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	06/14/2024

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 39779 Based on observation, interview, and record review the facility failed to ensure a resident who was self-administering medications had a self-administration of medications assessment, a physician's order, and a care plan completed for 1 (R54) resident reviewed for self-administration of medications in a sample of 22. Findings Include: R54 has diagnosis not limited to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Acute on Chronic Diastolic (Congestive) Heart Failure, Hypertensive Heart Disease with Heart Failure, Atrial Fibrillation, Dependence on Supplemental Oxygen, Major Depressive Disorder, Anxiety Disorder, Acute Respiratory Failure with Hypoxia, Muscle Weakness, Difficulty in Walking, Need For Assistance with Personal Care, Atherosclerotic Heart Disease of Native Coronary Artery, Gastro-Esophageal Reflux Disease, Presence of Cardiac Pacemaker, Patient's Noncompliance with other Medical Treatment and Regimen for other Reason. Order Summary Report dated 06/12/24 document in part: Spiriva Respimat Inhalation Aerosol Solution 2.5 MCG (microgram)/ACT (Tiotropium Bromide Monohydrate) 1 puff inhale orally one time a day. Ventolin HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for SOB (Shortness of breath), wheezing. R54 Medication Administration Record document in part: Spiriva Respimat Inhalation Aerosol Solution 2.5 MCG (microgram)/ACT (Tiotropium Bromide Monohydrate) 1 puff inhale orally one time a day. Ventolin HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate) 2 puff inhale orally every 6 hours as needed for SOB (Shortness of breath), wheezing. Care Plan document in part: Focus: R54 has Emphysema/COPD (Chronic Obstructive Pulmonary Disease). Interventions: Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Give oxygen therapy as ordered by the physician. On 06/11/24 at 11:04 AM R54 was observed sitting in bed with oxygen at 3.5 liters per nasal cannula in use. An albuterol inhaler was observed inside a tissue box at the bedside.) (Spiriva was observed in the top drawer of R54 bedside table). R54 stated I take the Spiriva once a day. If my shortness of breath starts up, I take a spray of the Albuterol every 4-6 hours. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/24 at 11:17 AM V7 (Agency Registered Nurse) stated R54 is completely alert and oriented. R54 does not have an assessment for medication self-administration. When asked by the surveyor was V7 aware that R54 had the albuterol and Spiriva inhalers in her room V7 responded I did know that. She uses the inhaler as a rescue. R54 will need some more education on that. On 06/13/24 the facility provided surveyor with R54 Self-Administration Evaluation dated 06/12/24. Self-Administration of Medications Evaluation of Resident's Ability dated 06/12/24 document in part: Medication name: Ventolin INH 2 puffs every 6 hours prn wheezing, SOB. Medication Name: Spiriva 2.5 mg INH 1 puff Daily COPD. Self-Administration of Medication Evaluation dated 06/12/24 and signed by the physician 06/13/24. On 06/13/24 at 09:11 AM V2 (Director of Nursing) stated There should be an assessment done for medication self-administration. Medication at the bedside pose a potential for error. Policy: Titled Self-Administration of Drugs revised 08/10 document in part: Residents in the facility who wish to self-administer their medications may do so, if it is determined that they are capable of doing so. Assessment of self-administration of drugs. 1. When a resident expresses a desire to self-administer one or more of their medications, the staff and practitioner will assess that resident's mental and physical abilities to determine whether a resident is capable of self-administering medications. 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment, including (but not limited to) the residents. a. Ability read and understand medication labels, b. Comprehension of the purpose and proper dosage and administration time for his or her medications. c. Ability to remove medications from a container and to ingest and swallow (or otherwise administer) them. d. Ability to reliably verify whether they have taken the medication and e. Ability to recognize risks and major adverse consequences of his or her medications. The staff and practitioner will document their findings in the medical record. Titled Medication Self-Administration revised 10/06/11 document in part: Assessment of self-administration of drugs. 1. As part of their overall evaluation, the staff and practitioner will assess each resident's mental and physical abilities, to determine whether a resident is capable of self-administering medications. Special Skill Assessment: 2. In addition to general evaluation of decision-making capacity, the staff and practitioner will perform a more specific skill assessment. Documentation: 5. The staff and practitioner will document their findings and the choices of residents who are potentially capable of self-administering medications. Documentation Responsibilities: 6. For self-administering residents, the nursing staff may rely on the resident's verification that the medications were taken. Quarterly Review of Self-Administration Ability: 10. The staff and practitioner will periodically to reevaluate a resident's ability to continue to self-administer medications. Titled Care Plans revised 11/13/23 document in part: To develop, implement and monitor care plans based on effective and person-centered care policy & procedure: 3. Care plans are to reflect person centered care and be unique to the resident and his/her individualized needs. 4. care plans are to be reviewed quarterly, annually, as needed or upon request of the family/resident representative/resident 5. care plans are to be updated to reflect the ongoing needs, goals, and interventions of the resident.

