STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145827	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
British Home, The	8700 West 31st Street Brookfield, IL 60513

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on interview and record review, the facility failed to follow its policy in conducting background checks for 1 of 10 residents (R34) reviewed for admission screening, and nine of ten (V9, V15, V16, V17, V18, V19, V20, V21, and V23) employees prior to hire. This failure has the potential to affect all 36 residents residing in the facility. Findings include: Census report for February 24, 2025 documents 36 residents currently residing in the facility. Per facility list, R34 is an identified offender. R34 is an [AGE] year-old male resident admitted to facility on 10/2/2024 with diagnoses including but not limited to blindness one eye, cognitive communication deficit, and adjustment disorder with depressed mood. His CHIRP (Criminal History Information Response Process) was checked on 10/18/2024, more than two weeks after admission. His CHIRP resulted in multiple hits and required fingerprints to be requested. V9, CNA (Certified Nursing Assistant), with a hire date of 2/12/2025. Illinois Department of Public Health, Health Care Worker Registry was checked 2/25/2025, and background checks were completed 2/17/2025, which was after hire date. V15 (CNA), with a hire date of 4/16/2024. Illinois Department of Public Health, Health Care Worker Registry was checked 4/23/2024, and other background checks were completed 4/23/2024, except Illinois Sex Offender background check, which was done 2/25/2025; all were after hire date. V16 (CNA) with a hire date of 8/20/2024. Illinois Department of Public Health, Health Care Worker Registry was not checked until 8/30/2024. All other background checks were completed on 8/30/2024, which is after hire date. V17 (CNA) with a hire date of 7/24/2024. Illinois Department of Public Health, Health Care Worker Registry was not checked until 7/30/2024. All other background checks were completed 7/30/2024 which is after hire date. V18 (CNA) with a hire date of 3/22/2024. Illinois Sex Offender background check was completed 2/25/2025. (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: 145827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V19 (Receptionist) with a hire date of 8/17/2023. Illinois Department of Public Health, Health Care Worker Registry was not checked until 2/15/2024. All other background checks were done on 2/15/2024, except Illinois Sex Offender background check, which was completed 2/25/2025, which are all after hire date. V20 (Scheduler) with a hire date of 1/14/2025. Illinois Department of Public Health, Health Care Worker Registry was not checked until 2/25/2025. V21, RN (Registered Nurse), with a hire date of 2/27/2024. Illinois Department of Financial and Professional Regulation website was checked on 3/4/2024. V23, RN (Registered Nurse), with a hire date of 11/16/2022. Illinois Department of Financial and Professional Regulation website was checked on 12/13/2022. On 02/25/25 at 11:44 AM, V6 (Director of Admissions) and V7 (Receptionist) came to do Identified Offender background check review with files. V6 and V7 both stated they do not know why CHIRP was not run for R34 until 10/18/2024. V6 stated they should have been run within 24 hours of admission. On 02/25/25 at 12:44 PM, V6 stated, When we commit to someone coming in, we set up profile, send out notification, pull records into chart and verify insurance. Then reception team does CHIRP, Custody and Illinois sex offender background checks. If reception is not here, my coworker and myself do the checks. Reception uploads into the resident's electronic medical record. If there are hits, Administrator gets notified, I get notified, and my coworker gets notified. From there, we check what the charge is against the list we have and see if we need fingerprinting. We have 5 days to do fingerprinting, but we get that done right away. Once we receive that we upload into the Identified Offender system and email to Administrator, my coworker, and myself. Once that is done, we wait to see if someone is going to come out and interview the resident. Then once the person is discharged , we discharge the resident out of the system and paperwork is filed. I have just been taught that those are the 3 background checks we do. I am not sure why (R34's) CHIRP was done late. We did find that it was done late via audit and administration was aware. On 02/25/25 at 01:52 PM, V1 (Administrator) stated, Everybody will have a national sex offender background check done. This will be done immediately today. And going forward National sex offender background check will