of 15. R150 is dependent on staff for all ADLs (activities of daily living).

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that one resident who was on pain medication had an effective bowel regime program to prevent constipation. This affected one of one resident (R18) reviewed for quality of nursing care and prevention of constipation. This failure led to R18 being sent to the hospital with a diagnosis of severe fecal impaction with stool ball measuring over 8 centimeters (CM). Findings include: R18 was admitted to the facility on [DATE] with a diagnosis of dependence on supplemental oxygen, heart failure , spinal stenosis, type II diabetes and atrial fibrillation. R18's brief interview for mental status dated 3/4/25 documents a score of 9 which indicates moderate cognitively impairment. R18 physician orders document: tramadol 50 mg (milligrams), take one tablet by mouth twice a day for moderate to sever pain. Start date 12/11/24. Fentanyl patch 12mcg/hr (micrograms/hour). Apply one patch every 72 hours for pain. Start date 1/17/25. On 5/23/25 at 12:00PM, V27(Nurse Practitioner) said fecal impaction is caused by constipation which is preventable but can be attributed to lack of movement, nutrition, hydration and pain medications. R18 did not mention being constipated and were unaware that R18 was having concerns. V27 said she would expect staff to notify them of any changes in bowel movement or lack of bowel movements for three days. On 5/22/25 at 11:46, V17(ADON) said R18's hospital stay related to fecal impaction was preventable. R18 was taking a pain medication and had a medication related to constipation but was not effective. R18's medical doctor assisted with putting in an effective bowel management for R18. Point of care charting for March 2025 bowel movements documents 3/1/25 and 3/2/25 a small bowel movement; 3/3/25 - 3/7/25 documents none. R18's hospital record dated 3/9/25 documents under CT abdomen impression severe fecal impaction at the rectum with stool ball measuring over 8 centimeters. Mild perirectal inflammatory changes may reflect stercoral proctocolitis. Under history documents Patient is found to have sever fecal impaction with findings consistent with stercoral proctocolitis. Patient disimpacted with large amount of stool collected, no blood noted or black, and she is feeling better afterwards, also received enema. Bowel management revised 7/26/24 documents: it is the facility policy to record resident's bowel movement in the medical record. The certified nurse aide each shift will record the resident's bowel movement. The facility will assess the resident when the resident shows sign and symptoms of abdominal stress, if there is a change in the resident's pattern of bowel movements, the facility will notify the physician.

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, this facility failed to consistently and accurately assess, monitor, and implement interventions to prevent skin breakdown, and failed to ensure the intervention of the low air loss mattress was implemented per manufacture guidelines. This affected two of three residents (R62, R176) reviewed for pressure sore and pressure sore prevention. This failure resulted in R62 being admitted to the facility on [DATE] with skin in tact and developing a facility acquired pressure sore (unstageable) wound to the sacrum area by 4/25/25. Findings include: 1. R62's braden scale evaluation, dated 4/2/25, notes R62 is at high risk for developing skin breakdown. R62's admission skin/wound evaluation, dated 4/2/25, notes R62 does not have a current skin alteration and/or newly healed wound. V13 (wound care nurse practitioner) initial assessment of R62's sacral wound, dated 4/30/25, notes R62 with an unstageable pressure injury to sacrum, measuring 9cm x 8cm x 0.1cm. 60% epithelial, 