STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145970	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Windsor Park	2649 East 75th St Chicago, IL 60649

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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 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure there are no more than 14 hours between the evening meal and breakfast the following day with a substantial bedtime snack available/offered to everyone. These failures have the potential to affect all 190 residents receiving oral diets from the facility's kitchen. Findings include:On 03/31/26 during initial tour on units observed mealtime schedule posted which documented in part, 3rd floor dinner is served at 4:40 PM and breakfast is served at 7:40 AM, 2nd floor is served at 4:55 PM and breakfast is served at 7:55 AM, 1st floor is served at 5:20 PM and breakfast is served at 8:20 AM. On 04/01/26 at 11:51 PM, V28 (Food Service Director) stated each floor after the dinner meal a tray of evening snacks which consists of ten peanut butter and jelly sandwiches, ten meat sandwiches, four to five pieces of fresh fruit, 10-15 packages of graham crackers and four containers of applesauce or pudding. V28 stated the evening snacks are intended to be given out to the residents who have diabetes and whatever is left over can be given out to any resident who wants a snack. V28 stated the snacks sent up to each unit are not enough for every resident to receive a snack because it is primarily intended only to be offered to the residents with diabetes. V28 stated the kitchen closes at 8:30 PM and after this time none of the staff can get into the kitchen. V28 stated the evening snacks are already prepared for today.On 04/01/26 at 11:57 AM, observed in the walk-in refrigerator with three different trays and on each tray there were ten peanut butter and jelly sandwiches, eight graham cracker packages, five oranges. V28 stated ten cold cut sandwiches, and some containers of pudding or applesauce will be added to the trays before they are sent up to the unit after dinner. V28 stated the residents on pureed diets are offered pudding or applesauce as a snack, they do not prepare pureed sandwiches for them on the evening snack trays.On 04/01/26 at 10:27 AM, V35 (Certified Nursing Assistant) stated she sometimes works the 3-11 shift on the 1st floor. V35 stated the kitchen sends up a tray with sandwiches, graham crackers, and applesauce or pudding on it. V35 stated she asks if a resident wants a snack. V35 stated there are not enough snacks sent up for every resident. V35 stated if a resident is on a pureed diet she offers them pudding or applesauce.On 04/02/26 at 8:40 AM, V30 (Registered Dietitian) stated via telephone interview there can be no more than 14 hours between dinner and breakfast. V30 stated if they are serving dinner at 4:40 PM and breakfast at 7:40 AM that means there is 15 hours between dinner and breakfast which is too long of a distance. V30 stated if the facility is serving meals outside the 14 hours window, then all residents must have access to a substantial snack. V30 stated a substantial snack would be a sandwich but applesauce or pudding or a piece of fruit would not be a substantial snack. V30 stated evening snacks should not only be available for the residents who can walk independently to the nursing station to get snacks, they need to be passed out room by room so everyone is offered an evening snack. V30 stated for pureed diets applesauce or pudding would not be adequate but a pureed sandwich would be acceptable.R171's diagnosis includes but not limited to Acquired Absence of Right Leg Below Knee, Acquired Absence of Left Leg Below Knee, Insomnia. R171's MDS dated [DATE] indicates R171 cognition is intact.On (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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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	04/02/26 at 10:05 AM, R171 stated he does not get offered a snack every night by staff and commented that they run out of snacks early. R171 stated if he wants a snack after dinner, he has to get himself out of his bed into his wheelchair and wheel himself down to the nursing station because the staff does come into his room to offer him a snack. R171 stated if he gets to the nursing station too late all the snacks are gone because the residents who can walk get to the nursing station first and take all the snacks. R171 thinks the time between dinner and breakfast is too long and wishes he could get an evening snack every day.R65's diagnosis includes but not limited to Type 2 Diabetes Mellitus. R65's Order Summary Record indicates R65 is receiving Trulicity and Metformin for diabetes. R65's [NAME] Data Set (MDS) dated [DATE] indicates R65's cognition is intact.On 04/02/26 at 10:11 AM, R65 stated he does not get offered a snack every night and he is a diabetic so he should be receiving something after dinner so his morning blood sugar readings are not low. V65 stated it is too long a time between dinner and breakfast and that is why he gets hungry at night.Facility provided document titled, Diet Roster - By Diet dated 03/31/26 listing residents with their diet orders. The report indicates there are 12 residents who receive nothing by mouth (NPO).Facility provided kitchen policy titled Snacks undated which documents in part, if meal services have more than 14 hours between dinner and breakfast, facility must provide a substantial snack to all residents, and intake must be recorded. If there are more than 14 hours between meals, a substantial snack must include a minimum of 2 food groups. Residents on texture-modified diets must also have an appropriate substantial snack offered.

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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 on observation, interview and record review, the facility failed to (a) ensure a resident received the correct oxygen flow rate, (b) obtain physician order for oxygen use, (c) ensure oxygen in use signage was posted, (d) develop comprehensive care plan for oxygen use, (e) ensure oxygen nasal cannula was labeled and dated and (f) ensure nebulization tubing mask was properly stored. These failures affected five (R41, R89, R105, R173, R207) of seven residents reviewed for respiratory care in a sample of 35. The findings include: R173's face sheet/admission record shows admission date on 11/1/2010 with diagnoses not limited to Type 2 diabetes mellitus, Hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, Dysphagia oropharyngeal phase, Essential (primary) hypertension, Hyperlipidemia, Benign prostatic hyperplasia, Gastro-esophageal reflux disease. MDS (Minimum Data Set) dated 1/27/26 shows R173's cognition is intact. On 3/31/26 At 12:20PM R173 was sitting up in a Geri chair, alert and responsive mouthing words. Appears comfortable and well groomed. Observed with oxygen inhalation via nasal cannula at 4L/min. No signage posted for oxygen in use outside R173's room. On 3/31/26 At 12:23PM V7 (Registered Nurse/RN) was requested in R173's room and she stated R173 is using Oxygen continuously. She stated there should be a signage by room entrance for oxygen in use for safety reasons, so staff and residents are aware that oxygen is being used inside the room. V7 said there was no signage posted for oxygen in use outside R173's room. V7 checked oxygen and stated it is on at 4L/min. V7 reviewed R173's EHR (electronic health record) and stated there was no order for oxygen use. On 4/2/26 At 10:59AM V2 (Director of Nursing/DON) stated there should be an order for oxygen use to ensure the proper amount of oxygen is administered to the residents. She said oxygen in use signage should be posted by room entrance to inform them that there is oxygen in use in the room and to make sure that there is no open flame nearby for safety reasons. V2 said care plan should be developed to make sure that staff would be able to know how to care for the residents. R173's EHR (electronic health record) reviewed no physician order and no care plan found for oxygen use. Facility's oxygen therapy policy (undated) shows in part: To deliver oxygen in conditions in which insufficient oxygen is carried by the blood to the tissues. It is the policy of this facility that oxygen shall be used in safe and effective manner in accordance with applicable rules and regulations and the standard of care. Verify physician's order. Attach the nasal cannula to the oxygen source and turn the flow meter to the ordered flow rate. Place Oxygen in use sign outside the room when in use. Facility's Comprehensive care plan policy dated 11/17/17 shows in part: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The facility will develop and implement a comprehensive person – centered care plan for each resident that includes measurable objectives and timeframes to meet a (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	resident's medical, nursing needs. 