be done on every admission. We already do weekly audits since last year around May 1st, 2024. (R34's) CHIRP being done late got missed as receptionist was not here and was caught in the audit. (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 02/25/25 at 02:47 PM, V5 (Human Resource Support) stated, For (V9) - Registry was checked today. Her hire date was 2/12/2025. The background checks were done 2/17/2025. All of the checks were done late. I do not know why they were done late. I do not do them, my coworker does them. For (V15), her hire date 4/16/2024. Her registry was done today. Her background check for Illinois Sex Offender was done today. Remaining background checks were done 4/23/2024. For (V16), her hire date was 8/20/2024. Her registry was checked 2/25/2025. All of her background checks were done 8/30/2024. For (V17), her hire date was 7/24/2024. Her registry was checked 2/25/2025. All of her background checks were also checked late on 7/30/2024. For (V18), she was hired 3/22/24. Her registry was checked 3/22/24. Her Illinois Sex offender was checked on 2/25/25. All other background checks were done 3/22/24. For (V19), his hire date was 8/17/23. His registry was done 2/15/2024. Illinois Sex Offender background check was done on 2/25/2025. All other background checks were done 2/15/2024. For (V20), her hire date was 1/14/2025. Her registry was done 2/25/2025. Her background checks were done 1/8/2025. (V21's) hire date was 2/27/2024. IDFPR website was checked on 3/4/2024. For (V23), her hire date was 11/16/22. IDFPR website was checked on 12/13/2022. On 02/25/25 at 03:18 PM, V4 (Medical Director) stated, My expectation of staff is that all of the background checks are done prior to hire or prior to admission. It is important to do the background checks prior to admission/hire to keep residents charged in our care safe from abuse/neglect/exploitation. On 02/26/25 at 09:10 AM, V8 (Human Resource Support Supervisor) stated, We were doing an audit in December to correct some of the things we were missing. After that audit, I was unaware of any further issues. I am unsure of why the items were missing or done late. We rely on the leadership team to tell us when the staff start. We are working towards better communication. We are trying to get leadership to understand the why no one can start until all paperwork is done. This should be done for safety and risk to the residents. It is our obligations to our residents to ensure safety of the residents. Facility Poicy Employee and Health Care Worker Background Check Policy and Procedure with Effective date of October 1,2016 and Revision Date of 2/1/2025 documents: Purpose: To ensure compliance with the Illinois Department of Public Health (IDPH) and the Centers for Medicare & Medicaid Services (CMS) regulations, this policy establishes the procedures for conducting background checks on all prospective and current employees who provide direct patient care or have access to patient records. Scope: This policy applies to all employees, contractors, volunteers, and affiliates who have direct access to patients or patient information within our organization. Policy 1. Pre-Employment Background Checks Health Care Worker Registry (HCWR) Clearance: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	o All prospective employees must undergo an HCWR clearance before hire to determine if they have a reported criminal background check result, a disqualifying criminal conviction, an IDPH waiver for a disqualifying conviction, or substantiated findings of abuse or neglect. o If no background check results are found in the HCWR, the employee must complete a fingerprint-based criminal background check using an IDPH-approved livescan vendor within 10 working days of hire. o The required livescan form will be printed from the IDPH Web Portal and must be provided by the hiring department to the employee. Registry and Background Check Verification: o The organization will verify each new hire's status on the HCWR before allowing them to start employment. o Employees with disqualifying convictions will not be hired unless an IDPH waiver has been granted o Individuals with substantiated findings of abuse, neglect, or financial exploitation will not be eligible for employment. 