STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145977	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation	2425 East 71st Street 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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45110 Based on observation, interview, and record review the facility failed to provide privacy and confidentiality for 3 [R62, R106, R129] of 4 residents personal medication administration record. Findings Include: On 7/23/24 at 9:25AM, Surveyor observed V11 [Licensed Practical Nurse] during medication administration. On 7/23/24 at 9:26 AM, V11 walked away from the medication cart and left the computer screen unlocked and displaying R129's personal medication information facing toward the hallway, visible to anyone walking pass. On 7/23/24 at 9:33 AM, V11 walked away from the medication cart and left the computer screen unlocked and displaying R106's personal medication information facing toward the hallway. On 7/23/24 at 9:46 AM, V11 walked away from the medication cart and left the computer screen unlocked and displaying R62's personal medication information facing toward the hallway. On 7/23/24 at 10:02 AM V11 stated, I forgot to lock the computer screen before walking away. I need to lock the computer screen to protect the resident's personal information from other residents or anyone walking down the hallway. On 7/24/24 at 1:10 PM, V2 [Director of Nursing] stated, The medication cart computer screen should always be locked before the nurse walks away from the cart. If the screen is left open, the nurse is not providing privacy to the resident, and anyone walking pass can view the resident medical record. Policy documented in part: Dignity - Staff shall maintain an environment in which confidential clinical information is protected. Resident Rights (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-You have a right to privacy and confidentiality of your personal and medical records. Your medical and personal care are private.

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 49486 Based on observations, interviews, and record reviews, the facility failed to ensure that residents' call lights were within reach for two (R43, R171) out of a total sample of 36 residents reviewed for accommodation of needs. Findings Include: 1. On 07/23/24 at 11:30 AM, surveyor observed R171 lying in bed. Surveyor observed R171's call light on the floor. R171 stated R171 cannot get out of bed without help, and R171 cannot find or reach for R171's call light. R171 must scream for help sometimes when the call light is on the floor. R171 stated the staff do not like when R171 screamed for help. R171 told staff to always keep R171's call light within R171's reach. On 07/23/24 at 11:46 AM, V23 (Certified Nursing Assistant/CNA) and surveyor observed R171's call light on the floor. V23 stated call light should not be on the floor, R171's call light should be within R171's reach. V23 stated the potential problem is that R171's need will not be met. V23 then attached the call light to R171's reach. On 07/23/24 at 2:30 PM, V2 (Director of Nursing/DON) stated, it is the expectation of V2 that staff will ensure safety of the resident by making sure the call light is within R171's reach. V2 stated call light should not be on the floor. V2 stated the potential problem of not having the call light within R171's reach is that it will cause a delay in R171's care. On 07/24/24 at 12:17 PM, V26 (CNA) stated call light is for the resident especially those who needs help with transfer and toileting. V26 stated, it is very important that the call light is within the reach of the resident to avoid, fall and skin alteration. R171's MDS Section C (06/20/2024) documents in part: R171's BIMS score is 13, which means R171 awareness is cognitively intact. Call light policy (08/2008) documents in part: When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident. 40061 2. R43's Admission Record documents in part medical diagnosis of difficulty in walking, repeated falls, limitation of activities due to disability, and other reduced mobility. R43's comprehensive care plan documents in part a focus for falls (initiated 9/26/2022). There are three listed falls. Interventions to decrease falls for R43 include to remind R43 to ask for staff assistance (initiated 9/26/2022 and 11/06/2023). R43's care plan also contains a focus related to R43's behavior of attempting to ambulate independently to the bathroom with unsteady gait (initiated 10/04/2022). Goal is for R43 to use call light to have aides assist R43 (initiated 10/04/2022). (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/2024 at 11:01 AM, R43 was sitting in a wheelchair between the window and R43's bed. R43 wanted water pitcher refilled. R43's call light was not within reach. Call light cord was strung on a chair that was on the opposite side of the bed. R43 stated could not reach it and didn't know how to call staff. R43 asked surveyor to get water. On 7/23/2024 at 11:05 AM, V7 (Certified Nurse Aide) went into R43's room. R43 stated [R43] wanted water. Surveyor asked how R43 is supposed to call staff. V7 stated R43 can use call light. V7 noticed call light's location. V7 stated R43's call light should be next to R43 and it's not. R43 placed call light on the bed within R43's reach. Facility's Answering the Call Light policy, last revised 8/2008, documents in part: When the resident is in bed or confined to a chair be sure the call light is within easy reach 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. 47304 Based on interview and record review the facility failed to obtain physician order for code status of 1 (R109) resident reviewed for advance directives in a sample of 36. The finding include: R109 face sheet documented admitted on 3/25/2024 with diagnoses not limited to Spinal stenosis, Presence of other vascular implants and grafts, Muscle weakness (generalized), Hyperlipidemia, Chronic obstructive pulmonary disease, Bipolar disorder, Solitary pulmonary nodule, Benign prostatic hyperplasia with lower urinary tract symptoms, Vitamin d deficiency, Paraplegia, Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, Obstructive sleep apnea, Other seizures. On 7/24/24 at 10:40 AM V3 (Social Service Director / SSD) said they are assisting resident and family with advance directives including code status. V3 said code status needs to have an order from the physician. Nurses are supposed to obtain an order for code status whether full code or DNR (Do Not Resuscitate) from physician so staff would know the code status of the resident. Surveyor reviewed physician order sheet with V3 and there was no code status order for R109. V3 stated R109 is DNR and POLST (Practitioner Order for Life-Sustaining Treatment) form was completed. At 1:03 PM V2 (Director of Nursing / DON) stated resident's code status whether full code or DNR should have an order from the physician and should be maintained in resident's health record. Stated code status is very important to determine how to proceed during emergency. POLST form reviewed and showed R109 is DNR. Care plan dated 3/26/24 documented in part: R109 has the following advance directives: DNR. POS (Physician order sheet) dated 7/23/24 reviewed no order for code status. Facility's policy for advance directives (undated) documented in part: If changes or revisions are required, the care plan team will initiate the necessary processed to modify the status changes in the resident's record, including contact of the resident's attending physician so that appropriate orders to reflect these status changes are secured.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. 47304 Based on interview and record review, the facility failed to have a policy and procedure in place on how to provide beneficiary notifications such as NOMNC (Notice of Medicare Non-Coverage) and ABN (Advanced Beneficiary Notice) to its residents. This failure could potentially affect 182 Medicaid / Medicare eligible residents residing in the facility with 2 residents under private pay for a total census of 184 as of 7/23/24. The findings include: On 7/23/24 at 1:10 PM facility provided a list of residents who were discharged from Medicare covered Part A stay in the past 6 months. On 07/24/24 10:40 AM V3 (SSD/ Social Service Director) said she started working in the facility January 2023 and transitioned as SSD in May 2024. V3 said NOMNC was not given for Medicare residents, it is only given for managed care / insurance residents. V3 stated she is not aware about ABN. At 11:06 AM V58 (Social Service Consultant) stated ABN should be provided to residents staying in the building and not covered by Medicare. V58 said NOMNC should be given to Medicare eligible residents within 48-72 hours before the last cover day. V58 said there is no process yet with regards to NOMNC and ABN notification. At 11:48am reviewed residents who were discharged from Medicare covered Part A stay in the past 6 months reviewed with V1 (Administrator) and stated no NOMNC or ABN were provided to residents. V1 stated no process yet regarding Beneficiary notification - ABN / NOMNC. V1 said moving forward, the facility will follow guideline or instructions for Beneficiary notifications provided by CMS (Center s for Medicare and Medicaid Services). Form completed by facility titled Beneficiary Notice - Residents discharged within the last 6 months listed 16 residents. Facility Census dated 7/23/24 showed 182 residents under Medicare / Medicaid and 2 residents under private pay for a total census of 184. Facility was not able to provide policy and procedure for Beneficiary notification (NOMNC and ABN). (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility provided Form instructions for the Notice of Medicare Non-Coverage (NOMNC) CMS-10123 and documented in part: A Medicare provider must deliver a completed copy of the Notice of Medicare Non-Coverage (NOMNC) to beneficiaries / enrollees receiving covered skilled nursing. The NOMNC must be delivered at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. Provider must deliver the NOMNC to all beneficiaries eligible for the expedited determination process. A NOMNC must be delivered even if the beneficiary agrees with the termination of services. Medicare providers are responsible for the delivery of the NOMNC. The provider must ensure that the beneficiary or representative signs and dates the NOMNC to demonstrate that the beneficiary or representative received the notice and understands that the termination decision can be disputed. Facility provided Form instructions Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNFABN) Form CMS-10055 (2018) documented in part: Medicare requires SNFs (Skilled Nursing Facility) to issue the SNF ABN to original Medicare, also called fee-for-service (FFS), beneficiaries prior to providing care that Medicare usually covers, but may not pay for in this instance because the care is: not medically reasonable and necessary; or considered custodial. The SNF ABN provides information to the beneficiary so that she / he can decide whether or not to get the care that may not be paid for by Medicare and assume financial responsibility.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assure that each resident's assessment is updated at least once every 3 months. 47304 Based on interview and record review, the facility failed to complete the Quarterly Minimum Data Set (MDS) assessment using the CMS-specified Resident Assessment Instrument (RAI) process within the regulatory timeframe for 1 (R124) of 4 residents reviewed for resident assessment in a sample of 36. The findings include: R124's face sheet documented admitted on 10/30/23 with diagnoses not limited to Type 2 diabetes mellitus, Major depressive disorder, Anemia, Schizophrenia, Bipolar disorder, Dysphagia. On 7/24/24 at 11:26 AM V42 (MDS Director) said V42 has been working in the facility for 5 years. V43 (Reimbursement specialist) said MDS assessment is done for all residents in the facility and completed by IDT (interdisciplinary team) such as SS, wound care, Activities, Dietary, Restorative, Therapy, Nursing. MDS assessment has different sections including demographics, cognition, hearing, speech, vision, mood, behavior, activities, functional abilities and goals, incontinence, diagnosis, health conditions, nutrition, dental, skin, medications, special treatment and procedures, restraints. V42 said based on MDS assessment the team develops the care plan and reimbursement. Care area triggers and develops plan of care for resident. V43 said MDS is important to develop plan of care of the resident and for payment purposes. V42 and V43 said they follow RAI guidelines in completing MDS assessment. If MDS assessment is not done timely there could possibly be a delay of care and payment. V42 and V43 said Quarterly Assessment ARD (Assessment Reference Date) is set 92 days or earlier and should be completed 14 days from ARD then transmitted within 14 days from completion date. R124 records review with V42 and V43 and the last quarterly assessment ARD was done on 2/4/24. V43 said there should have another MDS assessment 92 days after 2/4/24 and should be around first week of May 2024. V43 said facility will open quarterly assessment today, it is considered late quarterly assessment. R124 MDS record showed last MDS assessment completed was dated 2/4/24. Facility's policy dated October 2023 titled RAI OBRA - Required assessment summary documented in part: Quarterly assessment - ARD of previous OBRA assessment of any type + 92 calendar days. MDS completion date: ARD + 14 calendar days.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. 47304 Based on interview and record review, the facility failed to electronically transmit MDS (Minimum Data Set) records to CMS system using the CMS-specified Resident Assessment Instrument (RAI) process within the regulatory timeframes for 3 (R99, R147, R167) of 4 residents reviewed for resident assessment in a sample of 36. The findings include: R99's face sheet documented admitted on 4/13/22 with diagnoses not limited to Type 2 diabetes mellitus, Neuropathy, Atrial Fibrillation, Heart failure, Obstructive sleep apnea, Anemia, Acquired absence of right and left leg below knee, Essential hypertension. R147's face sheet documented admitted on 10/20/22 with diagnoses not limited to Dementia, Major depressive disorder, Essential hypertension, other seizures, Atrial fibrillation, Hyperlipidemia, Hemiplegia and hemiparesis following Cerebral infarction, Dysphagia, Presence of pacemaker. R167's face sheet documented admitted on 2/7/24 with diagnoses not limited to Type 2 diabetes mellitus, Asthma, Hyperlipidemia, Hypothyroidism, Essential hypertension, Congestive heart failure, Osteoarthritis. On 7/24/24 at 11:26 AM V42 (MDS Director) said V42 has been working in the facility for 5 years. V43 (Reimbursement specialist) said MDS assessment is done for all residents in the facility and completed by IDT (interdisciplinary team) such as SS, wound care, Activities, Dietary, Restorative, Therapy, Nursing. MDS assessment has different sections including demographics, cognition, hearing, speech, vision, mood, behavior, activities, functional abilities and goals, incontinence, diagnosis, health conditions, nutrition, dental, skin, medications, special treatment and procedures, restraints. V42 said based on MDS assessment the team develops the care plan and reimbursement. Care area triggers and develops plan of care for resident. V43 said MDS is important to develop plan of care of the resident and for payment purposes. V42 and V43 said they follow RAI guidelines in completing MDS assessment. If MDS assessment is not done timely there could possibly be a delay of care and payment. V43 said Admission MDS assessment should be completed by day 14 from admitted , CAA / CP (Care area assessment / care plan) should be completed 7 days after completion date and transmitted no later than 14 days after CP completion date. Quarterly Assessment ARD (Assessment Reference Date) is set 92 days or earlier, should be completed 14 days from ARD then transmitted within 14 days from completion date. Annual MDS ARD is set 366 days or earlier, should be completed 14 days from ARD. CAA / CP completed 7 days after completion date and transmitted 14 days after CAA / CP completion. Reviewed records of the following residents with V42 and V43: 1. R99's Quarterly ARD 12/1/23 was completed on 12/15/23 and transmitted 1/4/24. V42 said it is considered late transmission, should have been transmitted within 14 days from completion date. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R147's Annual MDS ARD 11/3/23 was completed on 11/17/23 and was transmitted on 1/4/24. V42 said it is considered late transmission, should have been transmitted within 14 days from completion date. 3. R167's Admission MDS ARD 2/12/24 was completed on 2/20/24 and was transmitted on 3/8/24. V42 said it is considered late transmission should have been transmitted within 14 days from completion date. R99's Quarterly MDS assessment showed ARD on 12/1/23, completion date on 12/15/23. Final validation report showed record submitted late. The submission date is more than 14 days after completion date. R147's Annual MDS assessment showed ARD on 11/3/23, care plan completion date on 11/17/23. Final validation report showed record submitted late. The submission date is more than 14 days after care plan completion date. R167's Admission MDS assessment showed ARD on 2/12/24, care plan completion date on 2/20/24. Final validation report showed record submitted late. The submission date is more than 14 days after care plan completion date. Facility's policy dated October 2023 titled RAI OBRA - Required assessment summary documented in part: Admission MDS ARD no later than 14TH calendar day of the resident's admission. CAA completion date no later than 14th calendar day of the resident's admitted . Care plan completion date no later than CAA completion date + 7 calendar days. Transmission date no later than care plan completion date +14 calendar days. Annual MDS CAA completion date no later than ARD + 14 days. Care plan completion date no later than CAA completion date + 7 calendar days. Transmission date no later than care plan completion date +14 calendar days. Quarterly MDS completion date no later than ARD + 14 calendar days. Transmission date no later than MDS completion date + 14 calendar days.