2. R89 has diagnosis not limited to Long Term (Current) use of Inhaled Steroids, Hypertensive Heart Disease with Heart Failure, Sleep Apnea, Chronic Obstructive Pulmonary Disease, Dependence on Supplemental Oxygen and Abnormal Finding of Lung Field. R89's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. R89's Care plan document in part: Focus: R89 has oxygen therapy as ordered related to Chronic obstructive pulmonary disease. Change Oxygen Tubing and Humidifier as ordered per facility policy. R89's Care Plan document in part: Focus: R89 has risk for altered respiratory status/Difficulty Breathing related to COPD (chronic obstructive pulmonary disease)/Sleep Apnea. Focus: has oxygen therapy as ordered related to COPD. Interventions: Change Oxygen Tubing and Humidifier as ordered per facility policy. On 03/31/26 at 11:52 AM R89 was observed on 2 liters of oxygen per nasal cannula. Oxygen tubing is not labeled and dated. R89's Physician order document in part: Oxygen at 2 LPM (liters per minute) per Nasal Cannula/Mask continuously – Monitor. 3. R105 has diagnosis not limited to Essential (Primary) Hypertension, Unspecified Dementia, Unspecified Severity, with other Behavioral Disturbance, Hyperlipidemia, Vitamin D Deficiency, Anemia, Iron Deficiency Anemia, Long Term (Current) use of Aspirin, Moderate Protein-Calorie Malnutrition, Pressure Ulcer of Left Buttock, Unstageable and Pressure Ulcer of Sacral Region, Unstageable. R8's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) indicate rarely/never understood. On 03/31/26 at 01:01 PM R105 was observed lying in bed on a low air loss mattress with oxygen at 2 liters per nasal cannula. R105's Care Plan document in part: Focus: R105 has oxygen therapy as ordered/see POS (Physician order summary) and MAR (medication administration record) for orders. There is no document order for R105's oxygen use with an oxygen flow rate of 2 liters. R105's Physician orders document in part: Check and ensure proper placement of ear cushion on oxygen tubing. Replace if needed every shift for Shortness of Breath and as needed. Policy: Titled Oxygen & Respiratory Equipment- Changing / Cleaning revised 01/07/19 document in part: Purpose: 1. To provide guidelines to employees for changing all disposable respiratory supplies. 2. To ensure the safety of residents by providing maintenance of all disposable respiratory supplies. 3. To minimize the risk of infection transmission. Procedure: 2. Nasal Cannula. a. Nasal cannulas are to be changed once a week and PRN. c. A clean plastic bag with a zip loc or draw string, etc. will be provided to store the cannula when it is not in use. It will be dated with the date the tubing was changed. 4. R207's Minimum Data Set (MDS) dated [DATE], Brief Interview Score (15) indicates he is cognitively intact. R207's Physician Order Sheet (POS) dated 03/31/26 noted an active diagnosis of (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	chronic obstructive pulmonary disease, malignant neoplasm of esophagus, and essential hypertension. R207 has an active order for ipratropium-albuterol solution 0.5-2.5 (3) milligram/3mililiter inhale orally every 12 hours for shortness of breath/SOB or wheezing via nebulizer. On 03/31/26 at 12:19 PM, R207 stated that he received his nebulizer treatment every day, and he has received the nebulizer treatment this morning. Surveyor observed nebulizer tubing mask not inside the bag, but on his nightstand when not in use. On 03/31/26 at 2:32 PM, the surveyor and V7 (Registered Nurse) entered R207's room, observed nebulizer tubing mask on R207's nightstand. V7 stated that she has been at the facility since January 2026, the nebulizer tubing mask should have been stored in a bag when not in use to prevent infection. She also stated that she will immediately discard and replace it with a new nebulizer tubing mask in a bag. On 04/02/26 at 11:16 AM, V2 (Director of Nursing) stated that the nebulizer tubing mask should be stored inside a bag when not in use to prevent respiratory infection. Facility policy titled; Nebulizer Therapy dated 12/1/21documents in part: Store in a plastic bag. 5. R41 has diagnosis not limited to Hypertensive Heart and Chronic Kidney Disease with Heart Failure, Chronic Pulmonary Embolism, Chronic Diastolic (Congestive) Heart Failure and Atherosclerotic Heart Disease of Native Coronary Artery. R41's Progress Note dated 03/31/2026 12:39:58 document in part: R41's oxygen was noted to be on 4 liters verified orders of 2 liters via nasal cannula, and the writer set oxygen on correct order. Writer made NP (Nurse Practitioner) aware. Resident shows no s/s (signs and symptoms) of respiratory distress or discomfort. R41's Progress Note dated 03/31/2026 13:28:59 document in part: R41 is lying in bed alert and verbally responsive no complaints of pain no s/s of SOB (Shortness of breath) or respiratory distress, Residents 02 (oxygen) saturation is 98% on 2 liters of oxygen. On 03/31/2026 at 11:59AM R41 was observed sitting in a wheelchair at the bedside asleep. R41 was observed using oxygen at 4 liters per nasal cannula. R41's physician order reads oxygen 2 liters. On 03/31/2026 at 12:02 R41 was arousable. V11 (Licensed Practical Nurse) stated I have been working here for 26 years. V11 checked R41's Blood Pressure to the left arm with a reading of 140/79 Heart Rate 70 Temperature 97.7. V11 stated it looks like R41's oxygen is on 4 liters. On 03/31/2026 at 12:08 PM V11 (Licensed Practical Nurse) checked the computer and said R41's oxygen order is supposed to be on 2 liters. Surveyor asked V11 what can potentially happen if the oxygen order is not followed. V11 stated there is a potential for hypoxia. V11 returned to R41's room to correct the oxygen setting. On 04/02/26 at 10:00 AM V2 (Director of Nursing) stated My expectation if a resident is admitted on oxygen that the orders are placed and are carried out, the resident is assessed, all the tubing is labeled and dated. The purpose of changing the oxygen tubing is for infection control to ensure the resident has clean and effective tubing. The nurse should have verified that R41 was at the correct (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	oxygen flow rate. The nurse should have checked R41's oxygen setting at the beginning of the shift. My expectations for oxygen tubing are to be maintained, in infection control the line should be dated and changed out every 7 days. Every shift the nurse should monitor oxygen saturation, need to know if the oxygen is therapeutic then reassess to see if we need new orders and follow the physician orders. If the resident is not receiving enough oxygen, they can become hypoxic and if they receive too much oxygen, it can disturb the CO2 (carbon dioxide) drive which can be dangerous. If a resident has chronic obstructive pulmonary disease too much oxygen can be dangerous.

