

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146065	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/21/2025
NAME OF PROVIDER OR SUPPLIER Abbington Vlge Nrsg & Rhb Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 31 West Central Roselle, IL 60172	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0583</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep residents' personal and medical records private and confidential.</p> <p>29562</p> <p>Based on observation, interview, and record review, the facility failed to provide privacy during provision of wound care.</p> <p>This applies to 1 of 15 residents (R41) reviewed for privacy in the sample of 15.</p> <p>The findings include:</p> <p>On February 19, 2025, at 10:30 AM, V3 (Assistant Director of Nursing/ADON/Wound Care Nurse) rendered wound care to R41 who had a pressure ulcer to her left buttock. During dressing change, V3 left R41's bedroom to get additional items to use for the wound care. V3 did not cover R41 with a blanket or a sheet which left R41 naked or exposed from the waist below.</p> <p>On February 20, 2025, at 11:50 AM, R41 said that staff (V3) should have covered her nakedness prior to leaving.</p> <p>R41's MDS (Minimum Data Sheet) dated 1/19/2025 shows that R41 is alert and oriented.</p> <p>On February 20, 2025, at 3:04 PM, V3 (ADON/Wound Care Nurse) stated that staff must ensure that privacy is always provided for dignity.</p> <p>Facility's Policy for Quality of Life-Dignity with revised date of 2017 shows:</p> <p>Policy Statement: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect, and individuality.</p> <p>Policy Interpretation: 10. Staff shall promote, maintain and protect resident privacy, including bodily privacy during assistance with personal care and during treatment procedures.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389</p> <p>Based on observation, interview, and record review, the facility failed to maintain a homelike environment for residents residing in the facility.</p> <p>This applies to 4 of 15 residents (R9, R24, R43, R45) reviewed for homelike environment in the sample of 15.</p> <p>The findings include:</p> <p>1. Face sheet showed R9 is [AGE] years-old who was admitted to the facility on [DATE], with diagnoses that include radiculopathy of the cervical region, multiple sclerosis, diabetes mellitus with diabetic nephropathy, chronic pain, other muscle spasms, myalgia, difficulty in walking, and other abnormalities of gait and mobility.</p> <p>On February 18, 2025, at 10:45 AM, V13 (Visitor/Volunteer for local church) was in R9's room when R9 agreed to speak with the surveyor. V13 stated she is in the facility regularly visiting residents. R9's bed was close to the window about 2-3 feet away. R9's window did not have a curtain or blinds up to the window. There was a bath towel placed and dangling in between two overlapping windowpanes in the middle of the window. Above the window air conditioner, there was a piece of Plexi-glass that had small holes in it all around the edge. R9 stated it was very cold in her room, especially since there was no curtain at the window. Surveyor observed it to be cold by the window. R9's curtain and its metal rod were lying against the wall between the inner/outside wall and the resident's tall wooden cabinet. R9 stated there has not been a curtain there for at least 3 days. R9 stated she told the staff three days ago that she needed a curtain up to her window. V13 then stated it is a shame how they don't keep up this facility. R9 and V13 pointed to the peeling paint on the ceiling next to the window and there was a pink (hospital) basin on the top of R9's cabinet below the peeling paint and water stain. R9 stated the basin was there to catch the water dripping from the ceiling. On the upper left window frame, there was a peeling paint and a couple of large holes in the dry wall. R9 stated she had told the staff about the peeling paint on the wall and the leakage; however, no one has fixed it. V13 stated the leaking from the ceiling happened in January and they still have not fixed the ceiling or wall. R9 stated one of the staff placed the towel in the window to help with the draft. V13 stated R24, another resident, has the same issue. R9 stated they don't fix anything here and she should not have to live here with these conditions.</p> <p>On February 19, 2025, at 9:00 AM, R9 still did not have a curtain up to her window, the towel was still stuck and dangling in the middle of the window, and the wall and ceiling were not repaired.</p> <p>On February 19, 2025, at 12:48 PM, R9 stated her room was cold and it was very cold last night. R9's window still did not have window coverings including blinds or curtain but still had the towel dangling in the middle of the window.