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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** 40061 Based on interviews and record reviews, the facility failed to conduct a Preadmission Screening and Resident Review (PASRR) for one (R101) resident out of a total sample of 36 residents reviewed for PASRRs. Findings include: Reviewed R101's 8/10/2023 Admission Minimum Data Set (MDS) assessment. It documents in part an admitted [DATE]. Under section A1500 PASRR, facility marked 0 to indicate that resident was not considered to have serious mental illness. R101's Admission Record, however, documents in part a medical diagnosis of bipolar disorder (onset date 7/28/2023). Surveyor requested to review R101's PASRR from V1 (Administrator), V2 (Director of Nursing), and V41 (Admissions Director) on multiple occasions including on 7/23/2024 at 3:10 PM and on 7/24/2024 at 9:25 AM, 10:55 AM, 1:43 PM, and 1:58 PM. Facility provided an old pre-admission screening for R101 from 1/10/2021 directed to another facility. Facility did not provide PASRR related to R101's 7/28/2023 admission to current facility. On 7/24/2024 at 1:58 PM, V41 stated facility admitted R101 prior to V41's start date at the facility (10/2023). V41 stated R101 was a transfer from another long-term care facility. V41 stated the previous Admission Director should have done a PASRR prior to R101 transferring or admitting to the facility. Facility's 3/2016 Pre-Admission Assessment Policy documents in part: Objective: To establish uniform guidelines for personnel to follow when admitting consumers to the facility. Prior to admission the facility, each consumer shall receive an assessment (MH PASRR) conducted under the auspices of [Department of Human Services-Department of Mental Health. The assessment shall be used to determine the appropriate level of service and is required for authorization of services.

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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. 47304 Based on observation, interview and record review, the facility failed to ensure incontinence care was provided in a timely manner for 1 (R109) resident who needed assistance with toileting. This failure affected 1 (R109) resident reviewed for ADL (Activities of Daily Living) care in a sample of 36. The findings include: R109 face sheet documented admitted on 3/25/2024 with diagnoses not limited to Spinal stenosis, Presence of other vascular implants and grafts, Muscle weakness (generalized), Hyperlipidemia, Chronic obstructive pulmonary disease, Bipolar disorder, Solitary pulmonary nodule, Benign prostatic hyperplasia with lower urinary tract symptoms, Vitamin d deficiency, Paraplegia, Acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, Obstructive sleep apnea, Other seizures. On 7/23/24 at 10:36 AM R109 observed lying in bed, alert and oriented x 3, verbally responsive. R109 stated he is not satisfied with care; he has been wet with urine and feces and was last changed around 3am and he told staff after breakfast around 8am that he needed to be changed. R109 said he has been waiting to be changed for 2 hours and activated the call light. At 10:40am V14 (Certified Nursing Assistant / CNA) and V15 (Medical Records staff) came in to R109's room and V15 stated she will be assisting V14. Surveyor conducted incontinence care observation with V14 assisted by V15. Observed R109 incontinence brief heavily soiled with urine and feces, overflowed / leaked to the bedsheet. Observed V14 wiped / cleanse and rinse perineal area. Incontinence care completed. At 10:55am V14 stated she has been working in the facility since 2015. V14 said rounding and incontinence care should be done at least every 2 hours and as needed to prevent skin breakdown. V14 said R109 told her that he needed to be changed after breakfast or after 8am but was not able to care for him right away because she was picking up breakfast trays and attended to another resident. V14 stated this is the first incontinence care provided to R109 and her shift started at 6am. At 7/24/24 at 1:03 PM V2 (Director of Nursing / DON) said staff is expected to do rounding including checking resident for incontinence episode and providing incontinence care at least every 2 hours and as needed to prevent skin breakdown or irritation. MDS (Minimum Data Set) dated 6/15/24 showed R109's cognition was intact. R109 needed Substantial / maximal assistance with oral and personal hygiene; Dependent with toileting hygiene, shower / bathe self, upper and lower body dressing, chair / bed and toilet transfer. MDS showed R109 was always incontinent of bowel and bladder. Facility's policy for perineal care dated August 2008 documented in part: The purposes of this procedure are to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.