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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. Based on observation, interview and record review the facility failed to ensure a) medications were discarded when expired, b) ensure medications were labeled with the resident's name and c.) ensure medications were dated when opened in 4 of 4 medication carts reviewed during the medications labeling and storage observation.Findings Include:On 04/01/26 at 09:34 PM V9 (Licensed Practical Nurse) handed the surveyor a zip lock bag containing Budesonide-Formoterol Fumarate Inhalation Aerosol 160-4.5 MCG/ACT with 135-1 and the date of 03/18/26 written in marker on the inhaler. There was no label or resident name on the inhaler. V9 stated I don't know what happened to the box, I will order a new inhaler.On 04/01/26 at 12:11 PM the second-floor team 1 medication cart was reviewed with V11 (Licensed Practical Nurse). A bottle of Aspirin 325 mg was observed in the top drawer of the medication cart with an expiration date of 08/25.On 04/01/26 at 12:28 PM the third-floor medication cart #2 was reviewed with V25 (Licensed Practical Nurse). During review of the controlled substance a Controlled Substances Proof of Use sheet dated 03/19, amount received 15 ml (milliliter) was observed with no name documenting in part: Morphine Sulfate 100 mg (milligram) per 5 ml (milliliter). Take 0.25 ml (5mg) by mouth or under tongue every 2 hours as needed for shortness of breath. A box with R75's name was observed in the narcotic drawer. V25 stated the sheet has 15 ml but there is about 13 ml in the bottle. A Controlled Substances Proof of Use sheet, amount received 30 ml (milliliter) document in part: R75, Morphine Sulfate 20 mg/ml. Take 0.25 ml (5mg) by mouth or under tongue every 2 hours as needed for or every 1 hour as needed for SOB (Shortness of Breath). V25 stated the sheet has 29.5 ml and there is 30 ml in the bottle. I counted with the nurse this morning.On 04/01/26 at 12:52 PM the third-floor team 3 medication cart was reviewed with V15 (Licensed Practical Nurse). Surveyor asked V15 how long the inhalers were good to be used after opening. V15 stated I have to look it up. I googled it and it is good for 6 weeks or 42 days. R70's Budesonide-Formoterol Fumarate Inhalation Aerosol 80-4.5 MCG/ACT 1 puff inhale orally two times a day was observed with no open date. R103's Proventil HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT 2 puff inhale orally every 4 hours as needed was observed with a dispensed date of 12/11/25 and no open date. R169'S Anoro Ellipta Inhalation Aerosol Powder Breath Activated 62.5-25 MCG/ACT (microgram/actuation) inhale 1 puff daily was observed with no open date. Geri max antacid/antigas 12 fluid ounces was observed with an expiration date of 10/25.On 04/01/26 at 01:02 PM V15 (Licensed Practical Nurse) stated the expired medication should be discarded, and I am going to discard it. If a resident receives an expired medication, it can cause a bad reaction and side effects.On 04/01/26 at 01:18 PM the first-floor team one medication cart was reviewed with V8 (Registered Nurse). R2's Humalog Solution 100UNIT/ML 9 unit before meals were observed with no date opened. Epoetin Alfa Solution 10000 UNIT/ML was observed in the medication cart drawer with no name/label or date opened. R152's Ketorolac Tromethamine Ophthalmic Solution 0.4 % 1 drop in both eyes four times a day was observed with no open date. Sodium Chloride Hypertonicity Ophthalmic ointment 5% was observed with no name or label with a date of 01/16/26 written on the tube.On 04/02/26 at 10:00 AM V2 (Director of Nursing) stated Labeling and storage for the medication cart, medication room and multi dose medications we use an open date to make certain the medication required care date and whatever the expiration date should be listed on there as well. For the medication carts that is my same expectation for dating the medications with an open date, expiration and discard date. If the medication is used beyond the expiration date the efficacy of the medications can be affected and that is an infection control issue with the multi-use bottles. The inhaler date is an infection control issue even if they wipe the inhaler off and the inhaler is not good after the expiration date and that is something that they should get rid of. Symbicort is good for 90 days and Albuterol is good for 12 months. For the insulin, follow the sticker to date with an open date (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and store according to pharmacy guidelines. Potentially the efficacy of the drug can be affected. If medications are not stored in the box or separated out it can be a medication error, and the purpose is to keep down contamination. If a room number with no other identifier is written on a medication that can potentially be a medication error and that does not mean it is that resident's medication. There should be a two-patient identifier on the medication. Expired aspirin, the efficacy of that drug I nonexistent. The expired Geri max is not effective, and expired medications are not effective. The Epoetin should have been in the resident container and dated to prevent medication errors. The medications can be put in a zip lock bag and labeled. Narcotic accountability, I pulled R75 (Morphine) bottles and sheet. I instructed the nurses to label the bottles and number them if there is more than one bottle, number them to make sure the right bottle has the right strength. There was no name on the narcotic sheet so I would not know what I am supposed to be giving R75. Fill out the narcotic sheet appropriately. The nurses ordered multiple bottles of morphine and one of the bottles was from a different pharmacy. Whatever is on the medication label should be transferred to the narcotic sheet, stop, count and measure. V2 placed four narcotic sheets, one with no name, one unopened and three open morphine bottles on her desk expressing the narcotic count error and confusion of having multiple open bottles of the same medication.Policy:Titled Medication Storage revised 07/02/19 document in part: Purpose: To ensure proper storage, labeling and expiration dates of medications, biologicals, syringes and needles. 4. Facility should ensure that medications and biologicals that (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guideline are stored separate from other medications until destroyed or returned to the supplier. 5. Once any medication or biological package is opened, Facility should follow manufacturer/supplier guidelines with respect to expiration dates for open medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. 6. Facility should destroy and reorder medications and biologicals with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels. 10. Facility should ensure that the medications and biologicals for each resident are stored in the container in which they were originally received.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure a) food items were properly labeled and dated, b.) food is rotated using First In, First Out (FIFO) guidelines, c.) kitchen equipment is sanitized based on manufacturers' procedure directions. These failures have the potential to affect all 190 residents receiving food prepared in the facility's kitchen. Findings include:On 03/31/26 at 9:38 AM, V28 (Food Service Director) stated all opened items in the refrigerator and freezer should be labeled with a delivery date, an opened date and a use by date. V28 stated different food items have different use-by dates. V28 pointed to a posted chart on the wall in between the refrigerator and freezer and said the staff follow that use by-date chart. V28 stated labeling the opened food items with an open and use-by date is important so the staff knows when to discard an item, so a spoiled item does not get served to a resident(s) and potentially make them sick.On 03/31/26 at 9:40 AM, observed the following items in the Walk-In Refrigerator:Opened 5-pound container of sour cream labeled with a delivery date of 02/24/26, an opened date of 03/02/26 and a use-by date of 03/09/26.Unopened case of whole milk ricotta cheese consisting of four 5-pound containers labeled with a delivery date of 02/03/26 and marked on each container by the manufacturer best if use by date of 03/26/26.On 03/31/26 at 9:45 AM, V28 went outside the walk-in refrigerator and checked the use-by chart posted on the wall. V28 stated the sour cream should be discarded seven days after it is opened. V28 stated therefore if the sour cream was opened on 03/02/26, it should have been used by or discarded on or before 03/08/26. V28 stated the expired sour cream has the potential to cause a food-borne illness which could harm the residents. V28 stated the ricotta cheese was going to be used this week to make lasagna which is on the menu later in the week. V28 had not realized the ricotta cheese best by date had expired last week.On 03/31/26 at 10:00 AM, V28 stated items are stored and organized in the dry storage room using FIFO which means the newest or most recently delivered items are stored in the back, the oldest items are stored in the front so that the older items are used first. Observed in the dry storage room [ROOM NUMBER]-pound cans of chocolate pudding labeled 03/07/26 in front of other 7-pound cans of chocolate pudding labeled 01/20/26. V28 stated the cans labeled 01/20/26 should be in front of the cans labeled 03/07/26 so that the older dated cans are used first.On 04/01/26 at 10:31 AM, during pureed food preparation observations observed V28 