30% granulation tissue, 10% slough. There is no order for LAL mattress or documentation of when it was placed on R62's bed; R62 had a LAL mattress at start of survey on 5/20/25. R62's POS (physician order sheet), dated 5/6/25 notes an order for juven supplement twice daily and prostat supplement twice daily. There also is an order for pureed diet, thin liquids. On 5/23/25 11:30 AM, wound care observation with V12 (wound care director). R62 was observed to have an unstageable sacral pressure injury, measuring 6cm (centimeters) x 7.5cm x 0.1cm, 30% epithelial tissue, 10% granulation, 60% eschar. Wound cleaned with normal saline, medihoney applied, calcium alginate applied and covered with bordered gauze. On 5/22/25 at 3:00 PM, V12 stated that R62 developed a facility acquired pressure ulcer. V12 stated that R62 has scarring on sacrum due to pressure ulcer from previous stay in this facility (2023) and it re-opened. V12 stated that R62 was placed on a low air loss mattress and heel protectors were applied bilaterally. V12 stated that R62 receives nutritional supplements to promote wound healing. 2. R176 was diagnosis with scalp surgical dehiscence and left lateral ankle full thickness wound. R176's vital report dated 5/6/25 documents: 124.6 (one hundred and twenty-four point six) pounds. Skin and wound note dated 5/15/25 documents: The patient (R176) continues on an alternation air mattress for pressure redistribution. Ensure settings are maintained at an appropriate level bases on the patient's needs and body habitus. (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	On 5/20/25 at 11:28am, R176 was observed laying on an alternation air mattress for pressure redistribution control panel/weight setting at one hundred and fifteen (115) pound. R176's mattress was observed deflated in the upper middle portion of the mattress. R176's shoulder was sunk in between the partially inflated sections of the middle top portion of the mattress. V17 (adon) said, R176's mattress was set at 115 pound. V17 said, R176 mattress was deflated middle top portion of the mattress. R176 who was alert and orient to person place and time, said his mattress had been deflated since yesterday. R176 said, his hurting his back. R176 complained of pain a 10/10. Pain management provided. On 5/20/25 at 11:32am, V12 (wound care director) said, the middle top portion of R176's mattress looks flat/deflated. V12 said, someone must have move R176's bed, the cord has been pulled out of the socket. R176's power cord to his alternating air mattress was observed hanging out of the electric socket. The electric cord was not secure to the power source so that R176's mattress would remain inflated. On 5/20/25 at 11:37am, V16 (cna) said, R176's alternative mattress was deflated in the top middle upper portion. V16 said, R176 mattress was full at the bottom and flat at the top. V16 said, she informed staff an hour ago that R176 mattress was deflated. On 5/21/25 at 12:35pm, R176 was observed on his specialized mattress which was set at one hundred and fifty (150) pounds. R176 said, his specialized mattress feels much better today. On 5/22/25 at 11:09am, V12 said, R176's weighs one hundred and twenty four (124) pounds. R176 requested for his specialized mattress to remain set at one hundred and fifty (150) pounds because it was comfort. On 5/23/25 at 8:23am, V12 (wound director) said, R176 has a full thickness wound on his ankle that could be classified as a stage three or four. V12 said, R176 is on the alternating pressure redistribution mattress. If the mattress is not fully inflated it's cannot providing redistribution. Alternating pressure redistribution mattress guidelines 3/2020 documents: Enter resident's weight accordingly if the alternating pressure redistribution mattress has a weight specification button.