</p> <p>On February 20, 2025, at 9:03 AM, the towel was off R9's window, frigid cold air was observed coming through the windowpanes, where the towel was located. R9 still did not have any window coverings.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>2. Face sheet showed R24 is [AGE] years-old who was admitted to the facility on [DATE], with diagnoses that include: poly-osteoarthritis, hypertensive heart disease without heart failure, spinal stenosis, radiculopathy cervical region, and other genetic causes of short stature.</p> <p>On February 18, 2025, at 10:50 AM, V13 (Volunteer) and surveyor walked into R24's bedroom. R24 was lying in bed. R24 stated water was dripping on her for days and the water wet her entire pillow. R24 stated they finally moved her to her current bed. While pointing up above her head at the water-stained ceiling, R24 stated that water has been dripping on her in her current bed also. R24 was angry and stated, You can tell them to fix things, and nothing happens. R24 pointed at the large water stains above her old bed and the wall that had a large area of peeling paint. R24 stated, They don't do anything here. V13 stated, it was sad for her to see the residents living in these conditions. V13 stated she has told the staff more than once about R24's wall. V13 stated the stains and peeling paint have been there at least since January. R24 stated the damaged wall and ceiling has been like that for a while and they moved her bed in January of 2025.</p> <p>R24's Resident Census showed she moved from bed 3 by the window to her current location (bed 2) on January 3, 2025.</p> <p>On February 20, 2025, at 9:23 AM, R24's wall still had peeling paint on the wall and water stains on the ceiling.</p> <p>On February 19, 2025, at 10:23 AM, V1 (Administrator) presented surveyor with maintenance request logs but the original dates of the maintenance request were not present. V1 said she did not know the original dates of the requests and the original forms of maintenance request where she transcribed them from was already thrown away. R24's maintenance request did not appear on any of the maintenance logs. V12 (Maintenance Director) and surveyor went to R9's bedroom. There was still a towel stuck in the window. V12 removed the towel and placed his hand where the towel was and stated There is a draft coming from the window. That is why the towel was probably stuck in there.</p> <p>41855</p> <p>3. On February 18, 2025, at 10:09 AM, in R43 there was a cord hanging down from the ceiling. It was a television cord that was in a flex-tube and was running from the television to the cable jack on the opposite side of the room. The television was mounted on the wall approximately two feet from the ceiling. The ceiling in the room was approximately 9 feet. The cord was currently attached to the television and then it was attached in the corner of the room above the room door. The cord from the television to the corner was sagging in the middle where it was not secured to the wall. The cord was connected to random areas on the wall near the ceiling but was sagging in between the areas connected to the wall. As the cord got closer to the left back corner of the room, the cord was coming down lower towards the cable jack. There was a cable splitter with a long, pointed screw that was not connected to anything. On one side of the cable splitter the cable from the television was connected to it and then connected to the cable jack in the wall. The cable jack on the wall was approximately four feet from the floor. There was an area of the wall in the back right corner of the room where the wall was dented in, and dry wall was crumbling onto the floor.</p> <p>4. On February 18, 2025, at 10:27 AM, in R45's, the metal radiator that runs along the wall in the room under the windows, was dented and the covering was falling off the wall. It had areas of rust on it that were cracking and flaking.</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On February 19, 2025, at 11:21 AM, V12 (Maintenance Director) said he is only covering this building, until the new maintenance man starts on Monday (February 24). V12 said there is a lot of work to be done in this building for sure. V12 went into R43's and R45's rooms and said the concerns shared by surveyor definitely needed to be repaired.</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855</p> <p>Based on interview and record review, the facility failed to implement a person-centered care plan for a resident with a diagnosis of PTSD (Post Traumatic Stress Disorder)</p> <p>This applies to 1 of 1 resident (R44) reviewed for PTSD in the sample of 15.</p> <p>The findings include:</p> <p>R44's EMR (Electronic Medical Record) showed R44 was admitted to the facility on [DATE], with diagnoses that included major depressive disorder, recurrent, severe with psychotic symptoms, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, and post-traumatic stress disorder, unspecified.