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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** 50057 Based on interview and record review, the facility failed to ensure that the provider order and care plan reflected the resident's wishes on the Provider Order for Life-Sustaining Treatment (POLST) form for one residents (R78) out of twenty-two total residents in the sample. Findings: On [DATE] at 12:57 PM the electronic medical record of R78 was reviewed. The Provider Order for Life-Sustaining Treatment (POLST) for R78 dated [DATE] stated: Section A: Do Not Attempt Resuscitation/Do Not Resuscitate (DNR). Section B: Selective Treatment: Primary goal of treating medical conditions with selected medical measures. In addition to treatment described in comfort-focused treatment, use medical treatment, intravenous (IV) fluids and IV medications (may include antibiotics and vasopressors) as medically appropriate and consistent with patient preference. Do not intubate. May consider less invasive airway support (e.g. CPAP, BiPAP) Transfer to hospital, if indicated. Generally avoid the intensive care unit. On [DATE] V30 (Physician) gave an order for DNR which was entered into R78's electronic health record. On [DATE] at 12:02 PM V23 (Director of Social Services) was interviewed and stated that upon resident admission, If a resident has a POLST and it is completed and signed by a physician, we implement it. V23 stated The directives in the POLST go in as a provider order and on the status bar. Part A would direct us to do cardiopulmonary resuscitation (CPR) or not do CPR. V23 stated We don't document full treatment, selective treatment or comfort measures. Most Nurses would look at the document itself and read the POLST. V23 stated We don't differentiate selective or comfort care in the DNR order. V23 stated that if a resident's POLST stated Part A: DNR and Part B: Full treatment, We consider that a partial code and color code the paper chart in yellow as a partial code. Partial code means that if they have no pulse, we would not do compressions or rescue breathing. If the heart is still pumping and they may or may not be breathing, they would want mechanical ventilation, rescue breathing and send the resident off to the hospital. On [DATE] at 3:31 PM V2 (Director of Nursing) was interviewed and stated that if a resident has a POLST that in section A stated do not resuscitate (DNR) and section B stated selective treatment, the nurse would not do resuscitation. The nurse would call the doctor and tell the doctor that the resident has a DNR order and would carry out the doctor's orders. V2 was asked what a nurse would do if the resident had a partial code order and V2 stated I am not familiar with that code. V2 asked to check on that type of order and returned to the interview with V19 (Infection Prevention Nurse). V19 stated that the facility does not have a partial code order and then stated Can we have this evening to look into this and get back together tomorrow? V19 stated We shouldn't be accepting an order for a partial code. We need more detail. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 10:01 AM, V2 (Director of Nursing) and V19 (Infection Control Nurse) were interviewed. V19 stated The POLST form is uploaded into the resident's chart. Social Services Department is responsible for getting that information from the resident. The order is then put in the chart. Do not resuscitate (DNR) is entered into the electronic health record if Section A of the POLST states DNR. For Section B, the nurses should 'ideally' look at the POLST if something happens to see if there is any specific changes such as comfort care, special instructions, or specifics like don't do compressions or give me oxygen. I am not going to lie. I don't know if they always do that. V19 stated We spoke to Administration about this last night. We don't have a good process. We should not be using the term partial code. V19 stated that the facility should have a way to enter the orders specific to Section B of a POLST form. V19 stated that the facility plans to work with the electronic health system vendor to see what options for POLST order entry are available. V19 stated For now, we are going to educate the staff and set expectation that they have to look at the POLST if there is an emergency with a resident. That is where we get lost. We don't have a process. Policy entitled Advance Directives revision date [DATE] stated in part: Standard: Facility will remain in compliance with Illinois state law regarding advance directives. Policy and Procedure: 1. Social services will review what/if any advance directives are in place. 2. If the desired advanced directives are in place, they are uploaded to the resident chart and a paper copy placed in resident hard chart. 6. The resident and/or representative is made aware they may modify their advance directives at any time. 7. These documents will be revised and discussed with the physician. 39779

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40061 Based on observations, interviews, and record reviews, the facility failed to follow physician orders and update a resident's (R14) care plan for one resident out of a total sample of 22 residents. Findings include: R14's Order Summary Report documents in part: Regular diet Regular texture, Regular / thin consistency, for 1:1 assist. Order date and start date listed as [DATE]. R14's care plan documents in part that R14 is at risk for alteration in nutrition related to diagnosis of cellulitis, blindness, chronic kidney disease, hyperlipidemia, gastroesophageal reflux disease, small bowel obstruction, metabolic encephalopathy, and significant, unplanned weight loss (last revised [DATE]). Intervention last revised [DATE] documents in part to provide necessary assistance at mealtimes and between meals. R14's care plan also documents in part that R14 has an activities of daily living self-care performance deficit due to decreased activities of daily living, decreased functional transfers and balance, deceased activity intolerance, left eye blindness with right eye visual impairment (last revised [DATE]). Intervention regarding 'EATING' documents in part that it was not updated to reflect [DATE] order for 1:1 assist. On [DATE] at 12:11 PM, R14 ate lunch alone at a table in the dining room. During multiple observations at 12:17 PM, 12:21 PM, and 12:28 PM, surveyor observed R14 eating without staff assistance. On [DATE] at 11:10 AM, R14 stated staff do not sit with or assist R14 during meals. R14 stated [R14] eats without staff assistance most of the time. At 12:15 PM, R14 sat alone at a table in the dining room. V15 (Certified Nurse Aide) dropped off R14's lunch tray, provided set up help, and left to get back into tray line. Observed R14 during entirety of lunch meal (R14 completed lunch at 12:31 PM). No staff provided one-to-one assistance to R14. At 12:33 PM, V16 (Certified Nurse Aide) stated [V16] takes care of R14 about three times a week. V16 stated staff do not provide one-to-one meal assistance to R14. At 12:36 PM, surveyor showed V17 (Nurse) R14's active diet order. V17 stated 1:1 assist stands for one-to-one assist. V17 was not sure why R14 required one-to-one assistance with meals. At 12:39 PM, surveyor showed V10 (Nurse) R14's active diet order. V10 stated 1:1 assist means one staff must feed the resident. V10 was not sure why R14 was on one-to-one assistance with meals. At 3:09 PM V29 (Nurse) stated entering the 1:1 assist after R14 returned from the hospital. V29 stated the order was either on the hospital discharge papers or through verbal report. V29 stated the order was for R14 to be fed by one staff. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reviewed R14's Admission Telephone Report dated ,d+[DATE]. It documents in part that V28 (Nurse) took the verbal report from the hospital staff. At 3:24 PM, surveyor reviewed the document with V28. V28 stated writing need 1:1 assist for feeding order because the hospital staff reported it as R14's order at the hospital and it was the recommended order for discharge back to the facility. On [DATE] at 11:35 AM, V2 (Director of Nursing) stated the hospital reported to the facility that R14 needed one-to-one feeding assistance because R14 was too weak at the time. Facility's Feeding Residents policy, last revised [DATE], documents in part: Standard: Assisting residents with meals. It documents in part procedural steps which include sitting down with the resident, preparing the food for eating, and assisting them with their meal.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observations, interviews, and record reviews, the facility failed to follow their policy and procedure to ensure proper linens were used on the low air loss mattress for 2 residents (R1, R63) and to ensure low air loss mattress devices were functioning and on the correct settings for 2 (R61, R90) out of 4 dependent residents who are at risk in developing pressure ulcer in a final sample of 22 residents. Findings Include: 1. On 6/11/24 at 11:05 AM, R61 was sleeping in bed and noted low air loss mattress weight control knob was set between 287 and 375 pounds. R61's clinical records show R61 has diagnoses not limited to Alzheimer's Disease and Type 2 Diabetes Mellitus. R61's Minimum Data Set (MDS) dated [DATE] shows R61 is cognitively impaired and is dependent on staff for turning and repositioning in bed. R61's care plan with review completed on 5/6/24 shows R61 had a history of having sacral pressure ulcer and requires an air loss mattress as one intervention. R61's current weight documents as 134 pounds dated 5/31/24. 2. On 6/11/24 at 11:52 AM, and on 6/12/24 at 9:57 AM, R63 was noted lying in bed alert and able to verbalize needs. R63 was noted on a low air low mattress lying on a flat sheet and a green non-disposal incontinence pad on top of the mattress. R63's clinical records show R63 has diagnoses note limited to Adult Failure to Thrive and Dementia. R63's MDS dated [DATE] shows R63 is cognitively impaired and requires substantial/maximal assistance for turning and repositioning in bed. R63's care plan with review completed on 5/16/24 shows R63 is at risk for pressure ulcer/skin breakdown due to impaired mobility and air mattress in place as one intervention. 3. On 6/12/24 at 9:55 AM, R1 was watching television in bed alert and able to verbalize needs. R1 was noted on a low air low mattress lying on a flat sheet and a green non-disposal incontinence pad on top of the mattress. R1's clinical records show R1 has diagnoses not limited to Major Depressive Disorder and Congestive Heart Failure. R1's MDS dated [DATE] shows R1 is cognitively intact and requires substantial/maximal assistance for turning and repositioning in bed. R1's care plan with review completed on 4/15/24 shows R1 has a potential for pressure ulcer development due to impaired strength and mobility and air mattress in place as one intervention. 4. On 6/12/24 at 10:55 AM, R90 was in lying in bed non-verbal. Surveyor noted R90's low air loss machine was turned off. At 10:57 AM, Surveyor asked for assistance from V21 (Nursing Supervisor) and entered R90's room. V21 stated that R90's low air loss machine might have been disconnected. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R90's clinical records show R90 has diagnoses not limited to Malignant Neoplasm of Pancreas and Dementia. R90's MDS dated [DATE] shows R90 is cognitively impaired and is dependent with staff for turning and repositioning in bed. R90's care plan with review completed on 5/23/24 shows R90 is at risk for pressure ulcer/skin breakdown due to impaired mobility. R90's physician orders with active orders as of 6/12/24 documents Air mattress in place. On 6/12/24 at 10:59, interviewed V22 (Wound Care Nurse/Restorative Nurse Supervisor) and stated that for residents who are dependent with staff for turning and repositioning in bed, they are placed on an air loss mattress to prevent them from developing pressure ulcer. V22 stated that if a resident is in bed, the low air loss mattress should be always turned on. V22 stated that the purpose of the low air loss mattress is to relieve pressure on the bony prominences that would help prevent pressure wounds. V22 stated that if the low air loss mattress' setting is too high it would be too hard and if it's too low, they'll sink and the resident would not get the benefits of the mattress. V22 stated that R1, R61, R63, and R90 are at risk in developing pressure ulcers due to their impaired mobility. On 6/12/24 at 11:07 AM, interviewed V21 and stated that the low air loss mattress should be set based on the current weight of the resident. V21 stated that linens to use for the low air loss mattress should be just a flat sheet or one non-disposal incontinence pad and cannot be both. The facility's policy titled; Low Air-Loss Mattress with no date documents in part: To maintain skin integrity and promote wound healing of existing pressure ulcers. Place a thin cotton flat sheet over the top of the air loss mattress so air flow will not be impeded Use only disposable incontinence pads and only if really needed Putting layers of linen disrupts the air flow of the mattress