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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 observation, interviews, records reviews the facility failed to follow the identified mechanical lift transfer status while transferring onto the toilet and failed to follow their policy and use a gait belt to perform a safe transfer from bed to wheelchair for one resident. This affected one of three residents (R52) reviewed for safety during staff assisted transfers. This failure resulted in R52 falling during the bed to wheelchair staff assisted transfer and sustaining an acute impacted right femoral fracture. The findings include: R52 cognition on 4/21/25 was 13 and on 5/8/25 her cognition score decreased to 8. Facility reported incident report for R52 dated 5/1/25 states R52 was lowered to the floor during a transfer and found to have right hip fracture requiring right hip pinning. On 05/20/25 at 11:21 AM V9, Certified Nursing Assistant (CNA), assisted R52 into the resident bathroom in her wheelchair. V9 told R52 to stand to use the toilet. R52 hesitant and required verbal and physical cueing from V9 to stand. No gait belt was applied to R52 during the transfer onto the toilet. When V9 stood a wheelchair cushion was on the seat of the chair, no other device. V9 stood and R52 assisted with removing the soiled brief. R52 turned with V9 assisting and sat on the toilet. V9 removed the wheelchair from the bathroom, closed the bathroom door, and stepped out of the room. At 11:26AM V9 went to retrieve towels and a brief. At 11:28AM V9 returned to R52. V9 said I know how to transfer the resident with the care cards instruction. V9 said R52 is recovering from a hip fracture. R52 alert to name and situation but did not want to answer the surveyors questions regarding the fall on 5/1/25. On 5/21/25 at 9:48AM V5, Restorative Nurse, said transfer status for R52 prior to her fall on 5/1/25 was stand and pivot with 1 assist. V5 said currently R52 should be a mechanical lift transfer due to a diagnosis of hip fracture. V5 said the Kardex identifies R52 as 2 person transfer because of limited mobility with the fracture. At 1:11PM V5 said I am in charge of training staff on using gait belt for 1 assistance. V5 said all staff are issued a gait belt. V5 said gait belts are issued by Human resources. On 5/21/25 at 11:39AM V6, Fall Nurse, said when investigating a fall, I gather witness statements from staff and I try to speak with the patient. V6 said I do a root cause analysis, and we discuss with the team to develop interventions. V6 said I notify the staff about the interventions, and I update the care plan. V6 said R52 was not a fall risk before her fall, she was a low risk. V6 said R52 has no history of falls. V6 said when R52 fell, her bed was at about waist height, she was wearing shoes, and as she was going from bed to chair. V52 said I don't know what R52 was wearing when she fell. V6 said R52 said her leg gave out and she was lowered to the floor. V6 said after the fall R52 was referred to therapy and her transfer status was changed. V6 said staff should utilize the identified transfer technique on residents for safety. On 5/21/25 at 12:55PM V2, Director of Nursing, was asked who is in charge of training staff on transfer techniques? V2 said that would be V5, Restorative Nurse. (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	On 5/21/25 at 12:46PM V7, CNA, said I was transferring R52 from her bed to wheelchair. V7 said R52 didn't say anything and her knees were buckling, she was :too heavy for me to hold up. V7 said she hit kind of hard. V7 said I had transferred R52 before. V7 said R52 was wearing pants, a shirt, a sweater and footies with her non skid shoes. V7 said I did not use any equipment to transfer her. V7 said R52 does not use a walker or cane for transfers. V7 said I don't recall using the gait belt, everything happened so fast. V7 said R52 was a stand and pivot with 1 person assist with transfers. V7 said after the fall the nurse and I got R52 off the floor and assisted her into the wheelchair. On 5/22/25 at 10:40AM V1, Administrator said the only policy for transfer is in the Restorative Nursing Program policy dated 8/19/24. V1 pointed in the policy where it reads Nursing and restorative services may include the following, transfer. V1 said the CNAs are expected have a gait belt as part of their uniform and restorative department does the training with CNAs for transfer of residents. On 5/22/25 at 10:41AM V20, CNA, said for 1 person assisted transfer we always use a gait belt. V20 said we have to use a gait belt to balance the resident if they are falling we can hang on. ON 5/22/25 at 10:45AM V21, Human Resources, said I tell CNAs at orientation that gait belts are part of their uniform. CNAs perform competency at