take a dirty blender container, blade and lid to the three-compartment sink and wash, rinse and quickly dip each piece into the sanitizing solution in the third sink (surveyor counted 2 seconds per item).On 04/01/26 at 10:51 AM, V28 stated kitchen equipment items being hand washed in the three-compartment sink only need to be dipped into the sanitizing solution in the third sink, they do not have to be fully submerged. V28 stated the purpose of sanitizing the kitchen equipment is to make sure the item is disinfected and clean to prevent cross-contamination. V28 stated they are using a commercial quat-based sanitizing solution.On 04/01/26 at 10:52 AM, observed V31 (Cook) take a dirty blender container, blade and lid to the three-compartment sink and wash, rinse and quickly dip each piece into the sanitizing solution in the third sink (surveyor counted 2 seconds per item).On 04/01/26 at 10:53 AM, V32 (Pot Washer) stated each item being cleaned in the three-compartment sink needs to be submerged in the sanitizing solution for at least 30 seconds and then allowed to air dried fully before use.On 04/01/26 at 10:54 AM, surveyor observed two posters above the three-compartment sink which had a picture and written diagram of washing procedure. V28 viewed the posters and confirmed that those posters are guidelines from the company the kitchen uses for the quat-based sanitizing solution.Facility provided document titled, Diet Roster - By Diet dated 03/31/26 listing residents with their diet orders. The report indicates there are 12 residents who receive nothing by mouth (NPO).Facility provided kitchen policy untitled, undated which documents in part, under the heading Refrigerator - items that have exceeded the manufacturer's expiration date or use by date (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	should be discarded.Facility provided document titled, Use-By (UB) Guidelines undated which documents in part, sour cream should be used with seven day from opening.Facility provided kitchen policy titled, Storage Labeling & Dating undated which documents in part, purpose - to ensure inventory is stored in a safe, sanitary manner to provide the best food quality and safety and all stored products will be labeled with the name, appropriate dates and rotated following the First-In, First-Out method (FIFO).Facility provided document titled, Labeling, Dating and FIFO undated which documents in part, food and beverages should be dated upon receipt and stocked rotating using the first-in, first-out (FIFO) method. The item delivered first should be used first.Facility provided kitchen policy titled Sinks, Three and Two Compartment undated which documents in part, purpose - to ensure food safety and sanitizing items in the 3rd sink. Submerge items for at least 60 seconds if using quat, or per the manufacturer's guidelines.Facility provided copy of posters above the three-compartment sink. The poster titled Pot & Pan Wash Procedure documented in part, submerge in sanitizer sink for one minute or as specified by product label and/or local guidelines. The other posted titled Multi-Quat Sanitizer documents in part, Directions for Use - Expose all surfaces of equipment, ware or utensils for the sanitizing solution for a period of not less than one minute.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to (a) ensure staff cleaned and disinfected reusable equipment between resident use, (b) perform hand hygiene during medication administration for five (R53, R56, R112, R119, R215) residents, (c) ensure proper Personal Protective Equipment (PPE) were worn during wound care treatment, (d) ensure Enhanced Barrier Precautions (EBP) signage was posted, (e) develop comprehensive care plan for one (R7) resident on Enhanced Barrier Precautions (EBP). These failures have the potential to affect six (R7, R53, R56, R112, R119, R215) residents reviewed for infection control in a sample of 35. The findings include: R7's face sheet/admission record shows initial admit date on 10/31/2025 with diagnoses not limited to Spinal stenosis lumbar region with neurogenic claudication, Unspecified injury to unspecified level of lumbar spinal cord, Pressure ulcer of sacral region stage 4, Peripheral vascular disease, Unspecified atrial fibrillation, Type 2 diabetes mellitus, Hypertensive heart disease with heart failure, Non-pressure chronic ulcer of other part of left foot, Heart failure, Thrombosis of atrium, auricular appendage, and ventricle as current complications following acute myocardial infarction, Neuromuscular dysfunction of bladder, Nontoxic diffuse goiter, Anemia, Neurogenic bowel. MDS (Minimum Data Set) dated 2/24/2026 shows R7's cognition is intact. He needed Supervision or touching assistance with oral hygiene, upper body dressing; Partial/moderate assistance with toileting and personal hygiene, shower/bathe self, chair/bed and toilet transfer; Substantial/maximal assistance with lower body dressing. R7's MDS shows 1 Stage IV pressure ulcer that was present on admission. On 4/2/26 at 9:46AM Wound care observation conducted with V14 (Wound Care Director, LPN/Licensed Practical Nurse) assisted by V38 (Certified Nursing Assistant/CNA). V14 stated R7 has Stage IV pressure ulcer to Sacral area. V14 and V38 observed wearing gloves but not gown. Observed V14 removed soiled dressing to R7's sacral area. Observed wound bed 100% beefy red, no signs and symptoms of wound infection. V14 cleanse sacral area with NS (normal saline) then applied hydro [NAME] blue to wound bed and covered with dry dressing. V14 and V38 not wearing proper PPE (Personal Protective Equipment) during wound care observation. R7's room with no EBP (Enhanced Barrier Precautions) signage posted. PPE (gown) supplies not accessible for staff to use. On 4/2/26 At 10:59AM V2 (Director of Nursing/DON) stated EBP (Enhanced Barrier Precautions) is used when residents have medical indwelling line or devices or open wound or colonized infection. She said residents with open wounds or stage IV pressure ulcer should be on EBP, signage should be posted, PPE should be accessible and proper PPE (personal protective equipment) such as gown, mask, gloves should be worn during wound care treatment to decrease the spread of infection. She said residents on EBP should have a care plan so staff would be able to know how to care for the residents. R7's POS (Physician Order Sheet) dated 4/2/26 shows active order not limited to: Wound Care: Sacrum Cleanse site with NSS, Pat dry with gauze, apply hydrofera blue to wound bed and cover with a dry dressing everyday shift for Wound Care AND as needed for soiled or compromised dressings. Reviewed R7's care plan, no care plan found for EBP (Enhanced Barrier Precautions). Facility's Enhanced Barrier Precautions (EBP) policy dated 3/20/26 shows in part: to minimize the risk of acquiring, transmitting, or complications resulting to multi-drug resistant organism (MDRO) (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	colonization among residents n this setting. Populations affected: Residents with wounds. Residents will require the use of personal protective equipment (PPE) for high-risk activities such as wound care. PPE required: Gowns, gloves. Persons expected to encounter these circumstances are to don PPE (gown and gloves) in accordance with the activity that will be encountered when caring for the resident. Facility's EBP signage shows in part: providers and staff must wear gloves and a gown for the following high-contact resident care activities – wound care: any skin opening requiring a dressing. Facility's Comprehensive care plan policy dated 11/17/17 shows in part: To develop a comprehensive care plan that directs the care team and incorporates the resident's goals, preferences, and services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being. The facility will develop and implement a comprehensive person – centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing needs. 2. On 03/31/26 at 09:21 AM V9 (Licensed Practical Nurse) requested that a staff member remove the blood pressure machine from R215's room with Enhanced Barrier Precaution signage observed posted on the door. V9 proceeded down the hall with the blood pressure machine to R53's room. On 03/31/26 at 09:25 AM V9 (Licensed Practical Nurse) entered R53's room with Enhanced Barrier Precaution signage observed posted on the door. V9 failed to clean and disinfect the blood pressure machine and pulse oximeter prior to placing the blood pressure cuff on R53's right arm and pulse oximeter on R53's right index finger, obtaining a blood pressure reading of 114/64, pulse 82 and oxygen saturation 98%. V9 then exited the room with the blood pressure machine without cleaning and disinfecting it. On 03/31/26 at 09:32 AM V9 (Licensed Practical Nurse) entered R56's room with the blood pressure machine, applied the blood pressure cuff to R56's right arm with the pulse oximeter on the right middle finger obtaining a blood pressure reading of125/64, pulse 85 and oxygen saturation 94%. At 09:35 AM V9 exited R56's room with the blood pressure machine without cleaning and disinfecting it then prepared R56's medication. On 03/31/26 at 09:47 AM V9 (Licensed Practical Nurse) entered R112's room, applied the blood pressure cuff to R112's right arm and pulse oximeter to the right index finger obtaining a blood pressure reading of 101/41 pulse 41. V9 exited R112's room then said the blood pressure machine is getting a low reading check. At 09:52 AM V9 retrieved a portable blood pressure machine from the bottom drawer of the medication cart then reentered