

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Alden Estates of Orland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 16450 South 97th Avenue Orland Park, IL 60467	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on interview and record review, the facility failed to provide a cognitively impaired resident with known exit seeking behaviors, adequate supervision to prevent resident from eloping. This failure affected one (R75) of 14 residents wearing an electronic alert band in the total sample of 71 residents. This failure resulted in R75 walking out the front door of the facility unsupervised and the facility unaware R75 was missing until R75 was returned to the facility by local police who saw R75 walking alone on the street. The facility also failed to follow policy procedures and failed to implement fall prevention interventions for three (R27, R61, R132) of 71 residents in the sample reviewed for falls. This past noncompliance occurred from 09/08/2025 to 09/12/2025 This was identified as an immediate jeopardy which began on 09/08/2025 at 2:30am when R75 was last seen by staff. V1 (Administrator) was informed of the immediate jeopardy, and a template was presented on 03/16/2026 at 2:26pm. The survey team confirmed by observation, interviews, and record reviews that the Immediate jeopardy was removed on 09/12/2025 when the facility initiated corrective actions to remove the immediacy. This is being cited as past non-compliance. Findings include: #1 The (09/08/2025) List of residents on electronic alert band documented there were 14 residents on electronic alert band which include R75. R75's (08/01/2025) Minimum Data Set documented, in part Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 6. Indicating R75's mental status as severely impaired. Section I - Active Diagnoses. Neurological. Other. I8000. A Dementia. C. Arthritis. D. Long Term use of Aspirin. R75's (05/11/2025) Nurses Note documented, in part electronic alert band applied to rt (right) ankle per MD orders d/t (due to) exit seeking behavior. Resident w/ (with) increased confusion. Verbal consent obtained via telephone for electronic alert band placement. Authored by: V52 (Former Registered Nurse) R75's (Date Initiated: 05/11/2025) care plan documented, in part Focus: is at-risk for elopement related to cognitive impairment, exit-seeking behavior, making comments regarding leaving the facility, physical ability to leave unit/facility, wandering behavior. Goal: Will safely remain on unit or off under supervision. Intervention: Utilize electronic alert band as appropriate. R75's (07/08/2025) Exit Seeking/Wandering/Elopement Risk Assessment documented that R75 is at risk for elopement. (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
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Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	R75's (09/08/2025 at 5:01am) progress note documented, in part The police brought resident to the facility at 3:36 am. Writer was told by the police that resident was located outside the facility at 3:00(am) at 97th avenue. Writer notified (V51 -Primary Care Physician/Medical Director) on-call service and (V58 &ndash; R75's family member) of the incident. The facility was unaware that the resident left the building. On 03/12/2026 at 9:30am, on 97th Avenue, facing the facility, there were 2 monument signs standing one on each side of the driveway that leads to the front of the facility. Behind the right monument sign was an ungated pond with sidewalk; the pond was adjacent to a residential building. Across the street was a movie theatre. On 03/12/2026 at 11:50am, V44 (Social Services Director) stated her elopement risk care plan was initiated on 5/11/2025. She was making comments about wanting to leave the facility. She (R75) was kind of wandering at the facility. On 03/12/2026 at 12:13pm, V44 handed R75's 5/11/2025 progress noted to this surveyor and stated it was a nurse who observed her (R75)'s exit seeking behavior. On 03/12/2026 at 5:10pm, V52 (Former Registered Nurse) stated she could not remember the incident. This surveyor read the progress note written by V52 on 05/11/2025. V52 stated she could not remember the exit seeking behavior, but she wrote the progress note because she (V52) observed the exit seeking behavior. On 03/09/2026 at 11:57am, R75 stated she did not know how to get to the parking lot, she has no reason to go there. R75 stated her family take turns visiting her and they usually sit in the dining room. R75 stated she never walked out of the facility alone. On 03/14/2026 at 9:07am, V45 (Certified Nursing Assistant) stated she just finished doing patient care with another resident and she was walking toward the soiled linen room when the nurse told her (R75) got out. Inquiring while she was walking towards the soiled linen room if she heard the alarm went off. V45 stated she did not hear the alarm went off because the double doors were closed. V45 stated the sound of the alarm was between the double doors. V45 stated, she did not hear it. V45 stated when the nurse told her (R75) got out., she (R75) was already back in her room. V45 stated the last time she saw her (R75) was between 2:15am and 2:30am on 09/08/2025; she was lying down on her bed, and her eyes were closed. V45 stated she (R75) was sleeping. V45 reiterated she did not hear the alarm went off because the double doors were closed. On 03/12/2026 at 10:11am, V42 (Former Licensed Practice Nurse) stated all she could remember was she was attending to another resident, and the police came to the front desk. V42 stated the police asked if she knew the resident (R75). She stated, Yes and the police told her she was found outside of the facility. V42 stated she was not aware the resident left the facility. On 3/11/2026 at 1:15pm, V1 (Administrator) confirmed that R75 left the facility without the facility's knowledge. V1 affirmed that the root cause of the incident was that the electronic alert alarms could not be heard at the nurse's station. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On 03/16/2026 at 1:45pm, V1 stated when they installed the electronic alert system and checked for the sound of the alarm, she was standing between the double doors, and she could hear the alarm. Inquiring if anyone thought of checking for the sound of the alarm outside of the double doors. V1 stated no one had thought about it. On 03/12/2026 at 11:50am, V44 (Social Services Director) stated her elopement risk care plan was initiated on 5/11/25. She (R75) was making comments about wanting to leave the facility, she was kind of wandering at the facility. Surveyor inquired if resident was able to elope, were the interventions in place effective. V42 stated it was not effective. Inquiring about the risk and danger posed to R75 who was cognitively impaired and who was able to elope from the facility. V44 stated she (R75) could be hit by a car because the facility is in the middle of residential areas and she could have drowned in the pond; there is an ungated pond close to the facility. On 03/12/2026 at 1:13pm, V51 (R75's Primary Care Physician/Medical Director) stated he was familiar with the resident. V51 stated he was made aware by the facility that she (R75) eloped. V51 stated she has cognitive issues, and the facility has a system in place for residents with elopement risk. This surveyor inquired if a resident was able to elope, was the system in place effective? V51 stated it was discussed during the meeting and there have been changes the facility made. V51 stated the changes the facility made are effective. Inquiring about a resident who was cognitively impaired and was able to elope, what are the risks or dangers to this resident when she was outside of the facility without supervision. V51 stated there are a lot of danger out there. V51 stated she (R75) could be hit by a car, she could get stuck outside, she could freeze. V51 stated there's a lot of risk factors. On 03/17/2026 at 3:29pm, V1 (Administrator) stated she cannot speculate as to what could have happened to her (R75). The (11.2023) electronic alert system documented, in part POLICY: Electronic alert system may be utilized and maintained to mitigate elopement risk. PROCEDURE: 11) Testing protected doors/elevators will be conducted weekly and after power outages. The (09.2020) Incident/accident Reports documented, in part POLICY: The Incident/Accident Report is completed for all unexplained bruises or abrasions, all accidents or incidents where there is injury or the potential to result in injury, allegations of theft and abuse registered by residents, visitors or other, and resident-to-resident altercations. 15. Facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. The Immediate Jeopardy that began on 09/08/2025 at 2:30am was removed on 09/12/2025, when the facility took actions to remove the immediacy prior to the survey date of 03/09/2026 On 03/16/2025, the survey team verified by observations, interviews, and record review, that the facility implemented the following to remove the immediacy. Corrective Action Taken: R75 was reassessed for elopement risk beginning on 9/8/25 and ending on 9/8/25 after the elopement occurred and deemed an elopement risk. R75 was located and returned to (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the facility on 9/8/25. A head-to-toe assessment was completed by the assigned nurse with no signs of injury. R75's care plan was updated on 9/8/25 pertaining to the elopement that occurred on 9/8/2025 by the Resident Care Coordinator. V58 (R75's family member and V51 (Primary Care Physician/Medical Director) were notified of the elopement on 9/8/25. On 9/8/2025 the DON, Administrator, ADON, and Medical Director reviewed the facility policies related to the occurrence: Elopement, Routine Resident Checks, Incidents/Accidents, Alarms, electronic alert band , Wanderers and Changes in Condition. The Wanderguard Policy was updated on 9/8/25 to include that in the event of equipment failure, facility may consider implementing alternative interventions including but not limited to room change to a more secure floor. Starting on 9/8/2025, the Memory Care Director, Resident Care Coordinator and Social Service Director updated the assessments and care plans for elopement risk residents. The assessments were completed on 9/10/2025. The immediacy was removed on 9/9/2025 as (R75) was placed on one to one supervision pending move to a more secured unit. Also, the only other resident requiring electronic monitoring was moved to a higher more secured unit on 9/9/2025. All residents were reassessed for elopement risk on 9/8/2025 and completed on 9/10/2025. All new admissions will have an elopement risk assessment that will be completed according to the MDS schedule; Within 7 days of admission, annually and as needed (by SSD/MCD). All residents that are identified as-risk for elopement during admission had a review of their care plan and updates were made where applicable, this audit began on 9/8/2025 and was completed on 9/10/2025. Pictures of at-risk residents were placed in a binder on all nursing stations (1st,2nd,3rd floors) and the receptionist desk which was completed on 9/10/2025 (by MCD). All residents determined to be at-risk for elopement and with active exit-seeking behaviors will be evaluated for a possible room change to a more secured unit to limit access to the front entrance door on the first floor. Additionally, residents will be evaluated to determine if an electronic monitoring bracelet is appropriate. Beginning on 9/8/2025, interviews were conducted (by the Administrator) with staff to determine further potential risk and completed on 9/10/2025. Code [NAME] Drills were conducted on all shifts to check staff knowledge and preparedness beginning on 9/8/2025 and ending on 9/12/2025 All staff and managers are being reeducated on routine resident checks, exit seeking, incidents/accidents, elopement policy and procedure and where to locate the at risk of elopement binders. The reeducation was provided on 9/8/2025 and was completed on 9/12/2025 All staff completed competency quizzes on elopement beginning on 9/8/2025 and ending on 9/12/2025 All staff and managers are being reeducated on elopement risk and reporting behaviors or changes in factors related to elopement risk to appropriate discipline. This was started on 9/8/2025 and completed by 9/12/2025. All reception staff were reeducated on monitoring the front doors and resident safety and proper procedure for code green started on 9/8/25 completed on 9/12/2025 All staff were educated on the electronic monitoring system starting on 9/8/2025 and completed on 9/12/2025. Exit doors will be monitored by staff when unalarmed. The receptionist will monitor the front entrance door 8am-8pm. From 8pm-8am door will be armed by receptionist and monitored by 1st floor nurses through the duration of that time. First floor staff will check and sign monitoring sheet for the alarm panel every 1/2 hour between the hours of 8pm to 8am to ensure that door alarms are activated while doors are not monitored by staff. Exterior door alarms will be checked weekly by the maintenance director and EVS Supervisor to ensure they are in working order and secured starting on 9/8/2025 and ongoing. After initial elopement on 9/8/2025 R75 was placed on one to one supervision. (continued on next page)		