orientation. V21 provided Competencies for V7 and V9. On 5/22/25 at 10:56AM V2, Director of Nursing, said staff should not leave residents at risk for falls on the toilet alone. V2 said the resident might forget to not get up and stand up and fall. V2 said the patient might forget they are here because they need help. R52's x-ray report from the hospital identifies an acute mild impacted right subcapital femoral fracture. According to the hospital records R52 underwent surgery for her hip. The surveyor requested a fall risk assessment for R52 prior to 5/1/25 fall and the facility provided 5/1/25 identifying her score as high risk. On a review of R52's chart the only Fall Risk Evaluation found is dated 5/1/25. On 5/21/25 at 1:18PM unsuccessful in attempting to contact V8, LPN, nurse on duty when R52 fell 5/1/25. V21 provided the employee handbook that includes Gait Belt Policy, page 57, states in part CNA is expected to use the gait belt whenever ambulating got transferring a resident for the safety of the resident and the employee. Gait belts will be used when helping the resident mover from bed , chair or commode/toilet. MDS dated [DATE] section GG states R52 utilizes a walker. Partial to moderate assistance for sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed. Partial to moderate assistance Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair). R52's care plan does not identify use of a gait belt or 1 person assist for period prior to 5/1/25. Facility Fall Prevention Program Guidelines dated 12/5/21 states this program shall include measures to determine the individual needs of each resident by assessing the risk for fall and the implementation of evidence-based prevention interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A fall risk assessment shall be completed upon admission, re-admission, quarterly, significant change, annually, an after each fall. Safety interventions shall be initiated and implemented for each resident identified at risk for fall. All nursing personal and facility staff shall be responsible for ensuring ongoing precautions are put into place. Interventions shall include staff, family and resident education, programs, purchase of equipment or other environmental -related alternative to prevent the resident from falling.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow their oxygen therapy and administration policy by failing to ensure residents have physician orders for oxygen use and ensure the oxygen concentrator is in working order. This affected one of one (R18) resident reviewed for oxygen use. Findings include: R18 was admitted to the facility on [DATE] with a diagnosis of dependence on supplemental oxygen, heart failure and atrial fibrillation. On 5/20/25 at 11:40AM, R18 observed in bed with nasal cannula in place. R18 oxygen concentrator was off. Staff notified of concern. At 12:03PM, V17(ADON) assisted R18 with oxygen and attempted to turn on concentrator but concentrator began to beep and not working properly. V17 exchanged oxygen concentrator for a new one. V17 said she was not notified prior of any concern to the oxygen concentrator. On 5/21/25 at 1:42PM, V2 (director of nursing) said there was no order for R18's oxygen. The last order for oxygen was discontinued on 4/7/25 when R18 went to the hospital. V2 said any oxygen should have an order and that the oxygen order was not continued when readmitted to the facility. V2 said R18 still has a need for oxygen and should have an order for oxygen. Oxygen therapy and administration policy revised 8/16/24 documents: Oxygen therapy shall be administrated to patients as indicated and upon a physician order. Confirm order from physician (this should include liter flow, FIO2 and delivery device) Assemble equipment as needed. Use humidifiers for all patients requiring nasal cannula. Before placing on the patient, test the setup by feeling for the flow at the patient connection. You may also occlude the flow to test the pressure release valve. Date your equipment. Oxygen rounds should be completed weekly by registered nurse, depending on facility. oxygen rounds include checking that the humidifier bottle has at least an inch of water; device is connected properly; Oxygen setups should be changed every seven days and as needed.