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview and record review, the facility failed to apply splint and complete quarterly restorative assessments that detail the progress or lack of progress in the restorative services for 1 (R61) out of 1 resident reviewed for limited range of motion and restorative services in the final sample of 22. Findings Include: On 6/11/24 at 11:07 AM, R61 was sleeping in bed. Surveyor noted R61 has both hands contractures, and no assistive devices/splints were in place. On 6/12/24 at 2:23 PM, interviewed V22 (Wound Care Nurse/Restorative Nurse Supervisor) and stated that R61 is on active and passive range of motion restorative programs. V22 stated that R61 is supposed to have a splint for the contracted hand. V22 stated, I forgot which hand. [R61] should always have it every day except during incontinence care or when bathing. Restorative assessment should be completed quarterly. Surveyor and V22 reviewed R61's electronic health records (EHR) and found that the last restorative assessment completed for R61 was in 8/1/23. There was no documentation found in R61's records that details R61's progress or lack of progress in the restorative services. V22 stated that it was a while that the facility had no full time restorative nurse. On 6/12/24 at 2:50 PM, interviewed V27 (MDS Coordinator) and stated that R61 has physical limitations with R61's hands. V27 stated that R61 is a feeder and on restorative programs that are addressed in the care plan. V27 stated that restorative assessments should be completed quarterly. R61's Minimum Data Set, dated dated dated [DATE] shows R61 has impaired cognitive skills, has functional limitation in range of motion on one side of R61's upper extremity, and is dependent of staff with activities of daily living (ADL). R61's ADL care plan shows that R61 is on restorative programs: bed mobility, dressing/grooming, and active range of motion. R61's physician orders with active orders as of 6/11/24 shows an order that reads, Remove right hand resting splint at bedtime. The facility's Restorative Policy dated 1/12/24 reads in part: Policy & Procedure: 1. The facility shall ensure that Restorative Care approaches and principles aimed at preventing deterioration or maintaining a resident's functional level ad quality of life are integrated into the home programs and individual care plans of all residents. 2. The program descriptions should include resident focused goals, program protocols, and monitoring and evaluation aimed at improving or maintaining the resident's function.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50057 Based on interviews and record reviews, the facility failed to obtain monthly weights and recognize, evaluate, and address weight loss for three (R17, R66, and R61) residents out of a total sample of 22 residents. This failure resulted in R17 having a 15.7 percent decrease in weight in six months between 12/4/2023 (121 pounds) and 6/4/2024 (102 pounds). Findings include: 1. On 6/11/2024 at 10:48 AM and at 1:26 PM, R17 was observed sleeping in bed with an intravenous (IV) in the left hand and 0.9 percent Dextrose with Sodium Chloride running at a rate of eighty milliliters per hour. On 06/11/24 at 2:47 PM V9 (Registered Nurse) stated that R17 felt weak, threw up and had diarrhea the morning of 6/11/2024. R17's blood pressure was also low. V9 called the doctor who ordered intravenous (IV) fluid. R17 was interviewed and stated that she was dizzy the morning of 6/11/2024. R17 stated I don't like the food here. R17 stated that she felt better after receiving the IV fluid and resting. On 06/11/24 at 03:17 PM R17's weights were read in the electronic health record as: 124 pounds on 7/22/2023, 125 pounds on 8/2/2023, 126.8 pounds on 8/7/2023, no weight was obtained in September 2023 or October 2023, 122 pounds on 11/8/2023, 121 pounds on 12/4/2023, no weight obtained in January 2024, 104.8 pounds on 2/5/2024, 105 pounds on 2/16/2024, 104.8 pounds on 2/26/2024, 98.6 pounds on 3/7/2024, 107 pounds on 3/16/2024, 107 pounds on 3/23/2024, 98.6 pounds on 4/14/2024, 105 pounds on 5/9/2024, 102.6 pounds on 5/23/2024 and 102 pounds on 6/4/2024. R17 had a 7.85 percent weight loss and an 8.4 pound weight loss in one month between 3/16/2024 (107 pounds) and 4/14/2024 (98.6 pounds). R17 had a 15.7 percent decrease in weight in six months between 12/4/2023 (121 pounds) and 6/4/2024 (102 pounds). (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 6/12/2024 at 10:05 AM V12 (Registered Dietician) was interviewed and stated that facility policy is that residents are weighed monthly. The facility has a weekly Nutrition-At-Risk meeting. The purpose of the meeting is to discuss any weight concerns or any other nutrition concerns that staff may have about a resident. Residents are discussed at the Nutrition-At-Risk meeting if the resident is newly admitted , is readmitted to the facility, or if nursing staff, dietary staff, the resident, or the family have concern about the resident's weight or nutritional status. If there are concerns about a resident's weight or nutritional status, V12 stated we then get weekly weights. Weekly weights are documented in the weight section of the electronic health record. V12 stated that she would be concerned about a resident's weight if there was a five percent decrease in one month, a seven and a half percent decrease in three months or a ten percent decrease in six months. V12 stated that if there was a concern about a resident's weight or nutritional status, V12 would assess the resident's food intake, supplement intake, diet order, any concerns about fluid retention and any use of diuretics. V12 would also speak to the resident, physician, and nursing staff to assess for any change in the resident's medical status or food intake. V12 stated that she speaks to the resident about food preferences and the possible need for supplements. Sometimes V12 encourages family to bring food in if that might be helpful. V12 considers appetite stimulants and if there are any chewing or swallowing issues, V12 considers a diet change. V12 reviewed R17's dietary progress note dated 2/24/2024 and stated that the resident had a weight warning because of significant weight loss at three and six months. The plan was for weekly weights and to continue same diet. V12 stated that R17 was again seen by the dietician on 3/16/2024. At that time, R16 continued weekly weights and R17's weight was trending back up. There was a concern about a weight that was low and that she was not eating all three meals a day. V12 reviewed R17's weights documented in the electronic health record. V12 stated the weekly weights were not documented. V12 stated There was significant weight loss in April. It doesn't look like anything was documented on that significant weight loss of 107 pounds on 3/23/2024 to 98.6 