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident. On 03/09/2026 11:42 AM, V19 (Certified Nursing Assistant) transferred R132 from the wheelchair to the toilet seat using the stand lift by herself. V19 stated when transferring her (R132) from the wheelchair to the toilet seat using the stand lift, there should be 2 persons doing the transfer; unfortunately, the facility is short staff, and she (V19) could not get any one to assist her with transfer. V19 stated there should be two persons assisting her with transfer to ensure no falls happened. On 03/10/2026 at 2:16pm, V25 (Restorative Nurse) stated restorative is in charge of care planning resident with transfer and use of mechanical lift. If a resident is careplanned for 2 staff assist with mechanical lift, it should be followed. V25 stated if the resident is coded 'dependent' with transfer, there should be 2 staff assisting her with transfer. The importance of following the careplan is for safety to prevent injuries and falls; to prevent staff and resident from getting hurt or injured. On 03/10/2026 AT 2:46PM, V61 (Physical Therapy Assistant) stated she (R132) is on ongoing treatment for therapeutic transfer. Once she (R132) is done with therapy, the Therapy Department will give recommendations for transfer. V61 stated there was no recommendation for transfer yet because she is still on therapy. On 03/19/2026 at 9:36am, V25 (Restorative Nurse) stated if she was careplanned to use a total body lift for transfer, the CNA is expected to follow the care plan and use total body lift to transfer the resident for safety. The (11/2017) Comprehensive Care Plans documented, in part POLICY STATEMENTAn individualized, person centered comprehensive care plan, including measurable objectives with timetables to meet Resident's physical, psychosocial and functional needs, is developed and implemented for each Resident. PROCEDURE: 1.) In coordination with the Resident and Resident representative, as applicable, the interdisciplinary team will develop and implement a person centered, comprehensive plan of care. Care plans are comprised of Focus statements, Goals and Interventions. 6.) The comprehensive person centered care plan will: a. Reflect treatment goals, timetables and objectives in measurable outcomes; b. Describe the services that are to be provided to attain or maintain the highest practical physical, mental and psychosocial well-being. R61's diagnoses include hemiplegia and hemiparesis affecting right dominant side. R61's (2/11/26) functional assessment affirms the resident is dependent on staff for chair/bed to chair transfer, walking was not attempted due to medical condition or safety concerns. R61's (2/6/26) fall risk assessment affirms that resident is at risk. R61's (3/17/23) care plan states resident is at risk for falls related to weakness, impaired mobility, use of assistive device and use of psychotropic medication, interventions: ensure that the bed is in the appropriate lowest position for the patient. Mechanical lift for transfers. (continued on next page)		

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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. Based on observation, interview, and record review, the facility failed to ensure kitchen staff did not store personal food items inside the facility's kitchen and failed to ensure kitchen staff with facial hair were wearing beard guards in an effort to prevent contamination of residents' food. These failures have the potential to affect all 154 residents taking oral nourishment at the facility. Findings include: The (03/09/2026) facility census was 175. The list of residents on NPO (nothing per Orem (Mouth) provided on 03/09/2026 documented there were 21 residents on NPO. On 03/09/2026 at 9:59am with V15 (Dietary Supervisor) inside the Kitchen's Dry Storage room, there were 2 General merchandising retail store plastic bags, one black plastic bag, and a tumbler inside the storage room. V15 (Dietary Supervisor) stated there should be no personal belongings or personal food items inside the dry storage room because she would not know how the food items were prepared and would not know the sanitation of the staff's kitchen. V15 stated she did not want to contaminate the residents food with the staff food items. This surveyor pointed out to V15 the 2 General merchandising retail store plastic bags, the black plastic bag, and a tumbler on the food cart inside the Dry storage room. V15 checked the tumbler and stated there's coffee inside the tumbler. V18 (Chef) went inside the Dry Storage room and stated the plastic bags and the tumbler were hers. V18 showed this surveyor and V15 the food items in one of the plastic bags. Inside the plastic bag were soft tortillas and jalapeno; the black bag contained 3 pieces of bread. V18 stated, she brought the food items to share with the ladies. On 03/09/2026 at 9:47am inside the facility kitchen, V8 (Executive Chef/Dietary Supervisor) had facial hair. V8 was not wearing beard guard. On 03/10/2026 at 9:45am inside the kitchen, V8 was not wearing a beard guard. This was pointed out to V8. V8 stated he should be wearing beard guard upon entrance to the kitchen. V8 stated he works with food and he does not want hair to get into the food; he does not want to contaminate the residents' food. On 03/10/2026 at 9:49am inside the kitchen, V29 (Chef) had facial hair; he was not wearing a beard guard. V29 stated he should have worn beard guard all the time while in the kitchen to prevent hair from getting into the residents' food. The (08/18) HAIR COVERING documented, in part POLICY: Hair will be covered when in the kitchen operations areas. PURPOSE: To prevent physical contamination of food. PROCEDURE: 1. While in the kitchen operations area staff will cover hair to prevent physical contamination of food. 3. Staff with facial hair, with the exception of eyebrows and eyelashes, will wear a beard cover. The (8/18) EMPLOYEE FOOD documented, in part POLICY: The Food & Nutrition Services employees will not store their food in dietary refrigerators. PURPOSE: To reduce the risk of food borne illness. PROCEDURE: 2. There will be a refrigerator designated for employee food.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure the dumpster's lids were closed and failed to ensure the dumpster's surrounding area was clean in an effort to prevent pest or rodent migration. These failures have the potential to affect all the 175 residents at the facility. Findings include: The (03/09/2026) facility census was 175. On 03/09/2026 at 10:09am with V15 (Dietary Supervisor), the facility's 2 dumpsters were enclosed. Two lids of one of the dumpsters were open. There were bags of trash and loose trash within the enclosure. V15 stated the dumpster lids should be closed at all times because pests and rodents are attracted to the food, and the facility does not want the pest and rodents to get inside the facility. These may infiltrate the building. V15 stated the surrounding area of the dumpster should also be clean, free of trash for the same reason. On 03/09/2026 at 10:30am, the exit/entrance door behind the building was close. There was a gap between the floor and the door. V15 stated the flush door was not properly sealed to prevent small critters from migrating to the facility. The (11/25) GARBAGE DISPOSAL documented, in part POLICY: Maintain and dispose of garbage in a clean, safe manner. PURPOSE: To reduce the risk of odors, breeding places for pests, and to keep the FNS (Food and Nutrition Services) Department clean. PROCEDURE: 5. Outside dumpsters shall be kept closed at all times.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Alden Estates of Orland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 16450 South 97th Avenue Orland Park, IL 60467	
