STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145748	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Place	5550 South Shore Drive Chicago, IL 60637

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 47304 Based on interview and record review the facility failed to determine, establish, obtain or discuss code status of 1 (R133) out of 4 residents reviewed for Advance Directives in a sample of 15. The findings include: R133's Admission record showed admitted on 11/6/2024 with diagnoses not limited to Unspecified displaced fracture of sixth cervical vertebra,Unspecified fracture of first thoracic vertebra, Fall on same level, Unspecified abnormalities of gait and mobility, Problem related to care provider dependency, Encounter for other orthopedic aftercare, Muscle weakness (generalized), Unsteadiness on feet, History of falling, Obesity. MDS (Minimum Data Set) dated 11/12/2024 showed R133 with intact cognition. At 10:09am V2 (DON / Director of Nursing) stated she started working in the facility March 2024. V2 stated residents should have an advance directive / code status ordered or documented in resident's record whether a DNR (Do Not Resuscitate) or Full code and should be care planned. Resident's code status is important during an emergency. The care plan serves as a guidance for the care of the resident that includes plan / goal and interventions and identified problem / concerns of the residents. If there is no care plan, there could potentially be missed opportunities of interventions. At 11:18 AM V17 (Social Services / SS) stated Advance directives would include code status, end of life issues and choices whether DNR or Full code. Code status is very important to know what the resident wishes are especially during emergency and staff would know what to follow whether to resuscitate or not. V17 stated not sure who should do the care plan for advance directives or code status. Reviewed R133's health record, not able to find order or documentation regarding code status. Reviewed R133's order summary report dated 11/13/24, no order found for advance directive / code status. Care plan reviewed, none found for code status or advance directives. Facility was not able to provide documentation regarding R133's code status or advance directives. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Montgomery Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5550 South Shore Drive Chicago, IL 60637	

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's Advance directive policy and procedure dated 5/5/24 documented in part: During the admission process the SS or designee will discuss with each resident and / or the person accompanying the resident the following: Whether they have an advance directives such as a health care surrogate designation, living will or durable power of attorney. Whether they have a Do not resuscitate form. SS or the appropriate designee should visit the resident and discuss advance directives with them to ensure that he / she has executed the advance directives that he / she would want. All residents who wish to have resuscitation withheld should have a physician's order in their medical record. In the event that a resident experiences cardiopulmonary arrest the nurse on duty shall immediately determine the resident's status as a code or no-code.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 47304 Based on interview and record review, the facility failed to electronically transmit MDS (Minimum Data Set) records to CMS system using the CMS-specified Resident Assessment Instrument (RAI) process within the regulatory timeframes for 1 (R18) of 1 resident reviewed for resident assessment in a sample of 15. The findings include: R18's admission record showed admitted on 6/21/22 with diagnoses not limited to Malignant neoplasm of prostate, Spinal stenosis, Anemia, Atherosclerosis, Chronic kidney disease, Essential hypertension. R18's Quarterly MDS (Minimum Data Set) ARD (Assessment Reference Date) 10/4/24 was completed on 10/14/24. Final validation report dated 11/11/24 showed record submitted late. The submission date is more than 14 days after the completion date. On 11/14/24 at 9:50 AM V19 (MDS manager) stated they are an outside company hired by facility and completing some sections of the MDS. V19 stated she is working remotely and coordinating with V2 (DON / Director of Nursing) to let her know what needs to be done for MDS completion. She said the MDS assessment is a comprehensive assessment that shows the need of the residents to develop the comprehensive CP / care plan and they are following RAI (Resident Assessment Instrument) MANUAL for policy and procedures in completing and transmitting MDS assessment. She said Quarterly MDS assessment should be completed 14 days from the ARD and transmitted 14 days from completion date. Stated transmission of MDS should be within the regulatory timeframes. If MDS assessment was transmitted late, it would mean that facility was not following regulation set by RAI manual or not following regulatory timeframes. Reviewed R18 Quarterly MDS ARD 10/4/24 with V19 and stated it was a late transmission. Completion date was 10/14/24, it should have been submitted / transmitted to CMS system on 10/28/24, 14 days from completion date. Per record, R18's MDS assessment was submitted / transmitted on 11/11/24, it was a late transmission and not following regulations. At 10:09 AM V2 (DON) stated the facility is Following RAI manual for MDS completion and transmission. They have outside company completing some of the MDS sections and transmitting MDS assessments. Facility's policy RAI OBRA - required assessment summary page 2-18 documented in part: Quarterly transmission date no later than MDS completion date + 14 calendar days.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47304 Based on interview and record review, the facility failed to follow their policy to develop and implement a comprehensive person-centered care plan to meet preferences and goals and address the resident's needs that include measurable objectives and timeframes for 5 (R6, R17, R21, R22, R29) of 5 residents reviewed for comprehensive care plan in the sample of 15. The findings include: R17's Admission record showed admitted on 8/30/2024 with diagnoses not limited to Unspecified fracture of shaft of left tibia, Anemia, Spinal stenosis cervical region, Essential (primary) hypertension, Polyosteoarthritis, Pain in left shoulder, Presence of artificial knee joint bilateral, Unspecified fracture of upper end of right tibia, Unspecified glaucoma. R22's Admission record showed admitted on 5/11/2024 with diagnoses not limited to Other nontraumatic intracerebral hemorrhage, Malignant neoplasm of colon, Essential (primary) hypertension, Unspecified convulsions, Malignant neoplasm of bladder, Gastrostomy status, Dysphagia following nontraumatic intracerebral hemorrhage, Hemiplegia unspecified affecting left nondominant side. R29's Admission record showed admitted on 9/1/2024 with diagnoses not limited to Acute respiratory failure with hypoxia, Adult failure to thrive, Suicidal ideations, Pleural effusion, Essential (primary) hypertension, Squamous cell carcinoma of skin of right upper limb, including