4. Compliance and Record Maintenance Documentation: o All background check results and HCWR clearance verifications will be maintained in the employee's personnel file. o Documentation must be readily available for audit or regulatory review. Ongoing Compliance Monitoring: o The HR department will conduct routine audits of background check records to ensure ongoing compliance with IDPH and CMS regulations. o Employees who fail to comply with background check requirements will be subject to disciplinary action, up to and including termination. Procedure: 1. Pre-Hire Screening: o HR will verify the applicant's HCWR status through the IDPH Web Portal. o If the applicant's background check is not listed, HR will provide the livescan form and require fingerprint submission within 10 working days of hire. 2. Record Maintenance: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	o HR will securely store background check results, waivers, and registry clearance records. o Records must be retained in compliance with state and federal regulations. By adhering to this policy, our organization ensures patient safety and regulatory compliance while maintaining high standards for employee integrity Identified Offenders Policy and Procedure with a reviewed date of 1/4/24 documents in part: PURPOSE To comply with the Illinois Department of Public Health Identified Offender law (Public Act [PHONE NUMBER]) and to ensure the safety of all residents of our community. PROCEDURES 1. Criminal Background and Sex Offender Checks will be completed on all residents admitted to the BHRS Health Center within twenty-four (24) hours from the admitted . The Admissions Coordinator or designee will request a Uniform Criminal Information Act (UCIA) name-based criminal history record from the Illinois State Police using the Criminal History Information Response Process (CHIRP) and verify the resident with the Illinois State Police Sex Offender Registry and the Illinois Department of Corrections Parole Sex Offender Registry to determine if the resident is a registered sex offender. If the resident is determined to be a registered Sex Offender, the Administrator and IOP must be informed immediately. 2. All background checks will be kept in a secure file and maintained for at least 3 years. 3. In the event that a resident has a hit response, the Administrator will be notified immediately. 4. The Administrator will review the UCIA Criminal History Record to determine if the resident is an identified offender.

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F 0684 Level of Harm - Minimal harm or potential for 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** 34071 Based on observation, interview, and record review, the facility failed to assess new skin condition on a resident with impaired mobility, and failed to notify licensed staff to evaluate skin for one (R24) of three residents in the sample of 30 reviewed for skin impairment. This failure resulted in R24 developing a new wound excoriation on right buttock area. Findings include: R24 is an [AGE] year-old, female, originally admitted in the facility on 10/22/2020, with diagnoses of Tubulo-interstitial nephritis, not specified as Acute or Chronic; Urinary Tract Infection, site not specified; and Extended spectrum beta lactamase (ESBL) Resistance. MDS (Minimum Data Set), dated 02/21/25, recorded R24 has short- and long-term memory problem. According to skin evaluation, dated 02/19/25, there are no new skin issues on R24, skin was intact. Skin Monitoring Comprehensive CNA (Certified Nurse Assistant) Shower Review, dated 02/21/25, recorded bed bath was provided on R24 with no skin issues noted. R24's care plans documented the following: Skin Condition/Pressure Injury (01/25/25): Interventions: Conduct weekly skin check and report negative findings to my doctor; Inspect my skin when repositioning and toileting and assisting with ADLs (activities of daily living) Skin Other (01/25/25): Interventions: Skin checks per facility protocol, complete skin risk assessments per facility protocol. On 02/25/25 at 11:30 AM, CNAs V10 and V30 were observed providing incontinence care on R24. A small, open red area on the right lower buttock was observed. There was also redness and swelling noted on R24's groin areas. V10 stated, She does skin sore here on the right buttock, we apply barrier ointment. On 02/25/25 at 11:55 AM, V3 (Licensed Practical Nurse, LPN/Wound Care Nurse) was asked regarding R24's skin impairment. V3 replied, Nothing on the bottom; nothing on legs/feet. I don't know anything about skin issues on her right buttock. No one reported to me. On 02/25/25 at 11:57 AM, V27 (LPN), the nurse of R24, stated, On (R24), I don't know anything about new skin issues. On 02/25/25 at 12:00 PM, V3 did an assessment on R24's skin. V3 verbalized, It was MASD (moisture associated skin damage) on the right buttock and on the right and left groin areas, barrier cream can be applied. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/25/25 at 12:00 PM, V30, CNA, stated V10 told the nurse about R24's new skin issue on the right buttock. V30 continued, CNAs are supposed to notify nurse immediately if they noticed skin issues on residents. There was no documentation related to R24's new skin issue on the right buttock. There was also no documentation the new skin issue was reported to the nurse. Progress notes, dated 02/25/25, documented: R24 has a small opening to right buttock. Upon assessment, R24 noted to have small area of excoriation due to MASD. Barrier cream applied. Education provided to CNA about keeping area clean and dry. Skin evaluation form, dated 02/26/25, documented: Partial Thickness Wound, Type: Other Treatment: Clean with NSS (normal saline solution), pat dry, apply barrier cream after each incontinence episode or as needed. Description: Superficial open area to reddened area on right buttock Size: 1.8 cm (centimeters) x 0.2 cm x 0.1 cm Surrounding skin: red, discolored Wound Evaluation and Management Summary, dated 02/26/25, recorded: Location: Perineum Diagnosis: Diaper Dermatitis Progress - Exacerbated Treatment: Zinc oxide based barrier cream R24's POS (Physician Order Sheet) documented the following: 02/26/25: Zinc Oxide 20% ointment topical to right buttock with normal saline solution, pat dry, apply zinc barrier cream with every incontinence episode and as needed. 02/25/25: Barrier cream to periarea and buttocks TID (three times a day and PRN (when needed) after incontinence episodes. On 02/26/25 at 9:25 AM, V2 (Director of Nursing) stated, Skin assessment is done upon admission, readmission, shower days, and when they are changing residents that when they happen to see any skin concerns that they have to notify the nurse on duty immediately. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 02/26/2025 at 4:02 PM, V31 (Wound Care Physician) verbalized, Her right buttock open area, its MASD. Right buttock area and the perineum area are all in the same area and considered dermatitis. Staff has to put moisture barrier/zinc cream during changing. She's had this before related to antibiotics and diarrhea. I am assuming this MASD is brand new. Facility's policy titled Skin Assessment, dated 02/01/25, stated: Policy: It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. Policy Explanation and Compliance Guidelines: 1. A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission. The assessment may also be performed after a change of condition or after any newly identified skin alteration.

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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** 50519 Based on interview and record review, the facility failed provide supervision to prevent a fall of a resident (R194) in the bedroom next to the nursing station, affecting one resident (R194) of 3 residents reviewed for falls. Findings Include: R194 is an [AGE] year-old female admitted to the facility on [DATE], with a medical diagnosis that includes but is not limited to dementia, cerebral infarction, right below-the-knee amputation, Covid-, 19, hypertension, left-sided weakness, and urinary tract infection. On the (MDS) Minimal data Set assessment of 2/23/2025, section C, the BIMS (Brief Interviewed Mental Status) score was 06/15, and indicates severe cognitive impairment. On MDS of 2/23/2025, GG section, R194 is dependent to move from Chair/bed-to-chair transfer. The ability to transfer to and from a bed to a chair (or wheelchair). Helper does ALL of the effort. The resident does none of the effort to complete the activity. Or the assistance of 2 or more helpers is required for the resident to complete the activity. On record review of the facility fall incident report, dated 2/24/2025 at 4:40 PM, R194 was observed on the floor next to her wheelchair, lying on her side. Hospital computerized tomography of the head records, dated 2/24/2025, showed a new small parietal scalp hematoma. On 2/26/2025 at 9:50 AM, surveyor interviewed R194, who was not able to recall what led up to the fall, but was able to state she went to the hospital after the fall. Surveyor observed R194 with bluish discoloration to the forehead and mild swelling. On 2/26/2025 at 9:57 AM, V13 (Physical Therapist Assistant) said, The speech evaluation ended at 2:20 PM, and I started working with (R194) and focused on chair and arm exercises. (R194) was using the right leg prosthesis and got up in the wheelchair for the first time after she was admitted to the facility. After therapy finished, I brought (R194) to her room and placed her by the door. On 2/26/2025 at 11:29 AM, V14 (Registered nurse) said, I was in the facility when (R194) fell . Earlier during the day, around 1:00 PM, (R194) went to have a speech evaluation and after that, she went to work with the Physical Therapist. (R194) came back at 3:00 PM and was placed by the door, so we could monitor her from the nursing station. On 2/26/2025 at 12:08 PM, V32 (Physical Therapist) said, I evaluated (R194) on admission. (R194) had fair turn control and needed corrections and constant reminders to keep her back straight while sitting in the wheelchair. Usually, I would recommend keeping (R194) up for a maximum of 1 hour at a time to prevent fatigue, and (R194) was deconditioned after the hospitalization . (R194) required maximum assistance to get out of bed and I recommended a mechanical lift for transfers and (R194) had left-sided weakness. I would recommend a tilted wheelchair or a high-back wheelchair because of trunk control. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 2/26/2025 at 2:40 PM, V33 (Nursing Practitioner) said, (R194) was admitted from the hospital with COVID, dementia, and left-sided weakness. (R194's) fall on 2/24/2025 and the x-ray and computerized tomography of the head, cervical, and thoracic were negative, but had a frontal hematoma. I can't say if poor trunk control or drowsiness was a factor related to the fall. Some of my recommendations to prevent falls for (R194) is to lower the bed, call light within reach, and round every two hours. On 2/26/2025 at 3:20 PM, video footage was reviewed with V1(Administrator) and V2 (Director of Nursing). R194 was shifting body forward and sat back a couple of times and moved her arm towards the front attempting to reach her leg, at times slumped in chair. At 4:29:47, R194 shifted her body forward, the wheelchair flipped forward, with R194 falling face down out of wheelchair. Nursing staff observed on video passing by the room during the last five minutes before the fall, and no one stopped to assist R194 while she was shifting her body from side to side, trying to reach for her leg, or when she was slumped in the wheelchair. On 2/26/2025 at 3:21 PM V22 (Registered Nurse) said, I was the nurse who completed the assessment for (R194), she was alert to person and place, stable after the fall. 911 was called and (R194) was sent to a local hospital for further evaluation and because (R194) is receiving anticoagulant. (R194) is at high risk for falls because of dementia and post Covid. I did not know how long (R194) was up before the fall. (R194's) room is close to the nursing station and (R194) was positioned by the door, and the staff can monitor her. I cannot recall the exact time I saw her before the fall. V22 was asked how long can R194 safely stay up in the wheelchair unattended. V22 was not able to answer. V14, dayshift nurse, was standing nearby and checked the care plan and orders and no information was found. On 2/26/2025 at 3:30 PM, V2 (Director of Nursing/Fall Coordinator) said, I expected the nursing staff to make sure the call light is within reach and to monitor residents that are fall risk closely. V2 was asked how R194 was being closely monitored at the time of the fall. V2 said, Monitoring was not effective because (R194) fell and had an injury, and I don't see any wheelchair mobility or a care plan to address mobility, transfers, or leg prosthesis. I don't know why the care plan is not updated. On 02/26/2025 at 2:22 PM, V1(Administrator) provided a facility policy titled, Falls, Fall Risk and Management, dated March 2018, documenting: Based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try to prevent the resident from falling and to minimize complications from falling. Resident-Centered Approaches to Managing Falls and Fall Risk 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls. Monitoring Subsequent Falls and Fall Risk (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1. The staff will monitor and document each resident's response to interventions intended to reduce falling or the risks of falling.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on observation, interview, and record review, the facility failed to administer medications as ordered; and failed to follow policy and manufacturer's guidelines in the administration of inhaler and insulin pen. There were 25 opportunities with three errors resulting in a 12% medication error rate. The errors involved three (R10, R25 and R141) of 16 residents in the sample of 30 reviewed for medications. Findings include: 1. R25 is a [AGE] year-old, female, originally admitted in the facility on 07/06/24, with diagnoses of Unspecified Dementia, Unspecified Severity, with other Behavioral Disturbances. POS (Physician Order Sheet), dated 01/10/25, recorded Calcium Carbonate 500 mg (milligrams) calcium (1250 mg) chewable tablet 1000 mg PO (by mouth) three times a day. On 02/24/25 at 12:25 PM, V27 (Licensed Practical Nurse, LPN) was preparing R25's Calcium Carbonate. V27 took one tablet from the bottle Calcium Carbonate 500 mg and administered to R25. On 02/25/25 at 11:55 AM, V27 was asked on how many tablets of calcium carbonate should be given to R25. V27 replied, The calcium carbonate tablet is 500 mg per tablet and order is 1000 mg, two tablets should be given as ordered. 