pounds on 4/14/2024. It also looks like the weight of 105 pounds on 5/9/2024, 102.6 pounds on 5/23/2024 and 102 pounds on 6/4/2024 triggered in the electronic health record as a significant weight loss, but no dietary assessment was completed. V12 stated that R17 should have had a dietary assessment after the 4/14/2024 weight of 98.6 pounds. V12 stated R17 is due for her quarterly assessment. She is on my list today so I will be seeing her. There may not have been follow up on R17's weight loss because there were several dieticians who were covering the Dietician position; some part time and some remotely, before V12 was hired. V12 stated now knowing that R17 has this weight loss, I will do her assessment today. On 6/11/2024 at 3:30 PM, the dietary progress note of R17 written by V20 (Dietician) dated 2/24/2024 was read and stated in part: Weight review/weight warning: 105 pounds. Body mass index (BMI) 17.5 underweight. Significant weight loss at 3 and 6 months noted, resident weight overall stable this month. Added to weekly weights for monitoring of weight loss. The dietary progress note of R17 written by V20 (Dietician) dated 3/16/2024 stated in part: R17 continues on weekly weight with interdisciplinary team following. Weight trending back up but question other weights of 90 pounds. Will continue supplements and weekly weights. The electronic health record had no dietary progress notes after 3/16/2024. Policy titled 3.01 Philosophy and Standards of Clinical Care, Section: Clinical Nutrition revised 1/2024 stated in part: Procedure: This area provides state of the art nutritional care and education to the patients, residents, medical staff, associates and the communicate. The Registered Dietician Nutritionist (RDN) will follow the standards of clinical care including: (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 6/12/2024 at 11:41 AM, surveyors interviewed V12 (Registered Dietitian) in-person with V13 (Regional Nutrition Director) on the phone. Both stated V12 was new to the facility and prior to that there were different consultants in the previous months. When asked about R66, V12 stated [V12] has not evaluated R66 and staff did not notify V12 that R66 had weight loss. V13 stated R66's most recent weight was from 5/14/2024 and prior to that it was from 2/22/2014. V12 stated significant weight loss is 5% in a month, 7.5% in three months, and 10% in six months. V13 stated when staff notify Dietitians of weight loss, then Dietitians will consult to add weekly weights for the residents. V13 stated at the minimum, staff should weigh residents monthly. V13 did not see documentation as to why staff did not do R66's weights. V13 also stated that if there is a questionable weight or weight loss, the Dietitians will request a re-weigh. V13 stated there was no re-weigh after 2/22/2024 weight. On 6/13/2024 at 11:35 AM, V2 (Director of Nursing) stated the Certified Nurse Aides (CNAs) weigh the residents. At the minimum the staff must weigh all residents monthly. If they cannot weigh the resident, the CNAs must notify the nurse so that the following shift can follow-up or staff can attempt the next day. V2 stated Dietary is supposed to do the weight calculations and address the weight loss. Facility's Policy: 3.01 Philosophy and Standards of Clinical Care Section: Clinical Nutrition, last revised 1/2024, documents in part: The Registered Dietitian Nutritionist (RDN) will assess the nutritional status of those patients/residents identified 'at risk,' and will communicate information that impacts care to the health care team. All nutritional care is recorded in the medical record in accordance with facility policy/protocol. Timely and periodic assessments of patients'/residents' tolerance, acceptance and appropriateness of their prescribed diet will be conducted. Facility's Policy: 3.14 (LTC/AL) Unintentional Weight Change Monitoring Section: Clinical Nutrition, last revised 1/2024, documents in part: The Registered Dietitian Nutritionist (RDN) should be alerted to significant weight changes including loss/gain of 5% in a month and/or three (3) pounds/week through communications from the nursing staff. In addition, monthly weight charts should be monitored closely for weight loss trends. Prior to initiation of a nutrition intervention, weight change should be validated by a reweight. Once actual loss/gain has been established and determined to be a nutritional concern, a nutrition reassessment/progress note is completed. The resident should be placed on weekly weights and monitored for one month until the weight change is resolved. Facility's Weights and Heights, last revised 10/06/2011, documents in part: Monthly weights will be completed by the 10th weekday of each month. Staff to request assistance if needed for completion. If there is a weight discrepancy the resident will be reweighed to ensure accuracy. Monthly weights will be documented on weight flow sheet. 44103 3. R61's electronic health records (EHR) show an admitted [DATE]. R61's Minimum Data Set, dated dated dated [DATE] shows R61 has impaired cognitive skills and requires substantial/maximal assistance with eating. R61's weight records show the following readings: 5/31/24 134.0 pounds, 4/24/24 135.0 pounds, 2/26/24 133.0 pounds, 12/2/23 145.0 pounds, and 11/26/23 144.0 pounds. No weights were obtained in January and March 2024. R61's weights show R61 had a 12 pounds weight loss from 12/2/23 to 2/26/24. R61's records do not show any documentation that R61's weight loss was recognized, evaluated, and addressed. R61 was evaluated by V33 (Registered Dietician) not until 5/2/24 and did not address the weight loss. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	On 6/12/24 at 11:52 AM, a phone interview was conducted with V13 (Regional Nutrition Director). V13 stated that R61's January and March weights are missing. V13 stated that the December and February weights show a significant weight loss and that should have been triggered and should have been addressed by the Dietician. V13 stated that V13 was not the consultant that was in the facility at that time and does not know if the weight loss was referred to a Dietician. V13 stated that V13 does not see any notes or assessment completed addressing the weight loss. V13 stated that an annual assessment was done on 5/2/24 and the last progress notes was in September 2023. V13 stated, I don't see any further interventions were put into place addressing the weight loss. V13 stated V13 would benefit for a nutritional supplement that would increase R61's calories and protein intake. V13 stated that it would at least maintain R61's weight. V13 stated that the goal is for R61 to have no more weight loss.