</p> <p>R44's MDS (Minimum Data Set) dated December 23, 2024, showed R44 had a diagnosis of PTSD.</p> <p>Progress note dated December 3, 2024, at 2:38 PM, by V21 (Nurse Practitioner) showed R44's history and physical identified R44 as having PTSD and a history of sexual abuse as a child.</p> <p>There was no care plan in place that addressed R44's diagnosis of PTSD (financial abuse, physical assault, sexual assault, mental abuse), nor identified her triggers, nor identified interventions to meet her medical, physical, or mental needs.</p> <p>On February 20, 2025, at 1:20 PM with V18 (Social Services) said she was unaware of R44's PTSD, stating she has only been at the facility for two weeks. V18, went into R44's EMR and pulled up the Trauma-Informed Care Observation done on admission and saw that R44 had personally experienced financial abuse, sexual assault, physical assault, and mental abuse. There were no triggers identified. V18 said she would have to review care plan and see what the previous social worker had addressed in R44's care plan. V18 said had she been aware that R44 had a history of PTSD, she would have met with the resident, identified her triggers, and updated her care plan.</p> <p>On February 21, 2025, at 9:47 AM, V1 (Administrator) said the facility does not have a policy on Trauma-Informed Care for Residents with PTSD.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562</p> <p>Based on observation, interview, record review, the facility failed to provide hygiene and grooming for residents who require assistance for activities of daily living (ADL) care.</p> <p>This applies to 3 of the 4 residents (R4, R9, R31) reviewed for ADL care in the sample of 15.</p> <p>The findings include:</p> <p>1. On February 18, 2025, at 11:04 AM, R4 was in her bedroom sitting in her wheelchair. R4 displayed overgrown facial hair on the upper lip and chin, long nasal hair which was sticking out from her nostrils, jagged and discolored fingernails, and uncombed/disheveled hair.</p> <p>On February 19, 2025, at 11:08 AM, V19 and V20 (Both Certified Nursing Assistant/CNA) rendered incontinence care to R4. R4 remained with overgrown nasal hair, facial hair, jagged and discolored nails, and uncombed disheveled hair. After V19 and V20 completed the incontinence care, they left R4 to attend to another resident without offering to shave her facial hair, trim her nasal hair, comb her hair, and provide nail care.</p> <p>On February 20, 2025, at 10:20 AM, R4 remained with overgrown facial hair on the upper lip and chin, jagged and discolored fingernails and overgrown nasal hair sticking from her nostril, uncombed/disheveled hair. Surveyor brought the concern of R4's grooming to V11.</p> <p>R4's MDS (Minimum Data Set) dated January 13, 2025, shows that R4 is totally dependent on staff for hygiene care/grooming care.</p> <p>2. On February 18, 2025, at 11:08 AM, R31 was in her bedroom. She was alert and oriented, and pleasant upon approached. R31 displayed jagged and discolored fingernails and curly facial hair.</p> <p>On February 20, 2025, at 11:15 AM, R31 was resting in bed, alert and oriented. She remained with jagged and discolored fingernails, and curly facial hair. R31 verbalized that she wanted her facial hair shaven, and her fingernails clipped and cleaned.</p> <p>R31's MDS dated [DATE], showed that R31 requires substantial to maximal assistance for grooming and hygiene.</p> <p>On February 20, 2025, at 3:00 PM, V3 (Assistant Director of Nursing/ADON) stated that nail care and shaving is supposed to be done during shower days and as needed. Hair care is to be done daily and as needed, this is to be done as part of the personal hygiene and grooming.</p> <p>43389</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>3. Face sheet showed that R9 is [AGE] years old who was admitted to the facility on [DATE], with diagnoses that include radiculopathy of the cervical region, multiple sclerosis, diabetes mellitus with diabetic nephropathy, chronic pain, other muscle spasms, myalgia, difficulty in walking, and other abnormalities of gait and mobility. R9's Minimum Data Set (MDS) dated [DATE], showed her to be cognitively intact and requiring substantial/maximal assistance for toileting hygiene.