STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145995	A. Building B. Wing	03/27/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Archer Heights Healthcare	4437 South Cicero Chicago, IL 60632

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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. 41611 Based on observation, interview,and record review the facility failed to ensure the call light device for two residents (R35, R41) were within reach of the residents. This failure affected two residents (R35, R41) and has the potential to affect all residents in the sample size of 128. Findings include: R35 has a diagnosis of but not limited to Bilateral Primary Osteoarthritis of knee, Paralytic Syndrome, Hemiplegia and Hemiparesis, Vascular Dementia, Peripheral Vascular Disease and Major Depressive Disorder. R35 has a Brief Interview of Mental Status score of 09. R35's care plan focus for self-care deficit (ADLs/Mobility) dated 1/06/2025 documents, in part, Call light within reach; encourage resident to use prior to attempting self-care. R35's Call light Ability Screen dated 6/01/2023 documents, in part, resident is unable to use the call light due to physical limitations and if resident is unable to use the call light what alternative type of light or device will be put in place. This question was left blank. R35's Minimum Data Set section GG dated 01/03/2025 documents, in part, Functional Limitation in Range of Motion: Upper extremities (shoulder, elbow, wrist, hand): Impairment on one side. On 3/24/2025 at 11:03am surveyor observed R35's call light on the floor behind her bed where she could not reach it. On 3/24/2025 at 11:03am R35 stated that she can push the call light button if the call light was within reach. R41 has a diagnosis of but not limited to dementia, protein-calorie malnutrition, intracapsular fracture of left femur, sequela, hypertension, and abnormalities of gait and mobility. R41 has a Brief Interview of Mental Status score of 00. R41's Call light Ability Screen dated 1/30/2023 documents, in part, RESIDENT IS ABLE TO USE THE CALL LIGHT. (continued on next page)

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

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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	R41's care plan focus for self-care deficit (ADLs/Mobility) dated 1/23/2024 documents, in part, Call light within reach; encourage resident to use prior to attempting self-care. R41's Minimum Data Set section GG dated 03/17/2025 documents, in part, Functional Limitation in Range of Motion: Upper extremities (shoulder, elbow, wrist, hand): No Impairment. On 3/24/2025 at 11:06 am surveyor observed R41's call light on the floor underneath the bed. On 3/24/2025 at 11:19am V4 (Registered Nurse) stated the call light should be within reach of the resident. On 3/26/2025 at 12:56pm V2 (Director of Nursing) stated the call light should be attached to the bed and within reach of the resident at all times. Call light policy with a revision date of 1/2025 documents, in part, all call lights will be answered by staff within a reasonable time and 1. all residents shall have the nurse call light system available and within easy accessibility to the resident at the bedside or other reasonable accessible location.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 50662 Based on observation, interview, and record review, the facility failed to ensure that housekeeping and maintenance services necessary to maintain a sanitary and comfortable environment were provided for four residents (R18, R27, R129, and R180). This failure affected the four residents reviewed for homelike environment in a total sample size of 128 residents. Findings include: R27's diagnoses include but are not limited to anxiety disorder, chronic systolic heart failure, atrial fibrillation, and essential hypertension. R27's Brief Interview for Mental Status (BIMS) dated 01/13/15 has a sore of 15, which indicates R27's cognition is intact. On 03/24/25 at 11:04am R27 stated that his room is cleaned sometimes but not often. R129's diagnoses include but are not limited to cerebral infarction, essential hypertension, schizoaffective disorder bipolar type, and primary osteoarthritis. R129's BIMS dated 03/06/25 has a score of 10, which indicates R129's cognition is moderately impaired. On 03/24/25 at 10:46am observed R129's closet missing one door and dresser missing top drawer. On 03/24/25 at 11:04am observed R27 and R129's bedroom floor with dark black stains and privacy curtain stained with multiple brown spots. On 03/24/25 at 11:31am V25 (Housekeeper) stated that R27's and R129's floor has dirt and trash on it. V25 stated that he is unsure of what is on the privacy curtain. V25 stated that either housekeeping or maintenance can change the privacy curtains. V25 stated that R129 is missing a closet door and a dresser drawer and that R129 should have both. 03/26/25 12:59 PM R180 room dirty with stains on floor. No bedsheets on bed. R18 has a diagnosis of but not limited to Type 2 Diabetes Mellitus, Dietary Folate Deficiency Anemia, Encounter for Screening for Nutritional Disorder, and Alzheimer's Disease. R18's Physician Order Summary documents, in part, Nothing by Mouth (NPO), Enteral Feed Order. On 3/24/2025 at 11:50am surveyor observed a dried brown substance covering R18's entire g-tube (gastrostomy tube) pole and gray dust-like particles covering the oxygen concentrator. On 3/26/2025 at 12:27pm surveyor observed a dried brown substance covering R18's entire g-tube pole and gray dust-like particles covering the oxygen concentrator. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/26/2025 at 12:27pm V12 (Licensed Practical Nurse) stated its probably g-tube feeding on the pole and dust on the oxygen concentrator. V12 also stated she (V12) thinks housekeeping is responsible for cleaning the g-tube pole and the oxygen concentrator. On 3/26/2025 at 12:56pm V2 (Director of Nursing) stated housekeeping, nurses and Certified Nursing Assistants are responsible for cleaning the g-tube and oxygen concentrator. Equipment Change Schedule Policy dated 5/2024 documents, in part, 5. IV Poles and Feeding Pumps a. Wash IV poles and empty feeding pumps weekly and prn. Facility's policy titled Residents' Rights for People in Long-Term Care Facilities dated 11/18 documents in part, Your rights to dignity and respect .Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life .Your rights to safety .Your facility must be safe, clean, comfortable and homelike. Facility's policy titles Safe, Clean, Comfortable and Homelike Environment dated 10/2024 documents in part, Policy: The facility will provide a safe, clean, comfortable, and homelike environment to the residents while taking into consideration a person-centered care, where residents' independence is promoted .Purpose: To ensure that the facility remains a pleasant place to live. To ensure that the facility is cleaned on a regular basis according to the federal/state guideline .Procedure: 1. The facility will be kept clean and well-maintained through regular cleaning schedule, preventive maintenance program, and repair or enhancement of existing structures, systems, and fixtures. 2. Promote a homelike environment by .a. Keeping the residents' room clear of debris, clutter, or spills and free of odors .F. Having a privacy curtain that is clean and good condition. Facility's job description titled Housekeeping Assistant dated 7/24 documents in part, Job Summary: The primary purpose of this job is to perform the day-to-day activities of the Housekeeping Department in accordance with current federal, state, and local standards, guidelines, and regulations governing the facility, and as may be directed by the Administrator and/or the Director of Housekeeping, to assure that the facility is maintained in a clean, safe, and comfortable manner .Main Duties: .4. Clean floors, to include sweeping, damp/wet mopping, stripping, waxing, buffing, and disinfecting in accordance with proper safety precautions . 7. Remove dirt, dust, grease, film, etc. from surfaces using proper cleaning/disinfecting solutions. 8. Clean/polish furnishings, fixtures, ledges, room heating/cooling units, etc. in resident rooms and common areas as instructed. 41611 45644

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50662 Based on interview and record review the facility failed to refer three residents R61, R104 and R141 to the appropriate state designated authority for a Level II PASARR (Preadmission Screening and Annual Resident Review) evaluation and determination after new mental disorder diagnoses. This deficient practice affected three residents (R61, R104, and R141) in a total sample size of 128 residents. Findings include: R141's PASARR dated 07/13/23 documents in part, Mental Health Diagnoses .No mental health diagnosis is known or suspected. R141's admitted to the facility is dated 07/17/23. R141's medical diagnoses include but are not limited to bipolar disorder (dated 07/17/23) and adjustment disorder with Mixed Anxiety and Depressed Mood (dated 07/17/23. On 03/25/25 at 12:17pm V35 (Business Office Manager) stated that every new resident should have a PASARR screening. V35 stated that the facility reviews the resident's PASARR upon admission to assure that they are correct. V35 stated that while reviewing the PASARR's, if they are not filled out correctly, the facility should initiate a new PASARR. V35 stated that R141 should have had a PASARR done that included his mental diagnoses. V35 stated that the facility is not in compliance with R141's PASARR. V35 stated that a PASARR is important to ensure that the resident is in the right kind of facility and that the facility can meet the needs of the resident. On 03/25/25 at 1:10pm V35 (Business Office Manager) stated that she initiated a new level 1 PASARR for R141 and included his mental diagnoses. V35 stated that the new level 1 PASARR triggered R141 for a level 2 PASARR. R141's PASARR screening dated 03/25/25 documents in part, PASRR Level I Determination: Refer for Level II Onsite. Suspected or confirmed PASRR Conditions: (MH) Mental Health Disability. 51772 Findings Include: R61's face sheet has an initial admitted [DATE] and the following diagnosis: Major Depressive Disorder onset date 1/11/23. Unspecified Lack of Expected Normal Physiological Development in Childhood onset date 1/10/23. Unspecified Intellectual Disabilities onset date 12/22/2022. R61's Minimum Data Set (MDS) Section C dated January 9, 2025, has a Brief Interview of Mental Health score of 1 which indicates the resident is severely cognitively impaired. R61's (MDS) D (MOOD) dated January 9, 2025, documents a severity score of 10. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R61's OBRA-I Initial screen dated 4/21/2017 documents No reasonable basis for suspecting Developmental Disability (DD) or Mental Illness (MI). R61's Pre-admission Screening and Resident Review (PASRR) Level I Outcome dated 12/12/2023 documents suspected or confirmed PASRR Condition: (ID) Intellectual Disability and (DD/RC) Developmental Disability/Related Condition and No mental health diagnosis is known or suspected. R61's Pre-admission Screening and Resident Review (PASRR) Pro Level II Screen dated 10/25/22 documents Exempted Hospital Discharge In State Review. R61's Physician Order Sheet documents R61 is prescribed Remeron (Mirtazapine) for Situational Depression with a start date of 3/24/25. R61's Care Plan dated 1/16/2025 documents no focus related to Major Depressive Disorder, but documents resident is at risk for mistreatment by peers related to diagnosis of dementia. R104's Face Sheet documents an original admitted [DATE] and an admitted [DATE]. R104's Face Sheet documents a diagnosis of Dementia without behavioral disturbance with an onset date of 7/19/20222 and a diagnosis of Major Depressive Disorder, single episode, unspecified with an onset date of 7/13/2021. R104's Minimum Data Set, dated dated dated [DATE] Section C documents a Brief Interview for Mental Status Score (BIMS) of 7 which indicates the resident is cognitively impaired. R104's Physician Order Sheet Report with active orders as of 1/23/2025 document, in part, Remeron Oral Tablet 15mg: Give 1 tablet by mouth at bedtime related to Major Depressive Disorder. R104's OBRA-I Initial Screen dated 7/15/2021 documents No reasonable basis for suspecting (DD) Developmental Disability and (MI) Mental Illness. On 3/24/2025 at 10:00 am record review of the PASRR I and PASRR II were not documented in the Electronic Health Record Point Click Care Software. On 03/25/2025 at 11:06M, surveyor requested V1 the PASRR Level I and PASRR Level II from R104. At 2:24pm, R104's PASRR Level I was received via email with a Notice of PASRR Level I Outcome that reads Refer for Level II Onsite due to Suspected or Confirmed PASRR Condition (s): (MH) Mental Health Disability dated 3/25/2025. On 3/26/2025 at 12:39 pm, V35 (Business Office Manager -BOM), stated V35's role with the Pre-admission Screening and Resident Review (PASRR) to submit the resident's PASRR when the PASRR is expiring and when there is a change in diagnosis or condition. V35 stated when a resident has a new mental health diagnosis, V35 submits a PASRR Level I to trigger a PASSR level 2 and Maximus determines when they will conduct the PASRR Level II Screening on site. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/2025 at 12:44pm, V22 (Social Services Director -(SSD) stated V22's role is to assist with supportive living and sending referrals. V22 stated the staff does not have to be a nurse to request a Preadmission Screening for Resident Review (PASRR). V22 stated, V22 does not submit PASRR Level I or PASRR Level II. On 3/26/25 at 3:43pm, V35 (Business Office Manager -(BOM), stated V35 submitted a Preadmission Screening and Resident Review (PASRR) Level I on 12/12/2023 because R61 obtained a new diagnosis of Major Depressive Disorder. V35 verified R61's Census Profile Face Sheet documents a diagnosis of Major Depressive Disorder on 1/11/23. On 3/26/2025 at 3:48 pm, V35, Business Office Manager (BOM), stated R104 was admitted before Maximus launched, so she has an OBRA-I and if there is a change in condition then a Preadmission Screening and Resident Review (PASRR) Level I is required to trigger a PASRR Level II. V35 verified R104's OBRA-I Initial Screen dated 7/13/21 documents No reasonable basis for suspecting (DD) Developmental Disability and (MI) Mental Illness and R104's Face Sheet documents a diagnosis of Major Depressive Disorder with an onset date of 7/13/2021. V35 verified R104's Preadmission Screening and Resident Review (PASRR) Level I has a PASRR Level I review date of 3/25/2025. Facility undated policy title Preadmission Screening and Resident Review PASRR documents in accordance with Federal and State of Illinois regulatory standards and recommended practices, this organization requires each resident to be screened for Level 1 prior to or shortly thereafter admission (e.g., post-screen for someone out of state or coming from home). The facility will expect Maximus to properly complete the Level 2 if a PASRR condition (SMI/ID) exists.

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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** 51772 Based on observation, interview, and record review the facility failed to ensure the completion of a new Pre-Admission Screening and Resident Review (PASARR) when a new mental health diagnosis is identified. This failure affects 3 residents (R61, R104, and 141) out of a sample of 128. Findings Include: R61's face sheet has an initial admitted [DATE] and the following diagnosis: Major Depressive Disorder onset date 1/11/23. Unspecified Lack of Expected Normal Physiological Development in Childhood onset date 1/10/23. Unspecified Intellectual Disabilities onset date 12/22/2022. R61's Minimum Data Set (MDS) Section C dated January 9, 2025, has a Brief Interview of Mental Health score of 1 which indicates the resident is severely cognitively impaired. R61's MDS Section D (MOOD) dated January 9, 2025, documents a severity score of 10. R61's OBRA-I Initial screen dated 4/21/2017 documents No reasonable basis for suspecting Developmental Disability (DD) or Mental Illness (MI). R61's Pre-admission Screening and Resident Review (PASRR) Level I Outcome dated 12/12/2023 documents suspected or confirmed PASRR Condition: (ID) Intellectual Disability and (DD/RC) Developmental Disability/Related Condition and No mental health diagnosis is known or suspected. R61's Pre-admission Screening and Resident Review (PASRR) Pro Level II Screen dated 10/25/22 documents Exempted Hospital Discharge In State Review. R61's Physician Order Sheet documents R61 is prescribed Remeron (Mirtazapine) for Situational Depression with a start date of 3/24/25. R61's Care Plan dated 1/16/2025 documents no focus related to Major Depressive Disorder, but documents resident is at risk for mistreatment by peers related to diagnosis of dementia. On 3/26/25 at 3:43pm, V35 (Business Office Manager -(BOM), stated V35 submitted a Preadmission Screening and Resident Review (PASRR) Level I on 12/12/2023 because R61 obtained a new diagnosis of Major Depressive Disorder. V35 verified R61's Census Profile Face Sheet documents a diagnosis of Major Depressive Disorder on 1/11/23. R104's Face Sheet documents an original admitted [DATE] and an admitted [DATE]. R104's Face Sheet documents a diagnosis of Dementia without behavioral disturbance with an onset date of 7/19/20222 and a diagnosis of Major Depressive Disorder, single episode, unspecified with an onset date of 7/13/2021. R104's Minimum Data Set (MDS) dated [DATE] Section C documents a Brief Interview for Mental Status Score (BIMS) of 7 which indicates the resident is cognitively impaired. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R104's Physician Order Sheet Report with active orders as of 1/23/2025 document, in part, Remeron Oral Tablet 15mg: Give 1 tablet by mouth at bedtime related to Major Depressive Disorder. R104's OBRA-I Initial Screen dated 7/15/2021 documents No reasonable basis for suspecting (DD) Developmental Disability and (MI) Mental Illness. On 3/26/2025 at 3:48 pm, V35, Business Office Manager (BOM), stated R104 was admitted before Maximus launched, so she has an OBRA-I and if there is a change in condition then a Preadmission Screening and Resident Review (PASRR) Level I is required to trigger a PASRR Level II. V35 verified R104's OBRA-I Initial Screen dated 7/13/21 documents No reasonable basis for suspecting (DD) Developmental Disability and (MI) Mental Illness and R104's Face Sheet documents a diagnosis of Major Depressive Disorder with an onset date of 7/13/2021. V35 verified R104's Preadmission Screening and Resident Review (PASRR) Level I has a PASRR Level I review date of 3/25/2025. On 3/24/2025 at 10:00 am record review of Preadmission Screening and Resident Review (PASRR I and PASRR II) were not documented in the Electronic Health Record Point Click Care Software. On 3/25/2025 at 11:06M, Preadmission Screening and Resident Review (PASRR) Level I and (PASRR) Level II were requested from V1, Administrator. At 2:24pm, R104's PASRR Level I was received via email with a Notice of PASRR Level I Outcome that reads Refer for Level II Onsite due to Suspected or Confirmed PASRR Condition (s): (MH) Mental Health Disability dated 3/25/2025. 50662 Findings include: R141's PASARR dated 07/13/23 documents in part, Mental Health Diagnoses .No mental health diagnosis is known or suspected. R141's admitted to the facility is dated 07/17/23. R141's medical diagnoses include but are not limited to bipolar disorder (dated 07/17/23) and adjustment disorder with Mixed Anxiety and Depressed Mood (dated 07/17/23. On 03/25/25 at 12:17pm V35 (Business Office Manager) stated that every new resident should have a PASARR screening. V35 stated that the facility reviews the resident's PASARR upon admission to assure that they are correct. V35 stated that while reviewing the PASARR's, if they are not filled out correctly, the facility should initiate a new PASARR. V35 stated that R141 should have had a PASARR done that included his mental diagnoses. V35 stated that the facility is not in compliance with R141's PASARR. V35 stated that a PASARR is important to ensure that the resident is in the right kind of facility and that the facility can meet the needs of the resident. On 03/25/25 at 1:10pm V35 (Business Office Manager) stated that she initiated a new level 1 PASARR for R141 and included his mental diagnoses. V35 stated that the new level 1 PASARR triggered R141 for a level 2 PASARR. R141's PASARR screening dated 03/25/25 documents in part, PASRR Level I Determination: Refer for Level II Onsite. Suspected or confirmed PASRR Conditions: (MH) Mental Health Disability. (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/26/2025 at 12:39 pm, V35 (Business Office Manager -BOM), stated V35's role with the Pre-admission Screening and Resident Review (PASRR) to submit the resident's PASRR when the PASRR is expiring and when there is a change in diagnosis or condition. V35 stated when a resident has a new mental health diagnosis, V35 submits a PASRR Level I to trigger a PASSR level 2 and Maximus determines when they will conduct the PASRR Level II Screening on site. On 3/26/2025 at 12:44pm, V22 (Social Services Director -(SSD) stated V22's role is to assist with supportive living and sending referrals. V22 stated the staff does not have to be a nurse to request a Preadmission Screening for Resident Review (PASRR). V22 stated, V22 does not submit PASRR Level I or PASRR Level II. Facility undated policy title Preadmission Screening and Resident Review PASRR documents in accordance with Federal and State of Illinois regulatory standards and recommended practices, this organization requires each resident to be screened for Level 1 prior to or shortly thereafter admission (e.g., post-screen for someone out of state or coming from home). The facility will expect Maximus to properly complete the Level 2 if a PASRR condition (SMI/ID) exists.