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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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 40061 Based on interviews and record reviews, the facility failed to supervise and use the appropriate shower equipment for one (R147) resident out of a total sample of 36 residents reviewed for falls. This failure resulted in R147 falling out of the shower chair and sustaining a closed nondisplaced fracture of the greater trochanter of the right femur. Findings include: R147's Admission Record documents in part medical diagnoses of dementia, seizures, cerebral infarction, hemiplegia and hemiparesis affecting the right dominant side. R147's 5/10/2024 Fall Risk Screen documents in part that R147 is at moderate risk for falls. R147's comprehensive care plan documents in part that R147 has a potential for falls and is at risk for injury from falls (initiated 10/02/2023). Intervention includes to Anticipate and meet resident's needs (initiated 10/21/2022). It documents in part that R147 had an actual fall on 6/26/2024 resulting in right trochanter fracture. On 7/23/2024 at 1:09 PM, R136 (R147's roommate) stated R136 was in the hallway when R136 saw V29 (Certified Nurse Aide-CNA) bring R147 from the shower room to the bedroom. R136 stated, [R147] was in the shower chair, then I just heard staff say [R147] was on the floor. Facility's working schedule for 6/26/2024 documents in part that facility assigned V29 to care for R147 that morning. On 7/23/2024 at 1:13 PM, V24 (Nurse) stated V24 has been taking care of R147 since May 2024. V24 stated R147's trunk/upper body control was not good. V24 stated R147 doesn't tolerate the shower chair and needs a shower bed. V24 stated this was R147's baseline status. On 7/23/2024 at 2:36 PM, V25 (CNA) stated V25 has been taking care of R147 for three out of five shifts a week for the past year. V25 stated R147's cannot sit up in a chair per baseline. V25 stated for bathing [V25] would bath R147 in a bed because R147 cannot sit in a shower chair. On 7/23/2024 at 2:40 PM, V26 (CNA) stated facility assigns [V26] mostly to the first floor. For the past 20 days, V26 has taken care of R147 four to five days out of the week. V26 stated R147 is bed bound and cannot sit up in a chair. V26 stated, [R147] can help sit up but beyond sitting upright by [self] [R147] can't. V26 stated that on the day of R147's fall, V29 asked [V26] for assistance to put R147 into the shower chair. After the shower, V29 took R147 back to the bedroom while V26 attended to another resident. V29 told V26 that during the time [V29] went to get linens for R147's bed, R147 fell out of the shower chair. V26 stated staff are not to leave residents unattended while on the shower chair including R147. (continued on next page)

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	145977	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation	2425 East 71st Street Chicago, IL 60649