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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure that staff don required PPE (Personal Protective Equipment) prior to repositioning (R15) and failed to ensure that soiled linen was bagged prior to placing it in the laundry chute to prevent contamination. These failures have the potential to affect all 175 residents residing at the facility. Findings include: Facility census dated 3/09/26, documents 175 residents residing in the facility. R15's face sheet documents diagnoses that include but are not limited to aphasia, psychosis, dementia, and gastrostomy. R15's MDS (Minimum Data Set), Section C: Cognitive Patterns, dated 2/19/2026, documents that R15's cognitive skills for daily decision making is severely impaired. R15 is unable to be interviewed due to altered mental status. On 3/09/26 at 10:07am, an Enhanced Barrier Precautions (EBP) sign was observed posted on R15's bedroom door. R15 was observed lying sideways in bed with both legs hanging out of the bed. V12 (Vent Certified Nursing Assistant/CNA) and V13 (Certified Nursing Assistant/CNA) entered the room without donning required personal protective equipment (PPE). V12 and V13 were observed wearing gloves; however, the required gowns for personal protective equipment (PPE) were not worn. V12 and V13 then made direct physical contact with R15 while assisting R15 by lifting and placing R15's legs back into the bed and repositioning the resident in bed. R15's physician order, dated 2/17/26, documents, in part, EBP (enhanced barrier precaution) for device care or use of feeding tube. R15's physician order, dated 8/06/25, documents, in part, every night shift every Wed observe & document g-tube site weekly. On 3/09/26 at 10:21am, V12 (Vent Certified Nursing Assistant/CNA) said that gowns and gloves are worn for residents that are on enhanced barrier precautions for prolonged contact and when changing the residents. On 3/09/26 at 11:58am, accompanied by V7 (Housekeeping Supervisor), a tour of the facility's laundry room was conducted. An open cart located directly below the laundry chute was observed containing soiled linen. The linen bag in the cart was not secured and remained open, with soiled linen exposed and hanging out of the bag. The laundry chute door above the cart was closed; however, a white cloth was observed protruding through the crack of the closed chute door. Upon opening the laundry chute door, the surveyor observed a bag of soiled linen that was not securely closed. The bag contained visibly soiled linens, including a white sheet that was partially hanging out of the bag with two quarter-sized brownish stains present. V7 said, Everything is supposed to be bagged. All dirty laundry is supposed to be bagged for infection control. On 3/11/26 at 10:00am, V30 (Infection Preventionist/Registered Nurse/RN) said that Enhanced Barrier Precautions are used for protective infection control measures, almost similar to neutropenic infections. The purpose is to prevent residents from developing nosocomial (healthcare-associated) infections. Residents who have chronic wounds, or medical devices that enter the body are often placed on Enhanced Barrier Precautions. This includes residents with ostomies or hardware exiting the body, as well as those with devices such as Foley catheters or gastrostomy tubes. Enhanced Barrier Precautions require the use of personal protective equipment during high-contact resident care activities. High-contact care includes activities such as changing the resident, providing peri-care, bathing, or any task that requires direct contact with the resident's body. Activities such as feeding the resident or simply answering the call light are not considered high-contact care. However, repositioning a resident in bed is considered a high-contact activity. Regarding soiled linen disposal, isolation linens are placed in black bags with red liners and tied securely before being placed in the laundry chute. Non-isolation linens are placed in clear bags. Each resident's linen is bagged separately. One bag of linen for one resident and then empty it before proceeding to the next resident. Hand hygiene is performed between residents. It is the facility's (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	expectation that bags are closed before being placed into the chute. This applies to both linen and garbage. The purpose of closing the bags is to prevent microorganisms or infectious materials from entering the chute and potentially spreading illness to staff or others. This practice helps protect everyone's safety, including both residents and staff. Record review of facility policy titled, Soiled Linen Processing, dated 6/18, documents, in part, Soiled linen will be handled safely and processed in a manner to provide clean linen in adequate numbers to meet the needs of the facility. All soiled linen will be transported either by hand, cart, or chute in closed impermeable bags to the soiled linen room located in the laundry. All soiled linen is regarded as potentially contaminated. Laundry personnel will use Personal Protective Equipment (PPE - gown, gloves, mask) when sorting soiled linen and filling the washing machines. Record review of facility policy titled, Enhanced Barrier Precautions, dated 12/2024, documents, in part, Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDRO) in nursing homes. As well as to prevent multi-drug resistant organism acquisition of those with an increased risk of acquiring MDROs including residents with a chronic wound or an indwelling medical device. EBP involves gown and gloves use during high-contact resident care activities for residents known to be infected or colonized with MDROs when contact precautions do not otherwise apply. As well as residents with a chronic wound and/or indwelling medical device. Residents that have indwelling medical devices, regardless of MDRO status, will be on EBP. a. Some examples may include central vascular line (including hemodialysis catheter), urinary catheter, feeding tube, tracheostomy, and ventilator (excludes peripheral IVs). Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.		