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 45644 Based on observations, interviews, and record review the facility failed to follow wound care treatment orders. This failure affected one resident (R138) reviewed for wounds in a sample of 128. Findings include: R138's diagnoses include but not limited to orthopedic surgical amputation, Type 2 diabetes with foot ulcers, peripheral vascular disease, absence of other left toes, atrial fibrillation, and hypertension. R138's (2/6/25) Minimal Date Set (MDS) documents in part, Section C. Brief Interview of Mental Status is 15. R138 is cognitively intact. Section M. Other ulcers, wound and skin problems: B. Diabetic foot ulcer(s). C. other open lesion(s) on the foot. On 3/24/25 at 11:15 am, observed R138 in room in bed with bilateral dressings on both great toes. Left toe dressing noted to be dirty with black dark drainage on it. Right toe dressing noted to be dirty. R138 stated that the dressings had not been changed since Friday (3/21/25) and supposed to be changed every day. R138 stated, I sometimes change the dressings myself because it drains so bad then I get the floor dirty. R138's Order Summary Report Active Orders As of 3/25/25 documents in part, Site left Plantar Hallux: Cleanse with NSS (Normal Saline Solution), pat dry, paint with soaked betadine gauze then cover with dry dressing daily and as needed for wound. Site Right great toe: Cleanse with NSS (Normal Saline Solution), pat dry, paint with soaked betadine gauze then cover with dry dressing daily and as needed. R138's (March 2025) Treatment Administration Record (TAR) documented in part, Site left Plantar Hallux: Cleanse with NSS pat dry, paint with soaked betadine gauze then cover with dry dressing daily and as needed for wound. Site Right great toe: Cleanse with NSS pat dry, paint with soaked betadine gauze then cover with dry dressing daily and as needed. Days not documented on the TAR for both treatments are 3/2/25, 3/8/25, 3/9/25, 3/10/25, 3/15/25, 3/16/25, 3/21/25, and 3/22/25. On 3/25/25 at 11:20 am, V23 Wound Care Nurse stated that the resident should not be doing their dressing changes themselves. The nurses are expected to follow wound care orders to prevent infections. On 3/25/25 at 11:25 am, V10 Wound Care Coordinator stated that R138's wound should be changed daily. On the weekends the nurses are responsible for dressing changes and the dressings should be dated and the date it was changed. I did change R138's dressings today and do not know if it was changed yesterday. On 3/25/25 1:43pm, Director of Nurses (DON) stated that if the order says change dressing daily the nurses should change the dressing daily. The residents should not be changing their own dressing. The nurses on the floor are to change the wound dressing on the weekends. (continued on next page)

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Archer Heights Healthcare	4437 South Cicero Chicago, IL 60632

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled Wound Policy dated 1/2025 documents in part, Prevention and Treatment Guidelines: 5. The goals of wound treatment are to: c. promote healing. Facility's policy titled Policy and Procedure Physician Orders Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 52136 Based on Observation, interview, and record review, the facility failed to thoroughly investigate a fall incident and implement fall interventions listed on revised care plan; and failed to ensure adequate supervision to prevent a resident from smoking in a residential room. These failures affected two residents (R65 and R172) reviewed for accidents and hazards in a sample of 128 residents. Findings include: Facility presented a list of 28 residents on fall list from the last 120 days, R65 was listed down that she had a fall on 1/3/25. R65's Face sheet dated March 25, 2025, documents that R65 was admitted to facility on September 6, 2020 with diagnosis including Polyarthritis, muscle wasting and atrophy, diabetes mellitus, dysphagia, morbid obesity, anemia, hypertension, bilateral primary osteoarthritis of knee, presence of right artificial hip joint, bipolar, schizoaffective disorder. R65's MDS (Minimum Data Set) dated January 13, 2025 section C , shows R65 has a score of 11 which means R65 has moderate cognitive impairment; section GG shows R65 requires Substantial/maximal assistance for transfers. R65's care plan dated February 5, 2025 shows that R65 is at risk for falls related to dx of Bipolar, Schizoaffective d/o and HTN. Interventions/Tasks: staff to place nonskid strip to side of the bed. On 3/24/25 at time 12:37 pm, observed R65 in bed. R65 reported that she had a fall in shower room and had bruising which resulted in pain, R65 stated that a staff member was in shower room with her assisting her with shower and helped her up off the floor after she fell . R65 stated the staff member was V43(Certified Nursing Assistant/CNA). R65 stated a nurse did not come to assess her after the fall but she (R65) was provided with pain medication when she requested it. On 3/24/25 at 2:00pm record review of R65's nursing notes in Electronic Medical Record chart did not show any documentation stating R65 had a fall on 1/31/25. Documentation in the Electronic Medical Record chart displays documentation on 2/1/25 from V4 referring to a fall incident that occurred the day prior 1/31/25 according to report she received from R65. On 3/25/25 at 12:25pm V43 (CNA) stated that she did work on 1/31/25 but was not assigned to provide care to R65, she (V43) has never picked R65 up from floor in shower. V43 stated she was not aware that R65 had a fall and if V43 had a fall she would inform the nurse right away. On 3/25/25 at 12:40pm V2 (Director of Nursing) stated if a resident falls on the floor the restorative nurse is the person that places the resident on the fall list. V2 stated she was not informed that R65 had a fall, and she expects the nurse to complete a full head to toe assessment of the resident and call the doctor for further guidance and orders. V2 stated she was not aware what date R65 had a fall. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/25/25 at 2:58pm V31 (Nursing Consultant RN) stated nurses should monitor residents for 72 hours after fall incident to assess for pain, change in condition, and any further injuries related to fall. It is my expectations that the director of nursing and her nursing team monitors and manages the care of residents who have had a fall and follow up with the physicians for further orders. V31 stated the purpose of the fall care plan is so that staff can ensure that interventions for falls are put in place and to potentially prevent falls from recurring. V31 stated a revision to the care plan should be implemented with each fall occurrence because the previous intervention may not be successful, so a new intervention is implemented, and the nurse should put fall interventions in place. V31 stated that these interventions are discussed in their facility Interdisciplinary clinical team meeting which the director of nursing and administrator both attend. V31 stated she was made aware that R65 sustained a fall on 1/31/25 and during the interdisciplinary clinical team meeting on 2/5/25 is when she revised the care plan and interventions for R65. V31 stated the date of 1/3/25 was a clerical error. On 3/26/25 at 10:00 am, V30 (Restorative Nurse)- stated R65 is a one person stand by assist for transfers from bed, but she requires x 2-person assistance if she is on the floor and maybe even a safety lift to get her off the floor. V30 stated she was not informed that R65 had a fall. On 3/26/25 at 11:30am, V34 (Licensed Practical Nurse/LPN) stated I was the assigned nurse on 1/31/25 for twelve-hour shift and no staff reported a fall to me, I was not aware R65 had a fall. On 3/26/25 at 11:44am, V44 (CNA) stated she worked on 1/31/25 but was not assigned to care for R65 and she was not made aware that she had a fall. On 3/26/25 at 12:49pm, V41 (LPN) stated I was the assigned nurse for R65 on 2/1/25 when I came on duty R65 reported she was having pain from a fall the day prior and when she assessed R65's right side there was bruising to her lower extremities. I called the nurse practitioner for orders and informed the family and the director of nursing then I completed the incident report and administered pain medication to R65. On 3/26/25 at 3:00pm, V2 and V31 went to the room of R65 and interviewed her about the fall. R65 stated she had a fall in shower room and that V43 picked her up by herself and placed her back in chair. R65 stated no nurse came to see her after the fall but she received pain medications afterwards. On 3/26/25 at 3:05pm, V2 (DON) was standing next to bed and informed the surveyor that there were no nonskid strips on either side of the bed for R65.V2 stated if that is the intervention that is on care plan then it should be on her floor. On 3/27/25 at 1:53pm, V1 emailed an electronic policy titled Falls. Policy: Titled Falls dated 6/24 Observed or unobserved and reported by staff member. Licensed nurse should conduct assessment immediately, including events leading up to the fall to determine when possible and causative factors. CNA: Call for the nurse and stay with resident, DO NOT MOVE resident, assist nurse and check the resident frequently. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	50662 Findings include: R172's diagnoses include but are not limited to psychoactive substance abuse, essential hypertension, depression, generalized anxiety, and chronic kidney disease. R172's Minimum Data Set (MDS) dated [DATE] has a Brief Interview for Mental Status (BIMS) score of 15, which indicated R172's cognition is intact. R172's care plan dated 03/0625 documents in part, I, R172, am a smoker and desire to smoke. I recognize that I will be assessed and monitored to fully manage my compliance with facility rules .I recognize that I may not be allowed to carry any smoking material and I agree not engage in any of the following behaviors: Smoking inside the facility in any area; .violating state, city, municipal smoking ordinances .I, R172, recognize that smoking is a privilege and I will comply with all rules and policies regulating smoking, including signing a smoking safety contract. On 03/25/25 at 2:05pm surveyor smelled a strong odorous smell of marijuana. Surveyor tracked smell to room XXX. Room XXX observed with the same odorous smell and a light haze of smoke. On 03/25/35 at 2:07pm R172 stated that the marijuana smell was from his clothing. R172 stated he smoked marijuana outside and had put it out and placed it in his coat pocket. On 03/25/25 at 2:10pm V21 (Social Service) stated that he smelled marijuana on the 2nd floor, and it smell as if someone was smoking. V21 stated that he seen a smoke film inside R172's room and would get another person to assist him to search R172's room. On 03/25/25 at 3:10pm V2 (Director of Nursing/DON) stated residents are not allowed to smoke marijuana in their rooms. V2 stated that if residents are getting high while out on pass privileges then their privileges will be revoked. On 03/26/25 at 11:38am V21 (Social Service) stated that he and a behavior tech searched R712's room and did not find any drug paraphernalia. V21 stated that he did see a haze of smoke, but the behavior tech disagreed with seeing smoke. V21 stated that it had took a few minutes for the behavior tech to come to the floor and R172's room door was open during this time. V21 stated that the smoke could have dissipated while he was waiting on the behavior tech to arrive to the room. V21 stated that he believes his own eyes and believes that R172 was smoking in his room. V21 stated that more frequent rounds would be made for those residents that are known smokers. V21 stated that the facility has smoking contracts with residents that smoke which consists of residents agreeing not to smoke inside their rooms. V21 stated that it is a safety hazard for residents to smoke in their rooms and could cause a fire. V21 stated that other residents may not be able to tolerate the smoke. On 03/26/25 at 12:08pm V22 (Social Service Director) stated that V21 (Social Service) never told him that he smelled marijuana or saw smoke in R172's room. V22 stated that there were no findings with the search of R172's room so they resumed normal daily activities. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's undated policy titled Facility Smoking Safety Policy documents in part, Policy Objective: To provide a safe and healthy living environment with respect for the health and well-being needs of each resident, staff member and visitor. It is also the objective of this policy to communicate to each resident that they are responsible for following each rule and on-going compliance with this policy .Guidelines: 1. Smoking is only allowed n designated areas established by management. If indoor smoking is prohibited by state or local law the interior of the facility will remain smoke-free at all times. The designated area will be outside in accordance with state/local standards .3. Smokers will be evaluated to determine their ability to comply with safety rules and their ability to carry smoking materials and safe design .4. Individual who are non-compliant potentially dangerous, exercise poor judgement and show a lack of concern for the welfare of others will be counseled accordingly. The facility maintains the right to limit and restrict access to smoking products, matches, and lighters for persons deemed unsafe. Smoking privileges will be revoked if there is a pattern of persistent, hazardous behavior .Consequences of non-compliance: 4. The facility recognizes the potential harm that may result from careless, hazardous smoking and has implemented this policy to maintain a safe living environment. Violation of this policy will be taken seriously and appropriate action will be forthcoming.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45644 Based on observations, interviews, and record reviews, the facility failed to ensure the CPAP (Continuous Positive Airway Pressure) mask was contained, failed to change oxygen tubing, failed to label humidifier bottle with dates and failed to get an doctor's order for oxygen administration. This failure affected 2 residents (R73 and R98) reviewed for oxygen therapy in a sample of 128. Findings include: R73's diagnoses include but not limited to cerebral palsy, asthma, Chronic Obstructive Pulmonary Disease (COPD), shortness of breath, dependence on Oxygen, and obstructive sleep apnea. R73's (1/2/25) Brief Interview of Mental Status (BIMS) documents a score of 15. R73 is cognitively intact. On 3/24/25 at 11:30 am observed R 73 receiving oxygen thru a nasal cannula at 3 liters. The nasal cannula tubing was dated 3/4. R73 stated I do not know how long it's been since my tubing has been changed. R73's CPAP mask was lying on the night stand uncontained. R73's Order Summary Report Active Orders As of 3/25/25 documents in part, Oxygen at 3 liters per nasal cannula every 6 hours as needed for shortness of breath related to Chronic Obstructive Pulmonary Disease . Change oxygen tubing weekly. Change Oxygen humidifier bottle weekly and PRN (As Needed) every night shifts every Sunday. Date humidifier bottle. On 3/25/25 1:43pm, V2 DON Oxygen tubing is changed once a week on Sundays on the night shift. Surveyor inquired to V2 if a tubing is dated 3/4/25. I would not say it has been changed, it should be dated the date it was changed. R73's care Plan dated 6/18/24 documents in part, Resident (R73) with diagnosis of asthma, morbid obesity, COPD, and shortness of breath. Resident requires supplemental oxygen related to comorbidities. Facility's policy titled Oxygen Administration and Storage reviewed 1/2025 documents in part, Tubing: Tubing should be changed weekly. Nasal cannula tubing may need to be changed more frequently. Facility's policy titled Equipment Change Schedule and dated 5/24, documents in part, A. Policy: Equipment will be changed following established schedules to prevent cross contamination. B. Procedure: 1. Oxygen a. Oxygen tubing, nasal cannula and masks are changed every seven (7) days and PRN (As Needed). c. Change pre-filled humidifier when water level becomes low or every seven (7) days. Facilities job description titled Charge Nurse Dated 7/24 documents in part, Main Duties: 18. At all times abide by policies of the facility . 25. Assure that established infection control and universal precautions practices are maintained when performing nursing procedures. 52136 (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/24/25 at 12:24 PM R98 was observed lying in bed resting, R98's oxygen concentrator was next to his bed and tubing was long and laying on the floor. Oxygen gauge was at 4 liters on dial. R98's face sheet dated March 25, 2025, shows R98 was admitted to the facility on [DATE] with diagnosis including Dependence on Supplemental Oxygen, anemia, long term use of anticoagulants, chronic obstructive pulmonary disease, asthma, and traumatic subdural hemorrhage. R98's MDS (Minimum Data Set) section C: dated February 3, 2025, shows R98 has a score of 14 which means R98 is cognitively intact, section O: dated February 3,2025, shows R98 with use of Respiratory treatments: Oxygen therapy while a resident. R98's care plan dated February 07, 2025 shows R98 is at risk for activity intolerance related to inadequate oxygenation and requires oxygen therapy. Intervention/Tasks: staff will administer [R98's] oxygen as ordered. R98's Physician Order Sheet with order dated for March 25, 2025, does not display any physician orders for R98's administration, parameters, or pulse oximetry for oxygen. On 03/24/25 at 10:00 AM V13 Licensed Practical Nurse (LPN) stated that she is the nurse for R98 and that his oxygen tubing is dated for 3/25/25, she stated that the tubing should be changed every 24 hours. V13 stated R98 is currently receiving 4 liters of oxygen as it is displayed on the oxygen concentrator dial. On 3/25/25 at 10:57AM V23 Licensed Practical Nurse (LPN) stated that residents should have an order in chart before administering medications or treatments. V23 checked the physician order sheet and stated that R98 does not have an order for oxygen administration or pulse oximetry checks in chart. She stated that there should be an order for the oxygen administration because R98 is currently receiving 4 liters of oxygen and if residents are given medications or treatments that are not followed by a doctors order it can result in harm. On 3/25/25 at 12:15PM V1(Administrator) provided policy. Facility policy dated 1/2025 titled: Policy & Procedure Oxygen Administration and Storage Purpose: To ensure staff follow safety guidelines and regulations for storage and use if oxygen. Procedure: Verify physician's order for the procedure. Emergency Oxygen administration: The nurse will then call the physician as soon as reasonable to obtain a physician's order. Tubing: Tubing should be changed weekly. Pulse Oximetry: Residents who have oxygen orders should have oxygen saturation levels measured by oximetry so the physician may determine a need to change the order to best meet the resident's oxygen needs.