2. R10 is a [AGE] year-old, female, originally admitted in the facility on 08/28/15 with diagnoses of Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation. POS, dated 02/24/25, documented Albuterol Sulfate HFA (Hydrofluoroalkane) 90 mcg/actuation (microgram per actuation) aerosol inhaler inhale 1 puff every 8 hours. On 02/24/25 at 4:15 PM, V28 (Registered Nurse, RN) was preparing R10's albuterol inhaler. V28 did shake the albuterol inhaler a couple of times and handed it to R10. R10 placed the mouthpiece to her mouth, did one puff, removed the mouthpiece, and started talking to V28. 3. R141 is a [AGE] year-old, female, originally admitted in the facility on 08/17/23 with diagnoses of Type 2 Diabetes Mellitus with Diabetic Neuropathy, Unspecified. According to POS 02/20/25, R141 is to receive Novolog Flexpen U-100 insulin aspart 100 unit/ml subcutaneous 10 units subcutaneous three times a day. On 02/24/25 at 4:48 PM, V29 (Licensed Practical Nurse/LPN) took the Novolog Flexpen from medication cart. V19 took a needle and placed it on the needle hub, turned the dose to 10 units and showed surveyor the 10 units, went to R141 and injected the Novolog on the left arm. After injection, V29 removed the flexpen right after. V29 did not clean the needle hub prior to putting the needle on. She (V29) also did not prime the flexpen or perform an airshot before injection. On 02/26/25 at 9:25 AM, V2 (Director of Nursing) stated, Nurses should adhere to pharmacy guidelines and medication administration policy. To make sure staff are following the manufacturer's guidelines in administering medications. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER British Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 8700 West 31st Street Brookfield, IL 60513	

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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled Insulin Pen, dated 02/01/25 stated in part but not limited to the following: Policy: It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort, and serve as a teaching aid to prepare residents for self- administration of insulin therapy upon discharge. Policy explanation and compliance guidelines: 6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir. 11. Procedure: g. Attach pen needle: i. Remove the pen cap from the insulin pen ii. Wipe the rubber seal with an alcohol pad. iii. Screw the pen needle onto the insulin pen. iv. Twist open and remove outer cover from the pen needle. Novolog Injection Manufacturer's Guidelines documented: Instructions for Use Giving the airshot before each injection Before each injection small amounts of air may collect in the cartridge during normal use. To avoid injecting air and to ensure proper dosing: E. Turn the dose selector to select 2 units. F. Hold your Novolog FlexPen with the needle pointing up. Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge. G. Keep the needle pointing upwards, press the push button all the way in. The dose selector returns to 0. A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than 6 times. Selecting your dose Check and make sure that the dose selector is set at 0. H. Turn the dose selector to the number of units you need to inject. The pointer should line up with your dose. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Giving the injection I. Insert the needle into your skin. Inject the dose by pressing the push-button all the way in until the 0 lines up with the pointer. J. Keep the needle in the skin for at least 6 seconds, and keep the push-button pressed all the way in until the needle has been pulled out from the skin. This will make sure that the full dose has been given. Facility's policy titled Administering Medications, dated April 2019 stated in part but not limited to the following: Policy Statement: Medications are administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation 4. Medications are administered in accordance with prescriber orders, including any required time frame. 10. The individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage, right time and right method (route) of administration before giving the medication. Facility's policy titled Administering Medications through a Metered Dose Inhaler, dated October 2010 documented in part but not limited to the following: Steps in the Procedure: 14. Administer medication: d. Ask the resident to inhale and exhale deeply for a few breath cycles. On the last cycle, instruct the resident to exhale deeply. e. Place the mouthpiece in the mouth and instruct resident to close his or her lips to form a seal around the mouthpiece. f. Firmly depress the mouthpiece against the medication canister to administer the medication. g. Instruct the resident to inhale deeply and hold for several seconds. h. Remove the mouthpiece from the mouth and instruct the resident to exhale slowly through pursed lips.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145827	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2025