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 7/24/2024 at 11:17 AM, V29 (CNA) stated during date of fall [V29] gave R147 a shower with V26's assistance. V26 and V29 used a shower chair for R147. After the shower, V29 took R147 back to the bedroom while V26 attended to another resident. While R147 was sitting in the shower chair by the bedside, V29 went to the linen cart in the hallway. V29 stated the cart was sitting by the door. I came to grab a sheet out of the cart. Once I grabbed the sheet, I turned around and [R147] was on the floor. [R147] just kind of slid out the chair. V29 stated R147 was sitting on [R147's] bottom with upper body leaning backwards towards the shower chair. During a witnessed interview among other surveyors on 7/23/2024 at 2:50 PM, V27 (Restorative Director) stated worked as the Restorative Director/Nurse since 10/2023 but worked at facility as floor nurse since 12/2022. V27 stated R147 cannot use a shower chair due to poor trunk control and one-sided weakness. V27 stated, [R147] has been like that since I've been working here. V27 stated R147 is not able to hold self-up even when sitting upright on the bed. V27 stated being part of the interdisciplinary team that investigated R147's recent fall on 6/26/2024. V27 stated, they shouldn't have utilized a shower chair. [R147] was improperly transferred and the wrong equipment was used for [R147]. V27 stated staff were supposed to use a shower bed for R147's showers. V27 stated facility did care plan for it. However, when reviewing R147's care plan, facility did not include shower bed intervention until 6/27/2024-after the fall. V27 stated after the fall R147 went to the hospital where they diagnosed R147 to have a right trochanter fracture. R147's 6/27/2024 hospital records and discharge papers document in part an acute nondisplaced fracture of the right greater trochanter. Facility's 8/2008 Falls-Clinical Protocol documents in part: As part of the initial assessment, the physician will help identify individuals with a history of falls and risk factors for subsequent falling. The staff will document risk factors for falling in the resident's record and discuss the resident's fall risk.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough food/fluids to maintain a resident's health. 46342 Based on observation, interview and record review the facility failed to provide physician generated diet orders. These failures affected 5 residents (R7, R15, R75, R110, R152) of 7 residents reviewed for nutrition in a total sample of 36. Findings include: On 07/23/24 at 12:29 PM, observed R110 eating lunch in unit dining room. R110's meal ticket read double portions. R110 received one scoop of mashed potatoes, a single portion of yellow squash, and a single portion of Turkey Pot Roast. R110 stated, Sometimes I get doubled portions and sometimes I don't. The doctor requested it because he wants me to get double portions. On 07/23/24 at 12:33 PM, observed R75 sitting in the unit dining room. R75 received a single portion of Turkey Pot Roast, single portion of Yellow Squash, and one scoop of mashed potatoes. R75's meal ticket read double portions as part of diet listed. R75 stated, I'm supposed to get double portions, but I didn't get it. On 07/23/24 at 12:57 PM, observed R15 sitting on bed in R15's room with lunch meal on R15's bed table. R15 took the dome lid off the plate. Observed one breaded meat patty, single portion of yellow squash, and one scoop of mashed potatoes. R15's meal ticket read double portions as part of R15's diet order. R15 stated R15 would like to receive the more food at meals and that the kitchen does not always send R15 double portions. On 07/23/24 at 01:00 PM, observed R7 lying in bed in room with lunch meal at bedside table. R7 took the dome lid off the plate. Observed one breaded meat patty, a single portion of yellow squash, and one scoop of mashed potatoes. R7's meal ticket read double portions as part of R7's diet order. On 07/23/24 at 01:04 PM, observed R152 sitting in wheelchair in room with lunch tray in front of him on the table. R152 had a single portion of Turkey Pot Roast, a single portion of yellow squash, and one scoop of mashed potato. R152's meal ticket read double portions as part of the diet order. R152 stated, That doesn't look like double portions to me. R152 said he often doesn't receive double portions and said, I don't like to complain. On 07/23/24 at 12:34 PM, in the unit dining room V6 (Dietary Aide) observed two resident trays; one tray had a meal ticket which listed double portion as part of the diet and the other tray had a meal ticket which had a standard portion diet order listed as part of the diet order. V6 looked at the two trays and stated both trays had single portions on them. V6 stated a double portion diet should receive doubles of the meat and vegetable. V6 stated V6 did not know about whether the mashed potatoes should be doubled or not. V6 stated neither of the trays shown to V6 had double portions on them. On 07/23/24 at 1:09 PM, in the unit dining room observed a tray which had the meal ticket for double portion diet untouched, not passed out yet. A Certified Nursing Assistant stated that resident had been discharged from the facility already and therefore the tray was an extra one. Surveyor took this tray down to the kitchen. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 07/23/24 at 1:14 PM, V5 (Dietary Manager) stated a double portion diet should receive double portion of meat, vegetable, and starch. V5 stated, Everything on the plate should be doubled. V5 stated the dessert and/or roll is not doubled. V5 stated for residents who did not like the Turkey Pot Roast they were given a Breaded Pork Chop instead. V5 stated based on the spreadsheets the standard portion size for the Turkey Pot Roast was 3.5-ounces so residents receiving a double portion diet should have received 7-ounces of Turkey Pot Roast. V5 weighed the Turkey Pot Roast from the leftover tray the surveyor brought down from the unit which had a meal ticket for double portion diet on it. The Turkey Pot Roast weighed 3.45 ounces. V5 stated this portion of meat should have been 7 ounces since the meal ticket listed double portion has part of the diet and that the 3.45 ounces was less than the standard portion of 3.5 ounces. On 07/24/24 at 9:00 AM, V5 stated the diet order is ordered by the doctor and listed on the meal ticket. V5 stated the kitchen follows the diet order listed on the meal ticket. V5 stated if a resident has double portions listed on their meal ticket, they should be receiving the double portions because it is what the doctor ordered. V5 stated there are many different reasons the doctor may have ordered double portions for a resident including to promote weight gain, maybe for wound healing, food preferences or a medical condition requiring more calories. V5 stated a double portion means the meat, the vegetable and the starch are each doubled. V5 stated yesterday those residents who did not receive double portions was because of miscommunication. V5 stated the residents should have received the double portions because the potential problem is those residents may not receive enough nourishment and this could potentially cause weight loss. On 07/24/24 at 12:46 PM, via phone interview V36 (Registered Dietitian) the kitchen should be providing the diet listed on the meal ticket. V36 stated a resident could be on a double portion diet for added calories/protein due to different reasons including history of weight loss, wound healing, dialysis, or increased nutritional needs related to specific medical condition. V36 stated the potential problem if a resident who should receive double portions does not receive double portions could be anything from weight loss, varying blood sugars, and possibly impaired wound healing. V36 stated R110 has a vascular wound so R110 has increased calorie/protein needs so the double portions is still indicated to support wound healing. V36 stated based on R75's estimated nutritional needs R75 requires more calories/protein than what a standard diet provides. V36 stated R15 requires the double portions to promote weight gain because R15's BMI is towards the lower end and R15 has a history of weight loss. V36 stated R152 requires double portions related to R152's medical diagnosis. V36 stated R7's calorie/protein needs are higher than what would be provided on a standard diet. R7's diagnosis includes but not limited to Insomnia, Schizoaffective Disorders, Benign Prostatic Hyperplasia with Lower Urinary Tract and Symptoms, Seizures, Chronic Obstructive Pulmonary Disease with Acute Exacerbation, Type 2 Diabetes Mellitus Without Complications, Hypotension, Urinary Tract Infection. R7's Order Summary Report dated 07/23/24 documents in part No Added Salt/No Concentrated Sweets Regular Texture, Double Portion. R7's MDS (Minimum Data Set) from 07/01/24 BIMS (Brief Interview for Mental Status) 15/15 indicating intact cognition. R7's nutrition care plan documents in part, provide and service diet as ordered. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R7's printed meal ticket documents in part, Regular, Double Portion, No Added Salt (NAS), No Concentrated Sweets (NCS). R15's diagnosis includes but not limited to Human Immunodeficiency Virus (HIV) Disease, Schizophrenia, Schizoaffective Disorder, Bipolar Type, Deficiency of other Specified Nutrient Elements, Bipolar Disorder, Pain. R15's Order Summary Report dated 07/23/24 documents in part General Diet, Regular Texture, Double Portion. R15's MDS (Minimum Data Set) from 06/13/24 indicates BIMS (Brief Interview for Mental Status) was 15 out of 15 indicating intact cognition. R15's nutrition care plan dated 07/24/24 documents in part, the resident has a potential nutritional problem related to Schizoaffective Disorder (SAD), deficiency of other specified nutrient elements, and HIV disease, and provide and serve diet as ordered. R15's Dietitian Assessment completed 05/21/24 documents in part, recommend double portions with meals and a Two Cal/ml supplement 237 ml every day to promote weight stability. R15's printed meal ticket documents Regular, Double Portion. R75's diagnosis includes but not limited to Gastroesophageal Reflux Disease without Esophagitis, Vitamin D Deficiency, Epilepsy, Post-Traumatic Seizures, Chronic Kidney Disease, Secondary Hypertension, Schizophrenia, Disorientation, Adjustment Disorder with Mixed Disturbance of Emotions and Conduct, Type 2 Diabetes Mellitus with Unspecified Complications. R75's Order Summary Report dated 07/23/24 documents in part, Low Concentrated Sweets, Regular Texture, Double Portion. R75's MDS (Minimum Data Set) from 06/24/24 indicates BIMS (Brief Interview for Mental Status) was 15 out of 15 indicating intact cognition. R75's nutrition care plan dated 12/09/20 documents in part, provide, serve diet as ordered. R75's printed meal ticket documents NCS, Regular, Double Portion. R110's diagnosis includes but not limited to Hypertension, Constipation, Reduced Mobility, Limitations of Activities Due To Disability, Weakness, Lack of Coordination, Difficulty in Walking, Cognitive Communication Deficit, Chronic Obstructive Pulmonary Disease, Parkinson's Disease without Dyskinesia, Bed Confinement Status. R110's Order Summary Report dated 07/23/24 documents in part, General Diet, Regular Texture, Double Portion. R110's MDS (Minimum Data Set) from 05/21/24 indicates BIMS (Brief Interview for Mental Status) 0 (resident unable to complete). (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R110's nutrition care plan dated 02/15/24 documents in part, provide diet as ordered. R110's printed meal ticket documents in part Regular, Double Portion. R152's diagnosis includes but not limited to Chronic Obstructive Pulmonary Disease, Limitation of Activities Due to Disability, Difficulty In Walking, Chronic Systolic Congestive Heart Failure, Pain And Left Knee, Lack Of Coordination, Reduced Ability, Cognitive Communication Deficit, Major Depressive Disorder, Hypotension, Paroxysmal Atrial Fibrillation, Type 2 Diabetes Mellitus, Hypertension, Hyperlipidemia. R152's Order Summary Report dated 07/23/24 documents in part, No Salt Packet, Regular Texture, Double Portions Every Meal. R152's MDS (Minimum Data Set) from 05/20/24 indicates BIMS (Brief Interview for Mental Status) was 15/15 indicating intact cognition. R152's nutrition care plan dated 02/21/23 documents in part, provide diet as ordered. R152's printed meal ticket documents in part Regular, Double Portion, No Added Salt. Kitchen provided document titled Spring & Summer Menus 03/18/24 Option 2 Week 1 which lists the meals with portions sizes served Sunday -Saturday. Tuesday lunch meal for regular diet listed standard portion size as 3.5 ounces Turkey Pot Roast, #8 scoop Homemade Mashed Potatoes, 4 ounces Roasted Yellow Squash. Facility provided policy titled, Resident Diets and Nutritional Needs dated June 2023 which documents in part, must provide each resident with a nourished, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preference of each diet and menus must be followed. Facility provided kitchen policy titled, Meal Plans with Increased Calories and Protein undated documents in part, the general diet ordered with extra portions, large portions, high protein, or as fortified foods is for the clients who requires additional calories or protein above what is provided in the planned general menu. Facility provided kitchen policy titled, General Diet - Extra Portions undated documents in part, this diet can also be ordered as General Diet with Double Portions and to provide for lunch and supper 2 servings of meat, 2 servings of starch, 2 servings of vegetable(s). Facility provided kitchen document titled Diet Orders and Portion Sizes which documents in part, ensure staff is providing the correct meal and liquid consistency to the resident per the physician diet order. Verify portion sizes are correct at the meal. Facility provided kitchen document titled, Correct Diet Order which documents in part, must provide prescribed diet in accordance with the MD orders. Verify you are serving the resident the correct diet ordered. Refer to the tray ticket as a guide.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50057 Based on observation, interview and record review, the facility failed to ensure oxygen was administered as ordered, failed to ensure oxygen masks and nebulizer masks and tubing were stored following professional standards of care and facility policy, and failed to ensure residents were provided humidity while on oxygen. These failures could potentially affect three (R18, R63, R80) residents out of a total of thirty-six residents reviewed for respiratory care. Findings On 07/23/24 at 10:25 AM R63 was observed lying in bed with oxygen running at four liters per minute per nasal cannula. An oxygen mask was observed on the bedside table not in a bag. On 7/23/2024 at 10:27 AM V32 (Certified Nurses Aide) stated, We store unused oxygen masks and cannulas wrapped in a plastic bag. V32 observed the oxygen mask on R63's bedside table and stated, It should be in a plastic bag. On 7/24/2024 at 8:44 AM R63's nasal cannula was observed on the floor with the oxygen machine running at four liters per minute. V33 (Licensed Practical Nurse) stated, I will get her a new nasal cannula. I should probably check her oxygenation as well. V33 checked R63's oxygen saturation and observed to be ninety-one percent. Policy titled Oxygen Therapy and Devices with no date stated in part: Purpose: Oxygen is a basic human need. Without it, we would not survive. The air that we breathe contains approximately twenty-one percent oxygen. For most people with healthy lungs, this is sufficient, but for some people with certain health conditions whose lung function is impaired, the amount of oxygen that is obtained through normal breathing is not enough. Therefore, they require supplemental amounts to maintain normal boxy function. Oxygen devices: 1. Nasal Cannula f. Place in a labeled bag when not in use. 46342 On 07/23/24 at 11:59 AM, observed R80's nebulizer mask lying on R80's side table. The nebulizer mask was uncovered and not in bag. R80 stated R80 received a nebulizer treatment this morning and the nurse removed the mask from R80's face when it was completed. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 07/23/24 at 12:13 PM - V8 (Agency LPN) observed nebulizer mask on the side of R80's nightstand, uncovered and stated, It should be in a bag to make sure it does not get contaminated and to keep it clean. I don't see a bag in here. I'll go get one now. Look for one. V8 stated, I took the nebulizer mask off this morning once (R80) was done with the treatment. To be honest, I didn't think about putting it in a bag, but it should be stored in a bag when it isn't being used. On 07/24/24 at 1:52 PM, V2 (Director of Nursing) stated the nebulizer mask and tubing should be dated and changed weekly and when not in placed in a plastic bag and left at the bedside. V2 stated it is the nurse's responsibility to place the nebulizer mask and tubing in a bag, not the resident's responsibility. V2 started the mask and tubing should be contained in a bag for infection control reasons so they will not hit the floor and/or something cannot fall on them. 07/24/24, 2:11 PM, V13 (LPN) observed R80's nebulizer tubing and stated it is dated 07/15/24. V13 stated, It's been 9 days since that has been changed. It should have been changed after 7 days. V13 stated the nebulizer mask should also be dated and there is no date on the mask, only the tubing. R80 has diagnosis which includes but not limited to Opioid Abuse, Other Pulmonary Embolism Without Acute Cor Pulmonale, Anemia, Gastro-Esophageal Reflux Disease Without Esophagitis, Constipation, Chronic Viral Hepatitis C, Benign Prostatic Hyperplasia Without Lower Urinary Tract Symptoms, Combined Systolic (Congestive) And Diastolic (Congestive) Heart Failure, Hypertension, Emphysema, Chronic Obstructive Pulmonary Disease, Limitation Of Activities Due To Disability, Other Reduced Mobility, Myasthenia Gravis With (Acute) Exacerbation, Hyperlipidemia, Major Depressive Disorder, Insomnia, Sciatica, Chronic Pain Syndrome, Other Lack Of Coordination, Dysphagia, Oropharyngeal Phase. R80's Order Summary Report dated 07/23/24 documents in part, DuoNeb Solution 0.5-2.5 (3) mg/3ML (Ipratropium Albuterol. 3 milliliter inhale orally four times a day for COPD. R80's MDS (Minimum Data Set) from 07/14/24 BIMS (Brief Interview for Mental Status) score 15/15 indicating intact cognition. Facility provided policy titled Oxygen Therapy and Devices, undated which documents in part to for simple mask to place in a labeled bag when not in use and change out weekly and PRN. 47304 R18's face sheet documented initial admitted on 6/23/2022 with diagnoses not limited to Type 2 diabetes mellitus with unspecified complications, Essential (primary) hypertension, Gastro-esophageal reflux disease without esophagitis, Generalized anxiety disorder, Chronic obstructive pulmonary disease, Malignant neoplasm of thyroid gland, Malignant neoplasm of prostate, Anemia, Heart failure, Atherosclerotic heart disease of native coronary artery with unspecified angina pectoris. On 7/23/24 10:52 AM Observed R18 sitting up in the wheelchair, alert and verbally responsive, with oxygen via nasal at 5L/min. Oxygen concentrator does not have a humidifier bottle. Requested V8 (LPN) to R18's room and stated there should have a humidifier bottle for oxygen concentrator. V8 stated oxygen is at 5L/min, not sure what is the order. V8 checked order and said R18's oxygen order is at 2L/min. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/24 at 1:03 pm V2 (Director of Nursing / DON) said oxygen administration should have a doctor's order and it is important to follow doctor's order to prevent any change in condition with resident. V2 stated if resident is using an oxygen concentrator there should be a humidifier bottle to keep the air from not getting dry as it provides moisture. MDS (Minimum Data Set) dated 6/22/2024 showed R18's cognition was intact. R18 needed partial / moderate assistance with chair / bed, and toilet transfer. R18's POS (Physician order sheet) documented order not limited to Oxygen (02) @ 2 Liters/Minute per nasal cannula, Maintain 02 Saturation 92% or greater Continuous every shift. Care plan dated 2/8/23 documented in part: R18 has Oxygen Therapy related to CHF (congestive heart failure). Administer oxygen per physician's orders. Facility's policy for oxygen therapy (undated) documented in part: Oxygen is a drug which must be ordered by a physician. Verify physician order. Obtain Humidity. Apply device to the patient with appropriate liter flow.