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45644 Based on observation, interview, and record review the facility failed to manage a resident's pain and administer pain medication that was documented given. This failure affected one resident (R114) reviewed for medications in a sample of 128. Findings include: R114's admission diagnoses include but not limited to COPD (Chronic Obstructive Pulmonary Disease), atherosclerosis of coronary artery bypass graft, peripheral vascular disease, pacemaker, and bilateral below the knee amputations. R114's Brief Interview of Mental Status (BIMS) score is 15. R114 is cognitively intact. On 3/24/25 at 12:05 pm, R114 stated, I have not gotten my pain medication since Thursday night (3/20/25). I get morphine pills for the pain in my legs. They say they don't have it and have to reorder it. On 3/25/25 at 10:56 am, this surveyor inquired to V32 LPN (License Practical Nurse) if R114 got his pain medication of morphine today? V32 looked in the computer at the MAR (Medication Administration Record) and V32 stated that R114 got his pain medication this morning at 6:00 am. It was documented that it was given by the night nurse, and the next dose is not due until 2:00 pm this afternoon. Surveyor went into R114's room and stated that his pain medication was documented given at 6:00 am this morning. R114 stated, They are lying, I did not get my morphine this morning. The last time I got it was Thursday night (3/20/25). The surveyor went to V32 and asked to see R114's narcotic sheet for his pain medication. V32 looked in the narcotic book and could not find R114's narcotic sheet for the morphine and there was no morphine medication in the narcotic drawer for R114. V32 stated, I don't think it came in from pharmacy yet. Surveyor inquired to V32 when the narcotic sheet is complete where does it go? V32 stated that the completed narcotic sheets go to the DON (Director of Nursing). R114's MAR for March 2025 was reviewed, and all scheduled doses of morphine was documented given on Friday 3/21/25, Saturday 3/22/25, and Sunday 3/23/25 at 6:00 am, 2:00 pm, and 10:00 pm. Monday 3/24/25 morphine was documented given at 6:00 am, not given at 2:00 pm and documented given at 10:00 pm. R114's Order Summary Report Active Orders as of 3/25/25 documents in part, Morphine Sulfate Oral Tablet 15 MG (Milligram). Give 1 tablet by mouth every 8 hours for moderate pain in bilateral BKA (Below Knee Amputation). R114's care plan documented in part, R114 is at increased risk for alteration in pain/discomfort R/T (Related to) Neuropathy and is receiving medication for treatment. Goal: R114 will verbalize pain relief after medication within 1 hour. Interventions: Administer analgesic medications as ordered . (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 3/25/25 1:43 pm, V2 DON stated, The narcotic sheets are given to me when the sheet is completed, and I put it in a folder and file it. Surveyor inquired to V2 if a narcotic sheet was given for R114. V2 stated that she has to check her mailbox. V2 stated that the sheet could be still in the narcotic book. Surveyor and V2 went to the 3rd floor and checked the narcotic book and the drawer of narcotics. The narcotic sheet was not in the narcotic book and the pain medication was not the narcotic drawer. V2 went into R114's room and R114 stated to V2 that he has not gotten his pain medications since Thursday night (3/20/25). On 3/26/25 at 12:15 pm, Surveyor inquired to V39 (License Practical Nurse) if V114 morphine medications were administered on Saturday (3/22/25), Sunday (3/23/25), and Monday (3/24/25). V39 LPN stated If I signed the medication out, then I gave it. There was morphine in the cart. I do not know how many was left. The morphine medication on the bingo card was low so, I told the nurse to tell the NP (Nurse Practitioner) when she come in on Monday. On 3/26/25 at 2:57 pm, V2 DON stated, On 3/18 morphine came in for R114. I do not know how many pills came in. I cannot find the narcotic sheet for 3/18. It is missing. We are investigating right now. Surveyor asked V2 when a resident does not get their scheduled pain medication than what can happen to them? V2 stated, When a resident doesn't get their pain medication then they are still in pain and is not being provided pain management. On 3/27/25 at 9:18 am, V46 RN (Registered Nurse) stated Morphine medications came in for R114 on 3/18/25. I (V46) received the medication because I was working the 1st floor and the nurse on the 3rd floor was not around, so I did not want the pharmacy to take the medication back. I signed for the medications then I walked to the third floor and gave V39 the medications. I put the medication in V39's (LPN) hand. I did not see how many pills was on the bingo card. On 3/27/25 at 10:33 am, V45 RN stated, I worked Friday the 21st from 7:00 pm to 7:00 am. I gave R114 his morphine Friday night and Saturday morning dose. I remember the medication was almost gone. On the 24th I reordered the morphine. I remember when I gave the morphine, it was one or two tablets left on the bingo card. Surveyor inquired to V45 when the narcotic sheet is full what happens to the sheet? V45 stated The completed narcotic sheets are placed in a red bin at the nurse's station, only nurses and CNAs (Certified Nursing Assistants) go behind the nurses' station. I did not put the morphine narcotic sheet for R114 in the red bin, because medications were still on the bingo card. Surveyor asked V45 did he document that R114 got the 10:00 pm scheduled dose of morphine medication on 3/24/25? V45 stated I did give R114 his scheduled nighttime dose of morphine on 3/24/25. On 3/27/25 at 11:55 am, Surveyor inquired to V14 LPN if V14 administered morphine for pain to R114 on 3/22/25 the 2:00 pm dose? V14 stated, If I documented that I gave the medication then I gave it. When I came back to work on Monday (3/24/25) R114 had no morphine in the narcotic box. The NP (Nurse Practitioner) was on the floor, and I ask her how many scripts she signed for R114's morphine? The NP said 60/90 was ordered, so I reordered the medication. R114 told me he had not gotten his morphine medication over the weekend. Some nurses don't click the medications given when they give the medications. They go to the nurse's station and sit down to chart then just click given. There was no morphine medication for R114 here on Monday morning (3/24/25). On 3/26/25 at 3:20 pm V48 Pharmacist stated that R114 had an order for morphine 15 mg every 8 hours. The medication was delivered to the facility on [DATE] around 4:00 am. The quantity was 28 tablets, so the medication should have lasted until March 27th. (continued on next page)

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Archer Heights Healthcare	4437 South Cicero Chicago, IL 60632

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 3/27/25 at V47 NP stated, I (V47) do attend to R114's care. I saw R114 Monday or Tuesday of this week. R114 told me he was not getting the scheduled morphine medication. I called the pharmacy and they said he still had scripts for 120 tablets left. I asked them if they could send the medication tonight. R114 is getting pain medication for bilateral below the knee amputations and is still having phantom pain. R114 does still need the morphine. If R114 does not get the morphine he is still in pain, he cannot sleep, he is restless and have involuntary leg trimmers. The nurses are expected to give ordered medication 1 hour before or 1 hour after scheduled medications ordered by the providers. I make rounds Monday to Friday and always ask the nurses if they need anything. If R114 is not getting his schedule pain medications, pain management is not effective. R114's pharmacy packings slip dated 3/18/25 delivery time 4:24 am, documents in part, Morphine Sulfate Tab 15 MG Quantity 28. Received by V46 RN. R114's pharmacy packing slip dated 3/26/25 delivery time 4:52 am, documents in part Morphine Sulfate Tab 15 MG Quantity 21. Facilities policy dated 10/25/2014 titled Controlled Substance Storage documented in part, 4. Controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and Forms . G. Current controlled substance accountability records are kept in the MAR, or designated book. Completed accountability records are submitted to the director of nursing and kept on file for 5 years at the facility. Facilities policy titled Medication Administration and dated 10/25/2014 documents in part, B. Administration: 2. Medications are administered in accordance with written orders of the prescriber. D. Documentation: The individual who administers the medication dose records the administration on the residents MAR directly after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented . Facility's policy titled Policy and Procedure Physician Orders documents in part, Purpose: To provide guidance to ensure physician orders are transcribed and implemented in accordance with professional standards. Facility's job description titled Charge Nurse documents in part, Job Summary: Organize and assign all jobs to be done on his/her shift so that the workload is evenly divided among his/her employees on the basis of staff size and qualifications pass medications at the appropriate times . 12. Administer all medications. Maintain a current and annual report of narcotics received and used. 13. Daily review the document of dispensing controlled substances and narcotics .

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51772 Based on observation, interview, and record review facility failed to obtain an informed consent before prescribing a psychotropic medication. This failure affected 1residents (R61) out of a sample of 128. Findings Include: R61's face Sheet has an initial admitted [DATE] and has a diagnosis of Major Depressive Disorder dated 1/11/23. R61's Minimum Data Set Section C dated January 9, 2025, has a Brief Interview of Mental Health score of 1 which indicates the resident is severely cognitively impaired. R61's Physician Order Sheet documents R61 is prescribed Remeron (Mirtazapine) for Situational Depression with a start date of 3/24/23. R61's Consent for Psychotropic Medications documents a verbal consent for the administration of a psychotropic medication dated 3/24/2025. R61's Medication Administration Record dated March 2025 documents Remeron, psychotropic medication administered daily from 3/1/2025 to 3/25/2025 at 8pm. On 3/25/2025 at 2:18 pm, V2 (Director of Nursing- (DON), stated the floor nurse or the Assistant Director of Nursing gets the Psychotropic Medication Consents signed before they are prescribed. V2 verified R61's consent for a Psychotropic Medication via Electronic Health Record (EHR) was obtained verbally on 3/24/25, and that R61 has been receiving the psychotropic medication Remeron since 3/24/2023. V2 stated a resident should have an informed consent for a Psychotropic Medication before the medication is prescribed. Facility Policy titled Policy and Procedure Psychotropic Medication received via email with a revision date 1/2025 documents Psychotropic medication shall not be prescribed without the informed consent of the resident, the resident's guardian, or other authorized representative.