</p> <p>On February 18, 2025, at 12:10 PM, R9 was assisted to the bed for a head-to-toe assessment. V14 (Registered Nurse) assessed R9 and as she pulled down R9's pants to assess her hips and thighs, it showed that R9 was wearing double incontinence briefs. V14 removed the fasteners from the right side of the two incontinence briefs. The inner was soiled from the front to the back. V14 then closed both incontinence briefs and went to the R9's left side. Surveyor asked if R9 was wearing 2 incontinence briefs. R9 then stated they always put two incontinence briefs on her. The staff did not respond to the question. V14 then opened both incontinence briefs on R9's left side and examined R9's left hip and groin area. The brief closest to R9's skin was again observed to be soiled. V14 then refastened both incontinent briefs onto R9's hip and was about to grab R9's pants when surveyor asked if R9 incontinent brief was soiled. In response, V14 said, No. It is dry, as she grabbed R9's double incontinent briefs at the crouch area and squeezes it. V14 then reopened the left side of R9's incontinence briefs, looked and said, Yes, it is soiled.</p> <p>On February 20, 2025, at 3:35 PM, V3 (Assistant Director of Nursing) stated that when a resident has a soiled incontinence brief, the resident should be cleaned immediately. V3 stated, residents should be kept clean, dry, and comfortable. V3 stated it is not a practice of the facility to put residents on double incontinence briefs because of risks of urinary tract infections.</p> <p>R9's physician orders do not include any diuretics.</p> <p>R9's Elimination and Activities of Daily Living care plans dated October 7, 2024, showed the following: R9 requires partial/Moderate assistance 1 person with personal hygiene and maximal assistance with toileting hygiene. R9 has alteration in elimination as evidenced by urinary incontinence and bowel incontinence requiring incontinent care. R9 continues to use the toilet for needs. One of the approaches to care for R9 was to provide R9 with incontinence care as soon as incontinence was noted.</p> <p>The facility's incontinent care policy showed the following: Purpose: to keep skin clean, dry, and free of irritation and odor.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29562</p> <p>Based on observation, interview, and record review, the facility failed to ensure that a resident who needed foot care is seen by a podiatrist.</p> <p>This applies to 1 of 1 resident (R26) reviewed for foot care in the sample of 15.</p> <p>The findings include:</p> <p>On February 19, 2025, at 9:44 AM, V11 (Certified Nursing Assistant) rendered hygiene care to R26. During hygiene care and skin assessment, it was observed that R26 had overgrown toenails. The long nails curled over the top of each toe. V11 stated that she already reported it to the nurse a while ago. V11 was not sure why it has not been clipped yet.</p> <p>On February 19, 2025, at 3:15 PM, R26 was sitting on his wheelchair and stated that he wishes that someone would clip his toenails because it is too long. R26 said that his toenails has not been cut since he came in the facility. R26 stated he mentioned to his CNA multiple times that he wanted his toenails clipped.</p> <p>On February 19, 2025, at 2:17 PM, V10 (Nurse) stated that whenever they do admission, they (nurses) do head to toe assessments, and when they see anything that needs attention of the physician, they would refer the resident. One of the routine consents that they obtained is the podiatry consult. R26 was admitted on [DATE], and he signed consent for podiatry service at the time of his admission. R26 should have been seen by the podiatrist.</p> <p>R26's Minimum Data Set (MDS) dated [DATE], shows that R26 is alert and oriented and requires substantial/maximal assistance for grooming/hygiene.</p>

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe, appropriate pain management for a resident who requires such services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36567</p> <p>Based on observation, interview, and record review, the facility failed to apply pain adhesive patches to residents that had a Physician order for the same.</p> <p>This applies to 2 of 2 residents (R19, R203) reviewed for pain management in the sample of 15.</p> <p>The findings include:</p> <p>1. R19's face sheet showed diagnoses of radiculopathy, cervical region, hemiplegia and hemiparesis following unspecified cerebrovascular disease affecting left non-dominant side, other reduced mobility, bilateral primary osteoarthritis of knee.</p> <p>R19's quarterly MDS (minimum data set) dated February 4, 2025 showed that R19 was cognitively intact.</p> <p>R19's POS (Physician Order Summary) included as follows:</p> <p>Lidocaine adhesive patch, medicated, 4%, apply one patch topical. Special Instructions: apply to bilateral lower heels for pain. Apply at 6:00 AM and remove at 6:00 PM.</p> <p>Lidocaine adhesive patch, medicated, 4%, apply one patch topical. Special Instructions: site lower back, apply at 6:00 AM and remove at 6:00 PM.</p> <p>Lidocaine adhesive patch, medicated, 4%, apply one patch topical. Special Instructions: site neck, apply at 6:00 AM and remove at 6:00 PM.</p> <p>On February 18, 2025 at 11:12 AM, R19 stated that he is in pain scored at 8/10 and has not got his pain patch for a week. R19 stated that he has pain in his heels, neck and lower back. R19 stated They say they don't have any (pain patch). That's not good at all. R19's roommate R203, who was in the room, chimed in from behind the curtain He (R19) did not get a pain patch. I heard the nurse say that they don't have any.