shoulder, Hyperlipidemia, Iron deficiency anemia, Benign prostatic hyperplasia, Sciatica. On 11/12/24 At 3:50 PM Reviewed R29's POS (Physician order sheet) showed active order not limited to: DNR (Do Not Resuscitate). No care plan found for advance directives or code status in R29's health record. On 11/13/24 at 12:55 PM Reviewed R17' POS showed active order not limited to: Full Code. No care plan found for advance directives or code status health record. On 11/14/24 at 9:10 AM Reviewed R22's physician order and showed active order not limited to Duloxetine HCl Capsule Delayed Release Particles 20 Give 2 capsule by mouth one time a day for depression. No care plan found for use of psychotropic medication use in R22's health record. At 10:09am V2 (DON / Director of Nursing) stated she started working in the facility March 2024. V2 said care plan should be done or developed by IDT (interdisciplinary team). Care plan serves as a guidance for the care of the resident that includes plan / goal, interventions and identified problem / concerns of the resident. If there is no care plan, could potentially miss opportunities of interventions or progress of the resident in going back to the community. Care plan should be individualized according to resident's needs. Advance directives, high risk meds such as psychotropic and anticoagulant medications and dementia care should be care planned. Reviewed R17, R22 and R29's records no care plan found for advance directives and psychotropic medication use. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 11:18 AM V17 (Social Services / SS) stated Advance directives would include code status, end of life issues and choices whether DNR or Full code. Code status is very important to know what the resident wishes are especially during emergency and staff would know what to follow whether to resuscitate or not. Stated she is not sure who should do the care plan for advance directives or code status. MDS (Minimum Data Set) dated 9/5/2024 showed R17 was cognitively intact. MDS ARD 8/15/2024 showed R22's cognition was moderately impaired. MDS dated [DATE] showed R29's cognition was moderately impaired. Facility was not able to provide person-centered comprehensive care plan for advance directives for R17 and R29 and care plan for psychotropic medication use for R22. Facility's comprehensive care plan policy and procedure dated 7/30/21 documented in part: each resident will have a person-centered comprehensive care plan developed and implemented to meet his / her preferences and goals and address the resident's medical, physical, mental, and psychosocial needs. It includes measurable objectives and timeframes to meet the resident's medical, nursing and mental / psychosocial needs that are identified in the comprehensive assessment. Facility's policy and procedure for psychotropic dated 8/12/21 documented in part: The resident's comprehensive care plan will reflect the plan for a gradual dose reduction or contraindications for same. 44103 On 11/14/24 at 1:14 PM, R6's clinical records were reviewed and showed an admitted [DATE] with included diagnoses but not limited to Ventricular Tachycardia and Hemiplegia and Hemiparesis Following Unspecified Cerebrovascular Disease Affecting Right Dominant Side. R6's physician orders with active orders as of 11/14/24 shows an order of anticoagulant Warfarin Sodium Oral Tablet 2 MG (Warfarin Sodium) Give 1 tablet by mouth in the afternoon for stroke (order date 11/5/24). R6's Minimum Data Set, dated dated dated [DATE] shows anticoagulant was marked. R6's comprehensive care plan does not address R6's anticoagulant medications use. On 11/14/24 at 12:56 PM, R21's clinical records were reviewed and showed an admitted [DATE] with included diagnosis but not limited to Unspecified Dementia, Unspecified Severity, Without Behavioral Disturbance, Psychotic Disturbance, Mood Disturbance, And Anxiety. R21's Minimum Data Set, dated dated dated [DATE] shows active diagnoses section I marked Non-Alzheimer's Dementia. R21's comprehensive care plans were reviewed and no care plan for dementia was identified. The facility's Dementia policy dated 5/15/24 documents in part: Care plans and management will be individual and seen from the perspective of the client. Clients Care Plans will reflect diversity, gender, ethnicity, age, religion, sexuality and personal care needs and protected characteristics.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 47304 Based on observation, interview, and record review, the facility failed to follow their policy and procedures by NOT (a) attempting to use appropriate alternatives prior to installing a side or bed rail, (b) assessing the resident for risk for entrapment from bed rails prior to installation, (c) reviewing the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation and (d) developing and implementing a comprehensive person-centered care plan for 4 (R1, R17, R29 and R132) out of 4 residents reviewed for accidents and hazards in a sample of 15. The findings include: R1's Admission record showed admitted on 10/4/2019 with diagnoses not limited to Cerebral infarction, Vascular dementia, other seizures, Essential (primary) hypertension, Unspecified osteoarthritis, anxiety disorder. R17's Admission record showed admitted on 8/30/2024 with diagnoses not limited to Unspecified fracture of shaft of left tibia, Anemia, Spinal stenosis cervical region, Essential (primary) hypertension, Polyosteoarthritis, Pain in left shoulder, Presence of artificial knee joint bilateral, Unspecified fracture of upper end of right tibia, Unspecified glaucoma. R29's Admission record showed admitted on 9/1/2024 with diagnoses not limited to Acute respiratory failure with hypoxia, Adult failure to thrive, Suicidal ideations, Pleural effusion, Essential (primary) hypertension, Squamous cell carcinoma of skin of right upper limb, including shoulder, Hyperlipidemia, Iron deficiency anemia, Benign prostatic hyperplasia, Sciatica. R132's Admission record showed admitted on 10/17/2024 Chronic respiratory failure with hypoxia, Acute on chronic diastolic (congestive) heart failure, Essential (primary) hypertension, Chronic obstructive pulmonary disease, Alzheimer's disease, Hyperlipidemia, Gastro-esophageal reflux disease, Chronic embolism and thrombosis of unspecified deep veins of left lower extremity, Chronic pulmonary embolism, Chronic kidney disease, Unspecified osteoarthritis. On 11/12/24 at 11:28 AM Observed R132 lying in bed, on moderate high back rest, alert and verbally responsive with confusion, both upper side rails were up. At 11:31 PM R17 Observed lying in bed, alert and verbally responsive, appears comfortable, well groomed. Stated she has weakness on both lower extremities. Observed both upper side rails were up. At 11:39 AM Observed R29 sitting up on the side of the bed, alert and verbally responsive, appears comfortable and well groomed. Bed on lowest position, upper side rails were up. On 11/13/24 12:22 PM Observed R1 lying in bed, nonverbal, head of bed elevated, both upper bed rails were up. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At 12:25 PM Observed R17 lying in bed, both upper side rails were up. V18 (Nursing Supervisor) requested to R17's room and stated side rails are up by staff to promote independence or help with turning and repositioning resident while in bed. On 11/14/24 at 10:09am V2 (DON / Director of Nursing) started working in the facility March 2024. She said there is no restorative nurse in the facility, she oversees side/ bed rail use. Stated upper side rails are used for residents to help them get out of bed, aid in mobility, turning or repositioning. V2 said use of side rails should be assessed and care planned but not sure if there should be an order for it. If not assessed properly the resident could be harmed by entrapment, risk for harm if side rail not functioning properly, resident could climb over it and risk for accident and hazards. V2 said the care plan should be individualized according to resident's needs. The care plan serves as a guidance for the care of the resident that includes plan/ goal and interventions and identified problem/ concerns of the residents. If there is no care plan, there could potentially be missed opportunities of interventions or progress of the resident. Reviewed R1, R17, R29 and R132's health record with V2, unable to find documentation for care plan, assessment and consent for use of side rails. MDS (Minimum Data Set) dated 9/13/2024 showed R1 was rarely or never understood. R1 needed total assistance or Dependent with eating, oral, toileting and personal hygiene, shower / bathe self, upper and lower body dressing. MDS dated [DATE] showed R17 was cognitively intact. R17 needed set up or clean up assistance with eating, supervision or touching assistance with oral hygiene; Partial/ moderate assistance with personal hygiene; Substantial / maximal assistance with shower / bathe self, upper body dressing; Dependent with toileting hygiene, lower body dressing, chair / bed and toilet transfer. MDS dated [DATE] showed R29's cognition was moderately impaired. MDS dated [DATE] showed R132's cognition was severely impaired. She needed set up / clean up assistance with eating; Supervision or touching assistance with oral hygiene; Dependent with toileting hygiene, shower / bathe self, upper body dressing, lower body dressing, chair / bed and toilet transfer; Substantial / maximal assistance with personal hygiene. Reviewed R1, R17, R29 and R132's health record with no order for side rails, no care plan, no assessment found for use of side / bed rails. R1, R17, R29 and R132's record did not show an attempt to use appropriate alternatives prior to installing a side or bed rail. Facility was not able to provide documents / records regarding care plan, assessment, consent for side rail use for R1, R17, R29 and R132. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's Bed rails policy and procedure dated 10/10/22 documented in part: Bed rails are adjustable metal or rigid plastic bars that attach to the bed. Entrapment is an event in which a resident is caught, trapped, or entangles in the space in or about the bed rail. This facility will attempt to use appropriate alternatives prior to installing a side or bed rail. Assess the resident for risk for entrapment from bed rails prior to installation. Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. Documentation in the resident's record will reflect this assessment and related information, including how the alternatives failed to meet the resident's assessed needs. After the installation of bed rails, it is expected that the facility will continue to provide necessary treatment and care, in accordance with professional standards of practice and the resident's choices. This should be evidenced in the resident's record, and include the following components, but are not limited to: the type of specific direct monitoring and supervision provided during the use of the side rails, including documentation of the monitoring. The identification of how needs will be met during use of the bed rails, such as for repositioning, hydration, meals, use of bathroom and hygiene. Ongoing assessment to ensure that the bed rail is used to meet the resident's needs. Ongoing evaluation of risks.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review, the facility failed to follow dietary recommendation and physician order to ensure nutritional supplement was provided to a resident with weight loss for one (R3) out of two residents reviewed for nutrition in a final sample of 28. Findings Include: On 11/12/24 at 11:30 AM, R3's electronic health records were reviewed. R3's Minimum Data Set, dated dated dated [DATE] shows R3 has severely impaired cognition. R3's physician orders have an order for Magic Cup two times a day for supplement Magic Cup or similar product w/L + D (ordered 3/21/2024) and Regular diet, Regular texture, Regular/Thin consistency (ordered 3/15/2022). R3's weight records documented the following weights: 153.2 pounds (lbs) on 11/5/24, 155 lbs on 8/15/24, 157.8 lbs on 7/17/24, and 159 lbs on 6/14/24. There were no weights recorded for the months of September and October. R3's progress notes documented by V7 (Registered Dietitian/RD) reads in part: continue magic cup with lunch and dinner; provides 580 kcal (kilocalorie) and 18 grams protein a day to help meet estimated needs. R3's dietary care plan dated 5/24/24 shows R3 triggered for significant weight loss and magic cup was added at lunch and dinner. On 11/12/24 at 12:33 PM, R3 was eating lunch in R3 room. R3's lunch tray consisted of corned beef sandwich, zucchini, minestrone soup, a can of cola, and a glass of water. R3's meal ticket does not indicate R3's magic cup for lunch and dinner. When asked if R3 likes to eat some type of ice cream or pudding, R3 answered, Yes I do. At 12:44 PM, Surveyor followed up with V20 (Dietary Aide) if the kitchen will be sending the magic cup. V20 stated, We don't have magic cup or ice cream. Some residents they ask but I guess they don't get them. At 12:56 PM, R3 ate approximately 25% of R3's lunch. R3 did not get the magic cup or other similar product. At 12:59 PM, V9 (Power of Attorney/Daughter) entered R3's room and was interviewed. V9 stated, She's [R3] lost a lot of weight. I spoke with some people about it. They put [R3] on dietary supplement. [R3] likes to eat sweet stuff. [R3] has ensure and the ice cream. They should be giving those to [R3]. At 1:17 PM, Surveyor came down to the kitchen and asked V6 (Support Chef) if the kitchen has magic cup or similar product. V6 stated that the facility has no magic cup in stock and only has ice cream. V6 stated, As far as I know no one needs the magic cup right now. On 11/13/24 at 10:40 AM, interviewed V3 (Director of Dining Services) and stated that the facility has no magic cup. V3 stated if there is an order for magic cup the kitchen staff would place it on the resident's tray and should follow what's on the meal ticket and the doctor's order. V3 stated nutritional supplements like magic cup would add some calories to address weight loss. V3 stated that currently, the facility is updating the diet cards manually and new orders such as supplements or diets are communicated to the kitchen verbally or via email. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/13/24 at 1:05 PM, a phone interview was conducted with V7 (RD). V7 stated that nutritional supplements should be given as ordered. V7 stated that R3 should be getting the magic cup for nutritional supplement with lunch and dinner. V7 stated magic cup is a nutritional supplement that provides more calories and protein to help maintain R3's weight. V7 stated that the kitchen should be providing the magic cup to the residents. The facility's Receiving Orders Policy dated 6/20/24 documents in part: Nurses and other clinical staff will implement and follow the providers orders unless the orders conflicts with safety concerns that may result in resident harm. The facility's Nourishment and Supplement Policy dated 7/10/24 documents in part: The director of dining services or designee will maintain nourishment and/or supplement lists, using written orders and individual requests as a guide. Assigned food and nutrition services staff will prepare nourishments and supplements according to the nourishment and/or supplement lists. All high protein/high calorie supplements, special nourishments, and other nourishments/supplements that have been ordered by a physician or designee will be individually wrapped, labeled and dated and include the patient's/resident's last name and room number for delivery.

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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 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** 49486 Based on observations, interviews, and record reviews, the facility: 1. Failed to date and store oxygen tubing in a plastic bag when not in use for 1 (R15) resident. 2. Failed to date and label nebulizer mask for 1 (R26) resident. These failures could potentially affect 2 (R15, and R26) residents in a sample of 15. Findings Include: 1. R15's electronic medical record (EMR) revealed R15 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: Respiratory failure unspecified with hypoxia, essential hypertension, and chronic kidney disease. 2. R26's electronic medical record (EMR) revealed R26 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: Chronic obstructive pulmonary disease with acute exacerbation, essential hypertension, and nontraumatic intracerebral hemorrhage in hemisphere subcortical. On 11/12/24 at 11:35 AM, R15 received in bed, oxygen tubing hanging on the oxygen tank, not dated and not inside a plastic bag when not in use. R15 stated R15 uses oxygen daily. On 11/12/24 at 11:45 AM, R26 received in bed, nebulizer mask undated by R26's bed side. On 11/12/24 at 2:58 PM, V8 (Licensed Practical Nurse/LPN) stated V8 has been in the facility for 8 months and V8 is not sure when the oxygen tubing and nebulizer mask should be changed and stored. V8 stated that V8 does not know the policy of the facility regarding nebulizer and oxygen tubing storage. On 11/12/24 at 3:00 PM, surveyor and V2(Director of Nursing/Infection Prevention) entered R15, and R26's room. V2 stated the oxygen tubing is not dated, not stored in a plastic when not in use, and nebulizer mask is not dated. V2 stated when the oxygen/nebulizer mask tubing is not dated, the staff will not know when the tubing was changed and that can increase the risk of infection for the resident. V2 stated Nebulizing mask/tubing, and oxygen tubing should be changed weekly and as needed and dated to prevent respiratory infection. When the oxygen is not in use, the tubing should be stored in a clean plastic bag to prevent infection. Facility Policy titled, Oxygen/Nebulizer Care and Storage Policy dated 04/10/2024 documents in part: Date tubing when new tubing is applied. Keep tubing in a clean bag (container) when not in use. Date tubing (mask).

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NAME OF PROVIDER OR SUPPLIER Montgomery Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5550 South Shore Drive Chicago, IL 60637	

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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 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 49486 Based on interview and record review, the facility failed to ensure to have a Registered Nurse (RN) staffed 8 hours with a 24 hour period on weekends to care for residents'needs based on the staffing scheduling and PBJ (Payroll Based Journal) staffing data report. This failure could potentially affect all 28 residents residing in the facility as of census 11/12/24. The findings include: On 11/14/24 at 10:40 am V2 (Director of Nursing/DON) stated that it is V2's expectation that there shall be a minimum of one Registered Nurse (RN) on duty in the facility for eight hours, seven days a week. V2 stated that V2 has four RNs and two of the RNs are as needed. V2 stated that V2 does not have a RN on duty some days and weekends especially in the month of April, May, and June, and V2 is interviewing more RNs for this position. V2 stated that the potential problem of not having RNs to take care of residents could result in poor outcomes to residents requiring specialized care that is beyond the scope of the Licensed Practical Nurse (LPN). On 11/14/24 at 12:15 PM, V1 (Administrator) stated V1 oversees staffing in the facility. V1 stated that it is V1's expectation that the facility meets the RN eight hours a day, 7 days a week. V1 stated that V1 has 2 nurses each shift and the nurses work 12 hour shifts (7am-7pm shift, and 7pm-7am shift). V1 stated that V1 has not been meeting the 8 hours of RN daily even on 11/11/24 and 11/12/24 and V1 has been utilizing V2 or agency at times, but V1 is looking into hiring more RNs. V1 stated that when there is a complex task like Total Parenteral Nutrition (TPN) that LPNs cannot perform this and it can lead to a delay in care. Reviewed facility's daily schedule with V1, showed the following: - On 4/6/24 (Saturday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. - On 4/7/24 (Sunday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. - On 4/20/24 (Saturday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. - On 4/21/24 (Sunday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. - On 5/5/24 (Sunday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. - On 5/18/24 (Saturday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. - On 5/19/24 (Sunday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. - On 6/9/24 (Sunday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. - On 6/22/24 (Saturday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. (continued on next page)

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- On 6/23/24 (Sunday) 2 LPNs worked for 7am-7pm shift, and 7pm-7am shift. V1 stated that having eight hours of RN daily, seven days a week including weekends should be maintained to provide adequate care and meet the needs of the resident. V1 stated if RN staffing is not met could potentially affect resident's care. CMS (Centers for Medicare and Medicaid Services) [NAME] report dated 11/07/24 documented in part: Triggered for no RN Hours. Facility's Daily Nursing Schedule dated 11/10/24 to 11/15/24 was reviewed. There was no RN scheduled to be working on the floor on 11/11/24 and 11/12/24. Facility's policy titled; Skilled Nursing Staffing Levels dated 1/1/2024 documented in part: There shall be a minimum of one (1) registered nurse on duty in the facility for eight (8) consecutive hours, seven (7) days a week.