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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. 52232 Based on observations, interviews and records review, the facility failed to ensure medication refrigerators and medication carts with narcotic medications are secured and locked; failed to remove expired medications from a medication cart and the medication refrigerator to prevent them from being administered; failed to label multi dose vials and inhalers with opened date and expiration date and failed to accurately document count of narcotic medications. These failures affected six residents (R20, R,22, R23, R61, R134, R173) and have the potential to affect 16 residents on the fourth floor of the facility in a sample of 128. Findings include: On 03/25/25 at 09:35 AM, observed the fourth-floor medication refrigerator unlocked, the latch was not functional leaving the refrigerator unsecured. V12 Licensed Practical Nurse (LPN) was observed opening the narcotic medication box inside refrigerator without a key and stated that she was able to open it without using the keys, that the box was not locked. V12 also stated that the narcotic medication box should be locked. V12 stated that they keep the medication room locked, so it's already locked, but the narcotic medication box in the fridge should be also locked. V12 stated that she will call maintenance to come and fix the narcotic medication box. Fourth floor medication refrigerator also contained R20's opened vial of Lorazepam 2mg/ml oral solution (10ml) with expiration date of 2/21/25 and open vial of Morphine Sulfate 200mg/ml solution with expiration date of 2/21/25. The medication refrigerator also contained an opened house stock multi dose vials of Tuberculin Purified Protein solution with open date of 1/1/24. V13 stated that the expired medications should be discarded. On 03/25/25 at 12:11 PM, observed fourth floor medication cart 1 with V13, Licensed Practical Nurse (LPN), R61's Diazepam solution 5mg/ml, 10ml vial was stored in the first drawer of medication cart instead of locked controlled substance drawer. V13 stated that she was unsure what class of drug Diazepam is, and if it should be stored in the locked narcotic drawer and that she will check with pharmacy for storage guidance. On 03/25/25 at 11:35 AM, observed the following on the third-floor medication cart 3A with V14, Licensed Practical Nurse (LPN): R23's AIRSUPRA inhaler 90mcg/80 mcg per inhalation (120count) open box with label date of 3/14/2025. V14 stated that she is unsure whether the 3/14/2025 is the open date or the expiration date because it was not clearly labeled. R173's open box of Symbicort Aer 80-4.5 inhaler with no open date or expiration date label. R22's open box of Symbicort Aer 80-4.5 inhaler with no open date or expiration date label. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	V14 stated that usually the night supervisor marks the open dates on the medications. V14 stated she is not sure about facility's policy on dating and labeling, and she will ask V2, director of nursing (DON) for clarification. V14 stated that that the DON clarified that the date marked on R23's inhaler was the open date and not the expiration date. V14 also stated that all open medications should be labeled and dated with the open date. R134's Controlled drug receipt/record/disposition form documents on 3/25/2025 Lorazepam 2mg with remaining quantity of 20 tablets. V14 stated that she has 21 tablets in the blister pack. V14 stated that she just got here, and she don't know what happened. On 3/2625 at 12:50 PM by a telephone Interview with V40, Pharmacist stated that usually opened medications such as insulins, inhalers and eye drops are good for 28 days after the medications are opened. If the vials of medications are not labeled with opened date, they should not be used and should be discarded. On 3/26/25 at 2:44 PM during interview with V2 Director of Nursing (DON), stated that the controlled substance medications should be stored in a locked compartment of the medication cart with a different key. Narcotic medications should be stored separately from other medications. Diazepam is a control substance medication, and it should be stored in the medication cart in a separate locked box with the control substances. The narcotic medications needing refrigeration, should be stored in the locked refrigerator inside a separate locked box. The expectation from nurses when locks on the narcotic box or the medication refrigerator are broken, is to immediately notify the DON and the pharmacy. In that instance, a recount of all narcotic medications in the storage box must be performed and compared with the documentation of the logbook for accuracy. DON also stated, that when insulin vial is opened, the nurse's expectation is to clearly date it with the open and the new expiration date. The open insulin vials should be discarded after 28 days from the open date. Inhalers should be clearly dated with the open date. Controlled substances and narcotic medication's documentation forms should be signed by the nurses daily, when reconciliating accurate inventory count of medications. Discrepancies in accuracy of the narcotic medications should be immediately reported to the DON and the pharmacy, and then investigation of missing narcotic medications should be performed. Any new ordered narcotic or controlled substance medication should arrive from pharmacy with its documentation form, and that document should be added to the narcotic/control substances logbook. On 3/25/2025 V1 presented a list of residents on the fourth floor with narcotic orders which documents total of 16 residents. Facility policy titled Controlled Substance Storage date effective 10/25/2014, documents in part that Schedule II-V medications and other medications that are controlled substance should be stored in a permanently affixed, double-locked compartment that is separate from all other medication. The access or a key to this compartment should be a different then the access to other medication. The controlled substances that required refrigeration should be stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator. This policy also documents that controlled substance inventory is regularly reconciled to the Medication Administration Record (MAR) and Forms titled Controlled Substance Count record. Current controlled substances accountability records are kept in the MAR or a designated book. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy titled Storage of Medications date effective 10/25/2014, documents in part that the medication rooms, carts, emergency kits/boxes and medication supplies are locked when not attended by authorized personnel. The policy also documents in part that the outdated medications are immediately removed from inventory, disposed of according to procedures for medication disposal. This policy also documents in part when the original seal of manufacture's container or vial is initially broken, the container or a vial should be dated. The nurse should place a date opened sticker on the medication and enter the date opened and the new date of expiration of the medication. The expiration date of the vial or container will be 30 days unless the manufacturer recommends another date.

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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. 45196 Based on observation, interview, and record review the facility failed to ensure that residents' food items in the facility kitchen are properly labeled, dated when received and when opened; failed to follow proper food storage practices and labeling food to prevent food-borne illnesses; failed to ensure that staff store their food and drinks out of the facility kitchen used for residents; and failed to maintain the proper sanitation levels of the kitchen sanitation bucket. These failures have the potential to affect all 207 residents receiving an oral diet in the facility. Findings include: On 03/24/25 at 9:16 am, Surveyor entered the facility's kitchen and conducted a tour with V6 (Dietary Director) and observed the following: In the walk-in refrigerator Surveyor and V6 observed a box of tomatoes undated and unlabeled on the left middle top shelve. When V6 was asked regarding the box of tomatoes without a date V6 stated, All food should be dated so we know how long we had them. Tomatoes should be dated so we know how long before they will rot. It had a date on the top of the box, but someone must have thrown it away. In the walk-in refrigerator Surveyor and V6 observed a plastic bag with a package of pork sausage, a package of meat titled Salami and a package of open breaded chicken on the left middle top shelf. V6 stated, That belongs to the staff. In the walk-in refrigerator Surveyor and V6 observed a water bottle on the top right side shelve area. V6 stated, That belongs to the staff. In the reach-in refrigerator Surveyor and V6 observed a cup of blue Gelatin. V6 stated, That belongs to the staff. When V6 was asked regarding the importance of staff not storing food in the kitchen used for residents V6 stated, It can cause cross contamination. In the dry storage area Surveyor and V6 observed an open package containing a white powered substance, (V6 stated, that's cake mix) that was unlabeled, undated, and not properly stored. When V6 was asked regarding the importance of food items in the kitchen being containing a label, an open date and properly stored, V6 stated, So we know what it is, when it was used and how much time we have left until it expires. In the dry storage area Surveyor and V6 observed 3 food ingredient bins (a food bin with a white powdered substance, a food bin with a white grain texture substance that had torn pieces of blue paper mixed in, and a bin with a oats texture that was brown (V6 did not identify the items in the ingredient bins), and all ingredient bins were without a label and date. When V6 was asked regarding the importance of labeling and dating the food bins V6 stated So we know what they are and how long we will have to use them. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 03/24/25 at 9:34 am, Surveyor observed V7 (Dietary Aide) preparing food at the preparation station in the kitchen. Surveyor requested V6 to test the sanitation buckets at the preparation station in the kitchen and observed V6 reading the sanitation buckets register a sanitation level at 0 parts per million (PPM). V7 (Dietary Aide) stated, I didn't put sanitizer in there. When V7 was asked regarding the importance of having the proper sanitation level in the sanitation buckets in the kitchen and V7 stated, Sanitizer should be in there to sanitize the area and to prevent the spread of germs. The facility's policy dated 01/25/25 and titled Policy and Procedure Food Storage documents, in part: Policy: The facility shall promote food safety through proper food storage. Purpose: To protect food from contamination, ensure wholesomeness, and to prevent the spread of infection and communicable diseases. Procedure: 2. all food being stored shall be protected against contamination from dust, rodents, and other vermin; unclean utensils and wood surfaces; unnecessary handling, human excretions, flooding drainage, overhead leakage, and other sources of contamination. 