</p> <p>On February 18, 2025 at 11:28 AM, V4, RN (Registered Nurse) stated that R19 gets a pain patch which is applied by the night nurse. V4 stated that R19 also gets Norco (Acetaminophen tablet 650 mg) every 6 hours as needed and he already received the same that morning.</p> <p>On February 18, 2025 at 11:54 AM, R19's neck and heels were checked in presence of V4 and there was no patch. R19 stated again that he does not have any on as they haven't had any for a week. V4 stated that she was aware that there was no Lidocaine patch on February 17, 2025. V4 stated Yesterday they told me that they don't have any. But I thought they got it after that. He (R19) did not tell me this morning that he did not get a pain patch. When asked is she was going to notify the doctor, V4 stated He already got his Norco. It is not time for him to get it again.</p> <p>(continued on next page)</p>		

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<p>F 0697</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On February 20, 2025 at 9:20 AM, V17 (Licensed Practical Nurse) confirmed that she worked overnight (February 16-February 17, 2025) as the night nurse and administers the pain patch in the morning. V17 recalls one instance where there was no Lidocaine patch available and she explained it to R19 and gave him an as needed Norco. V17 stated that she also does not put it on R19's shower days and the AM nurse is supposed to put it on after his shower at 10:30 AM.</p> <p>R19's care plan initiated February 4, 2025 showed that R19 has complained of chronic neck (radiculopathy cervical), lower back pain related to history of compression fracture of left-spine he sustained from fall at home April/2022 prior to admission to facility. Interventions included to apply Lidocaine pain patches to neck, lower back, bilateral lower heels daily and remove after 12 hours.</p> <p>2. R203's face sheet included spinal stenosis, cervical region, arthritis due to other bacteria, right ankle and foot, osteomyelitis of vertebra, lumbar region.</p> <p>R203's admission MDS dated [DATE] showed that R203 was cognitively intact.</p> <p>R203's POS had an order for Lidocaine adhesive patch, medicated 4 %, 1 patch, topical. Apply to the neck for pain. Apply at 6:00 AM and remove at 6:00 PM.</p> <p>On February 18, 2025 at 2:48 PM, R203 stated that he is supposed to get a patch on his neck but has not gotten one in the last two or three days. R203 stated They said they don't have any. R203 stated that he has a pain score of 7/10. This information was relayed to V4 (RN) who stated that he may not have gotten any Lidocaine patch as they did not have any in the house.</p> <p>On February 19, 2025 at 9:54 AM, V2 (Director of Nursing) stated that the Lidocaine adhesive patch are house stock and that V9 (Central Supply) orders it. V2 stated that if not available, the nurse's should call the doctor and order another medication. V2 stated that previously the facility would get doctors order to change to Biofreeze topical cream until Lidocaine patch available.</p> <p>On February 19, 2025 at 1:24 PM, V9 (Central Supply Staff) stated that he orders Lidocaine adhesive patch weekly and that he places the order on Thursday and the order comes in on Thursday unless there is a deficit in supply. V9 stated that the nurses usually call the doctors and switch to a cream and there must have been a miscommunication. V9 stated I wasn't made aware that they were running short. V9 added that he went and picked up Lidocaine adhesive patch from their supply chain when it was brought to his attention on February 18, 2025.</p> <p>R203's pain care plan initiated February 12, 2025 showed that R203 has diagnoses of spinal stenosis, cervical region, arthritis due to other bacteria, right ankle and foot (septic- arthritis, right foot) and has complaints of chronic pain on neck, lower back and right lower extremity. Intervention for the same included to administer medications: see MAR (medication administration sheet) / ORDERS for details. Administer Lidocaine [OTC/over the counter] adhesive patch,medicated; 4 %; amount: 1 patch; topical Special Instructions: Apply to the neck for pain. Apply at 6:00 AM and remove at 6:00 PM.</p>		

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NAME OF PROVIDER OR SUPPLIER Abbington Vlge Nrsg & Rhb Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE 31 West Central Roselle, IL 60172	