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. Based on observation, interview and record review, the facility failed to follow policy and procedure and failed to clean the lint screen thoroughly to provide a safe environment for the residents. This failure has the potential to affect all 175 residents residing at the facility. Findings include: Facility census dated 3/09/26, documents 175 residents residing in the facility. On 3/09/26 at 11:58am, accompanied by V7 (Housekeeping Supervisor), a tour of the facility's laundry room was conducted. V7 opened the lint compartment for dryer #1 (dryer farthest from the washing machines) and the lint compartment floor had loose lint on the floor, and the lint screen was fully covered with lint. V7 said, Yeah. This (dryer #1's lint compartment) definitely needs a little bit of attention. We (staff) clean the dryers out daily and after each dry. Lint compartments are cleaned out to prevent a fire and so the laundry dries. Record review of facility policy titled, Equipment Maintenance, dated 06/18, documents, in part, Laundry staff will clean all dryer lint screens and any accumulation of lint below the screens at the end of each shift and more often if needed. Laundry Supervisor will monitor to assure screens are cleaned. Lint accumulation may cause inefficient drying and dryer malfunction. Building Manager will vacuum the dryer(s) fire box, lint compartment, blower motors and any lint accumulation behind the dryers weekly. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to ensure that five residents (R30, R80, R107, R117, and R145) of 71 residents reviewed for resident rights, were treated with dignity and respect. Findings include: R80's face sheet documents diagnoses that include but are not limited to dementia with psychotic disturbance and frontotemporal neurocognitive disorder. R80's BIMS (brief interview for mental status) score, dated 12/30/25, is 1 which indicates R80's cognition is severely impaired. R80 is unable to be interviewed due to altered mental status. R80's care plan, dated 2/26/24, documents, in part, (R80) demonstrates socially inappropriate behaviors as evidenced by: Spitting on her roommate's bed, with interventions that document, in part, Support appropriate moods and behaviors. R80's care plan, dated 12/02/24, documents, in part, (R80) has dementia. Due to the disease prognosis, (R80) may not be able to make preferences known. On 3/09/26 at 12:06pm, R80 was observed, in the dining room, seated at a table with 3 other residents (R30, R117, and R145) during lunch. R80 was observed expectorating into a clear cup, and two spots of thick mucus-like secretions, each approximately the size of a quarter, were observed on the table surface. R30 said, There she (R80) go again. She (R80) gonna make me puke. R80's clear cup was observed to be approximately an inch high filled with R80's sputum. On 3/09/26 at 12:09pm, R80 expectorated again and missed the cup, resulting in sputum landing on the table. R80 then used R80's fingers in an attempt to pick up the thick sputum from the table and place it into the cup. On 3/09/26 at 12:13pm, R30 said, She (R80) spitting in that cup, keeps spitting in that cup. On 3/09/26 at 12:15pm, R80 was again observed expectorating into a clear cup at the table seated with 3 other residents (R30, R117, and R145) during lunch. On 3/09/26 at 12:18pm, R80 was again observed expectorating into a clear cup at the table seated with 3 other residents (R30, R117, and R145) during lunch. R30 pointed at R80 and said, Look at what she (R80) doing. V14 (Aide) said, I know (talking to R30). She (R80) can't help it. On 3/09/26 at 12:19pm, R80 was again observed expectorating into a clear cup at the table seated with 3 other residents (R30, R117, and R145) during lunch. R145 said, Here we go again. She (R80) makes herself spit. She (R80) usually spits on the floor, but they (staff) gave her a cup a today. Well, I don't like it, but I don't think she (R80) can help herself (R80). On 3/09/26 at 12:20pm, R80 stood up and walked out of the dining room. On 3/09/26 at 12:23pm, R107 entered the dining room and sat in the chair previously occupied by R80. R107 then placed R107's arm on the table, coming into contact with R80's respiratory secretions that were present on the table surface. On 3/11/26 at 12:14pm, V2 (Director of Nursing/DON) said, I can't imagine residents would appreciate that (R80 expectorating into a cup at the table). V2 affirmed that many of the residents residing on the floor with R80 are cognitively impaired and based on the reasonable person concept the residents would not appreciate that (R80 expectorating into a cup at the table). R30's face sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease and dementia. R30's BIMS (brief interview for mental status) score, dated 1/20/26, is 4 which indicates R30's cognition is severely impaired. R107's face sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease and dementia. R107's BIMS (brief interview for mental status) score, dated 2/03/26, is 9 which indicates R107's cognition is moderately impaired. R117's face sheet documents diagnoses that include but are not limited to vascular dementia and chronic kidney disease stage 4. R117's BIMS (brief interview for mental status) score, dated 2/03/26, is 10 which indicates R117's cognition is moderately impaired. R145's face sheet documents diagnoses that include but are not limited to hypertensive heart disease with heart failure and dementia. R145's BIMS (brief interview for mental status) score, dated 2/03/26, is 10 which indicates R145's cognition is moderately impaired. (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	interview for mental status) score, dated 2/12/26, is 15 which indicates R145 is cognitively intact. Record review of facility policy titled, Residents' Rights, dated 11/17, documents, in part, The facility will respect and uphold residents' rights. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observation, interview and record review the facility failed to follow policy procedures, failed to ensure that (R79's) nebulizer tubing/mouthpiece were dated, and failed to ensure that respiratory equipment was properly contained when not in use - to prevent contamination for four of 71 residents (R38, R71, R79, R112) in the sample reviewed for respiratory care. Findings include: R38 is [AGE] years old and has resided at the facility since 2021, face sheet listed the following past medical history: Bilateral osteoarthritis of knee, type 2 diabetes, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypercapnia, chronic diastolic (congestive) heart failure, hyperlipidemia, hyperlipidemia, generalized anxiety disorder, etc. 03/09/2026 11:20AM, R38 in room sitting up in wheelchair, alert and oriented stated that she has been at the facility for 5 years, originally came for therapy and ended up long term. Respiratory equipment mask noted on top of resident's bedside table open to air and not contained. R38 have the following active order DuoNeb Solution 0.5-2.5 (3) MG/3ML (Ipratropium- DuoNeb Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 1 vial inhale orally via nebulizer every 6 hours as needed for Respiratory Symptoms related to hypertensive heart disease without heart failure. R112's (Active Order as Of: 03/09/2026) Order Summary Report documented, in part Diagnoses: (include but are not limited to) chronic cough, hypertension, and COPD (Chronic Obstructive Pulmonary Disease). Order Summary. Albuterol Sulfate Nebulization Solution (2.5 MG/3ML) 0.083% 3 ml inhale orally via nebulizer every 4 hours for Respiratory Symptoms: Shortness of Breath and/or Wheezing. Active: 03/06/2026. On 03/09/2026 at 11:06am inside R112's room, R112's nebulizer mouth piece was not in used and was not contained. This surveyor requested V21 (Registered Nurse) to check R112's nebulizer mouth piece. V21 stated her mouth piece had to be in a plastic bag, contained for infection control. V21 stated she did not see a plastic bag in the room. On 03/11/2026 at 9:50am, V2 (Director of Nursing) stated it is expected when the nebulizer mouthpiece is not in used, this should be bagged for infection control and to maintain the cleanliness of the mouthpiece. R112'S (03/06/2026) care plan documented, in part noted with potential for respiratory difficulty secondary to active diagnosis of COPD. Will tolerate oxygen therapy. On 3/09/26 at 10:15am, R71's oxygen tubing and oxygen mask, which were not currently in use, were observed in R71's room across from the bed under a hanging wall shelf. R71's oxygen tubing and oxygen mask were observed on top of R71's oxygen concentrator, removed from a clear plastic bag, laying on top of the bag, leaving the equipment exposed and not contained. (continued on next page)		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R71's face sheet documents diagnoses that include but are not limited to Alzheimer's disease, dementia, delusional disorders, and dysphagia following nontraumatic intracerebral hemorrhage. R71's BIMS (brief interview for mental status) score, dated 2/10/26, is 1 which indicates R71's cognition is severely impaired. R71's physician order, order date: 9/18/25; end date: indefinite, documents, in part, respiratory: oxygen per nasal cannula @ 2 liters per minute prn as needed for respiratory symptoms: shortness of breath. R71 is unable to be interviewed due to altered mental status. On 3/09/26 at 10:22am, V12 (Vent Certified Nursing Assistant/CNA) confirmed R71's oxygen tubing and oxygen mask were not contained laying on top of R71's oxygen concentrator and removed from a clear plastic bag, laying on top of the bag. V12 stated that the nurse's take care of the oxygen stuff. R79's diagnoses include chronic obstructive pulmonary disease. R79's (11/27/25) physician orders state change nebulizer tubing/mask/mouthpiece weekly. On 3/9/26 at 1:20pm, R79's (undated) nebulizer mouthpiece was observed in the dresser (uncontained). Surveyor inquired if R79's nebulizer tubing and/or mouthpiece were dated. V5 (Licensed Practical Nurse) inspected R79's nebulizer tubing/mouthpiece and stated, It's not labeled. Surveyor inquired about concerns with R79's nebulizer tubing/mouthpiece storage. V5 responded, It's not in a bag. Surveyor inquired if nebulizer tubing and mouthpiece are supposed to be labeled and bagged when not in use. V5 replied, It should be. The (10/2025) Equipment Change Schedule documented, in part POLICY: Equipment will be changed following established schedules to prevent cross contamination. 6. NEBULIZERS: Nebulizer tubing shall be stored appropriately in a bag when not in use. Record review of pamphlet titled, RESIDENTS' RIGHTS' For People In Long-Term Care facilities, revised date 11/18, documents, in part, . Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life. Your facility must provide equal access to quality care regardless of diagnosis. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to follow policy procedures, failed to ensure that (R27, R47, R52, R53, R60, R159, R184) multidose medications were dated when opened, failed to ensure that (R42) treatment was labeled/contained, failed to discard (R100) expired medication, failed to ensure that TB (Tuberculin) solution was stored within the required temperature range, failed to ensure that (R1, R53, R54, R122, R127) refrigerated medications were stored within the required range, and failed to maintain the (2nd floor) medication refrigerator temperature within the required range. This failure has the potential to affect 60 (2nd floor) residents. Findings include: The [DATE] facility census includes 60 (2nd floor) residents. On [DATE] at 2:08pm, the (1st floor - back hall) medication cart was inspected with V5 (LPN/Licensed Practical Nurse). R60's Systane solution was opened and undated. Surveyor inquired if there was an opened date on R60's Systane. V5 stated, It's open but there's no date on it. R52's Latanoprost solution was opened and undated. Surveyor inquired if R52's Latanoprost was dated when opened. V5 responded, No. R27's Brinzolamide ophthalmic suspension was also opened and undated. Surveyor inquired if V5 knows when R27's Brinzolamide was opened. V5 replied, I don't. On [DATE] at 2:12pm, the (2nd floor - front hall) medication cart was inspected with V21 (RN/Registered Nurse). Hydrocortizone cream was noted to be opened, unlabeled, and uncontained in the drawer. Surveyor inquired about the Hydrocortizone cream. V21 stated, That's for (R42's name) because I (V21) know it's for his arm. Surveyor inquired if the Hydrocortizone cream was labeled with R42's name. V21 responded, No. Surveyor inquired if R42's Hydrocortizone cream was bagged. V21 replied, No and proceeded to place it in a bag. R100's Systane Ultra solution was opened and dated 1/14 (almost 2 months ago). Surveyor inquired when eye drops expire (after opened). V21 stated, If it's opened, its 28 days. On [DATE] at 2:28pm, the (2nd floor) medication refrigerator was inspected with V21 (RN) the temperature (per thermometer) was noted to be 50F (Fahrenheit). V21 inspected the thermometer and stated, This is 50, the target is 41 but it can go all the way to 46. On [DATE] at 2:31pm, surveyor inquired about the temperature of the (2nd floor) medication refrigerator V31 (ADON/Assistant Director of Nursing) inspected the thermometer - dangling from the door and stated, It's 62, I (V31) don't think this is accurate cause now it's going to 63. Surveyor inquired what the medication refrigerator temperature should be. V31 responded, The target is between 46 and 36. V31 subsequently inspected the medication refrigerator thermometer - on the 2nd shelf and stated, This one in here says 52. Surveyor inquired if there was ice buildup on the freezer (inside the medication refrigerator). V31 responded, Yeah. The following contents were inside the refrigerator: TB solution. R1's Zerbaxa IVPB (Intravenous Piggyback). R53's Procrit. R54's B12 solution. R122's Vancomycin suspension. R127's Vancomycin suspension. On [DATE] at 2:35pm, the (2nd floor - split) medication cart was inspected with V31 (ADON). R53's Brimonidine ophthalmic solution was opened and undated. Surveyor inquired if R53's Brimonidine was dated when opened. V31 stated, There's no date on it. V31 subsequently affirmed that R159's Dorzolamide/Timolol ophthalmic solution was also opened and undated. Surveyor inquired about the requirement for opened multidose vials. V31 responded, It has to be labeled. On [DATE] at 2:40pm, the (2nd floor - vent) medication cart was inspected with V32 (LPN). R47's Albuterol inhaler was opened/unboxed and undated. Surveyor inquired when R47's Albuterol was opened. V32 stated, I'm not sure, they (staff) didn't put a date on here (referring to the plastic (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	bag that it was contained in). R184's Albuterol inhaler was also opened/unboxed and undated. Surveyor inquired if R184's Albuterol was dated V32 responded, No. Surveyor inquired about the requirement for opened multidose medications. V32 replied, We (staff) put a label on it and mark it with a date when it was opened. The (12/2023) storage/labeling/packaging of medications policy states medications requiring refrigeration should be stored at temperatures between 36F to 46F. The (03/2021) multi-dose vials, use of policy states if the vial has been opened longer than 28 days, or has expired per the manufacturer's guidance, it should no longer be used and should be discarded in a sharps container, and a new vial of medication should be obtained. If this is a new vial, remove the cap from the vial. Using an ink pen, write the opened and expiration date as well as the staff initials, on the vials label or pharmacy provided sticker.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145963	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Alden Estates of Orland Park		STREET ADDRESS, CITY, STATE, ZIP CODE 16450 South 97th Avenue Orland Park, IL 60467	
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow their psychotropic medication policy by failing to ensure that residents on psychotropic medications have a valid consent before receiving the ordered medications. This failure affected two (R163 and R184) of five residents reviewed for psychotropic medication. Findings include: R163 is [AGE] years old and has resided at the facility since 2022, face sheet listed the following medical history: hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, aphasia following cerebral infarction, dysphagia following cerebral infarction, trigeminal neuralgia, other muscle spasm, essential primary hypertension, chronic pain syndrome, etc. Minimum Data Set (MDS) assessment dated 12/26/2025 section C (cognitive) scored resident with a brief interview for mental status (BIMS) score of 00 out of 15, indicating that resident is not cognitively intact. Physician order listed the following medication, Mirtazapine 15mg, give 1 tablet by mouth at bedtime for depression. R184 is [AGE] years old and has resided at the facility since 2025. Past medical history includes, but not limited to amyotrophic lateral sclerosis primary, acute respiratory failure with hypoxia, depression, insomnia, dysphagia unspecified, generalized anxiety disorder, etc. MDS assessment dated [DATE] is not completed and did not indicate any BIMS score for R184. R184 have the following orders: Lorazepam 1mg, 1 tablet via G-tube every 4 hours and as needed for anxiety. Sertraline 25mg once a day via G-tub for depression. R184 has been on these medications since 2025. On 3/11/2026 at 12:09PM, V32 (LPN) said that she got the consent for the psychotropic medication for R163 and R184, the protocol is to have resident sign the consent upon admission, if the resident cannot sign, the family member/POA will be contacted, V32 is not sure if there is a policy for the staff to write a progress note when the family is contacted, but the name of the person contacted will be documented with the date and time. V32 added that verbal consent can be obtained by one nurse, the copy of the verbal consent is kept and the family/POA will be asked to sign when they come in. Review of psychotropic medication consents provided by the facility for both R163 and R184 showed R163 has a verbal consent dated 1/26/2026, resident has been on Mirtazapine Oral Tablet 15 MG (Mirtazapine) since 8/12/2025, surveyor requested for any other informed consent for R163, but facility did not provide any. R184's consent stated that resident cannot sign, then there is a signature beside the writing, V32 (LPN) was documented as the nurse obtaining consent. A question on the consent form that asked for the classification and side effect medication was marked no to all categories of medication. Surveyor presented this observation to V32, and she said, Oh I am sorry, I must have done that in a hurry. For the signature on R184's consent, V32 said, this is not my signature, I don't know who signed this. On 3/11/2026 at 4:21PM, V2 (DON) said that the facility does not have any other consent for R163's psychotropic medication, the nurse is in the process of getting one now, she is calling the family, but they are not picking up the phone. Psychotropic medication use policy dated 09/2022 stated in part: Purpose: To establish a standardized system to inform residents and/or their responsible parties about psychotropic medications and their side effects. Policy: A resident will not receive psychotropic medications unless behavioral programming and/or environmental changes have failed to sufficiently modify a resident's target behavioral disturbance. A resident will not receive psychotropic medications unless such medication is ----- to treat clearly defined target behaviors. Consent: 1. For each psychotropic medication ordered either verbal or written consent from the resident or the resident's responsible party will be obtained prior to initiation of the medication. Consent will not be obtained for a dosage decrease. 2. Information regarding (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	possible side effects will be discussed with the residents or the resident's responsible party.3. If the consent is verbal, a copy of the form will be placed in the chart, and the original will be sent to the party responsible for a signature. A copy will remain in the chart until replaced by the returned original.4. The resident and/or resident party responsible will be notified regarding any changes in medication dosage, this information will be documented in the resident's medical record.		