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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. 47304 Based on observation, interview, and record review, the facility failed to: (a) follow standards of professional practice and facility policy by leaving medications at the bedside of one resident (R488); (b) ensure that one medication cart were locked during medication administration; (c) properly date opened multi-dose eye drops, insulin vials and pen; (d) properly discard expired house stock medication from 4 of 8 medication carts and 2 of 4 medication storage room inspected for medication storage and labeling. The findings include: On 7/23/24 at 11:01 AM Inspected 2 east medication cart with V9 (Licensed Practical Nurse / LPN) and observed R94's opened Insulin Lispro vial with no open date. Pharmacy label indicated discard after 28 days. R94's POS (Physician Order Sheet) dated 7/23/24 documented active order not limited to: Humalog injection solution 100unit/ml (Insulin Lispro inject as per sliding scale. At 11:18am 2 west medication cart inspected with V8 (LPN) and observed R13's opened Insulin Glargine pen and Aspart insulin vial with no open date. Pharmacy label indicated: Throw away any medicine that remains 28 days after first use. Opened Levemir Insulin vial with no open date. Pharmacy label indicated: Discard after 42 days. R13's POS dated 7/23/24 documented order not limited to: Insulin Glargine Inject 26 unit subcutaneously in the morning and 16 unit at bedtime. Insulin Aspart Inject 4 unit subcutaneously before meals and at bedtime and as per sliding scale. No active order of Levemir insulin found in R13's POS. At 11:25am 3 east medication cart inspected with V13 (LPN) and observed the following inside the medication cart: 1. R76's opened Latanoprost eye solution with no open date. Pharmacy label indicated: After opening, may store at room temperature. Throw away any drug left after 6 weeks. R76's POS dated 7/23/24 documented order not limited to Latanoprost Instill 1 drop in both eyes at bedtime. 2. R173's opened Latanoprost eye solution with no open date. Pharmacy label indicated: After opening, may store at room temperature. Throw away any drug left after 6 weeks. R173's POS dated 7/23/24 documented order not limited to Latanoprost Instill 1 drop in both eyes at bedtime. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation	2425 East 71st Street Chicago, IL 60649

