STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145974	A. Building B. Wing	02/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Norwood Crossing	6016 North Nina Avenue Chicago, IL 60631

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 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. 30279 Based on observation, interview, and record review the facility failed to ensure medications were not left at bedside for one (R2) resident and failed to ensure a treatment cart was locked when not in visual proximity of the nurse and not in use. This failure has the potential to affect all 36-residents residing on the 4th floor of the facility. Findings include: 1. On 02/24/25 at approximately 11:12am, R2 noted in bed, on the cabinet in the room a bottle of Fluocinonide topical solution with instruction to apply to scalp topically@ bedtime with a pharmacy label to Avoid contact with eyes. In addition, a tube of Econazole nitrate cream 1% left on the table. When V4 ADON (Assistant Director of Nurse's) was shown and was asked about the facility policy/protocol on medication storage at the bedside. V4 stated no medicine should be left at bedside without an order (referring to physician order) but let me check if there is an order to leave at the bedside. V4 then took the medications to V5 RN (Registered Nurse) assigned to R2. Both V4, V5 and the surveyor checked the EPO (Electronic Physician Order) for R2 there was no written order for R2 to keep those medication at the bedside or self-administer the medication. V5 asked the surveyor whether topical medications can be kept at bedside. The surveyor asks V5 about the professional standard of medication storage/ administration. V5 stated I don't know, can we move to the next question. V4 who was present at the time stated, I will have to educate the nurses on medication storage when there is no order (Physician Order) to do so. On 02/24/25 at 11:58am V2 DON (Director of Nurse's) stated that all medication should be locked in the medication cart unless the physician ordered it to be kept at bedside. The facility policy and professional standard of medication administration is that any medication should be prescribed by the doctor (physician). Any one on elf-administration program will be evaluated and see if they are able to self-administer the medication. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145974	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2025
NAME OF PROVIDER OR SUPPLIER Norwood Crossing		STREET ADDRESS, CITY, STATE, ZIP CODE 6016 North Nina Avenue Chicago, IL 60631	

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 02/24/25 at 10:57am, on the 4th floor upon getting on the floor treatment cart with treatment medications noted unlocked with no licensed nurse or any staff at the nurse's station. When this was shown to V5 RN (Registered Nurse) and was asked about the facility policy on medication storage and cart policy. V5 stated it is not my cart, but the treatment cart should always be locked when not in use. On 02/24/25 at 11:05am, V4 ADON (Assistant Director of Nurse's) who was present on the floor was asked about the facility policy on carts storage, medication storage and expectation of the licensed nurse staff responsibility. V4 stated that the medication carts that includes treatment cart should be locked always when the nurse is not in view of the cart. It should not be left unlocked. On 02/24/25 at 11:22am, the surveyor asks V6 (RN) assigned to the treatment cart about the treatment cart that was left unattended and unlocked. V6 stated that when she got to work this morning (02/24/25, she did not look (check) at the treatment cart, but it should be locked (treatment cart) when not visual few. On 02/24/25 at 11:56am, V2 DON (Director of Nurse's) stated that medication cart and treatment carts should be locked. Nurses has the key to the treatment cart and the medication cart for each side assigned so they are to make sure the carts are locked when not in few of the nurse. On 02/25/25 at 11:50am, on the 2nd floor treatment cart noted unlocked on the (odd side) of the floor. V16 CNA (Certified Nurse's) stated that the nurse on this side (odd) is on lunch break but the other nurse (referring to V5) is in the dining room passing medicine. V5 was shown the treatment and she stated it should be locked always. V12 IP (Infection Preventionist) nurse who was on the 2nd floor was asked about the facility policy on medication and cart storage. V12 stated that the carts should be locked always when not in the nurse view. On 02/25/25 at 11:55am, when the surveyor made V11 RN (Registered Nurse) assigned to the odd side aware the observation and was asked about the facility policy on medication storage and treatment cart storage. V11 stated I was so sure I locked the treatment cart, V5 then told V11 that it was not locked. then V11 stated it (referring to the treatment cart) should be locked every time is not in use or leave it. On 02/25/25 at 12:03pm, V12 RN (Registered Nurse) / IP (Infection Preventionist) stated that all carts containing any medication should be locked when not in use and in view of the nurse. The facility policy on Medication Storage presented with revised date 04/2024 documented that the standard is medications will be stored correctly. Listed procedure includes but not limited to nursing staff is responsible for maintaining medication storage and compartments that includes carts containing medications and biologicals are locked when not in use and carts used in transport such items are not left unattended if open or otherwise potentially available to others.