3. Perishable foods shall be stored to protect against spoilage. 5. All stored food products will be covered, identified, and dated. Dating of potentially hazardous foods shall indicate the last day the item can be consumed. 7. Food storage areas shall be used for no other purpose. 10. Ingredient bins and bulk food containers will be properly labeled to identify the food products stored, unless visually identifiable such as pasta rice etc. (etcetera). The facility's policy dated 04/2022 and titled Sanitizing Buckets documents, in part: Policy: The facility will use sanitizing buckets with wipe cloths to sanitize preparation and food service equipment. Procedure: The Food and nutrition department manager or designee will ensure that sanitizing buckets are used in food preparation and service areas and are changed often. The facility will follow manufacturer's recommendation on the amount of sanitizing solution used. Sanitizer concentration will be checked using a test kit. The facility's policy dated 04/2002 and titled Policy: Storage of dry foods and supplies. Policy: the facility will follow safe handling and storage of dry foods and supplies. Procedure open products will be labeled and stored in tightly covered containers. Dry foods stored in bins such as flour and sugar will be removed from the original packaging. Storage bins used will be kept clean, labeled, and dated.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50662 Based on observation, interview, and record review the facility failed to monitor personal refrigerator temperatures and ensure that personal refrigerators had thermometers for four residents. These failures affected four residents (R47, R100, R110, R190) out of 128 residents in the total sample. Findings include: R100's medical diagnoses include but are not limited to cerebrovascular disease, essential hypertension, major depressive disorder, and chronic kidney disease. R100 has a Brief Interview for Mental Status (BIMS) dated [DATE] has a score of 12, which indicates R100's cognition is moderately impaired. On [DATE] at 12:02pm R100's refrigerator observed with no temperature log sheet, no thermostat inside the refrigerator, six cartons of expired milk dated [DATE] and [DATE], one expired yogurt dated [DATE], and an opened sandwich undated. R110's medical diagnoses include but are not limited to chronic obstructive pulmonary disease, morbid obesity, acute respiratory failure with hypercapnia, dependence on supplemental oxygen, and major depressive disorder. R110's BIMS dated [DATE] has a score of 13, which indicated R110's cognition is intact. On [DATE] at 10:27am R110's refrigerator observed with no temperature log sheet and no thermostat inside the refrigerator. R190's medical diagnoses include but are not limited to paraplegia, essential hypertension, cellulitis of right lower limb, depression, and eneralized anxiety disorder. R190's BIMS dated [DATE] has a score of 15, which indicated R190's cognition is intact. On [DATE] at 11:55am R190's refrigerator observed with no temperature log sheet and no thermostat inside the refrigerator. On [DATE] at 11:00 AM R47 was observed lying in bed resting with V49 (R47's family member) at bedside, V49 stated that she supplied R47 with personal refrigerator at bedside and that she cleans the refrigerator and there is no thermometer located in refrigerator. V49 stated there has never been a thermometer in the refrigerator. R47's face sheet dated [DATE], shows R47 was admitted to the facility on [DATE] with diagnosis including Spinal stenosis, emphysema, moderate protein calorie malnutrition, chronic obstructive pulmonary disease, bronchitis, anemia, hypertension, rheumatoid arthritis, and osteoarthritis. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 11:02 AM refrigerator of R47's refrigerator was observed without a thermometer to record temperature and a daily temperature log that was located on side of refrigerator with last date of ,d+[DATE] at 6:00am. On [DATE] V9 (Certified Nursing Assistant/CNA) stated that she does not know who is supposed to check the resident's refrigerators. V9 stated that R100 had six expired milks, one expired yogurt and a sandwich that was hard. V9 stated that expired food could make the residents sick. On [DATE] at 2:28pm V2 (Director of Nursing/DON) stated that she thinks housekeeping is responsible for checking the resident's refrigerators. On [DATE] at 3:23pm V31 (Nurse Consultant) stated that housekeeping is responsible for checking the resident's refrigerators. V31 stated that housekeeping should remove all expired food items from the refrigerators. V31 stated that if a resident ingested expired food then they could get a food borne illness. Facility's policy titled Food Brought into the Facility by Friends/Family/Others (Outside Sources) for Residents Policy dated [DATE] documents in part, Procedure: 4. Facility staff will monitor resident room, resident personal refrigerators, unit pantries as well as facility refrigerators and freezers for food and beverage disposal needs for safety .6. All refrigerators in use in the facility have an internal thermometer to monitor temperature. All refrigerators have their internal temps recorded daily. Any refrigerators found to have an internal temperature that is outside of the accepted safe parameters of temperature will be immediately addressed by maintenance and will be taken out of service if the internal temperature cannot be corrected within a reasonable time frame to maintain food safety. Any affected food/beverages will be discarded. 52136

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067 Based on observation, interview and record review, the facility failed to ensure that staff don PPE (personal protective equipment) while performing wound care for a resident (R199); failed to visibly post Enhanced Barrier Precautions (EBP) signage outside a resident's room door for two residents (R96, R199); failed to place a PPE bin directly outside a resident's (R204) Contact Precautions door; failed to ensure that staff perform hand hygiene when passing meal trays; and failed to ensure that staff perform hand hygiene after touching staff's personal body then passing meal trays. These failures affected R25, R40, R96, R113, R118, R153, R177, R178, R199, R201, and R204 and had the potential to affect the 38 residents on the first floor of the facility. Findings include: On 3/24/25 at 11:50 am, this surveyor observed R204's door open with a Contact Precautions sign posted on the front of the door, and there is no PPE bin directly outside R204's door. On 3/24/25 at 11:54 am, V18 (Licensed Practical Nurse, LPN) observed walking down hallway in direction of R204's room. When asked V18 about isolation rooms and where are the staff are to get PPE, V18 stated that staff get the PPE from the bin outside the isolation room. When asked about R204's room having an isolation sign and not having a PPE bin outside the room, V18 stated, They have to refill them and bring more up. V18 stated that there are extra PPE bins downstairs. When asked who is responsible for supplying PPE and brining up PPE bins for isolation rooms, V18 stated it's the IP (Infection Preventionist) nurse and we don't have one. When asked who is responsible then in the absence of an IP nurse, V18 stated, It's the DON (Director of Nursing) and ADON (Assistant Director of Nursing). On 3/24/25 at 11:59 am, R204 observed in wheelchair with bilateral below the knee amputations. R204 stated that R204 has wounds to bilateral stumps due to infection. On 3/25/25 at 9:55 am, V34 (LPN) stated that R204 has open wounds to bilateral below the knee amputations. V34 stated with contact precautions, staff have to gown up and glove with each time going into the that resident's room. Facility isolation sign titled Contact Precautions documents, in part, Everyone Must: Clean their hands, including before entering and when leaving the room. Providers and staff must also: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. R204's Admission Record documents, in part, diagnoses of methicillin resistant staphylococcus aureus (MRSA) infection, encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below knee and acquired absence of left leg below knee. R204's Minimum Data Set (MDS), dated [DATE], documents, in part, a Brief Interview for Mental Status (BIMS) score of 13 which indicates that R204 is cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R204's Care Plan (date initiated 3/14/25) documents a focus of (R204) has MRSA of the wound with an intervention of Contact Isolation. R204's Order Summary Report documents, in part, an active order from 3/17/25 indicating Contact isolation precaution. On 3/24/25 at 12:01 pm, V17 (Certified Nursing Assistant, CNA) entered the first floor dining room (where two covered lunch meal carts were just delivered by dietary staff) V17 observed filling up the cups with yellow drink from drink dispenser and placing covers on the cups. On 3/24/25 at 12:03 pm, V17 started passing lunch meal trays to residents sitting in the dining room at tables. On 3/24/25 at 12:05 pm, V18 (Licensed Practical Nurse, LPN) observed walking up to V17 in the dining room, squirting alcohol based hand sanitizer from a pump bottle into V17's hands, and V17 rubbing hands together. V17 continued to pass meal trays to residents sitting in the dining room. On 3/24/25 at 12:07 pm, V17 observed bending down (squatting) to look at lunch meal tray on the lower shelf on the meal cart, standing up and then pulling up V17's pants by the waistband. V17 then flipped V17's long (approximately down to mid back) hair (which is not contained) away from V17's face and neck with V17's hands. V17 did not perform hand hygiene and continued to pass resident meal trays. On 3/24/25 at 12:14 pm, V17 observed pushing the meal cart with the remaining lunch trays into the hallway. V17 did not perform hand hygiene. This surveyor observed the following: V17 removed R153's lunch meal tray from the cart in the hallway, passed R153's meal tray in the room and exited the room without performing hand hygiene. V17 removed R178's lunch meal tray from the cart in the hallway, passed R178's meal tray in the room and exited the room without performing hand hygiene. V17 removed R113 and R177's lunch meal trays from the cart in the hallway (held one tray in each hand), passed their meal trays in the room and exited the room without performing hand hygiene. V17 removed R40's lunch meal tray from the cart in the hallway, passed R40's meal tray in the room and exited the room without performing hand hygiene. V17 removed R118 and R201's lunch meal trays from the cart in the hallway (held one tray in each hand), passed their meal trays in the room and exited the room without performing hand hygiene. V17 removed R25's lunch meal tray from the cart in the hallway, passed R25's meal tray in the room and exited the room without performing hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/24/25 at 12:18 pm, when asked the process of V17 (CNA) passing meal trays to residents, V17 stated that V17 