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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. 39779 Based on observation, interview, and record review the facility failed to ensure (R54) residents' oxygen was on the correct setting as ordered by the physician, ensure (R4) residents' oxygen tubing was connected and functioning properly, ensure (R41, R54, R60) residents oxygen supplies were labeled and dated per the facilities policy and ensure (R41, R60, R70) residents respiratory supplies were stored to prevent contamination in a sample of 22. Findings Include: R4 has diagnosis not limited to Heart Failure, Depressive Episodes, Mild Cognitive Impairment, Chronic Obstructive Pulmonary Disease, Hypertensive Heart Disease, Personal History of Transient Ischemic Attack and Need for Assistance with Personal Care. Care Plan document in part: R4 has COPD (Chronic Obstructive Pulmonary Disease). The resident will display optimal breathing pattern daily through review date. 04/09/24 2L O2 via NC (nasal canula) to keep O2 > 92%. Give oxygen therapy as ordered by the physician. Monitor for s/sx (signs/symptoms) of acute respiratory insufficiency: Anxiety, Confusion, Restlessness, SOB at rest, Cyanosis, Somnolence. Order Summary Report dated 06/11/24 document in part: 2L O2 via NC (nasal canula) to keep O2 > 92%. On 06/11/24 at 10:37 AM R4 was observed sitting in the wheelchair watching television with oxygen at 2 liters per nasal cannula in use. Oxygen connector tubing from the oxygen concentrator to the humidity bottle was observed disconnected with the oxygen nasal canula tubing kinked near the humidity bottle. R4 stated I get out the bed and pull the tubing. Surveyor exited the room to get the nurse and asked V7 (Agency Registered Nurse) to check R4 oxygen. On 06/11/24 at 10:39 AM V7 (Agency Registered Nurse) stated let me get my pulse oximeter then V7 entered R4 room with the surveyor. V7 placed the pulse oximeter on R4 left index finger and was unable to obtain a reading. R4 stated my fingers are cold, and I have on nail polish. V7 turned the pulse oximeter to the side of R4 left index finger and was unable to obtain a reading. V7 removed the pulse oximeter then placed it on R4 right finger and obtained a reading of 90%. Surveyor asked V7 to check the oxygen concentrator and how many liters of oxygen was R4 receiving. V7 responded 2 liters then observed and stated, the oxygen tubing was kinked, and the tubing was not connected to the humidifier part. R54 has diagnosis not limited to Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Acute on Chronic Diastolic (Congestive) Heart Failure, Hypertensive Heart Disease with Heart Failure, Atrial Fibrillation, Dependence on Supplemental Oxygen, Major Depressive Disorder, Anxiety Disorder, Acute Respiratory Failure with Hypoxia, Need For Assistance with Personal Care, Atherosclerotic Heart Disease of Native Coronary Artery, Presence of Cardiac Pacemaker, Patient's Noncompliance with other Medical Treatment and Regimen for other Reason. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Order Summary dated 03/29/24 document in part: O2 at 4 lpm (liters per minute) via NC (nasal cannula), every shift related to Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation titrate O2 (oxygen) to keep Spo2 (oxygen saturation) between 90-92% Care Plan document in part: Focus: R54 has Emphysema/COPD (Chronic Obstructive Pulmonary Disease). Interventions: Give aerosol or bronchodilators as ordered. Monitor/document any side effects and effectiveness. Give oxygen therapy as ordered by the physician. On 06/11/24 at 11:04 AM R54 was observed sitting in bed with oxygen at 3.5 liters per nasal cannula in use. R54 stated I turn the oxygen to 4 liters when I go to therapy because I get short of breath. When I am finish with therapy, I turn the oxygen to 3.5 liters. On 06/11/24 at 11:17 AM V7 (Agency Registered Nurse) stated R54 is completely alert and oriented. I believe the oxygen tubing is changed every week during night shift. R54 Oxygen order is for 4 liters. On 06/11/24 at 11:29 AM V7 (Agency Registered Nurse) was observed at the nurse station labeling oxygen tubing and a humidity bottle. When asked was she (V7) going to R54 room to change the humidity bottle and oxygen tubing V7 responded, yes. On 06/13/24 at 09:11 AM V2 (Director of Nursing) stated Oxygen should be checked to make sure it is the right order. The nurse should check to make sure that the oxygen tubing is connected and not kinked. There is a potential that the resident might have shortness of breath, might get sick or something. If the oxygen tubing is not connected to the oxygen concentrator or kinked it can affect the residents pulse ox if not, they are not receiving the oxygen. The oxygen tubing is changed every week and it should be labeled and dated make sure we change the tubing regularly. The nurse should check to make sure the oxygen is set on the correct liters of oxygen. If a resident changes the oxygen settings, we need to educate the resident not to change the setting because it is already set as ordered. Policy: Titled Oxygen Concentrator and Tubing revised 08/10/18 document in part: Standard: Residents will receive supplemental oxygen per physician's orders in a clean and sanitary manner. 1. Oxygen will be administered as per physician's order. 5. Oxygen tubing, cannula, mask, and humidifier will be changed weekly and prn (as needed). Oxygen tubing must be stored in a protective plastic bag by nursing personnel when not in use. 6. Once weekly, the oxygen plastic bag will be changed and dated. In addition, cannula will be dated and placed in a plastic bag. 45110 On 6/11/24 at 11:03 AM, surveyor and V5 [Agency Registered Nurse] observed R41 's open oxygen tubing on bed side nightstand without a date. V5 stated, R41 was using his oxygen this morning when I made rounds. R41 usually wants on his oxygen during the night while he is sleeping. The oxygen tubing should be dated and changed weekly by the night nurse. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/24 at 11:05 AM, R41 stated, I used my oxygen last night. I use it every night, but not during the daytime. R41's Care plan dated 5/10/22- R41 receives oxygen as needed for oxygen absorption. On 6/11/24 at 11:10 AM, surveyor and V6 [Registered Nurse] observed R70's suction machine with whitish colored liquid in the suction canister and attached oral suction tube uncovered on the floor between R70's bed and nightstand table. V6 stated, R70's suction machine and attached oral suction tube should never be on the floor. The suction machine should have been placed on the bed side nightstand table next to the bed. The oral suction tube should have been stored in plastic bag, not on the floor. R70's physician orders. Dated 6/6/24 May suction secretions PRN (as needed). On 6/11/24 at 11:18 AM, surveyor and V6 [Registered Nurse] observed R60's oxygen infusing per nasal cannula dated 6/3/24. Also, another oxygen green tank on the back of R60's wheelchair with oxygen tubing attached and laying on the wheelchair's footrest with no date and not stored in a bag, that was placed in the seat of the wheelchair. V6 stated, The oxygen tubing should be dated when the tubing is removed from the package. The dated oxygen tubing should be placed in plastic bag for infection control. R60 do get up in his wheelchair, and the oxygen tank on the back is for him to use while up in the chair. The oxygen tubing in the wheelchair should be dated and placed in a plastic bag, not laying on the wheelchair leg rest. On 6/11/24 at 11:30 AM, V14 [R60's Care Provider] stated, I been R60's care provider for several years. R60 always needs oxygen. When R60 gets up into his wheelchair, he switches and use the oxygen tubing that hooked on the wheelchair. R60's Physician orders: -3/7/23 O2 2L/NC (liters/nasal cannula) PRN keep O2 between 90-92% every shift. -CPAP (continuous positive airway pressure) while sleeping, setting 12/5 to keep SPO2 (peripheral oxygen capillary saturation) 92% or higher. Every shift for apply BiPap if resident is sleeping or napping. On 6/13/24 at 1:22 PM, V2 [Director of Nursing] stated, All oxygen tubing should be dated and placed in a plastic bag weekly. The night nurse is responsible to complete changing of oxygen tubing. Suction equipment, tubing, and oral suction tubes must be kept on a table next to the bedside. Once an oral suction tube is used it should be discarded after use. The yankauer oral suction tube is stored in a place bag and dated. All oxygen and oral suction devices should be dated and kept in a plastic bag to prevent infection. Policy: Documents in part Oxygen Concentrators and Tubing -Oxygen tubing, cannula, mask, and humidifier will be changed weekly and as needed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Oxygen tubing must be stored in a protective plastic bag when not in use -Once weekly, the oxygen plastic bag will be changed and dated. The cannula will be dated and placed in a plastic bag.