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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** 47304 Based on observations, interviews, and record reviews, the facility failed to account for and dispose of controlled medications in a manner that would decrease the possibility of loss or diversion and failed to dispose expired controlled medication for 1 (R1) resident. These failures could potentially affect 12 residents assigned to the west medication cart as of census dated [DATE]. The findings include: On [DATE] at 12:07 PM V10 (Licensed Practical Nurse / LPN) stated she has been working in the facility since [DATE]. The west side medication cart was inspected and the controlled medications counted with V10. She said outgoing and incoming nurses are counting the narcotic medications and signing off in the controlled medication sheet after every count. R11's Tramadol with remaining 2 half tablets, blister packet / slots were compromised or broken and had a piece of transparent tape over the back. At 12:28 PM The west side medication room was inspected with V10 and observed R1's Hydromorphone concentrates about 30ml with Expiration date of [DATE] was kept inside the refrigerator. V10 stated expired medication should be returned to hospice care or should be discarded or wasted because it is expired. On [DATE] at 10:09am V2 (Director of Nursing / DON) stated she started working in the facility in [DATE]. She said the expiration date for all medications should be checked daily. If expired medication is kept inside the refrigerator, this could potentially be given to the resident and could have an adverse reaction. V2 said, nurses are expected to sign / initial controlled substances record sheet after counting off between shifts, incoming and outgoing nurse should sign to ensure that controlled medications are accounted for. If there are missing signature or initials it could indicate that they are not counting the controlled medications. Stated medication packaging should remain in original packaging, not tampered. V2 said if blister packet or slots for controlled medication like tramadol was tampered or taped, it should be discarded or wasted because you will not know if the medication is correct or has been contaminated. Tampered medication packaging could be a hazard, you don't know if somebody has done something to it. Nurse should get somebody to witness and waste / dispose the medication. R1's order summary report dated [DATE] showed active order not limited to Hydromorphone oral liquid 4mg/ml every 2 hours as needed for pain / shortness of breath. Give 0.25ml. R11's Controlled substance proof of use record showed remaining 2 Tramadol 50mg ,d+[DATE] tablet. Record indicated if dose is contaminated, lost, broken enter the information under comments. Reviewed facility's shift change accountability record for controlled substances showed multiple missing nurse's initial or signature on [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE] to [DATE], [DATE], [DATE], [DATE], [DATE]. Facility record showed the west medication cart assigned to 12 residents as of census dated [DATE]. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's controlled substances policy and procedure dated [DATE] documented in part: This policy provides guidance for controlled substances and their storage, administration, documentation, and disposal. Facility will continue to ensure in complying with all Centers for Medicare and Medicaid Services (CMS) and the Centers for Disease Controls and Prevention (CDC) guidance related to controlled substances. Expired containers of controlled substances (with any contents remaining) must be separated from expired containers of controlled substances and must be clearly labelled as being expired.

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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. 47304 Based on observations, interviews, and record reviews, the facility failed to follow their policy by not ensuring that medications are stored in original containers, properly labeled, and separate from food for one out of 2 medication carts and storage rooms reviewed for the medication storage and labeling. These failures could potentially affect 12 residents assigned to the west medication cart as of census dated 11/12/24. The findings include: On 11/12/24 at 12:07 PM V10 (Licensed Practical Nurse / LPN) stated she has been working in the facility since November 2018. [NAME] side medication cart inspected with V10 and found about 20 loose yellow capsules and white tablets inside plastic container covered with tape and with no label, kept inside the narcotic box. V10 unable to determine the name of the medications and for whom they belonged to. V10 stated these loose medications should have been disposed or discarded. At 12:28 PM the west side medication room inspected with V10. Observed the locked refrigerator with medications such as insulin, flu vaccine, acetaminophen suppositories, hydrocortisone suppositories, Morphine concentrate, Hydromorphone concentrate, Carton of Jevity 1.5 and bottle of ensure were also kept inside the fridge together with multiple medications. On 11/14/24 at 10:09 AM V2 (Director of Nursing / DON) stated the medications kept inside the refrigerator should be separated from food/ beverages to avoid or prevent possible contamination. V2 said any medications with no proper label should be discarded or disposed. Somebody could give it to the resident unknowingly and it could be a hazard. Facility record showed the west medication cart assigned to 12 residents as of census dated 11/12/24. Facility policy and procedure for medication and biological storage dated 7/1/18 documented in part: The community shall store all drugs and biologicals in a safe, secure, and orderly manner. Drugs and biologicals shall be stored in the packaging, containers, or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The community will not use discontinued, outdated, or deteriorated drugs or biologicals. All such drugs will be returned to the dispensing pharmacy or destroyed. Medications requiring refrigeration must be stored in a refrigerator, medication must be stored separately from food and must be labelled accordingly.