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record reviews, the facility failed to follow its side rail policy and assess residents for the need of side rails use and/or obtain consent prior to the use of side rails for four residents (R26, R150, R159, and R161) of seven in a sample of 49. Findings include: On 5/20/25 at 10:00 AM, R159 was observed to have raised upper quarter side rails on both sides of bed. R26 was observed to have upper 1/2 side rails on both sides of bed. R150 was observed to have raised upper quarter side rails on both sides of bed. R161 was observed to have upper 1/2 side rails on both sides of bed. On 05/21/25 11:17 AM V5 (restorative nurse) stated that all beds in this facility have bilateral upper side rails. V5 stated that all residents should have a side rail assessment completed on admission, quarterly, significant change, and annually. V5 was unable to locate a side rail assessment for R159, admitted on [DATE]. V5 stated that side rail consents are kept in a binder. On 5/21/25 at 3:00 PM, V2 DON (director of nursing) and V5 stated that the resident's first and last name should be printed on the consent form. Both stated that the consent should also have the signature of the resident/resident representative and the date signed (month, day, and year). Both stated that the reason for side rail use and the type of side rail in use should be documented on the consent. Both stated that two nurses need to witness verbal consent. 1. R26: R26's medical record notes R26 was admitted to this facility on 10/3/2009. R26's side rail care plan was initiated on 3/7/19. There are no quarterly side rail assessments other than one completed on 3/7/19. There is no consent for side rails found in R26's medical record. 2. R150: On 5/20/25 at 1:45 PM, V4 CNA (certified nurse aide) stated that R150 is not able to assist staff with ADLs; R150 is totally dependent on staff for care. V4 stated that R150 is not able to use side rails. R150's medical record notes R150 was admitted to this facility on 1/7/25. R150'2 MDS (minimum data set), dated 1/9/25, notes R150's BIMS (brief interview of mental status) score is 3 out of 15. R150 is dependent on staff for all ADLs (activities of daily living). (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R150's side rail care plan was initiated on 1/22/25 noting ADL side rail enabler to enhance functional independence. There are no quarterly side rail assessments found in R150's medical record. The facility presented a consent for the use of side rails for R150 that notes R150 cannot sign for self and there is no consent obtained from R150's representative. On 5/21/25, the facility presented a corrected consent for side rail use signed by R150's representative. 3. R159: R159's medical record notes R159 was admitted to this facility on 10/3/24. R159's side rail care plan was initiated on 10/30/24. There are no consent for side rails found in R159's medical record. 4. R161: R161's medical record notes R161 was admitted to this facility on 11/12/24. R161's side rail care plan was initiated on 12/10/24. There is no consent for side rails found in R161's medical record. On 5/21/25, the facility presented a corrected consent for side rail use signed by R150's representative. The facility's side rail policy, revised 8/19/24, notes prior to the use of side rails, alternative devices will be utilized first for residents in need of repositioning. If the alternative devices failed to assist the resident in repositioning, the resident will be assessed for the use of side rails. If side rails are appropriate for the resident, a verbal or written consent will be obtained by the facility prior to the use of side rails. The use of side rails will be evaluated at least on a quarterly basis.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to follow their medication labeling, Storage of medications and insulin administration policies by not discarding medication for discharge residents, ensuring open date and expiration dates were labeled on insulin pens, (R80, R136, R33, R59, R172) of five of five residents reviewed for medication storage. Findings include: On [DATE] at 10:56am, V15 (nurse) said, when insulin has been opened, it must be dated with an open/ expiration date. Resident who are currently residing in the facility should be the only residents with medication on the cart. R80 was discharged . R80's insulin should have been discarded. R80's was observed with a lispro insulin bottle dispensed on [DATE] on the medication cart opened and not dated. R80 had two bottles addition bottles of lispro insulin dispensed on [DATE] on the medication cart opened and not dated. V15 (nurse) said, expired insulin must be discarded. On [DATE] at 8:36am, V17 (adon) said, resident that have been discharge should not have any medication on the medication cart. V17 said, insulin must have an open date written on it. R80's face sheet documents: Type 2 Diabetes Mellitus. Date of discharge [DATE]. R80's physician order dated [DATE] documents: lispro insulin discontinued [DATE]. Progress note dated [DATE] documents: Resident discharge home. On [DATE] at 10:56am, R136 had insulin degludec with the open date of [DATE] and expiration dated [DATE] written in the bottle on the medication cart R136 had insulin degludec with the