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R162's opened Latanoprost eye solution with no open date. Pharmacy label indicated: After opening, may store at room temperature. Throw away any drug left after 6 weeks. R162's POS dated 7/23/24 documented order not limited to Latanoprost Solution Instill 1 drop in both eyes at bedtime. 4. R29's opened Lantus insulin vial with no open date. Pharmacy label indicated: Discard after 28 days. R29's POS dated 7/23/24 documented order not limited to Lantus Solution 100 UNIT/ML (Insulin Glargine) Inject 40 unit subcutaneously at bedtime. 5. R52's opened Latanoprost eye solution with no open date. Pharmacy label indicated: After opening, may store at room temperature. Throw away any drug left after 6 weeks. R52's POS dated 7/23/24 documented order not limited to: Latanoprost Ophthalmic Solution Instill 1 drop in both eyes in the evening. At 11:30am 3 west medication cart inspected with V12 (LPN) and observed the following inside the medication cart: 1. R112's opened Latanoprost eye solution with no open date. Pharmacy label indicated: After opening, may store at room temperature. Throw away any drug left after 6 weeks. R112's POS dated 7/23/24 with order not limited to Latanoprost Solution Instill 1 drop in both eyes at bedtime. 2. R97's opened Latanoprost eye solution with no open date. Pharmacy label indicated: After opening, may store at room temperature. Throw away any drug left after 6 weeks. R97's POS dated 7/23/24 with order not limited to Latanoprost Ophthalmic Solution Instill 1 drop in both eyes in the evening. 3. R146's opened Latanoprost eye solution with no open date. Pharmacy label indicated: After opening, may store at room temperature. Throw away any drug left after 6 weeks. R146's POS dated 7/23/24 with order not limited to Latanoprost Solution 0.005 % Instill 1 drop in both eyes at bedtime. At 11:50am 3rd floor Medication room inspected with V12 (LPN) and found 1 unopen bottle of Vitamin B6 50mg tablet with manufacturer expiry date on 6/2024. V12 said will discard this expired medication. On 7/25/24 at 11:26am V2 (Director of Nursing / DON) stated medication should be dated / labelled once opened to know when to discard the medication. She said when it is not dated or labelled could potentially use the medication beyond expiry or discard date and resident could have an adverse reaction when given. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility's policy for storage of medications dated 10/25/14 documented in part: Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. Certain medications such multiple dose injectables, vials, ophthalmic, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. 45110 On 7/23/24 at 9:25AM, Surveyor observed V11 [Licensed Practical Nurse] during medication administration. On 7/23/24 at 9:26 AM, V11 walked away from the medication cart and left the cart unlocked, to administer R129's medication. The medication cart was facing toward the hallway out of V11's view. On 7/23/24 at 9:33 AM, V11 walked away from the medication cart and left the cart unlocked, to administer R106's medication. The medication cart was facing toward the hallway out of V11's view. On 7/23/24 at 9:46 AM, V11 walked away from the medication cart and left the cart unlocked, to administer R62's medication. The medication cart was facing toward the hallway out of V11's view. On 7/23/24 at 10:00 AM, stated, I forgot to lock the medication cart, I was nervous. I need to lock the medication cart, because other residents or visitors could open the medication cart and have access to the resident medications. On 7/24/24 at 1:10 PM, V2 [Director of Nursing] stated, The medication carts must be always locked when not in use. Leaving the medication unlocked, potentially any resident, visitor, or unauthorized staff could enter the medication cart. The cart should be locked for safety protocols. Policy documents in part: Storage of Medications -Medications and biologicals are stored safely, securely, and properly. -Medications rooms, Medication carts, are locked when not attended by persons with authorize access. 50057 On 07/23/24 at 10:42 AM R488 was observed lying in bed. A plastic water cup was observed on the overbed table which was positioned over R488's bed. A medicine cup with a small light-yellow pill and a larger white pill were observed in the medicine cup. R488 was asked what the pills were and R488 stated, I don't know, but I will take them. As R488 was moving the pills to her mouth, surveyor stated that we should ask the nurse before R488 took the pills. R488 agreed. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/2024 at 10:45 AM V11 (Licensed Practical Nurse) was presented with the plastic water cup with the medicine cup and pills inside the medicine cup. V11 stated, That looks like R488's Vitamin C and her Aspirin or Folic Acid. V11 stated, I explain all of the meds before I give them to patients. R488 must have forgot what I told her they were. R488 started taking them when I was in the room and another patient needed me, so I walked away. I saw her take some of them, but not all of the medicine. On 7/25/2024 at 4:25 PM R488's care plan and provider orders were reviewed. There was no care plan or provider order for medication self-administration. Policy titled Storage of Medications dated 10/24/2014 stated in part: Policy: Medications and biologicals are stored safely, securely and properly, following manufacturer's recommendation or those of the supplier. Procedure: B. Only licensed nurses, pharmacy personnel, and those lawfully authorized to administer medications are permitted to access medications. Medications rooms, carts, emergency kits/boxes, and medication supplies are locked when not attended by persons with authorized access. Policy titled Medication Administration dated 10/24/2014 stated in part: Policy: Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to do so. Procedure: B. Administration. 1. Medications are administered only by licensed nursing staff, medical, pharmacy or other personnel authorized by state laws and regulations to administer medication. 4. When medications are administered form a mobile cart taken to the resident's location (room, dining area, etc.) medications are administrated at the time that they are prepared. 14. Residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications. 18. Residents is always observed after administration to ensure that the dose was completely injected.

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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. 46342 Based on observations, interviews, and record reviews, the facility failed to ensure a.) kitchen staff wearing facial hair covering b.) food items were properly labeled, dated, and stored, c.) refrigerator kept clean. These failures have the potential to affect all 180 residents receiving food prepared in the facility's kitchen. Findings include: On 07/23/24 at 9:10 AM, during initial tour with V5 (Dietary Manager) observed V6 (Dietary Aide) walking around the kitchen. V6 had a mustache and beard which was not covered with a beard protector/covering. V6 stated, I got going and forgot to put on a beard protector this morning. I should be wearing one now. I'll go put one on. V5 stated there is an adequate supply of beard guards in stock and V6 should be wearing a beard guard in the kitchen. On 07/24/24 at 9:08 AM, V5 stated beard guard's purpose is to prevent hair from falling in food and to prevent contamination of the food. V5 stated any kitchen employee with a beard or facial hair should put on a beard guard before they enter the kitchen. On 07/23/24 at 9:18 AM, V5 stated all items in the refrigerators should be labeled with an open and use by date. A non-prepared item such as condiments/spices should also have a delivery date on them, in addition to the open and use by date. V5 stated the kitchen follows the manufacturer guidelines if they have a printed date for a use by or best by date on the item. V5 stated whoever opens the item or prepares the item is responsibility for labeling and dating that item. On 07/23/24 at 9:25 AM, observed inside the Behind Reach-In Cooler a thermometer hooked to the grate of the refrigerator fan on the ceiling of the cooler. The thermometer was covered in black spotted material with a larger clump of gray/black/white on the face of the thermometer. Black spots could be seen inside and outside the fan covering. Observed the following items inside the Behind Reach-In Cooler: 1.) Opened 1-gallon Balsamic Vinaigrette Dressing dated with delivery date of 07/08/24. There was no opened date on the item or use by date. 2.) Opened 1-gallon Barbeque Sauce dated with delivery date of 07/15/24. There was no opened date on the item or use by date. On 07/23/24 at 9:30 AM, V5 stated the Balsamic Vinaigrette Dressing and Barbeque Sauce should be labeled with the opened date so that the staff can keep track of how long the product has been opened and so they know when to discard it. On 07/23/24 at 9:35 AM, V5 stated spices are good for one year and should be discarded after one year from the opened date. All items should have a delivery date, open date and use by/best by date if not already printed on the containers by the manufacturer. Observed the following spices in the Cook/Prep Area: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	1.) Opened 1.75-pound Basil Leaves labeled with best by date 01/31/22. Labeled with delivery date 10/01/20. 2.) Opened container Ground Cloves labeled with delivery date 01/07/21. No use by or best by date observed on the container. 3.) Opened container Ground Rosemary. Container appeared old. Unable to reach delivery date, opened date and/or use by/best by date because all of the dates were worn off. 4.) Opened container of Cayenne Pepper labeled with a delivery date 11/30/20. Expiration date 06/01/22. On 07/23/24 at 9:46 AM, observed opened bag of Pureed Bread Mix in an opened box. V5 stated the bag should be closed tightly with a twist closure and the box should be closed so that something doesn't crawl or fly in there. On 07/23/24 at 9:49 AM, observed in dry storage room an opened 1-gallon container of Lemon Juice 50% full. The Lemon Juice was not refrigerated. On the bottle label manufacturer printed refrigerate after opening. V5 read the label out loud and stated the lemon juice should be stored in the refrigerator, not on the shelf. V5 stated, that container will be thrown out right away. On 07/23/24, facility provided list of diet orders for residents receiving an oral diet in the facility printed 07/23/24 at 02:46 PM. On 07/23/24, facility provided list of residents on NPO (Nothing by Mouth) Diets indicating there are four residents receiving nothing by mouth (NPO). Facility provided document titled Hairnets and Hair Coverings which document in part, all employees working in the kitchen must have their hair covered by hair net or cap and all mustaches and beards must have a beard covering and hairnets are required to be worn in the kitchen all times. Facility provided policy Culinary Experience Sanitation and Infection Control undated which documents in part, 1.) Sanitation and Infection Control techniques will be implemented by the Culinary Services Department to protect food from contamination and spoilage; to ensure vermin control; to maintain physical plant and equipment in a clean and sanitary manner; and to prevent the transmission of infections. 2.) All storage areas, freezers and refrigerators should be cleaned and sanitized on a regularly scheduled basis. 3.) Refrigerator and freezer should be cleaned regularly and free from food debris or spillage. Gaskets, shelving and fan covers should be checked occasionally for mildew and food build-up. 4.) All open nonperishable food products must be labeled, dated, and used within 30 days of opening or following the manufacturer's label suggestions. 5.) Dry goods should be placed in plastic containers, sealed and labeled after being opened. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility provided policy titled, Food Storage dated June 2023 documents in part that all food products will be stored under proper conditions of sanitation, temperature, light, moisture, ventilation and security and to meet all federal and state guidelines and protecting the safety of the resident from any cross contamination of food born illnesses; all refrigeration equipment is thoroughly scrubbed weekly and cleaned daily; and all exposed foods should be stored tightly covered.