R112's room. V9 applied the blood pressure cuff to R112's right arm and obtained a blood pressure reading of 112/67. V9 returned to the medication cart and placed the blood pressure cuff on top of the medication cart without cleaning and disinfecting it. On 03/31/26 at 09:53 AM V9 (Licensed Practical Nurse) returned to the medication cart without performing hand hygiene then V9 began preparing R112's medications. V9 entered R112's room and administered R112's oral medications. At 10:09 AM V9 exited R112's room without performing hand hygiene then proceeded down the hallway with the medication cart and blood pressure machine. On 03/31/26 at 10:11 AM V9 (Licensed Practical Nurse) entered R119's room with Enhanced Barrier (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Precaution signage observed posted on R119's door without performing hand hygiene. V9 placed the blood pressure on R119's right arm and could not get a reading. V9 returned to the medication cart and retrieved the portable blood pressure cuff from the top of the medication cart then reentered R119's room and placed the blood pressure cuff on R119's right arm obtaining a blood pressure reading of 123/77 pulse 77. On 03/31/26 at 10:18 AM surveyor asked V9 (Licensed Practical Nurse) the procedure for cleaning the reusable blood pressure machine and portable blood pressure cuff. V9 responded we are supposed to wipe it down when it is used between two residents. It is sanitized to decrease infection, bacteria and contamination to the next resident. We are supposed to use sanitizer or wash our hands between residents to keep down infection and bacteria. On 04/02/26 at 10:00 AM V2 (Director of Nursing) stated When taking a resident's blood pressure, perform hand hygiene, clean the blood pressure cuff between each resident for infection control, not to transfer bacteria or anything on the blood pressure cuff from one resident skin to another. Policy: Titled Cleaning and Sanitizing -Wheelchairs and other Medical Equipment revised 01/25/18 document in part: Purpose: To ensure that devices are cleaned and sanitized on a regular or as needed basis. Equipment/devices used by more than one resident will be cleaned and sanitized between each use. 4. All surfaces shall be thoroughly cleaned with a sanitizing agent which prohibits the growth of bacteria and microorganisms. 5. Devices/equipment used for more than one resident shall be cleaned between each resident. Titled Hand Hygiene/Handwashing revised 01/10/18 document in part: Hand hygiene means cleaning your hands by using either handwashing, antiseptic hand wash, or antiseptic hand rub. Examples of when to perform hand hygiene (either alcohol-based hand sanitizer or handwashing): Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure). After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient. Titled Medication Administration dated 10/25/14 document in part: Procedures: 2. Handwashing and Hand Sanitization: The person administering medications adheres to good hand hygiene, which includes washing hands thoroughly before beginning a medication pass, prior to handling any medication, after coming in direct contact with a resident.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview and record review, the facility failed to ensure the call light was within reach for two (R1 and R13) of two residents reviewed for reasonable accommodation of needs in a sample of 35. The findings include: 1.) R1's face sheet/admission record shows admission date on 9/12/25 with diagnoses not limited to Pneumonitis due to inhalation of food and vomit, Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Essential (primary) hypertension, Nontraumatic subdural hemorrhage, Chronic embolism and thrombosis of unspecified deep veins of left lower extremity, Conversion disorder with seizures or convulsions, Dysphagia, Adult failure to thrive. R1's MDS (Minimum Data Set) dated 2/4/2026 shows R1's cognition is intact. He needed Supervision or touching assistance with eating, chair/bed and toilet transfer, Partial/moderate assistance with oral, toileting and personal hygiene, shower/bathe self, upper and lower body dressing. R1's Care plan dated 11/25/2025 shows in part: R1 is at risk for falls due to Deconditioning, Gait/balance problems, and Paralysis. Be sure call light is within reach and encourage R1 to use it for assistance as needed. On 3/31/26 At 11:44AM R1 was sitting up in a wheelchair at the bedside, alert and verbally responsive. R1's left hand is contracted with splint/device on left arm. R1's call light on the other side of the bed on the floor not accessible to R1. R1 stated he can't reach the call light. He said he uses call light when he needs something from the staff. On 3/31/2026 At 11:49AM V6 (Certified Nursing Assistant/CNA) requested in R1's room and picked up the call light on the floor and kept it by R1's side accessible to him. V6 stated call light should always be within reach. On 4/2/26 At 10:59AM V2 (Director of Nursing/DON) stated call light is used for safety, and alert staff regarding needs of the residents. She said call light should always be placed within physical reach of the resident, so safety and personal needs are met. Facility's Call light policy dated 2/2/18 shows in part: All residents that have the ability to use a call light shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location. 2.) R13's has diagnosis including and not limited to Type 2 Diabetes Mellitus with Unspecified Diabetic Retinopathy, Primary Generalized (Osteo)Arthritis, History of Falling and Peripheral Vascular Disease. R13's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 09 indicating moderate impairment. R13's Care Plan document in part: Focus: R13 is at risk for falls Deconditioning, History of falling and, Gait/balance problems. Interventions: Keep needed items, water, etc. in reach. Be sure call light is within reach and encourage R13 to use it for assistance as needed. On 03/31/26 at 12:51 PM R13 was observed lying in bed. Surveyor asked R13 did he used the call light. R13 stated I would use the call light if I knew where it was. I don't even know where it is. R13's call light was observed on the floor under the left side of R13's bed out of reach. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/31/26 at 12:54 PM V12 (CNA) entered R13's room. Surveyor asked V12 the location of R13's call light. V12 proceeded to pick up R13's call light and clipped it to R13's sheet. Surveyor asked V12 was the call light on the floor. V12 responded, yes ma'am it was under R13's bed. R13 knows how to use the call light, and it should have been attached to R13's bed. I made my rounds, and I thought R13's call light was on his bed. If the call light is not in the residents' reach it could have been something R13 really needed. On 04/02/26 at 10:00 AM V2 (Director of Nursing) stated The call light is put in the resident reach and assessed if the resident can reach the call light. It should be within physical reach and place it with the resident's preference. If the call light is not within the residents' reach, there is a potential that they will not get the assistance they need or get anyone's attention. The call light placement should be checked when rounding.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to obtain a physician order for a code status for two (R10, and R12) out of eight residents reviewed for advance directive in a total sample of thirty-five. Findings Include: R10's Minimum Data Set (MDS) dated [DATE] noted she is moderately cognitively impaired. R10's Electronic Medical Record (EMR) noted she was admitted to the facility on [DATE]. She is [AGE] years old with diagnoses not limited to type 2 diabetes mellitus without complications, dementia, obstructive and reflux uropathy, myocardial infarction, and chronic kidney disease. 2. R12's Minimum Data Set (MDS) dated [DATE] noted she is cognitively intact. R12's Electronic Medical Record (EMR) noted she was admitted to the facility on [DATE]. She is [AGE] years old with diagnoses not limited to type 2 diabetes mellitus with neuropathy, heart failure, end stage renal disease, dependence on renal dialysis, chronic obstructive pulmonary disease, cervicalgia, and adult failure to thrive. On 04/01/26 at 10:16 AM, V20 (Assistant Social Services Coordinator) stated that she oversees the care plan section of the code status. The code status should be in the Physician Order Sheet (POS) to ensure the residents' wishes are documented and honored. The surveyor and V20 reviewed R10 and R12's POS, but the code status was not documented at this time. On 04/01/26 at 10:43 AM, V21 (Licensed Practical Nurse) stated that she has been in the facility for one year six months. The code status, either Do Not Resuscitate/DNR or Full Code should be documented in the POS upon admission to prevent wrong intervention during an emergency. On 04/02/2 at 11:16 AM, V2 (Director of Nursing) stated that it is her expectation that nurses will document residents' code status in the POS upon admission, and a corresponding care plan should be completed by the social worker. R10's full code status care plan initiated on 01/30/26, R10's late POS with a date stamped 04/01/26 at 11:32 AM. R12's full code status care plan initiated on 07/24/25, R12's late POS with a date stamped 04/01/26 at 20:56 (8:56 PM). Facility Advance Directives Policy dated 02/12/25, documents in part; (9) A written physician's order is required in response to the resident's Advance Directive(s). Physician's order shall be specific and address each Advanced Directive(s).