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review the facility failed to ensure menu was followed for a resident (R9) receiving a mechanical soft diet and failed to ensure standardized recipes were followed during pureed food preparation. This failure has the potential to affect 2 residents on pureed diet (R1, R32) out of 26 receiving foods prepared in the facility's kitchen. Findings Include: On 11/12/24 at 12:36 PM, V24 (Certified Nursing Assistant) was feeding R9 for lunch. Observed R9 receive a glass of juice, apple sauce, mashed potatoes, ground corned beef sandwich, chicken noodle soup, ground zucchini, and a glass of water. At 12:54 PM, R9 ate 100% of R9's lunch. R9's physician orders with active orders as of 11/13/24 show a diet order of NAS (No Added Salt) Mechanical Soft Texture, Regular/Thin consistency (order date 3/16/22). R9's Minimum Data Set, dated dated dated [DATE] shows R9 is cognitively impaired. The facility's menu spreadsheet for August 2024 - Week 3 Mechanical Soft indicates minestrone soup, ground grilled corn beef sandwich, basil roasted zucchini, and blueberry buckle. On 11/13/24 at 11:06 AM, during pureed meal preparation observed V6 (Support Chef) added 3 pieces of quinoa stuffed peppers and 3 scoops of sauce in the blender to puree the quinoa stuffed peppers. V6 stated the scoop used had no measurement. Surveyor observed the consistency of pureed quinoa stuffed peppers to be thin. Surveyor asked V6 what [V6] thinks of the consistency of the pureed item. V6 stated, It's a little thin. V6 added more cooked quinoa and blended it together to desired consistency. After rinsing the blender in the sink, Surveyor observed V6 added 6 scoops of boiled baby carrots in the blender to puree the boiled carrots. V6 stated it was about 8 ounces per scoop. Surveyor observed the consistency of pureed carrots to be thin. Surveyor did not observe V6 reading or looking at the pureed quinoa stuffed peppers and buttered carrots recipes before, during or after preparing the pureed quinoa stuffed peppers and buttered carrots. At 12:46 PM, interviewed V3 (Director of Dining Services). V3 stated that the chef should be following the recipe during pureed food preparation, so it is done properly so the texture is appropriate. V3 stated pureed consistency should have a texture like baby food or is smoother than apple sauce. On 11/13/24 at 1:05 PM, V7 (Registered Dietician) stated the menus are reviewed by a Registered Dietician for nutritional adequacy. V7 stated menus and recipes should be followed to meet the nutritional calories needed so the residents are getting adequate nutrition per meal. V7 stated residents on pureed and mechanical soft diets should be getting the same menu items as the regular diets except the consistency are different. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility recipe titled Quinoa Stuffed Peppers lists ingredients for 48 servings as 47.92 each quinoa stuffed peppers, 1 1/4 quarts stock vegetable, and 2 1/3 cup thickener. Recipe instructions documented in part to chop item in food processor until it reaches a fine grind. Gradually add stock in a thin stream to finely ground product in food processor and continue to process until the product is completely pureed (smooth, no lumps or bits). Gradually add food thickener, fold into food product with a wire or rubber spatula, blend until it develops a smooth mashed potato consistency. Facility recipe titled Buttered Carrots lists ingredients for 48 servings as 11 pounds 16 ounces buttered carrots, 1 2/3 cup broth vegetable base, 1 2/3 cup melted butter, and 3 1/3 cup thickener. Recipe instructions documented in part to blend vegetables in food processor until smooth. Prepare broth per separate recipe. Gradually add broth and margarine in a thin stream to vegetables; blend until completely pureed, no lumps or bits. Remove from processor, place in a bowl twice the volume of the food product. Gradually add Thickener, fold into product with a wire whip or rubber spatula blend until a smooth Mashed Potato consistency is reached. The facility's MODIFIED TEXTURE FOODS policy dated 1/24 reads in part: Provide a standardized process for modified texture foods to meet community-approved diet guidelines and to assure palatability, flavor, texture, and nutritional value. The regular diet menu item will be used to prepare all modified-textured menu items unless otherwise indicated by the menu diet spreads. Foods requiring modification to a puree texture will have a smooth texture. Portions of modified-texture menu items will be provided in the proper amounts according to menu diet spreads. The facility's Diet Type Report printed on 11/13/24 shows there are 2 residents (R1, R32) currently receiving pureed diet texture in the facility.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observations, interviews, and record reviews the facility failed to follow their policy and procedure for food and supply storage to ensure foods in the walk-in coolers, walk-in freezer and dry storage were properly covered, labeled and dated when they were opened and prepared, and discarded on the discard by date. The facility also failed to ensure kitchen staff was wearing hair restraint while in the kitchen, failed to ensure frozen foods were stored six inches above the floor in the walk-in freezer, failed to obtain temperature checks prior to serving the food to the residents, and failed to sanitize and air dry the blender and lid after staff washed during pureed preparation. These failures have the potential to affect 26 residents in the facility who are receiving oral diet. Findings Include: On [DATE] at 9:36 AM, during the initial kitchen observation conducted with V3 (Director Dining Services), the following were found in the main cooler for meat and dairy: opened foods with no labels when they were opened/prepared and when to discard such as, canned prunes in the container, two opened jars of low fat cottage cheese, a container of lettuce, a container of chicken salad, a container of olives, a container of coleslaw, a container of pears, a container of grilled chicken, a container of tofu, a container of spring mix lettuce, a container of romaine lettuce, a container of cranberries, a container of nuts, a container of spinach, a container of vanilla pudding, and a bag of Monterey jack cheese. Surveyor and V3 also found unwrapped and unlabeled opened parmesan cheese, an opened box of carrot cake, an opened box of double chocolate cake, an opened box German chocolate cake, and opened shredded mozzarella cheese with an opened date of [DATE] and discard by [DATE] written on the label. In the dry storage area, there was an opened box of cream of wheat mix that was not wrapped and not labeled with opened date. In the walk-in freezer, there were six boxes of frozen cods, a big box of bread buns, and a container of demi-[NAME] placed on the floor. V3 stated that there should not place anything on the floor per food storage policy and foods should be stored 6 inches about the floor. In the walk-in cooler for produce, Surveyor and V3 found a tray of [NAME] sandwiches not wrapped on the rack and no date when it was prepared, a container of sliced pineapples good thru [DATE] on the label, and a container of tomato paste with discard by date of [DATE] on the label. On [DATE] at 12:12 PM, food containers were placed on the steam table on the 2nd floor dining area. V20 (Dietary Aide) began serving lunch from the tray line and started plating the food. Surveyor asked for the food temperatures and V20 stated [V20] did not check food temperatures. V20 stated that food temperatures are done in the kitchen. On [DATE] at 1:13 PM, V5 (Cook) was preparing the foods to be served for dinner. V5 had short length hair on V5's head and was not wearing any hair restraint. On [DATE] at 11:06 AM, observed V6 (Support Chef) preparing pureed food for lunch service. When V6 finished pureeing the quinoa stuffed peppers, V6 rinsed the blender and lid in the sink with water. Observed that the blender container was still wet and still with residuals of the pureed quinoa stuffed peppers left inside the blender container. V6 then added 6 servings of 8 ounces boiled baby carrots then pureed in blender. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:40 AM, interviewed V3. V3 stated all opened foods are supposed to be properly covered, labeled and discarded by the date written on the labels for food safety. V3 stated expired foods should not be kept stored and should not be served to the residents. V3 stated prepared and opened foods should be completely wrapped, and must be labeled and dated for safety, to maintain freshness, and avoid bacteria. V3 stated, They are not supposed to be storing expired foods. They have to discard expired foods by the discard date. We did the in-service yesterday in regards to labeling, dating, expired foods, and food safety. We're going to be running that daily to train and enforce. They should never serve expired food. If it's opened and unlabeled it should be thrown out. After it's cooked here in the kitchen, they record the temperatures when it's put in the cart and it's taken upstairs and when the diet aide takes it upstairs and put in the steam table, they have to record temperatures in the beginning before serving the food meaning before food is placed on the tray and take temperatures also the end of serving. The temperature log is kept in a binder on each floor. It's important to temp the foods before serving. Hot food should be hot, and cold food should be cold. If it's below the hot of 141 degrees Fahrenheit, we need to reheat it or replace it to prevent bacteria in the food. We don't want it in the danger zone. We have a high-risk population that are prone to sickness. V3 also stated that staff entering the kitchen have to put on the hairnet to keep hair in the head and not on the food. The facility's MEAL QUALITY AND TEMPERATURE policy dated ,d+[DATE] documents in part: When bulk food is transported to a dining serving location, temperatures are taken and recorded in the kitchen before transport as well as at the final serving location. If temperatures are not optimal at the receiving location, corrective action is taken and documented on the taste and temperature log. The facility's [NAME] Job Description (undated) documents in part: Maintains basic food recipes, preparation, and service and storage sanitation principles. The facility's FOOD AND SUPPLY STORAGE policy dated ,d+[DATE] documents in part: All food, non-food items and supplies used in food preparation shall be stored in such a manner as to prevent contamination to maintain in the safety and wholesomeness of the food for human consumption. Foods past the use by, sell-by, best-by, or enjoy by date should be discarded. Cover, label and date unused portions and open packages. Refrigerated storage: unused portions of canned fruits and vegetables must be transferred to clean, approved storage containers. Label and date container. Frozen storage: store food items 6 inches above the floor, and 18 inches below sprinklers. Wrap food tightly to prevent cross contamination. The facility's Infection Control - Food Handling (undated) documents in part: Food should be properly labeled and expired foods will be discarded. The facility's roster dated [DATE] documents 28 residents residing in the facility with 2 residents who are NPO (Nothing By Mouth).

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. 44103 Based on observation, interview and record review, the facility failed to ensure the dumpster was properly covered and not overflowing to prevent the harborage and feeding of pests. This deficient sanitation practice has the potential to affect all 28 residents residing in the facility. Findings include: On 11/12/24 at 9:36 AM, during the initial kitchen observation conducted with V3 (Director Dining Services), observed 3 garbage bins with no covers filled with waste from the kitchen. V3 stated they all should be covered. On 11/12/24 at 9:55 AM, V3 (Director of Dining Services) brought surveyor outside to inspect the facility's dumpsters. Surveyor observed one dumpster with the lid not fully closed due to overflowing of garbage. V3 stated that all dumpsters should be fully closed to prevent rodents and other pests' infestation. On At 10:14 AM, V12 (Maintenance Director) that the lids of the dumpster should be closed when not in used so no rodents get in there and no debris would fly out. V12 stated that the lids should be closed for pest control, and if it's open the garbage would attract flies and rodents. V12 stated that it could cause pests in the building because all garbage from the building is being thrown there. V12 stated that if there are too many flies, the flies get in the building. On 11/14/24 at 10:49 AM, interviewed V13 (Facilities Director) and stated [V13] oversees waste management and environmental services in the facility. V13 stated that the lids of the dumpsters outside the facility should be closed when not in use and should not be overflowing to keep rodents and other pests away from the property. V13 also stated that it is also for the safety of the staff if the lids are not closed items could be tossed and hit staff or the workers. The facility's SOLID WASTE DISPOSAL policy dated 1/24 documents in part: Garbage containers are clean, lined and covered at all times. Keep lids closed on all outside trash receptacles. The facility's roster dated 11/12/24 documents 28 residents residing in the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Montgomery Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5550 South Shore Drive Chicago, IL 60637	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 49486 Based on observations, interviews and record reviews, the facility failed to follow their infection control procedures. The facility failed to: 1. Handle linen in a manner to prevent cross contamination. 