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care or services that was trauma informed and/or culturally competent.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855</p> <p>Based on interview and record review, the facility failed to identify triggers and provide trauma-informed care for a resident with a diagnosis of PTSD (Post Traumatic Stress Disorder).</p> <p>This applies to 1 of 1 resident (R44) reviewed for PTSD in the sample of 15.</p> <p>The finding include:</p> <p>R44's EMR (Electronic Medical Record) showed R44 was admitted to the facility on [DATE] with diagnoses that included major depressive disorder, recurrent, severe with psychotic symptoms, unspecified psychosis not due to a substance or known physiological condition, anxiety disorder, and post-traumatic stress disorder, unspecified.</p> <p>Progress note dated December 3, 2024, at 2:38 PM, by V21 (Nurse Practitioner) showed R44's history and physical identified R44 as having PTSD and a history of sexual abuse as a child.</p> <p>R44's MDS (Minimum Data Set) dated December 23, 2024, showed R44 had a diagnosis of PTSD.</p> <p>R44's Care Plan dated December 20, 2024 showed R44 is an adult living with chronic mental illness. The intervention showed to review the PASRR (Pre-Admission Screening and Resident Review) material and incorporate information that remains relevant into the assessment and care plan process. Discuss /review any discrepancies between the current assessment/evaluation and the PASRR document.</p> <p>PASRR II showed R44's diagnoses included PTSD, Bipolar Disorder, Depressive Disorder, Anxiety Disorder, and Polysubstance Abuse.</p> <p>R44's Admission Trauma-Informed Care Observation dated December 3, 2024, showed R44 has personally experienced financial trauma, physical assault, sexual assault, and mental abuse. The area on the form where it asks about triggers, what was her reaction when reminded of the events, and what type of help has she received to address her response to the events, was all left blank. Under current treatment plan, refer to psych services was checked.</p> <p>Behavior monitoring was reviewed and there were no resident specific behaviors identified for staff to be mindful of.</p> <p>Progress notes were reviewed and showed R44 has seen V22 (Psychiatric Nurse Practitioner) on December 18, 2025, January 11, 2025, and February 15, 2025. V22 only identified medication as a plan for treating her mental illness.</p> <p>(continued on next page)</p>

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<p>F 0699</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On February 20, 2025, at 1:20 PM with V18 (Social Services) said she was unaware of R44's PTSD, stating she has only been at the facility for two weeks. V18, went into R44's EMR and pulled up the Trauma-Informed Care Observation done on admission and saw that R44 had personally experienced financial abuse, sexual assault, physical assault, and mental abuse. There were no triggers identified. V18 said she would have to review R44's care plan and see what the previous social worker had addressed in R44's care plan. V18 said had she been aware that R44 had a history of PTSD, she would have met with the resident, identified her triggers, and updated her care plan.</p> <p>On February 21, 2025, at 9:47 AM, V1 (Administrator) said the facility does not have a policy on Trauma-Informed Care for Residents with PTSD.</p>		

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<p>F 0805</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>36567</p> <p>Based on observation, interview, and record review, the facility failed to serve pureed consistency diets for residents that have an order for the same.</p> <p>This applies to 2 of 2 residents (R13, R32) reviewed for pureed diets in the sample of 15.</p> <p>The findings include:</p> <p>Week at a glance menu for week 1 Tuesday, February 18 lunch meal included Beef Taco and Spanish Rice.</p> <p>On February 18, 2025 at 9:44 AM, V8 (Cook) stated that the ground beef did not come in as ordered and that she is using ground turkey instead. V8 stated that she is preparing pureed food for 2 residents.</p> <p>On February 18, 2025 at 12:36 PM, the tray line, and food consistencies was observed in the facility kitchen. The pureed rice and pureed turkey appeared granular and lumpy and R13 and R32 received the same. A sample when taste tested , was very granular and had to be chewed in order to be swallowed. When V5 (Consultant Dietitian), who was in the vicinity was shown the same, she stated that the consistency does not look smooth enough for pureed. V5 remarked that the pureed food should be smooth, pudding or mashed potato consistency that can be swallowed without chewing. V5 and V8 were notified that the pureed meals already plated for R13 and R32 were not safe to serve.</p> <p>Facility policy titled National Dysphagia Diet Level 1 Pureed (NDD Level 1) taken from Nutrition Manual for Healthcare Communities, 2021 included as follows:</p> <p>The dysphagia pureed diet (also known as NDD Level 1) is the least advanced of the texture modified diets. It provides foods that are pureed, homogenous, and cohesive. The food should be semi-solid smooth consistency. No chewing or bolus formation is required. All foods must be pureed or be naturally pudding like.</p> <p>Facility Client List Report printed February 18, 2025 showing resident diet orders included that R13 and R32 are on pureed diets.</p>