open date [DATE] and expiration date [DATE] written on the pen in the medication cart. V15 (nurse) said, expired insulin must be discarded. On [DATE] at 8:36am, V17 (adon) said, insulin must have an open date written on it. R136's face sheet documents: Type 2 Diabetes Mellitus. R136's physician order dated [DATE] documents: insulin degludec: Inject 15 unit subcutaneously at bedtime. Order Status: Active. On [DATE] at 10:56am, R33 was observed with insulin glargine on the medication cart opened and not dated. V15 (nurse) said, insulin should be dated after it's been opened. On [DATE] at 8:36am, V17 (adon) said, insulin must have an open date written on it. R33's face sheet documents: Type 2 Diabetes Mellitus. R33's physician order dated [DATE] documents: insulin glargine: Inject 10 unit subcutaneously at bedtime. Order Status: Active. On [DATE] at 12:14pm, R59 was observed with lispro insulin opened and not dated on the medication cart. V19 (nurse) said, insulin should be dated after it's been open. On [DATE] at 8:36am, V17 (adon) said, insulin must have an open date written on it. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R59's face sheet documents: Type 2 Diabetes Mellitus. R59's physician order dated [DATE] documents: insulin lispro: Inject 6 unit subcutaneously three times a day. Order Status: Active. On [DATE] at 12:14pm, R172 was observed with a lispro insulin that was open and not dated. V19 (nurse) said, insulin should be dated after it's been open. On [DATE] at 8:36am, V17 (adon) said, insulin must have an open date written on it. R172's face sheet documents: Type 2 Diabetes Mellitus. R172's physician order dated [DATE] documents: insulin lispro: Inject as per sliding scale. Order Status: Active. Medication Pass Policy dated [DATE] documents: Medication Labeling- All opened medication vials in the refrigerator should be labeled with the date when it was opened and discarded with in twenty-eight (28) days of opening expect levemir inulin which can be discarded forty-two (42) days after opening and eye drops which can be discarded six (6) weeks after opening.

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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 observations, interviews, and record review this facility failed to follow their infection prevention and control policy and perform appropriate hand hygiene before entering and after exiting resident room, failed to follow their infection control policy for donning appropriate PPE (personal protective equipment) prior to entering resident rooms in enhanced barrier precautions to perform resident care. This affected four of four (R26, R150, and R137) residents reviewed for infection control practices Findings includes: On 5/20/25 at 12:40 PM, V15 (nurse) was observed donning gloves and entering R150's EBP room. V15 was observed bringing R68's bedside table to R150's bedside. V15 was observed flushing R150's gastrostomy tube with water. V15 did not don a gown prior to providing care to R150. On 5/21/25 at 8:45 AM, V13 NP (nurse practitioner) and V14 NP donned gloves and entered an EBP resident room. V13 and V14 performed a new admission skin assessment on the resident. V13 and V14 assessed resident head-to-toe for any skin abnormalities. Neither donned a gown prior to performing direct resident care. On 5/21/25 at 8:55 AM, V12 (wound care director) was observed entering R26's EBP room. V12 did not don PPE. V12 was observed removing a dressing on R26's left forearm, placed dressing in garbage, touched both sides of head with hands, moved bedside table, raised R26's bed, performed hand hygiene and exited R26's room. At 9:05 AM, V12 returned to R26's room with dressing supplies and placed supplies on R26's bed. V12 then donned PPE and performed wound care to R26's left forearm. On 5/22/25 at 8:53 AM, outside laboratory employee was observed entering an EBP resident room to perform blood specimen collection. The laboratory employee donned gloves prior to entering R137's EBP room. The laboratory employee was observed touching bed controls to raise bed, turned on the light over bed, and obtain blood specimen. No hand hygiene performed or no gown donned. 05/21/25 09:30 AM, V3 (infection prevention nurse) stated that before staff enter a resident's room they are expected to observe the sign on the resident's door to determine what PPE is needed, if providing direct care, staff are expected to don a gown, enter room, clean hands, and then don gloves. As long as staff are not physically touching the resident they do not have to don PPE. V3 stated that staff are expected to perform hand hygiene before and after entering resident rooms. The facility's infection prevention and control policy, revised 7/31/24, notes a sign will be provided outside the room for residents on transmission-based precaution indicating the type of the precaution (contact, droplet, EBP). Hand hygiene will be performed by staff before and after direct patient contact and after each situation that necessitates hand hygiene. EBP involves the use of gloves and gowns during high contact resident care activities.