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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** 40061 Based on observations, interviews, and record reviews, the facility failed to label a personal use medication (R8), discard medications past the 'Best By date,' discard open medications not in their original packaging and return discontinued medications (R15). This has the potential to affect R8 and all residents that receive medications from the fourth floor, odd side, medication cart. Findings include: On [DATE] at 11:45 AM, surveyor reviewed the fourth floor, odd side, medication cart with V9 (Nurse). On the first drawer, there was an open bottle of Multivitamin with Minerals with a stamped Best By ,d+[DATE]. V9 stated using the medications from the bottle that morning. On the top section of the first drawer there were two unknown, loose, green tablets at the bottom of the drawer. The tablets were out of their original packaging. On [DATE] at 12:05 PM, surveyor reviewed the controlled medications bin with V9. There was a blister pack of Alprazolam 0.25 milligram for R15. The seals for pill slots 28 and 29 were broken with clear tape reinforcing the back side to keep them closed. V9 stated the pills in slots 28 and 29 are supposed to be Alprazolam but was not sure. V9 stated [V9] was not sure why the seals were broken. V9 stated the medication is written for night shift and was not sure if R15 was still on it. V9 stated [V9] did not know the facility protocol for medications outside of their original packaging. V9 did not know the facility protocol for accurate reconciliation and accounting for controlled medications. R15's Order Summary Report as of [DATE] documents in part that R15 was no longer on Alprazolam. R15's Medication Administration Record documents in part that facility discontinued R15's Alprazolam on [DATE]. On [DATE] at 12:30 PM, V10 (Nurse) stated discontinued medications get returned to the pharmacy. The nursing supervisors make rounds daily to collect the medications that need to be returned to the pharmacy and pharmacy stops by daily to collect them. On [DATE] at 2:44 PM, surveyor reviewed the second floor, even side, medication cart with V6 (Nurse). In the fifth drawer there was a bottle of Audiologist Choice Wax Softener. The seal was broken. It was not in its original bag and there was no resident name or open date on the bottle. V6 did not know who it belonged to but stated that the Audiologist was recently at the facility. After looking it up on the computer, V6 stated the bottle belonged to R8. R8's Order Summary Report as of [DATE] documents in part: Audiologist Choice Wax softener ear drops. Instill 5 drops to both ears two times a day for earwax for 5 days (order date [DATE]). (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:37 PM, V2 (Director of Nursing) stated the nurses are responsible for their medication carts. In addition, night shift nurses are responsible for reviewing the medication carts to make sure everything is up to date and not expired. V19 (Infection Preventionist) stated the facility uses the Best By date as the expiration date for medications. V19 stated staff should toss medications after the Best By date. On [DATE] at 11:35 AM, V2 stated staff should discard loose medications or medications not in their original packaging. If the seal is broken, staff must take it out and waste it in the treatment destroyer jug because it's been exposed, and it can be contaminated. Anything not sealed in its original blister packet must be discarded because it is not safe to keep it. Facility's Medication Storage policy, last updated [DATE], documents in part: Medications and biologicals are stored in the packaging, containers or other dispensing systems in which they are received. Only the issuing pharmacy is authorized to transfer medications between containers. The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner. If the facility has discontinued, outdated or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items. Medications are stored in an orderly manner in cabinets, drawers, carts, or automatic dispensing systems. Facility's Destruction of Medications policy, last revised [DATE], documents in part: All unused medication will be destroyed or returned to pharmacy. If a medication dose is not given it will be placed in a plastic bag and marked as not given in the [Medication Administration Record]. Any discontinued narcotic must be returned to the nursing office for destruction.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110 Based on observations, interviews, and record reviews the facility failed to label, and date stored food, failed to discard expired food, and failed to store food items separate from cleaning products. These failures have the potential to affect 106 residents in the facility who is receiving an oral diet. The facility's Tally sheet documents 109 residents in the facility with 3 being NPO [nothing by mouth]. Findings include: On [DATE] at 8:55 AM, during the initial tour of the kitchen with V8 [Food Service Director] the following was observed in the walk-in refrigerator/Dairy cooler: [NAME] container of egg salad half filled with no date On [DATE] at 9:04 AM the following items were observed in the walk-in freezer: Open to air plastic bag of bread sticks, no date of open or expire, open to air plastic bag of French Fries no date, open to air box of corn of the cob no date, open to air plastic bag of pepperoni no date, plastic bag of shrimp half filled with no date and open loose bag with a personal pan pizza no date. On [DATE] at 9:07AM, V8 stated, I will discard these items, all food items must be covered securely and dated to prevent contamination and food born illness. On [DATE] at 9:20 AM, the following items were observed in the dry storage room: Half-open lid of chocolate cake frosting dated [DATE] [Date opened], open plastic bag of pasta with no date, dry seasoning with no date: Ground Nutmeg, Ground Cinnamon, Black pepper, Cajun, Lemon Pepper, and Season Sea Salt. On [DATE] at 9:28 AM, V8 stated, Open cake frosting is only good for 90 days. The chocolate cake frosting should have been discarded on [DATE]. Dry open seasonings is good for six months, the bottles should have been dated to keep up with the expired date. On [DATE] at 10:01 AM, V8 stated, All food items stored in the cooler, freezer and dry storage areas should have an open and discard date wrote on the packaging and always covered to decrease the risk of food borne illness and to prevent cross contamination. Serving residents food that does not have an open or discard date could potentially cause a food borne illness. Policy: 3.4 Storing: Food and Equipment -Team members must store food in a manner that ensures quality, freshness and safeguards against food borne illness. -Label: Ensure all food items are labeled. Be especially cautions to label all food items that are: (continued on next page)

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	145974	A. Building B. Wing	06/14/2024

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not kept in their original containers Label Information: Each label must contain the following information. -Product name -Use by Date -Date the product was prepared or opened -Time prepared and team member initials where applicable -Date Frozen, Date thawed Freezing Foods: -The calculation for seven days must still take into account the number of days from initial date of preparation//opening. Refrigerator Storage: Storage Practices: -Store all food containers so they are protected from contamination -Cover, date, and label food removed from its original container Maximum storage period: -Seasonings and spices open are good for six months -Cake icing open are good for 90 days 40061 On [DATE] at 12:30 PM, surveyor reviewed the fourth-floor medication room with V10 (Nurse). In the bottom right metal cabinet, there were eight 4.5-ounce containers of applesauce next to a bottle of (Disinfecting Spray). V10 stated applesauce were not supposed to be there and didn't know who stored them there. Document titled 4th Floor residents who use applesauce lists 24 residents who usually consume applesauce. On [DATE] at 2:56 PM, surveyor reviewed the second-floor medication room with V6 (Nurse). In the bottom left metal cabinet, there were three 187-milliliter bottles of cabernet sauvignon stored next to bleach sanitation wipes. The wine holder had R53's first name on it. V6 stated it was for R53 but did not know why it was stored next to the bleach wipes. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R53's Order Summary Report as of [DATE] documents in part: May have 30 [milliliter] of wine (mix [with] water) [with] dinner [as needed]. [Please] keep wine in med room. Dietary will provide as needed for pleasure. Order active as of [DATE]. On [DATE] at 11:35 AM, V2 (Director of Nursing) stated staff should not be hoarding applesauce and storing next to cleaning products. V2 stated resident food should not be stored in the lower metal cabinets in the medication rooms. The lower cabinets are for dry paper goods and other supplies. Facility's Storage Practices, Part 1: General Guidelines training material, dated [DATE], documents in part: Store all food containers so they are protected from direct, insects or rodents, overhead leakage, or other sources of contamination. Food should be stored in a clean, dry location away from dust or other contaminants. Non-food items, such as chemicals, should be stored separately from food items. Facility's 3.4 Storing: Food and Equipment policy from the Food Safety Manual Version 090619 documents in part: Designated Areas. Store all items in designated storage areas. Store like items together--food items with food items, cleaning products with cleaning products and paper products with paper products.