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>36567</p> <p>Based on observation, interview, and record review, the facility failed to follow sanitary practices in the facility kitchen.</p> <p>This applies to 57 residents that received foods prepared in the facility kitchen.</p> <p>The findings include:</p> <p>Facility filled CMS Form 671 dated February 18, 2025, showed that the facility census was 57 residents. Facility provided information that there were no residents on NPO (nothing by mouth) status.</p> <p>On February 18, 2025, at 9:35 AM, during initial tour of kitchen, V6 (Dietary Aide) was washing dishes on the soiled side of the dish machine and was seen putting on new gloves without washing her hands and go to the clean side to pick up cleaned dishes. The hand sink near the dish machine did not have soap nor paper towels. V7 (Dietary Aide) who was in the area stated that there is none and she asked the Housekeeping for supplies, and they did not have it either.</p> <p>A red sanitizer bucket in the kitchen area was tested with a QUATS (quaternary ammonia) test strip and showed an almost white to pale yellow color. This when compared to the color scale of the test strip reel, registered at 0-150 ppm (parts per million). V8 (Cook) stated that she just changed the sanitation buckets and wiped down the counters with the same.</p> <p>In the walk-in Cooler, was a tub of cottage cheese with a broken lid in two places and exposed the contents. The use by date on the tub showed January 31, 2025.</p> <p>In the walk-in Freezer, there was a 4 lb. (pound) plastic bag of sliced strawberries and a 3 lb. plastic bag of blueberries both of which were opened to air. V7 (Dietary Aide) stated that it is used for one resident (R300).</p> <p>On February 18, 2025, at 12:45 PM, V5 (Consultant Dietitian) stated that the QUATS sanitizer strip should test between 150-400 ppm, ideally 200 ppm. V5 stated that the staff should wash their hands before donning clean gloves. V5 added that if not wearing gloves, hands must be washed when going from dirty to clean side of the dish machine. V5 stated that all items that are opened in cooler and freezer must be sealed or wrapped and dated with open on or use by date.</p> <p>Facility policy taken from Policy and Procedure Manual 2017 titled Dish Room Safe Food Handling included as follows:</p> <p>The task of loading the dirty dishes and utensils into the dish machine is handled by one person. The task of removing the clean dishes and utensils from the dish machine is handled by a different person. If there is only one person working in the dish room, the person will remove their gloves, wash their hands, and put on fresh gloves whenever they cross over to the clean side of the dish machine to unload the sanitized dishes and utensils.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Facility policy taken from Policy and Procedure Manual 2017 titled Storage of Frozen Foods included that if taken out of original container, food is tightly wrapped and labeled with name of item and use by date.</p> <p>Facility policy titled taken from Policy and Procedure Manual 2017 titled Sanitation Buckets/Wiping Cloths. included as follows:</p> <p>Policy: Wiping cloths kept in a sanitation bucket containing a solution of water and chemical sanitizer are used to sanitize food contact surfaces and equipment too large to immerse in the three-compartment sink.</p> <p>Procedure: In the red sanitation bucket mix the water and the chemical sanitizer. The most common chemical sanitizers are chlorine, iodine, and quaternary ammonia. Sanitizing the food contact surfaces and equipment is accomplished according to the following color chart:</p> <p>Quaternary 150-400 or 200-400 per manufacturers direction.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>45303</p> <p>Based on interview and record review, the facility failed to follow their water management plan for Legionella. The facility also failed to have control measures in their water management plan to address prolonged closure of a resident unit.</p> <p>This applies to all 57 residents residing in the facility.</p> <p>The findings include:</p> <p>The facility's Long-Term Care Facility Application for Medicare and Medicaid dated February 28, 2025, showed the facility's census was 57 residents.