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. Based on interviews and records reviewed the facility failed to develop and implement protocols and a system to monitor antibiotic use for one resident with a history of Clostridium difficile currently on antibiotics. This failure affected one of eight (R28) residents reviewed for infection control practices. Findings include: On 5/21/25 1:21PM V3, IP (Infection Prevention) Nurse, said R28 was removed from contact isolation for C-Diff because there were no symptoms. Symptoms would include loose stools or abdominal cramping. There have been no reports that he has 3 loose stools or cramping. Consistency for c-diff stool can be putty, loose, runny, or slimy. Stool putty like should be reported. R28 Is on antibiotics currently and the floor nurse are responsible to monitor him. There should be an antibiotic assessment or progress notes to show the documentation of the assessment. On 5/21/25 2:01PM V3 said They (nurses) are not documenting the assessments for R28. V3 said we should be doing it, I expect it, but we don't have a policy for them to document when on antibiotics. V3 said they should document daily on the antibiotics, at least when the antibiotic is given. The purpose was to monitor antibiotic use and monitor for any side effects. On 5/22/25 at 12:51PM V22, MDS Nurse, said the care is driven by the Care Area Assessment (CAAs) medications, and acute issues. V22 said the care plan reflects the residents care needs. V22 said staff should follow the interventions on the care plan. R28 progress notes dated 5/19/25 identify Doxycycline and Amoxicillin used of for under arms skin microbiota. This is the only antibiotic monitoring for R28 R28's Consistency of bowel movements identifies stool loose/diarrhea on 5/13/25 - 5/17/25. Putty like 5/8/25-5/12/25 and again 5/17-20. Order summary report for R28 includes Amoxicillin every 12 hours and Doxycycline every 12 hours R28's care plan interventions include any antibiotic may cause diarrhea, nausea, vomiting, anorexia, and hypersensitivity/allergic reaction. Monitor every shift for adverse side effects.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review the facility failed ensure that the resident was provided a clean homelike environment for one residents (R7) reviewed for home like environment. Findings include: On 5/20/25 at 11:15am R7 was observed resting in bed, there was dry substance on the tube feeding machine, thick dry substance was observed on the floor, numerous dry substances observed on the wall (flowing down the wall), dry substance observed on the bed side table, and dark substance observed on the bed framing. At 3:00pm dry substance remains on the floor, walls, machine and bed framing. On 5/21/25 at 10:56am dry substance remains on the floor, walls, machine and bed framing. On 5/21/25 at 11:20am R7 was observed resting in bed, R7 said she received a bed bath today, R7 said she is dry, and not soiled. R7 pillowcase was observed with a wet yellow/brown stain, smelled of urine. R7 said the aide did not change her bed linen today. R7 said she doesn't know if the sheets have the same stains as the pillowcase. R7 agreeable for observation of checking her bed sheets. V23 (RN-Registered Nurse) summons to the room to assist with observation. R7 bed sheets was observed soiled with yellow/brown stains. R7 said she doesn't want to be smelling like urine. V23 said the staff should have changed the pillowcase and bed sheets when they provided R7 bed bath today. On 5/22/25 at 12:01pm during a tour with V24 (Housekeeper supervisor) to observe the environment of R7's room, V24 stated that he was aware of the substance on the bedrails, the substance on the wall, and the dried substance on the floor. V24 said the substance should not be on the floor, walls and bed frame. V24 said the substance on the wall looked like feeding and he doesn't know what the substance on the bed framing. V24 said he is working to get the rooms deep cleaned including R7 rooms. V24 said the Nurse should remove the substance when it spills and not wait until it gets dry and harden. Facility policy titled General Housekeeping with last revised date of 7/30/2024 denotes in-part the facility will ensure that the facility and resident rooms will be clean, orderly and sanitary through housekeeping services. The house keeping will clean and sanitize the resident rooms and bathrooms daily using (cleaning solution) and keep surfaces wet x 4 minutes.