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide a clinical contraindication for gradual dose reduction (GDR) for residents receiving psychotropic medications. This failure resulted in three residents (R3, R11, R70) not having a gradual dose reduction (GDR) attempted/completed for medications they receive. Findings include: 1. R3's electronic health record (EHR) documents in part a diagnosis of Dementia with Moderate Mood Disturbance, Schizophrenia, Bipolar Disorder, Brief Psychotic Disorder. R3's Minimum Data Set (MDS) dated [DATE] documents in part, R3 receives antipsychotic medications on a routine basis, a GDR has not been attempted, and the physician has not documented GDR as clinically contraindicated.R3's Order Summary Report review of physician orders documents in part, R3 has an active order for the following medications: Depakote 500 mg two times a day for agitation (start date 12/13/24), Haloperidol 10 mg give 0.5 tablet by mouth two times a day for bipolar (start date 06/07/25), Lithium Carbonate extended release 450 mg one time a day (start date 11/12/24), Melatonin give 9 mg at bedtime (start date 11/11/24), Trazodone HCL tablet 50 mg give 1 tablet at bedtime related to Schizophrenia (start date 06/08/24).Review of R3?s Psychiatry/Mental Health progress notes dated 09/18/25, 10/08/25, 11/08/25, 12/06/25, 01/11/26, 02/25/26 reveals that there was no recommendation for a GDR and there was no description of a clinical contraindication to attempt a GDR. Also, note R3's Psychiatry/Mental Health progress notes indicate R3 is receiving Depakote 500 mg daily however actual active order R3 is receiving is Depakote 500 mg two times a day.2. R11's EHR documents in part a diagnosis of Vascular Dementia with Other Behavioral Disturbance, Unspecified Psychosis Due To a Substance or Known Physiological Condition, Cognitive Communication Deficit. R11's MDS dated [DATE] documents in part, R11 receives antipsychotics on a routine basis, and a GDR has not been attempted, and the physician has not documented GDR as clinically contraindicated.R11's Order Summary Report review of physician orders documents in part, R11 has an active order for Quetiapine Fumarate 50 mg every 12 hours (start date 11/27/25). Note R11 was hospitalized from [DATE] to 11/26/25. Prior to hospitalization R11 had been receiving Quetiapine Fumarate 25 mg tablet with orders to give 50 mg two times a day for dementia with behavioral disturbance with psychotic features (start date 06/11/25, end date 11/25/25).Review of R11?s Psychiatry/Mental Health progress notes dated 09/18/25, 10/08/25, 11/05/25, 12/06/25, 01/11/26, 02/06/26, 03/04/26 reviewed reveals that there was no recommendation for a GDR for Quetiapine Fumarate and there was no description of a clinical contraindication to attempt a GDR for Quetiapine Fumarate.3. R70's electronic health record (EHR) documents in part a diagnosis of Major Depressive Disorder, Paranoid Schizophrenia, Other Psychoactive Substance Abuse with Psychoactive Substance Induced Persisting Dementia. R70's Minimum Data Set (MDS) dated [DATE] documents in part, R3 receives antipsychotic medications on a routine basis.R70's Order Summary Report review of physician orders documents in part, R3 has an active order for Trazodone HCL 50 mg at bedtime (start date 04/02/25).Review of R70?s Psychiatry/Mental Health progress notes dated 09/18/25, 10/08/25, 11/08/25, 12/06/25, 01/11/26, 02/25/26 reveals that there was no recommendation for a GDR for Trazodone and there was no description of a clinical contraindication to attempt a GDR for Trazodone. Note on the Psychiatry/Mental Health progress note dated 03/02/26, 12:38 Late Entry which documented GDR contraindicated. Patient needs this meds and dosage for stabilization is time stamped as being created on 04/02/26, 12:40:48.On 04/02/26 at 12:37 PM, V2 (Director of Nursing) stated GDR is gradual dose reduction for psychotropic medications (antidepressants, antipsychotics, hypnotics) and GDR should be considered every six months to determine what is the lowest dosage of that medication the resident can be on to give the optimal therapeutic result. V2 stated it is the prescribing providers responsibility to consider GDR and document reasoning if contraindicated. V2 stated the (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	pharmacy consultant will send V2 recommendations for residents to consider GDR on and these pharmacy recommendations are then emailed to the Psych Nurse Practitioner. V2 stated it is then up to the Psych Nurse Practitioner to review the pharmacy form and decide if he wants to proceed with the recommendation or not and this should be indicated on the pharmacy recommendation form. V2 stated pharmacy recommendations do not become part of the resident's EHR. V2 started working at the facility in February 2026 she has not received any signed pharmacy recommendations back from the Psych Nurse Practitioner to date. V2 stated if the pharmacy recommendation is not signed, then it is not done. V2 stated the Psych Nurse Practitioner sees all of the residents on psychotropic medications monthly and puts all of his documentation in the resident's EHR under the progress note section. V2 stated the Psych Nurse Practitioner reviews the medications but does not specifically address GDR. V2 stated his notes do not have anything saying the GDR is contraindicated or provide a reasoning why. V2 stated the Psych Nurse Practitioner's progress notes only say to continue with the psychotropic medication or that the resident is stable. V2 stated this does not mean GDR is contraindicated because a resident could be stable but on a lower dose of the medication. V2 stated there needs to be an attempt to decrease the medication dosage to see if there is a negative outcome and this needs to be documented.V2 stated this issue also came up on the last annual survey and the regional nurse consultant did education with the Psych Nurse Practitioner when this occurred last year. V2 stated she had a conversation with the Psych Nurse Practitioner in February 2026 about the GDR and that he needed to document rationale if GDR was contraindicated because she could see that they were not being done. V2 stated the Psych Nurse Practitioner said, okay, I'll get it done. V2 stated since taking to the Psych Nurse Practitioner in February 2026, V2 has not noticed any change in his monthly documentation, he is continuing to list out the medications the resident is receiving, and then commenting that the resident is stable and to continue with the medication as ordered.On 04/02/26 at 2:27 PM, V2 stated the situation has been escalated and the Psych Nurse Practitioner will be terminated.Facility policy titled, Psychotropic Medication- Gradual Dose Reduction dated 02/01/28 documents in part, Purpose: To ensure that residents are not given psychotropic drugs unless drug therapy is necessary to treat a specific or suspected condition as per current standards of practice and are prescribed at the lowest therapeutic dose to treat such conditions and residents who use psychotropic drugs shall receive gradual dose reductions and behavior interventions, uncles clinically contraindicated, in an effort to discontinue or reduce the medication. A gradual dose reduction shall be encouraged at least twice yearly unless previous attempts at reduction have been unsuccessful or reduction is clinically contraindicated.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to refer a resident (R11) who was later identified with a mental disorder to the appropriate state-designated authority for a Level II PASARR (Preadmission Screening and Resident Review) evaluation and determination for one out of a total sample of 35 residents. Findings include:R11's Notice of PASRR Level I Screen Outcome dated 10/31/22 documents in part PASSR Level I Determination: No Level II Required - No SMI/ID/RC.R11's PASRR Outcome Explanation Notice of No PASRR Level II Required which documents in part, Your Level I screen does not show that you have a mental illness or an intellectual/developmental disability (IDD). You do not need more screening unless you have or may have a serious mental illness or an IDD and experience a significant change in treatment needs.R11's admission Record documents in part an initial/original admit date of 11/04/22. It documents in part a diagnosis of Unspecified Psychosis (added 03/06/25).R11's admission Minimum Data Set (MDS) dated [DATE] indicates R11 did not have a Psychiatric/Mood Disorder.R11's MDS dated [DATE] indicates R11 has a Psychiatric/Mood Disorder with specific diagnosis of psychotic disorder.R11's Order Summary Report dated 04/02/26 indicates in part, R11 is receiving Citalopram, Quetiapine Fumarate and Divalproex Sodium.R11's care plan a care plan for R11 use of psychotropic medications related to behavior management dated 09/13/23.On 04/01/26 at 12:42 PM, V17 (Assistant Social Service Consultant) stated PASSR is to make sure residents are appropriate placed in a skilled nursing facility and not inappropriately placed if they have severe mental illness (SMI) such as depression, schizoaffective disorder, schizophrenia, bipolar, psychosis, delusional disorder, paranoid disorder. V17 stated a PASRR Level I screen gets completed prior to admission at the hospital to make sure the resident is appropriate for admission to the facility. V17 stated if a resident is initially admitted without a SMI diagnosis but then one is added after their initial admission then the facility would resubmit for a PASRR level I/II re-screen. V17 stated this is important to do to make sure the facility is providing the appropriate care for their diagnosis and the facility is still an appropriate placement for the resident. V17 stated for newly acquired SMI diagnosis it is the Social Service Departments responsibility to resubmit for another PASRR I/II screening to be completed. V17 stated R11 has a diagnosis of psychosis which was added after his initial admission and therefore R11 should have been referred to have a PASRR level I/II re-screen completed.Facility provided policy titled, Pre-admission Screening and Resident Review (PASRR) dated 11/17/17 which documents in part, the facility will refer all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or related condition for a level II review upon a significant change in status assessment to the state PASRR representative.