2. Have measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems. These failures could potentially affect all 28 residents residing in the facility. Findings Include: On 11/12/24 at 12:55 PM, the laundry room was reviewed with V13 (Facilities Director) and V14 (Environmental Services Manager). Surveyor observed V14 and V17 handling clean linens on the folding table without proper hand hygiene. V13 stated V13 should have sanitized V13's hand and wear a pair of gloves before handling clean linens. V14 stated that the policy is to sanitize hands and put on gloves when handling clean linens. V14 stated that touching clean linens with dirty hands can result in cross contamination, spreading of bacteria to residents, and increase the risk for infection. On 11/12/24 at 1:05 PM, surveyor reviewed the water management area with V13. Surveyor asked V13 for measures in place to prevent the growth of Legionella. V13 stated V13 is not sure, and V13 could not provide any documentation. V13 stated V13 will follow up with V1 (Administrator) On 11/12/24 at 1:45 PM, V2(Infection Preventionist/IP) stated that staff should sanitize hands before touching clean linens to prevent cross contamination, and the water should be tested yearly for legionella to prevent growing of pathogens. On 11/13/24 at 9:55 AM, V1(Administrator) stated that Legionella should be checked yearly, and V1 has not checked for Legionella this year. V1 stated that V1 has no record when Legionella was last checked, and it was not checked last year. V1 stated that V1 will call the company to come over later. V1 stated that failure to perform an annual check for Legionella, is a potential for waterborne infection. The facility could not provide any policy on prevention of Legionella and other opportunistic waterborne pathogens in building water systems. The facility policy titled Hand Hygiene dated 08/27/2024 documents read in part: Failure to clean contaminated hands can result in the spread of these pathogens to residents, staff, and environmental surfaces. The facility policy titled Linen Management, documents read in part: Ensure linens are handling in a way to prevent cross contamination and the spread of infection in accordance with State and Federal Regulations, and national guidelines. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145748	A. Building B. Wing	11/15/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montgomery Place	5550 South Shore Drive Chicago, IL 60637

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility policy titled Infection Control, General Policy and Procedure dated 05/05/2024 documents read in part: This policy provides a comprehensive infection control program for distribution to, and by its employees and contractors.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER Montgomery Place		STREET ADDRESS, CITY, STATE, ZIP CODE 5550 South Shore Drive Chicago, IL 60637	

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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on interview and record reviews, the facility failed to provide eligible residents and/or resident representatives education regarding the benefits and potential side effects of all available pneumococcal vaccination and assess eligibility and offer pneumococcal vaccination to four (R9, R11, R12, and R18) of six residents reviewed for pneumococcal and influenza vaccinations. Findings Include: 1.R9's electronic medical record (EMR) revealed R9 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: Unspecified Asthma, type 2 diabetes mellitus with diabetic polyneuropathy, other specified disease of pancreas, chronic embolism and thrombosis of unspecified vein, and bullous pemphigoid. R9's EMR revealed no documentation indicating the facility assessed R9's eligibility to receive the pneumococcal vaccination and/or that R9 was provided education related to the pneumococcal vaccination. There were no signed consents for pneumococcal immunizations found in R9's EMR. 2. R11's EMR revealed R11 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included, but not limited to: cervical disc disorder with myelopathy, spinal stenosis, and anemia. R11's EMR revealed no documentation indicating the facility assessed R11's eligibility to receive the pneumococcal vaccination and/or that R11 was provided education related to the pneumococcal vaccination. There were no signed consents for pneumococcal immunizations found in R11's EMR. 3. R12's EMR revealed R12 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included, but not limited to: parkinsonism unspecified, cerebral ischemia, adult failure to thrive, and cerebrovascular disease. R12's EMR revealed no documentation indicating the facility assessed R12's eligibility to receive the pneumococcal vaccination and/or that R12 was provided education related to the pneumococcal vaccination. There were no signed consents for pneumococcal immunization found in R12's EMR. 4. R18's EMR revealed R18 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included, but not limited to: chronic kidney disease, anemia, essential primary hypertension, malignant neoplasm of prostate, spinal stenosis, and atherosclerotic heart disease of native coronary artery without angina pectoris. R18's EMR revealed no documentation indicating the facility assessed R18's eligibility to receive the pneumococcal vaccination and/or that R18 was provided education related to the pneumococcal vaccination. There were no signed consents for pneumococcal immunization found in R18's EMR. The facility's immunization log provided by V2 (Infection Preventionist) on 11/13/24 shows no pneumococcal vaccines provided for R9, R11, R12, and R18. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145748	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/15/2024
NAME OF PROVIDER OR SUPPLIER: Montgomery Place		STREET ADDRESS, CITY, STATE, ZIP CODE: 5550 South Shore Drive Chicago, IL 60637	

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/14/24 at 10:35 AM, V2 (Infection Preventionist) stated that V2 should obtain consents and provide the residents and/or their family representatives the educations regarding influenza and pneumococcal vaccinations. V2 stated that the education should be in the progress notes in the resident's EMR, and the consents should be uploaded in the EMR. V2 stated that since V2 started in March 2024, V2 have not given any pneumonia vaccines to any resident. V2 stated that V2 has not provided any education or obtain any consents for pneumococcal vaccines since V2 started. V2 stated, V2 is not sure when to order pneumonia vaccine, but V2 will find out from the pharmacy. The facility's policy titled; Infection Control - Influenza and Pneumococcal Immunizations for Residents reads in part: Pneumococcal Immunizations: Before offering the pneumococcal immunization, each resident and or resident representative receives education regarding the benefits and potential side effects of the immunization. Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized. Pneumococcal immunization will be offered in accordance with CDC immunization algorithm for PCV13 and PPS23. The resident's medical record includes documentation that indicates, at a minimum, the following: That the resident or resident representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.