gets the juice ready in cups, checks the resident names on the meal tray tickets, passes to residents in the dining room first and then passes meal trays to residents who choose to eat in their rooms. When asked during this process, when is V17 performing hand hygiene, and V17 stated that V17 washes V17's hands before beginning to pass trays and at the end of passing trays (stating that V17 was going to go wash V17's hands now). This surveyor informed V17 of the observations of V17 pulling up V17's pants by the waist band and touching/flipping V17's hair away from neck and face during the resident meal tray passing process. When asked what is V17 to do after V17 touches V17's own personal body/hair during meal tray pass, V17 stated, I should sanitize. This surveyor informed V17 of no observation of V17 using alcohol based hand sanitizer after V17 touched personal body/hair, and V17 stated, I didn't. I don't have any (hand sanitizer) on me as V17 reached into V17's scrub top empty pockets. When asked the purpose of performing hand hygiene, V17 stated, So there's no cross contamination. On 3/26/25 at 10:32 am, when asked to describe the process of nursing staff passing meal trays to residents on the floor (in dining room and resident rooms), V2 (Director of Nursing, DON) stated that staff are to wash their hands, identify the resident, pass the meal tray, open the meal plate cover and milk container (if needed), and perform hand hygiene after passing each resident's meal tray. V2 stated that hand hygiene can be washing hands with soap and water or supplementing with alcohol based hand sanitizer (ABHS) every so many tray passes if the staff members hands are not soiled. When asked the purpose of staff performing hand hygiene in between passing each resident's meal tray, V2 stated, Not to spread anything. Their (staffs) hands are supposed to be clean. When asked to clarify what anything means, V2 stated, Infection. V2 stated that when staff are passing meal trays into resident rooms, the staff are to perform hand hygiene before entering into the resident's room and when exiting out of the room. When asked if a staff member is in the process of passing meal trays to residents and is observed touching their hair or pulling up their pants by the waistband, what should the staff member do after touching his/her own person, and V2 stated, After that, they have to wash their hands with soap and water before touching a resident's meal tray. When asked why, V2 again that this is to prevent the spread of infection. V2 stated that know what PPE to don before going into an isolation room by the isolation sign that is posted, showing the pictures of what to wear. V2 stated that for Contact Precautions, staff are to don the PPE (gown and gloves) prior to entering into the room and to doff PPE before exiting from the isolation room. When asked where are staff to access the PPE to enter into a Contact Precautions isolation room, V2 stated that the PPE bin is located outside the Contact Precautions isolation room. V2 stated, There is to be one bin for each room to use for that isolation room. When asked who is responsible for maintaining that there is a PPE bin outside each isolation room stocked with PPE, V2 stated that it's the Infection Preventionist Nurse and Central Supply staff. V2 stated that V37 (Infection Preventionist Nurse) started on 3/24/25. When asked who was responsible prior to 3/24/25 for ensuring this (PPE bin outside isolation room), V2 stated, The floor nurses and myself as well. V2 stated that resident's who are on Contact Precautions will have a physician's order, and the resident's care plan will have the Contact Precautions documented. When asked why isolation precautions are care planned for, V2 stated, The care plan shows the care of the resident. When asked about R204's current isolation status, V2 stated that V2 can't remember, but R204 was on Contact Precautions, had a re-hospitalization in March 2025, and then returned to the facility. Facility's Census Report, dated 3/24/25, documents, in part, that 38 residents currently reside on the first floor. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility policy dated December 2023 and titled Policy & Procedure: Transmission Based Precautions documents, in part, Purpose: To establish transmission-based precautions for residents who are suspected or confirmed to have communicable diseases/infections that can be transmitted to others. Procedure: 1. Transmission-based precautions will be used when transmission cannot be reasonably be prevented by standard precautions alone. 2. The decision to isolate is based on the ability to contain secretions, excretions, and/or drainage, and not the use of antibiotic therapy. 3. Appropriate communication/notices will identify the resident/room with isolation precautions implemented . Contact Precautions: 1. Implemented for residents suspected or confirmed to be infected with a communicable disease/infection that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces/equipment in the resident's environment. 2. Residents shall be placed in a private room when available. If a private room is not available, residents may be cohorted with a low-risk roommate upon evaluation of risks associated with cohorting. 3. Prior to entering the isolation room, the following steps are required: a. Perform hand-hygiene and apply gloves and gown prior to entering room. b. While providing direct resident care, remove gloves and wash hands after coming in contact with infectious material. c. Remove gloves and perform hand-hygiene before leaving room (do not use alcohol-based hand gels for isolation due to suspected or confirmed Clostridium difficile). d. Adequately clean/disinfect an item with an approved solution prior to removing the item from the room and before use on another resident. 4. Whenever possible, use disposable or dedicated resident-care items/equipment to avoid sharing among residents . Contact Precautions: Multi-drug resistant organisms . MRSA. Facility policy dated January 2024 and titled Policy & Procedure: Infection Control documents, in part, Policy: It is the policy of this facility to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment, and to prevent or eliminate, when possible, the development and transmission of disease and infection. Purpose: To establish methods and criteria, necessary within the facility and its operation, to prevent and control infections and communicable diseases. Procedure: 1. The facility has established an Infection Control Program which addresses all phases of the organization's operation to reduce or prevent the risks of nosocomial infections in residents and healthcare workers . 14. All facility personnel are required to routinely wash hands and use appropriate barrier precautions to prevent transmission of infection. 15. All facility personnel shall adhere to the Infection Control Program in the performance of their daily assignments . 16. The facility shall assure that necessary training, equipment and supplies are maintained to carry out an effective Infection Control Program. 17. Handwashing is essential. Alcohol-based hand rubs/gels is the Gold Standard of Prevention. 18. Contact precautions in addition to standard precautions will be initiated as specified in the specific isolation policy. Facility policy dated 11/8/2022 and titled Policy & Procedure: Hand Hygiene documents, in part, Purpose: Provide guidelines on proper and appropriate hand washing and hygiene techniques that will aid in the prevention of the transmission of infections. Procedure: 1. The facility will train and validate competencies of all staff on hand hygiene. Staff will regularly be educated on the importance of hand hygiene in preventing the transmission of healthcare-associated infections. 2. The facility shall encourage persons entering the facility to perform hand hygiene and ensure hand hygiene products are available at the point of care. 3. The use of gloves does not replace hand hygiene. 4. Hand hygiene is always the final step after removing and disposing of personal protective equipment (PPE). (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility Job Description titled Certified Nursing Assistant documents, in part, Job Summary: The purpose of this position in and sit too assist the nurse says in providing of resident care primarily in the area of the daily living routine . 18. Assure that established infection control and universal precaution practices are maintained . 26. Follow established . infection control . policies and procedures. 50662 Findings include: On 03/24/25 at 10:23am observed V23 (Wound care nurse) changing R199's wound dressing without wearing PPE (Personal Protective Equipment). R199's room door observed with no EBP (Enhanced Barrier Precaution) sign on the door. R199's diagnoses include but are not limited to chronic obstructive pulmonary disease, paranoid schizophrenia, peripheral vascular disease, essential hypertension, superficial frostbite of left toes. R199's active physician order dated 02/25/25 documents in part, Precautions: Enhanced Barrier Precautions related to wound care. R199's care plan dated 02/25/25 documents in part, R199 at higher risk for infection secondary to wound care .R199 will receive enhanced barrier precautions during care through next review .PPE to be worn during high contact activities: gown and gloves, and shield when risk of splash is present .Wear PPE during wound care. On 03/25/25 at 2:18pm V23 (Wound care nurse) stated that she did not wear PPE when doing wound care for R199 because R199 was in a rush to get the wound care done. V23 stated that she knows that she should have been wearing PPE while doing R199's wound care. On 03/24/25 at 12:00pm R96's room door observed with no EBP sign on the door. R96 observed with a right subclavian hemodialysis catheter. On 03/25/25 at 09:07am V28 (Licensed Practical Nurse/LPN) stated that R96 should have an EBP sign on his door and that EBP should be used for caring for R96. V28 stated that the EBP sign lets the staff know that PPE should be worn when caring for R96. On 03/25/25 at 3:10pm V2 (Director of Nursing/DON) stated that staff should wear gown and gloves when caring for a resident on EBP. R96's diagnoses include but are not limited to type 2 diabetes mellitus with foot ulcer, present of cardiac and vascular implant and graft, chronic kidney disease stage 4, dependence on renal dialysis. R96's active physician order dated 02/13/25 documents in part, Precautions: Enhanced Barrier Precautions related to Dialysis care. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R96's care plan dated 02/10/25 documents in part, Resident at higher risk for infection secondary to Dialysis . Resident will receive enhanced barrier precautions during care through next review .PPE to be worn during high contact activities. Facility policy dated 11/28/2022 and titled Policy & Procedure: Enhanced Barrier Precautions documents, in part, Purpose: Reduce the transmission of novel or targeted multi-drug-resistant organisms (MDRO). Procedure: 1.Enhanced Barrier Precautions (EBP) require the use of gown and glove during high contact resident care activities.