</p> <p>The facility's undated Water Management Program showed Purpose: To manage the risk of exposure to Legionella from the water in the facility. The Identifying Buildings at Increase Risk Assessment was completed. Due to the fact that we are a healthcare facility with residents who stay overnight, a water management program is indicated. The following areas where Legionella could grow and spread were noted: A. Municipal water intake. a. External factors- construction, water main break, disruption in water service: i. The facility will monitor village activity. ii. Test disinfectant (free chlorine) residual values where water enters our building quarterly. B. Ice Machine. a. Possible conditions for bacteria spread. i. The ice machine is visually inspected for signs of biofilm and cleaned monthly by an outside service. ii. Ice machine is fed by all copper piping. C. Sinks/Showers. a. Sinks and showers. i. Temperatures are tested weekly. See spreadsheet for acceptable ranges. ii. Residual free chlorine levels are tested quarterly. iii. Fixtures closest to and farthest away from the central distribution point will be tested. D. Water Heaters. a. Water heater 1, 2, 3, and 4 have temperature gauges which are checked monthly. Units will be adjusted accordingly to maintain temperatures about 120 degrees. E. In the event of any water system failure or interruption, testing the entire system will be completed. F. All testing will be documented and kept in the maintenance director's office. Activities of the water management program will be reviewed during the safety committee meetings and Quality Assurance meetings.</p> <p>The facility does not have documentation to show quarterly free chlorine testing was conducted, monthly ice machine maintenance was conducted, weekly water temperatures of the sinks/showers conducted, or monthly monitoring of the water heaters were conducted.</p> <p>On February 19, 2025, at 10:54 AM, V1 (Administrator) said she does not have any water temperature logs. V1 continued to say V12 (Maintenance Director) does not keep water temperature logs.</p> <p>On February 19, 2025, at 11:14 AM, V12 said he does not have any documentation regarding the control measures of the facility's water management plan for Legionella. V12 said he thinks the ice machine company comes to the facility quarterly for ice machine maintenance. V12 said he does not have documentation to show the last time the company performed an inspection or cleaning of the ice machines. V12 said he does not have documentation of free chlorine testing of the water.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>On February 19, 2025, at 11:33 AM, V2 (DON/Director of Nursing) said the second floor was closed to residents on April 8 or April 9, 2024, and reopened to residents in September 2024. V2 said the census was low on the second floor until recently.</p> <p>The facility does not have documentation to show control measures were conducted on the second floor during the prolonged closure of the second floor. The facility does not have documentation to show Legionella testing was conducted while the second floor was not being inhabited by residents or prior to reopening the second floor after being closed for five months.</p>		

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<p>F 0916</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident has a room at or above ground level.</p> <p>41855</p> <p>Based on observation, interview, and record review, the facility failed to ensure residents' rooms were located at or above ground level.</p> <p>This applies to 13 residents (R1, R5, R6, R7, R8, R23, R30, R33, R43, R44, R45, R52, and R53) on the first floor reviewed for room/level/location.</p> <p>The findings include:</p> <p>On February 18, 2025, at 9:58 AM, during the initial tour of the facility, observations were made that seven rooms (101, 102, 103, 104, 105, 106, and 107) were below ground level. The facility's Resident Roster dated February 17, 2025, showed R1, R5, R6, R7, R8, R23, R30, R33, R43, R44, R45, R52, and R53 were all residing in the bedrooms on the first floor below ground level.</p> <p>On February 20, 2024, at 3:27 PM, V1 (Administrator) said she was aware of the facility's noncompliance with having residents residing in rooms below ground level on the first floor. V1 said the facility sent in an application for a waiver. V1 did not provide any waiver but provided a letter received from IDPH (Illinois Department of Public Health) after the previous annual survey was completed. The letter showed, As a result of this survey and any revisits, the Department is recommending to the Centers for Medicare and Medicaid Services and the Illinois Department of Healthcare and Family Services that the facility be certified for continuing participation in the Medicare (Title 18) and Medicaid (Title 19) programs. Based on review of this document, there was no waiver awarded to this building for the rooms located below ground level (101, 102, 103, 104, 105, 106, and 107).</p>		