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or get specialized rehabilitative services as required for a resident. 50057 Based on observation, interview and record review, facility failed to follow provider orders and provide speech evaluation for one resident (R176) out of a sample of seven residents (R31, R63, R106, R131, R133, R176, R488). Findings On 07/23/24 at 10:35 AM R176 stated I was expecting to get speech therapy on a regular basis, but I don't know if I should be expecting that. R176 stated that R176 has had multiple strokes. R176 stated I don't recall getting speech therapy. I have been to physical therapy. On 07/23/24 at 12:41 PM review of the orders for R176 includes Speech Therapy to Evaluate and Treat. Order was written on 5/22/2024. Order for Speech Therapy was signed by V53 (Physician) on 6/19/2024. On 7/23/2024 at 3:20 PM V52 (Director of Rehabilitation Services) stated that physical therapy (PT) services ended for R176 on 6/17/2024, occupational therapy (OT) services for R176 ended on 6/13/2024, and R176 did not have speech therapy. V52 stated that R176 was admitted to the facility for skilled therapy. V52 stated that upon new resident admission, a speech therapy evaluation or screen is performed for all residents. V52 stated that for R176, a speech therapy screening was performed and an evaluation and/or speech therapy was not indicated. V52 stated that screens are not documented in the electronic health record. They are kept in paper format in a binder. When surveyor asked for a copy of R176's speech therapy screen, V52 stated I will need to find it and get it to you. On 07/24/24 at 2 PM V52 (Director of Rehabilitation Services) stated I know that I told you yesterday that everyone gets a screen, but I looked at this case. R176 is on a regular diet. We don't do evaluations if the resident is on a regular diet. V52 stated If a resident comes in on a regular diet, they don't warrant a speech evaluation. Surveyor and V52 reviewed R176's order for speech therapy in the electronic health record. On 5/22/2024, an order for speech therapy to evaluate and treat was entered. The order was signed by the V53 (Physician) on 6/19/2024. V52 stated But it was a standing order for speech. The purpose of speech is to address swallow problems. What needs to be figured out if whether the order needs to come out (of the EMR). V52 stated Screens for speech are related to swallowing. Speech Therapy screening is triggered by an altered diet. On 07/24/24 at 2:15 PM A1 (Administrator) stated We follow provider orders V1 stated We have standing orders, but they should be followed. If an order cannot be followed or is not in the best interest of the resident, we should reach out to the physician to discuss. 07/24/24 03:07 PM V1 (Administrator) stated We are seeing R176 today for a speech therapy screening. On 7/25/2024 at 12:27 PM facility provided the Speech Language Pathology / Minimum Data Set Communication Worksheet dated 7/24/2024 for R176. In category A on the form, the question is Is a neuro dx the primary reason for the SNF stay? The question is answered no. Under recommendations on the form, the recommendation is Speech Language Pathology Evaluation for Speech/Language/Voice. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/2024 at 12:46 PM V1 (Administrator), V2 (Director of Nursing), V52 (Director of Rehabilitation Services), and V38 (Speech Language Pathologist) were interviewed. V52 stated that the Speech Language Pathology / Minimum Data Set Communication Worksheet is the screening tool. The clinical category (section A) of the form is the section related to a neuro diagnosis. When V38 was asked what would constitute a neuro diagnosis, V38 stated I don't have a direct answer for you. V38 stated that for the clinical category section of the form, the neuro diagnosis for R176 should probably be yes. V38 stated R176 has a diagnosis of Cerebrovascular Accident (CVA) so the answer should be yes. For section D: Swallowing Disorder V38 stated We do not do a swallow evaluation. R176 came in on a regular diet, so we have no indication that any of the disorders in Section D are triggered. V52 stated that if a resident comes in on a regular diet, Section D is answered as none of the above. V52 stated Screens are hands-off approaches so we are only looking to see if there is anything that will trigger an evaluation. V38 stated that for R176 the recommendation is an evaluation based on R176's presentation in the screening. When asked for clarification of R176's presentation that created a recommendation that a speech language pathology evaluation be completed, V38 stated R176 demonstrated deficits in attention, speech, language. That was the trigger for the evaluation. R176's evaluation will be completed on Monday. On 7/25/2024 at 2:56 PM V2 (Director of Nursing) provided the Speech Therapy Evaluation and Plan of Treatment dated 7/25/2024 for R176. The evaluation documented that objective progress and short-term goals were established based on the evaluation. The document stated that treatment approaches may include: Speech and hearing therapy and evaluation of speech sound production and language assessment. Frequency was three times per week. Duration was forty-one days. Intensity was daily. Certification period was 7/25/2024 to 9/3/2024. Short term goal number one was: Patient will recall new information, up to three elements with seventy-five percent of opportunities in order to participate in higher level of cognitive-communicate tasks. Target date is 8/14/2024. Baseline is fifty percent. Prior level of functioning was one hundred percent. Short term goal number two was: Patient will use WRAP strategies for new coding novel two-three part content parcels with MAX speech language pathology (SLP) to eighty percent accuracy for coding and retrieval after five minute latency. Target date is 8/7/2024. Baseline is moderate changes in coding and recall. Prior level of functioning was within functional limits (WFL) Short term goal number three was: Patient will perform functional planning tasks with seventy-five percent accuracy in order to facilitate ability to live in environment with least amount of supervision/assistance. Target date is 8/7/2024. Baseline is fifty percent. Prior level of functioning was one hundred percent. Short term goal number four was: Patient will demonstrate adequate cognitive-communicative skills as evidenced by ability to complete age-appropriate complex living tasks ninety-one to one hundred precent of the time. Target date is 8/7/2024. Baseline is seventy-six to ninety percent. Prior level of functioning was ninety-one to one hundred percent. Long term goal number one was: Patient will demonstrate adequate cognitive-communicative skills as evidenced by ability to complete age-appropriate complex living tasks ninety-one to one hundred percent of the time. Target date is 9/3/2024. Baseline is seventy-six to ninety percent. Prior level of functioning was ninety-one to one hundred percent. R176's desired change in condition risk area, which is a lack of a place to live, is that R176 needs assistance to find a place to live. The focus of the plan of treatment is restoration. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/25/2024 at 3:27 PM V52 (Director of Rehabilitation Services) stated that V38 (Speech Language Pathologist) was not available. V52 stated that WRAP strategies are memory strategies. V52 stated It means Write it down, Repetition and Routine, Association and Picture it. The sentence Patient will use WRAP strategies for new coding novel two-three part content parcels with MAX speech language pathology (SLP) to eighty percent accuracy for coding and retrieval after five minute latency means that if someone has a sequencing task with pictures or by memory, where they need to put something in order or sequence, it is how well the patient can do something in sequence. V52 stated If V38 gave a story, she is saying that the resident should be able to repeat that story with eighty percent accuracy. R176's baseline was moderate changes in coding and recall. Moderate changes means that R176 was averaging fifty percent and V38 wants R176 to increase to eighty percent accuracy. V52 stated WFL means within normal limited. V52 stated that she did not know why MAX was capitalized. It means maximum. V52 stated that the treatment plan is based on the computer system. Even though it states that the treatment plan may include, V52 stated That is R176's treatment plan. V52 stated The computer system automatically writes it as 'may include'. R176's speech therapy will be three times per week. The intensity of daily means that R176 will receive speech therapy three times a week once a day. V52 stated that baseline is what V38 observed today. V52 stated that prior level of functioning is determined based on chart review and patient interview. When V52 was asked if the delay in ordering speech therapy on 5/22/2024 and the speech therapy evaluation on 7/25/2024 would have a negative impact on R176, V52 stated I can answer that by saying that when we look at prior level of functioning, it may have been in the past or on the day of admission. Prior level of functioning means prior to coming to the facility. For a stroke patient, prior level of functioning may have been five years ago. The prior level of functioning is often gathered from chart review and the patient as to how they were functioning prior to coming to the facility. You are trying to piece the information together because it may not be accurate. Some of it is clinical judgement. When V52 was asked, With cognition changes, would a 2-month delay in starting speech therapy negatively impact a resident? V52 stated There is not a way to say yes or no. R176 had intervention with physical therapy and occupational therapy. I say that because if we had seen a concern in physical therapy or occupational therapy, we would have addressed it. There is an overlap in cognition assessment with occupational therapy, so speech therapy assessment is part of the occupational therapy assessment. In occupational therapy, there were not glaring issues in R176's cognition. Policy titled Medication and Treatment Order Policy dated February 2014 stated in part: Policy Specifications: 12. If a treatment, test of another intervention is included in a protocol that has been reviewed and approved by the Medical Director, then a licensed nurse may write a verbal order for a situation that is covered by the protocol. Otherwise, no one should write verbal orders or sign a physician's name to an order that is not based on a conversation with the physician or a faxed order. 16. Interruptions in the delivery schedule, when known, will be communicated to the prescribing physician. Policy titled Standing Orders (Optional) dated 10/25/2014 stated in part: Policy: Certain, common, self-limited standing conditions are often amenable to treatment with nonprescription medications, using good nursing judgement. To facility prompt treatment of such conditions and to avoid unnecessary telephone calls to prescribers who approve, standing orders are used. Standing orders cannot be utilized for controlled substances. (continued on next page)

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F 0825 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy titled Rehabilitation Screens last revised 1/30/2023 stated in part: Policy: The Rehabilitation Department should perform screenings on patients to identify change in function in coordination with the patient's Minimum Data Set (MDS) review schedule, when triggered by the Quality Measures Report, when a change in status has been identified and reported by an interdisciplinary team member, or if a resident has been newly admitted to the facility. Procedure: 1. Performed at admission based on clinical need.