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to refer a resident to the appropriate state-designated authority for a PASARR Level II Screen evaluation and determination with known mental illness for one (R35) out of eight residents reviewed for Pre-admission Screening and Record Review (PASARR) in a total sample of 35.Findings include:R35's electronic health records (EHR) indicate R35 was admitted to the facility on [DATE] with diagnosis including but not limited to Delusional Disorders upon admission.R35's Order Summary Report dated 04/01/26 includes but not limited to Seroquel 50 mg two times a day for delusional disorder.R35's MDS (Minimum Data Set) dated 03/09/26 documents in part, R97's active diagnoses include but not limited to Psychiatric/Mood Disorder including Psychotic Disorder.R35's Notice of PASRR I Screen Outcome dated 11/30/22 documents in part, PASRR Level I Determination: No Level II Required - No SMI/ID/RC.R35's PASRR Outcome Explanation Notice of No PASRR Level II Required document in part, Your Level I screen does not show that you have a mental illness or an intellectual/developmental disability (IDD). You do not need more screening unless you have r may have a serious mental illness or an IDD and experience a significant change in treatment needs.On 04/01/26 at 12:42 PM, V17 (Assistant Social Service Consultant) stated PASSR is to make sure residents are appropriate placed in a skilled nursing facility and not inappropriately placed if they have severe mental illness (SMI) such as depression, schizoaffective disorder, schizophrenia, bipolar, psychosis, delusional disorder, paranoid disorder. V17 stated a PASRR Level I screen gets completed prior to admission at the hospital to make sure the resident is appropriate for admission to the facility. V17 stated if the resident has a SMI they are referred to for a PASRR Level II screen unless the resident has exemptions such as dementia, terminal illness, vent dependency, neuro cognitive. V17 stated collectively it is the facility responsibility to make sure that the information submitted by the hospital for the PASRR Level I is accurate. V17 stated R35 PASRR Level I screen was completed 11/30/22. V17 stated R35 was admitted to the facility with a diagnosis of delusional disorder which is a SMI but it was not included on the initial PASRR Level I Screen and it should have been. V17 stated R35 needs to have a PASRR level II screening completed.Facility provided policy titled, Pre-admission Screening and Resident Review (PASRR) dated 11/17/17 which documents in part, it is the policy to screen all potential admissions on an individualized basis. As part of the preadmission process, the facility participates in the Preadmission Screening and Resident Review (PASRR) screening process (Level I) for all new and readmissions per requirement to determine if the individual meets the criterion for mental disorder (SMI/SMD), intellectual disability or related condition. Based upon the Level I screen, the facility will not admit an individual with a mental disorder or intellectual disability until the Level II screening process has been completed.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nail care was provided for one (R126) resident who requires supervision in grooming reviewed for Activities of Daily Living (ADL) out of eight residents in total sample of thirty-five. Findings Include: R126's Minimum Data Set (MDS) dated [DATE], Brief Interview Score (15) indicates he is cognitively intact. R126 Electronic Health Record/EHR noted an active diagnosis of hemiplegia and hemiparesis affecting right dominant side, contracture of right hand, acquired absence of left leg below knee, acquired absence of other right toes, chronic kidney disease, and type 2 diabetes mellitus with diabetic nephropathy.R126's Minimum Data Set (MDS) dated [DATE] functional abilities assessment noted R126 requires partial/moderate assistance with personal hygiene.On 03/31/26 at 1:24 PM, R126 was observed up in a wheelchair in his room. R126's right hand was contracted with very long fingernails that overgrown the tips of his fingers. He also stated that no one ever offered to cut his long nail, but he wants his fingernails cut. On 4/1/26 at 10:45 AM, R126 was in his room still with very long fingernails, and stated no staff have come to cut his fingernails.On 04/01/26 at 10:47 AM, Surveyor and V22 (Licensed Practical Nurse) observed R126's fingernails, she stated that the fingernails are surely long! The Certified Nursing Assistant (CNA) should be providing nail care during daily grooming and as needed, but she will inform the CNA to cut R126's long fingernails now.On 04/01/26 at 10:52 AM, V23 (CNA) stated that she has been working at the facility for five years, fingernail clipping is part of grooming which should be done daily and as needed by the CNA. She also stated that having long fingernails could be a dignity issue.On 04/02/26 at 11:16 AM, V2 (Director of Nursing) stated that the CNAs should be providing nail clipping care during shower twice a week and as needed. She also stated that R126 could scratch himself, his long fingernails could cause indentation into the palm of his hand which could lead to skin breakdown and infection. The facility policy for Nail Care dated 1/25/18, documents in part: (1) Observe condition of resident nails during each time of bathing, note cleanliness, length uneven edges, hypertrophied nails.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, interview, and record review, the facility failed to assist a resident (R78) out of bed for 1 out of a total sample of 35 residents reviewed for Activities of Daily Living (ADLs).Findings include: R78's admission Record documents in part diagnoses of pathological fracture of right femur, malignant neoplasm of prostate, secondary malignant neoplasm of bone, adult failure to thrive, hemiplegia and hemiparesis (weakness and paralysis) following cerebral infarction (stroke) affecting the left non-dominant side, absolute glaucoma in the right eye, and history of falling. R78's 2/27/2026 MDS (Minimum Data Set) assessment documents in part that R78 is cognitively intact, has functional limitations to upper extremity on one side, and is dependent on staff to transfer from bed to chair. R78's Care Plan Report documents in part that R78 presents with functional deficit in bed mobility related to generalized weakness and musculoskeletal impairment (revised 10/14/2024). R78 has an ADL (Activities of Daily Living) self-care performance deficit related to impaired balance, limited mobility, and musculoskeletal impairment (revised 12/05/2025). R78 is dependent on staff to transfer between the bed and chair (revised 2/04/2025). R78 uses wheelchair for locomotion (revised 2/04/2025). On 3/31/2026 at 12:59 PM, R78 laid in bed. R78 was oriented to person, place, and date. R78 stated wanting to get up out of bed because he has not gotten up to wheelchair in a while. R78 stated it feels like months since [R78] sat on the wheelchair. R78 stated can only tolerate wheelchair for a couple of hours due to right hip pain but would still like to get up out of bed. R78 stated [R78] does not have a schedule for facility to get R78 out of bed. During interview, R78 turned on call light at 1:02 PM stating I'm gonna call them now and see what they say. V10 (Certified Nursing Assistant/CNA) answered the call at 1:03 PM. R78 asked to get up out of bed. V10 stated you can get up today. I'll get you up. On 3/31/2026 at 1:59 PM, R78 remained in bed. R78 stated CNAs came into the room a couple of times stating they were going to get R78 up but has not done so. R78 stated I told you I knew it wasn't going to happen. I'm still in bed. On 3/31/2026 at 2:01 PM, surveyor observed V10 with another CNA down the hall assisting another resident. On 3/31/2026 at 2:27 PM, R78 remained in bed. On 3/31/2026 at 2:45 PM, V8 (Nurse) stated R78 did not have a get up out of bed schedule. On 3/31/2026 at 2:47 PM, V10 stated R78 did not have a get up out of bed schedule and can get up when R78 wants to. When asked if R78 will get up today, V10 stated not knowing that R78 wanted to get up (despite earlier observations). V10 asked V8, who was sitting nearby, if R78 could get up out of bed. V8 stated it should be fine if it's in R78's chair. After a couple of minutes, V10 pushed the mechanical lift near R78's room. On 3/31/2026 at 3:04 PM, V10 was at the nurses' station. R78 remained in bed and the mechanical lift outside R78's room. R78 stated V10 came into the room about five minutes ago asking where R78's high-back wheelchair was. R78 stated hasn't