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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. 50057 Based on observation, interview and record review, the facility failed to maintain enhanced barrier precautions for three residents (R28, R64, R78), failed to educate visitors on contract isolation precautions for one resident (R166), failed to maintain suction equipment within professional standards of practice for one resident (R78) and failed to annually update policies relative to infection prevention and control. This failure has the potential to affect the entire facility census of one hundred and nine residents. Findings Include: On 6/11/2024 at 2:34 PM R78 had an EBP (enhanced barrier precautions) sign on the door. V10 (Registered Nurse) entered R78's room without performing hand hygiene and touched R78's suction equipment. On 6/11/2024 at 2:42 PM R78 had an EBP (enhanced barrier precautions) sign on the door. V10 (Registered Nurse) entered R78's room without performing hand hygiene and changed the suction cannister. On 06/11/24 at 1:33 PM R78's suction tubing was observed on the bedside table with the suction catheter open and in the packaging. V10 (Registered Nurse) was at bedside and stated that R78 gets suctioned each shift as needed. V10 stated We change the suction catheter each time we suction R78. This suction catheter is open, so I am not sure if we used it on him. It looks like the outside covering is dirty, but the catheter has not been used. I am not sure. On 6/12/2024 at 10 AM R78's suction machine, suction cannister, suction tubing and suction catheter was observed on the bedside table in a plastic bag. The suction catheter was in its original packaging and sealed. On 6/12/2024 at 10:47 AM an EBP (enhanced barrier precautions) sign was observed on R64's door. V17 (Registered Nurse) entered R64's room without performing hand hygiene. On 06/11/24 at 12:00 PM V19 (Infection Prevention Nurse) was interviewed and stated that during new hire orientation nurses and certified nursing assistants review policies with V19. V19 does in-services with the staff and reminds staff about the policies related to infection prevention and control. V19 stated that she reviews enhanced barrier precautions (EBP) and EBP signage and its importance with staff. Staff non-compliance with hand hygiene and enhanced barrier precautions and infection prevention results in on-the-spot education by V19. On 6/13/2024 at 10:01 AM V2 (Director of Nursing) and V19 (Infection Control Nurse) were interviewed. V19 stated that the facility does not have a policy on suctioning or suction equipment maintenance. V19 stated that the suction catheter is kept in the packaging until it is to be used. It is single use so once it is opened, it should be discarded. Suction catheters should never be left open and in the room. Policy titled Hand Hygiene was last updated on 3/6/2020 and stated in part: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Standard: To protect our residents and others, facility promotes hand hygiene practices during all care activities and throughout the facility. Policy titled Infection Control was revised September 2016 and stated in part: Standard: The facility will establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Policy titled Enhanced Barrier Precautions was approved 9/26/2023 and stated in part: Purpose: A resident-centered and activity-based approach to preventing MDRO transmission. Policy and Procedure: 1. Employees will implement enhanced barrier precautions on residents who meet the criteria, to prevent the spread of MDROs from resident to staff. This process will decrease the risk of staff transferring MDRO's to other residents and areas. 2. Staff will utilize minimally, gowns, gloves and hand washing for any high contact resident care for individuals who meet criteria. Signage entitled Enhanced Barrier Precautions stated in part: Everyone must: Clean their hands, including before entering and when leaving the room. Policy titled Protective Equipment had a revision date of December 2020. Policy titled Antimicrobial Stewardship was approved November 5, 2022. Policy titled Facility TB Infection Control Policy and Protocol was updated 2/3/2023. Policy titled Immunization Policy had a revision date of May 8, 2023. Facility census provided at the start of survey documented one hundred and nine residents residing in the facility. 40061 R28's Admission Record documents in part diagnosis of gastrostomy status. R28's Order Summary Report documents in part orders for some medications to be given via gastrostomy tube. R28's care plan documents in part that R28 is on Enhanced Barrier Precautions (EBP) related to gastrostomy tube and left hip pressure ulcer (last revised 5/31/2024). Intervention documents in part to wear gloves and a gown for high contact resident care activities. Provided list does not include device care or use. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/11/2024 at 1:05 PM, V10 (Nurse) prepared medications for R28. There was an EBP sign on the door. It documents in part for providers and staff to wear gloves and a gown for high-contact resident care activities. Activities included device care or use for feeding tubes. At 1:12 PM, V10 entered the room with R28's medications which included Calcium Carbonate Antacid 500 MG (milligram), Gabapentin 300 MG, Guaifenesin 10 ML (milliliter), and Midodrine Hydrochloride 5 MG. V10 donned gloves and administered medications via R28's gastrostomy tube. V10 completed medication administration at 1:22 PM. V10 did not wear a gown throughout the high contact resident care activity. Facility's Enhanced Barrier Precautions policy, dated 9/26/2023, documents in part: Purpose: A resident-centered and activity-based approach for preventing MDRO (Multi-Drug Resistant Organism) transmission. Standard: To utilize enhanced barrier precautions to decrease the transfer of MDRO's to staff hands and clothing and transferring resident to resident. Staff will utilize minimally, gowns, gloves and hand washing for any high contact resident care for individuals who meet the criteria. These precautions will be utilized with residents who have indwelling medical devices including feeding tubes. Enhanced barrier precautions will be required for high-contact residents care including tube feeding care. 39779 R166 has diagnosis not limited to Urinary Tract Infection, Sepsis, Personal History of Transient Ischemic Attack, Hypertensive Heart and Chronic Kidney Disease, Alzheimer's Disease with Early Onset, Hydronephrosis, Type 2 Diabetes Mellitus, Chronic Diastolic (Congestive) Heart Failure, Chronic Kidney Disease, Stage 3, Hyperlipidemia, Benign Prostatic Hyperplasia with Lower Urinary Tract Symptoms, Insomnia, Retention of Urine, Occlusion and Stenosis of Unspecified Carotid Artery, Gastro-Esophageal Reflux, Anxiety Disorder, Vascular Dementia, Major Depressive Disorder, Abnormal Findings of Blood Chemistry, Metabolic Encephalopathy, Elevated [NAME] Blood Cell Count, Muscle Weakness, Need For Assistance With Personal Care, Difficulty In Walking, Dysphagia, Oropharyngeal Phase, Cognitive Communication Deficit and Extended Spectrum Beta Lactamase (Esbl) Resistance. Order Summary Report dated 06/11/24 document in part: Contact Isolation precautions 06/05/24 - 06/16/24 off Isolation 06/17/24. Care Plan document in part: Focus: R166 has a Urinary Tract Infection Contact Precautions - ESBL in urine Interventions: Contact Isolation ESBL in urine - All staff and visitors to wear gloves and gowns with all resident contact. Dispose of PPE in red biohazard containers in room. Wash hands before and after all resident contact. Signage indicating Contact Precautions document in part: (Stop) Contact Precautions Everyone Must: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. On 06/11/24 at 10:56 AM V11 (R166's Family Member) was observed in the hallway near R166 room. V11 stated this is R166 fifth day here. R166 is usually in memory. Signage indicating Contact Precautions was observed on R166 entrance door indicating (Stop) Contact Precautions Everyone Must: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. There was a bin containing PPE (Personal Protective Equipment) located near R166 door. V11 entered R166 room without donning PPE and said to R166 I can't take you outside because you are on isolation. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 06/11/24 at 11:00 AM a staff member donned PPE, entered R166 room then exited R166 room. On 06/11/24 at 11:02 AM V11 (R166's Family Member) exited R166 room. Surveyor asked V11 did the staff member inform him that he needed to put on a gown. V11 responded yes. Surveyor asked V11 how often he visits R166. V11 responded I have visited R166 every day and this is the first day that they told me to wear a gown. On 06/11/24 at 11:20 AM surveyor asked V7 (Agency Registered Nurse) what type of PPE should be worn in R166 room. V7 responded a gown and gloves, even for visitors. We definitely would not let anyone go in R166 room without the PPE and if they did, we would redirect them. On 06/13/24 at 09:11 AM V2 (Director of Nursing) stated Anyone entering a resident room that is on Contact Precautions should wear the gown and gloves. The purpose is to protect themselves and to prevent cross contamination. Policy: Titled Protective Equipment revised 12/20 document in part: Protective Equipment must be worn to prevent contamination from any bodily fluid or infectious material. When contamination is possible from bodily fluid or infectious material, protective equipment must be worn: this can include but is not limited to goggles, mask, gown, face shield, protective eyewear, and head protection.