NAME OF PROVIDER OR SUPPLIER British Home, The		STREET ADDRESS, CITY, STATE, ZIP CODE 8700 West 31st Street Brookfield, IL 60513	

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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 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. 50519 Based on observation, interview, and record review, the facility failed to ensure food is prepared and served under the sanitary conditions, failed to ensure food items were labeled and dated per facility policy, and failed to ensure high-temperature dishwasher final rinsing cycles gauge temperature worked properly during final rinse. These failure applies to 37 residents who receive food prepared in the facility kitchen. Findings include: On 2/24/2025 at 09:29 AM, during the initial rounds in the kitchen with V12 (Director of Dining Services), surveyor observed a box of twenty-four cucumbers, box of broccoli, and a box of tomatoes sitting directly on the floor. V12 said, The delivery just got to the facility, and I expect the staff not to place directly on the floor, and use the cart next to the produce. On 02/25/2025 at 09:45 AM, surveyor checked the temperature for the dishwasher with V12. Surveyor observed the final rinse temperature gauge was not working. V12 said, I already placed a work order, and the facility is waiting for the technician to come and fix it. The facility is using the temperature strip. I could not tell for sure if the final temperature could hold the temperature up above 180 Fahrenheit, and not washing dishes properly can cause infection. The ice machine was observed to have dust and hard water marks built up around the outside on the left side of the leakage area. V12 said, The facility does monthly maintenance cleaning, and staff are expected to wipe out and clean it (ice machine) daily at the end of the shift, but it was not done. The ice cream freezer had six-3 gallons of ice cream half full, with no open date or best buy date. V12 said, I expect staff to date the ice cream as soon as each gallon is opened. A garbage container without a lid was observed half full of garbage across from the ice machine. V12 said, I expected the garbage containers to always have a lid to prevent contamination. On 02/25/2025 at 2:00 PM, V1 (Administrator) said, I was not aware of the dishwasher temperature final rinse gauge not working. The Kitchen will switch and start using (white foam) plates and disposable silverware until the machine is fixed. I expect the staff to follow facility policy and protocol and follow infection control to prevent food poisoning. On 02/26/2025 at 09:10 AM, V12 said, The technician already fixed the dishwasher. The final rinse gauge temperature was working, and surveyor able to observe two rinse cycles, and the temperature was 182 degrees Fahrenheit. On 02/27/2025 at 1:00 PM, V3 (Infection Preventionist) said, I expect the garbage to always have a lid, equipment to be fixed and cleaned. If the dishwater final wash temperature gauge is not working, the kitchen staff need to use (white foam) disposal plates and silverware. Food should be handled properly per facility policy to prevent germ contamination and infection. Facility policy titled, Sanitation and Infection Prevention Control, Dishwasher Temperature dated 1/24, reads: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145827	A. Building B. Wing	02/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
British Home, The	8700 West 31st Street Brookfield, IL 60513

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Multi-tank conveyor, multi-temperature machine-Final rinse temperature 180F-194F. Production, Purchasing, Storage dated 1/25, Which reads in part (but not limited to), The words sell by, best buy, enjoy by or used by, should proceed a date on the product. Food past the sell by, best buy, enjoy by date should be discarded. Refrigerator storage Store food 6 above the floor, the bottom shelf must be solid to protect the product from splash and dust. Frozen storage Once the packaging around the food has been opened, food must be used within 3 months. Sanitation and Infection Prevention Control, Solid Waste Disposal dated 1/25, Which reads in part (but not limited to), Garbage containers are clean, lined, and covered at all times.