seen it since being moved to the current room for isolation. R78 stated V10 was going to look for it. On 3/31/2026 at 3:45 PM, R78 remained lying in bed. R78 stated staff have not been back to give R78 an update about getting out of bed or finding R78's wheelchair. R78 stated still wanting to get out of bed. On 4/01/2026 at 1:41 PM, R78 was lying in bed. R78 was oriented to person, place, date, and recalled surveyor and surveyor's roll. R78 stated facility did not get R78 out of bed yesterday. R78 stated facility brought in a high-back wheelchair this morning. R78 stated informing V10 that [R78] wanted to get up today. R78 stated wanting to be up in the wheelchair for two hours sometime after lunch and back in bed before dinner. On 4/01/2026 at 1:51 PM, V8 stated that staff including V10 are aware that R78 wants to get up to wheelchair. On 4/02/2026 (following day) at 10:11 AM, R78 stated staff did not assist R78 out of bed yesterday. R78 stated informing the morning staff and the evening staff that [R78] wanted to get out of bed, but they did not do so. On 4/02/2026 at 9:22 AM, V2 (Director of Nursing) stated R78 is alert and oriented and able to make needs known. V2 stated there are no contraindications as to why R78 cannot get up out of bed. V2 stated staff should have gotten R78 up out of bed into a high-back wheelchair. Facility's ADL Care policy documents in part: Activity of Daily Living will be performed according to resident needs and preferences. ADL will include bathing, (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dressing, grooming, toileting/incontinent care, eating, bed mobility, transfer, and restorative exercises. Facility's Resident Rights policy (effective 8/23/17) documents in part: Purpose: To promote the exercise of rights for each resident, including any who face barriers (such as communication problems, hearing problems and cognition limits) in the exercise of these rights. Exercising rights means that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review the facility failed to ensure the controlled substances were counted and documented correctly in one of 4 medication carts reviewed during the medication storage and labeling observation.Findings Include:On 04/01/26 at 12:28 PM the third-floor medication cart 2 was reviewed with V25 (Licensed Practical Nurse). During review of the controlled substance a Controlled Substances Proof of Use sheet dated 03/19, amount received 15 ml (milliliter) was observed with no name documenting in part: Morphine Sulfate 100 mg (milligram) per 5 ml (milliliter). Take 0.25 ml (5mg) by mouth or under tongue every 2 hours as needed for shortness of breath. A box with R75's name was observed in the narcotic drawer. V25 stated the sheet has 15 ml but there is about 13 ml in the bottle. A Controlled Substances Proof of Use sheet, amount received 30 ml (milliliter) document in part: R75, Morphine Sulfate 20 mg/ml. Take 0.25 ml (5mg) by mouth or under tongue every 2 hours as needed for or every 1 hour as needed for SOB (Shortness of Breath). V25 stated the sheet has 29.5 ml and there is 30 ml in the bottle. I counted with the nurse this morning.On 04/02/26 at 10:00 AM V2 (Director of Nursing) stated Narcotic accountability, I pulled R75 (Morphine) bottles and sheet. I instructed the nurses to label the bottles and number them if there is more than one bottle, number them to make sure the right bottle has the right strength. There was no name on the narcotic sheet so I would not know what I am supposed to be giving R75. Fill out the narcotic sheet appropriately. The nurses ordered multiple bottles of morphine and one of the bottles was from a different pharmacy. Whatever is on the medication label should be transferred to the narcotic sheet, stop, count and measure. V2 placed four narcotic sheets, one with no name, one unopened and three open morphine bottles on her desk expressing the narcotic count error and confusion of having multiple open bottles of the same medication.Policy:Titled Narcotic/Controlled Substances-Counting revised 11/26/17 document in part: Purpose: 1. To count controlled substances with a partner and to verify the accuracy of the log sheet. 2. Always note the integrity of any liquid form of controlled substance to ensure that the bottle has not been tampered with nor that the solution appears diluted in any manner. 7. Count the remaining doses. 11. Determine amount of liquid medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on interview and record review, the facility failed to ensure a resident (R78) was up-to-date with their pneumonia vaccine series for 1 out of 5 residents reviewed for immunizations.Findings include: R78's admission Record documents in part multiple comorbidities including malignant neoplasm of prostate, secondary malignant neoplasm of bone, atrial fibrillation, high blood pressure with heart failure, adult failure to thrive, stroke, diabetes, and high cholesterol. R78's 2/27/2026 MDS (Minimum Data Set) assessment and care plan documents in part that R78 is cognitively intact. On 4/01/2026 at 10:09 AM, V2 (Director of Nursing) stated the facility has pneumonia immunization trackers in their electronic medical records. Facility is to run the reports and see which residents are due for vaccines. R78's View Immunization documents in part that R78 received the Pneumovax 23 (PPSV23) on 10/25/2024. R78's immunization records do not indicate any other pneumonia vaccine. Center for Disease Control and Prevention's PneumoRecs VaxAdvisor documents in part that for individuals older than 50 years, who have received prior dose of PPSV23 but no prior doses of PCV13, they recommend giving one dose of PCV15, PCV20, or PCV21 at least 1 year after the last dose of PPSV23. On 4/01/2026 at 3:11 PM, R78 was oriented to person, place, and date. R78 stated wanting to receive the pneumonia vaccine if not up to date with the immunization. On 4/02/2026 at 9:28 AM, V2 reviewed R78's immunization records online and in their electronic medical records. V2 stated did not see any other pneumonia vaccine records besides the one administered on 10/25/2024. V2 stated that R78 is due for an additional pneumonia vaccine. V2 stated V2 did not see documentation that facility rescreened or offered R78 the additional dose of pneumonia vaccine to complete the series. Facility's Influenza and Pneumococcal Immunizations policy (effective 11/28/12) documents in part: Purpose: To minimize the risk of residents acquiring, transmitting, or experiencing complications from influenza and pneumococcal pneumonia. Each resident is offered a pneumococcal immunization per CDC recommendations (see CDC Pneumococcal Vaccine Timing for Adults reference table) unless the immunization is medically contraindicated or the resident has already been immunized; A second pneumococcal vaccine will be offered only when necessary according to the CDC guidelines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145970	A. Building B. Wing	04/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Care Windsor Park	2649 East 75th St Chicago, IL 60649

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 0814 Level of Harm - Potential for minimal harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure the dumpsters were covered with lids to prevent the harborage and feeding of pests, insects, and rodents. This deficient sanitation practice has the potential to affect all 202 residents who reside in the facility.Findings include:On 03/31/26 at 10:23 AM, during initial tour of kitchen traveled outside with V28 (Food Service Director) to view the outside dumpster area. There were two large dumpsters outside and both dumpsters were missing lids. V28 stated these are the dumpsters the kitchen and housekeeping staff use to throw away garbage in. V28 stated she does not know why neither of them have lids or why they are missing. V28 stated the problem with the lids missing means rodents can easily crawl inside and get to the garbage inside.On 04/02/26 at 8:26 AM, V34 (Housekeeping Supervisor) stated there are currently no lids on the dumpsters outside to keep the garbage inside or to prevent rodents from getting inside the dumpster. V34 stated the facility does not want rodents getting inside the dumpsters to feed on the garbage because that will attract the rodents toward the building and they do not want that. V34 stated the staff does a tap test' and went on to explain that the staff knocks on the outside of the dumpsters and then wait six seconds to see if any rodent crawls outside of the dumpster before they put the garbage inside. V34 stated this is mostly a problem when bringing garbage out to the dumpsters at night. V34 stated he does not know why the first set of lids on each dumpster are missing, he does not know what happened to them. V34 stated he usually tells his staff to close the lids after they bring garbage to the dumpster but right now there are no lids for them to close, which leaves the dumpsters wide open.On 03/31/26 in the afternoon, V1 (Administrator) stated he will be ordering new dumpsters to arrive later this week because they should both had lids on them.Facility provided policy titled, Trash Disposal undated documents in part, the dietary department should dispose of trash appropriately and maintain the dumpster area for cleanliness and prevention of rodents, purpose is to prevent the spread of infection and deter pests and rodents, and the dietary department should ensure the dumpster lids are closed when disposing of trash.