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	145977	A. Building B. Wing	07/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
South Shore Rehabilitation	2425 East 71st Street Chicago, IL 60649

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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 update infection prevention and control policies at least annually resulting in current policies and procedures dating as far back as 2006. This failure has the potential to affect all residents at the facility. The facility also failed to ensure shared equipment was sanitized between each use for 3 [R62, R106, R129] of 4 [R127] residents reviewed for medication administration observation. Findings On 07/23/24 at 02:14 PM infection prevention and control policies were reviewed. Policy titled Infection Control Protocol for All Nursing Procedures was revised January 2019. Policy titled Blood and Body Fluids Exposure was revised August 2008. Policy titled Cleaning Spills or Splashes of Blood or Body Fluids was revised December 2006. Policy titled Exposure Classification or Tasks and Procedures was revised December 2006. Policy titled Exposure Determination was revised December 2006. Policy titled Handwashing/Hand Hygiene Policy had an effective date of March 2020. Policy titled Hepatitis B Vaccination was revised August 2008. Policy titled HIV Antibody Testing was revised August 2006. Policy titled Influenza and Pneumococcal Immunizations had an effective date of November 2016. Policy titled Laundry and Bedding, soiled was revised August 2008. Policy titled Needlesticks and Cuts was revised December 2006. Policy titled Sharps Disposal was revised August 2008. Policy titled Standard Precautions was revised December 2006. Policy titled Vaccination of Residents was revised August 2008. Policy titled Visitation, Infection Control During was revised August 2008. On 07/23/24 at 3:20 PM V4 (Infection Prevention Nurse) stated that infection control policies are revised and updated yearly. When surveyor stated that the policies that were presented were dated as far back as 2006, V4 stated, Our corporate consultant sent those. On 07/24/24 at 10:14 AM V2 (Director of Nursing) was asked about the policy review process at the facility. V2 stated, I have already spoken to V4 (Infection Prevention Nurse). Policies get reviewed at the corporate level and corporate sends us the policy to us. 45110 On 7/23/24 at 9:25AM, Surveyor observed V11 [Licensed Practical Nurse] during medication administration. On 7/23/24 at 9:26 AM, V11 obtained R129's blood pressure with a manual blood pressure device that was on top of the medication cart. After use, V11 then placed the manual blood pressure device back on top the medication cart and did not sanitize the blood pressure device. On 7/23/24 at 9:33 AM, V11 obtained R106's blood pressure with the same blood pressure device without sanitizing the device blood pressure device. V11 then placed the manual blood pressure device back on top the medication cart and did not sanitize the blood pressure device. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/23/24 at 9:46 AM, V11 used the manual blood pressure cuff, to obtain R62's blood pressure without sanitizing the device. V11 then placed the manual blood pressure device back on top the medication cart and did not sanitize the blood pressure device. On 7/23/24 at 10:05 AM, V11 stated, I forgot to sanitize the blood pressure device. I have the wipes, but I just forgot to use the wipes. I need to clean the blood pressure device between residents to prevent the spread of possible infections. On 7/24/24 at 1:10 PM, V2 [Director of Nursing] stated, The nurses must sanitize all shared medical equipment before and after each use between each resident. If the nurse does not sanitize the equipment, it could potentially spread infection from one resident to the next resident, not provided infection control. Policy-Document in part: Cleaning, Disinfecting, and Maintaining Durable Medical Equipment -Medical equipment must be disinfected between each resident's use.

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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. 50057 Based on observation, interview, and record review the facility failed to follow facility policy and standards of professional practice in the timely education and/or administration of pneumococcal vaccine for two residents (R176, R488) out of seven residents in the sample (R31, R63, R106, R131, R133, R176, R488). Findings On 07/23/24 11:20 AM V4 (Infection Prevention Nurse) stated that resident education, resident consent, resident declination, and resident vaccination of the pneumococcal and/or influenza vaccines will be documented under immunizations in the electronic health record. On 7/23/2024 at 12 PM, the electronic health record of R31, R63, R106, R131, R133, R176, R488 were reviewed. Under the immunization record in the electronic health record, there was observed to be no education, consent, or declination of the pneumococcal vaccine for R488. There was a signed consent for R176 but no pneumococcal vaccination administration. On 07/23/24 at 3:20 PM V4 (Infection Prevention Nurse) stated that upon admission of a new resident, the staff and V4 assess what vaccines the resident has had or has not had and if the resident is due for vaccines. If the resident is due for a vaccine, nurses educate the resident or resident representative and resident consents or declines the vaccine after education. V4 stated, I get all signed consents and we have a company that come out to give the vaccines every few months. There must be a clinic who gives the residents their vaccines. The clinic does multiple vaccinations. They do not come out for only 1 vaccine. Our last clinic was in November 2023. When V4 was asked about any residents who were admitted since November 2023, V4 stated that the nurses or V4 will then give the vaccine. V4 and surveyor reviewed the immunization record of R176. V4 stated, R176 consented to the pneumococcal vaccine on 5/22/2024, but I did not get the consent and I was not aware that R176 needed the vaccine. R176 also does not have an order. R176 did not get the vaccine. On 7/24/2024 at 9:24 AM V4 (Infection Prevention Nurse) and surveyor reviewed the electronic health record of R488. V4 stated, R488 does not have anything about the pneumococcal vaccine. R488 did not consent or decline the vaccine. I will follow up. V4 stated R176 will get the pneumococcal vaccine. The facility will need to pay for it. V4 stated that V4 would administer the vaccine as soon as it arrived which she believed would be in the afternoon on 7/24/2024. On 7/24/2024 at 9:45 AM V2 (Director of Nursing) stated that residents are evaluated for the pneumococcal vaccine upon admission. V1 stated V4 (Infection Prevention Nurse) get the consent for pneumococcal vaccination. The education is on the consent. Residents can refuse to be vaccinated. V2 stated that if a resident consents to the influenza or pneumococcal vaccine, the facility administers the vaccine after consent is obtained. Influenza and Pneumococcal Immunizations Policy effective date 2016 stated in part: (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: To assure that each resident receives education regarding the benefits and potential side effects before being offered influenza and pneumococcal immunizations and securing their informed consent for administration of these immunizations. Policy Specifications: 1. Each resident, or when appropriate their resident representative, will be educated regarding the benefits and potential side effects of both influenza and pneumococcal immunizations and will be provided the opportunity to accept or refuse. 2. While each resident will be offered these immunizations, residents excluded from the immunization process will be those for whom the immunizations are medically contraindicated or those who have already been immunized during the standard of practice time periods: Influenza - Annually from October 1 to March 31. Pneumococcal- Five years. 3. The facility will document both the education provided and the resident's decision, or when appropriate that of the resident representative, to accept or refuse the offered immunizations that will be maintained in the resident's clinical record.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. 50057 Based on observation, interview and record review the facility failed to maintain effective pest control as evidenced by flying insects visualized both in resident rooms and common areas in the facility. This failure had the possibility of affecting the one hundred and eighty-four residents at the facility. Findings: On 07/23/24 at 9:29 AM V24 (Licensed Practical Nurse) stated that she tries to have the Certified Nurses Aides (CNA) get food trays picked up quickly after meals so that there are no fruit flies. V24 stated that she saw fruit flies on one occasion a few years ago in the unit kitchenette area. On 07/23/24 at 9:34 AM V32 (Certified Nurses Aide) stated, In the summer, we have seen a fly here and there if there are windows open. On 07/23/24 at 9:40 AM - V39 (Housekeeping) stated, We have little gnats. I let V40 (Maintenance Director) know when I see one so that V40 can call pest control. As surveyor was speaking to V39, a flying insect flew by the surveyor's face. V39 stated, I just saw one. It just flew by your head. It looked like a little gnat. It is only common in the hot months. On 07/23/24 at 9:55 AM - Flying insects were observed in the conference room provided to the surveyors by the facility. Flying insects were also observed in the ground floor hallway outside of the conference room. On 7/23/2024 at 10:58 AM R133 was observed to have a flying insect on R133's bed linen and an insect flying around R133's head. On 07/23/24 at 11:09 AM V40 (Maintenance Director) stated the facility has an outside vendor come to the facility every 2 weeks. V40 stated, We have had some gnats and a roach here and there. V40 stated the outside vendor just dropped off fly and gnat catchers. V40 stated that V40 also bought drain cleaner to treat the sewer lines. On 07/24/24 at 8:33 AM V40 (Maintenance Director) stated, They finally send me the drain fluid so that I can address the drains and the flies and gnats. When V40 was asked if the outside vendor was aware that there are flies and gnats throughout the facility, V40 stated, Yeah. They are a little behind. On 7/24/2024 at 9 AM flying insects were observed in the conference room provided to surveyors by the facility. On 7/24/2024 at 11:30 AM V54 (Director of Housekeeping) was asked about pest control. V54 stated, I am glad that you brought that up. We recently met and are working it out. When asked when the meeting took place, V54 stated, Yesterday. (continued on next page)

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 7/24/2024 at 11:42 AM a woman who appeared to be a visitor was observed at the first-floor elevator swatting the air around her head. The woman stated, Oh, these gnats. A flying insect was observed around the right side of the women's face. Review of outside agency pest control report 7/8/2024 - General comments: Report of flies and gnats in resident rooms. Fruit flies found in 2 areas. Pest totals: 26 7/3/2024 - General comments: In addition to the regular service flies and gnats in resident room, first floor dining room and kitchen. 3/4/2024: General Comments: Gnats sighted on 4th floor dining room in additional to regular service. Fruit flies 2 areas. Total Pests: 14. German Roaches in 1 area. Total pests: 7 2/15/2024: Fruit flies in 1 area. Total Pests: 5 Document titled Guideline for Pest Control effective date 11/1/2023 stated in part: Purpose: The facility maintains an effective pest control program to remain free of pests and rodents.