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview, and record review the facility failed to ensure that linen (layers) were not beneath a resident while lying on a LALM (Low Air Loss Mattress), failed to replace a malfunctioning LALM, failed to ensure that a LALM was on the correct setting (while in use), and/or failed to ensure that nursing staff were aware of required LALM settings, for three of 71 residents (R5, R13, R27) in the sample reviewed for pressure ulcers. Findings include: R5's (2/2/26) initial physician wound assessment includes the following pressure wounds (stage 4) sacral extending to both hips, (stage 3) right buttock, left heel, and (unstageable) right heel. R5's (2/19/26) POS (Physician Order Sheets) include low air loss mattress. On 3/9/26 at 10:24am, R5 was observed lying atop of a LALM however multiple layers (incontinence brief, flat sheet, and additional folded sheet) were noted beneath the resident - which impedes mattress air flow. Surveyor inquired about the layers beneath R5 V4 (Registered Nurse) stated We (staff) have a sheet, diaper, and draw sheet. Surveyor inquired how many draw sheet layers were beneath R5 V4 responded, 2 parts therefore 3 linen layers and a brief were between the mattress and resident. The (3/2/21) prevention and treatment of pressure injury and other skin alterations policy states implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations. The (undated) low air loss mattress operation manual states you may place a thin cotton sheet over the quilted mattress top cover. R13's diagnoses include paraplegia. R13's (5/16/25) POS includes low air loss mattress. R13's (12/12/25) BIMS (Brief Interview Mental Status) determined a score of 15 (cognition intact). On 3/9/26 at 10:15am, R13 was observed lying atop of a LALM and the alarm was sounding. The Low Pressure setting on the LALM was noted to be flashing (orange) at this time. Surveyor inquired about concerns with the LALM. R13 responded, The mattress is missing a bubble, it's so uncomfortable. It's like a void in the mattress. Eight (8) months ago I (R13) asked for a new mattress, and they (staff) never followed up. On 3/9/26 at 10:17am, surveyor inquired why R13's LALM was alarming. V3 (Certified Nursing Assistant) stated, He (R13) probably just moved from side to side. V3 subsequently inspected R13's LALM settings and stated, It says low pressure, it only does it when he moves however the mattress should not alarm when resident moves. The (undated) low air loss mattress operation manual states a visible indicator (orange) warns the pressure is below a preset or user-defined level. R27's diagnoses include paraplegia. R27's (11/7/23) POS includes low air loss mattress. R27's (12/8/25) BIMS determined a score of 15 (cognition intact). On 3/9/26 at 11:25am, R27 was lying atop of a LALM while in static mode. Surveyor inquired about concerns with the LALM. R27 responded, It's supposed to let down and rose up, it haven't done nothing lately and affirmed the mattress is firm. On 3/9/26 at 11:28am, surveyor inquired about R27's LALM settings. V5 (Licensed Practical Nurse) stated, I (V5) would have to look at the exact order. V5 subsequently inspected R27's LALM settings and stated, It should be stagnant. Surveyor inquired if R27's LALM should be in static mode while lying in bed. V5 responded, I'm not 100% sure. On 3/11/26 at 1:46pm, V2 (DON/Director of Nursing) stated We (facility) don't have a policy for the use of our low air loss mattresses and affirmed that staff follow the manufacturer guidelines. On 3/11/26 at 2:43pm, surveyor inquired about requirements for use of LALM V2 (Director of Nursing) stated Anyone with multiple stage 2, or stage 3, stage 4 or if they (residents) are requesting it for comfort. Surveyor inquired how many layers are allowed between the resident and LALM. V2 responded, I'm (V2) not gonna guess, I (V2) will let you know and affirmed that she (V2) was unsure. Surveyor inquired when static mode is required for LALM use. V2 replied, This is outside of my (V2) lane; this is wound care and affirmed that she didn't know. Surveyor inquired about staff requirements for malfunctioning LALM - in use. V2 stated, To (continued on next page)		

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	notify somebody.On 3/11/26 at 4:01pm, surveyor inquired about requirements for use of LALM. V31 (Assistant Director of Nursing) stated, I (V31) know it's a weight-based requirement; we (facility) use them for people with pressure wounds and things like that. Surveyor inquired what's allowed on the LALM while in use. V31 responded, Just a flat sheet. Surveyor inquired what static mode indicates on the LALM. V31 replied, The static mode is to firm the mattress, but the resident is not on it continuously. The (undated) low air loss mattress operation manual states in static mode, the mattress provides a firm surface.		

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. Based on observation, interview, and record review, the facility failed to follow policy procedures, failed to follow physician orders, failed to implement care plan interventions, and failed to ensure that an IV dressing was changed (weekly) to prevent infection, for one (R5) of 71 residents in the sample reviewed for quality of care. Findings include: R5's (2/18/26) Physician Orders include IV midline: Transparent sterile dressing change weekly and prn (as needed). R5's (2/19/26) care plan states resident requires IV medication, intervention: change midline/PICC (Peripherally Inserted Central Catheter) dressing weekly and prn (as needed). On 3/9/26 at 10:24am, R5's right upper extremity IV dressing was dated 2/22/26 (15 days ago). Surveyor inquired about R5's IV access. V4 (Registered Nurse) stated, This is um midline, a PICC line. Surveyor inquired how frequent IV dressings are changed at the facility. V4 responded, We (staff) change every weekly. Surveyor inquired about the date on R5's IV dressing V4 replied 2/22/26. On 3/9/26 at 10:36am, surveyor inquired when IV dressings should be changed at the facility V6 (Assistant Director of Nursing) stated Usually we (staff) change it when they (residents) first come in from the hospital then PRN (as needed) and also I think after a month. On 3/11/26 at 2:45pm, surveyor inquired when IV dressing changes are required, V2 (Director of Nursing) stated At least weekly and if noted to be soiled. R5's (March 2026) Medication Administration Record includes IV midline: transparent sterile dressing change weekly (every Sunday), which was documented on 3/8 (the day prior) as administered. The (04/2025) central venous access catheter devices: dressing change policy states dressings are changed one (1) time per week and PRN.		