

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146069	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/11/2024
NAME OF PROVIDER OR SUPPLIER East Bank Center, LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 6131 Park Ridge Road Loves Park, IL 61111	

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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40085</p> <p>Based on interview and record review the facility failed to obtain treatment orders for a resident with a stage 3 pressure injury. This applies to 1 of 2 residents (R5) reviewed for pressure injury in the sample of 12.</p> <p>The findings include:</p> <p>R5's face sheet shows she was admitted to the facility on [DATE] with diagnoses including septic shock and a stage 3 pressure injury to her left heel and sacrum.</p> <p>Hospital discharge records for R5 show prior to admission to the facility she was in a local community hospital with a diagnosis of septic shock due to a left heel ulcer which had been debrided and antibiotic therapy provided while she was at the hospital.</p> <p>An initial nursing admission assessment for R5 dated 8/21/24 and not signed, shows she has a left heel ulcer measuring 1.6 centimeters (cm.) x 1.8 cm. The same assessment shows she has 3 open areas to her sacrum/coccyx and right and left buttocks measuring: 2.0 x1.0 cm. and 1.5 cm x 2.0 cm. and 1.0 cm. x 1.0 cm.</p> <p>R5's current Physician Order Summary (POS) and Treatment Administration Record (TAR) from 8/1/24-8/31/24 shows no active treatment orders for her coccyx and sacrum until 8/26/24, which was to initiate Medi-honey and Xero foam every other day and apply zinc ointment to her buttocks two times a day. There were no orders for her left heel ulcer until 8/26/24 when an order was entered to clean left ulcer with normal saline and apply iodoform, (sp.) xeroform and foam dressing daily.</p> <p>On 9/10/24 at 09:46 AM, V9 (Wound Nurse) said she initially saw R5 when she was admitted on [DATE] and assessed the wounds. R5 did not see the facility wound care physician until 8/29/24 because he was out of town. V9 said she thought there were orders prior to 8/26/24 for her sacral/buttocks and heel but verified with this surveyor by review of the POS and TAR that no orders were obtained until 8/26/24. V9 said R5 currently still has the pressure area to her heel but it has improved a lot.</p> <p>On 9/10/24 at 11:02 AM, V2 (DON) said she had reviewed R5's discharge orders from the hospital and she did not see any treatment orders for R5's pressure injuries. V2 said no treatment orders were obtained until 8/26/24 when V9 caught this and called the facility wound physician for orders.</p> <p>(continued on next page)</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 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24 at 11:45 AM, V7 (Wound Care Physician) said he is treating R5 at the facility and she currently has only a pressure injury to her left heel. V7 said he was messaged or called on 8/26/24 for treatment orders for R5's pressure to her heel and coccyx. V7 said 5 days is not acceptable to wait to begin treatment to her heel wound because it could have deteriorated in that time. V7 said the hospital should have sent treatment orders with her on admission but someone from the facility should have caught it before 5 days. V7 said sometimes residents at the facility see him and sometimes they see outside providers so that could have been part of the problem also.</p> <p>On 09/10/24 at 12:24 PM, V8 (Podiatrist/surgeon) said he saw V5 in the hospital for a foot ulcer and he debrided the wound. V8 said he was at the facility yesterday but could not recall without his list in front of him if he saw V5 or not. V8 said there should be some treatment orders for R5 prior to 5 days because the dressing would need to be changed, and in the hospital, it was being changed every other day. V8 said in wounds like this I defer treatment to the facility wound physician who see residents regularly because I only go to the facility on e time a month.</p> <p>The facility provided Pressure Ulcers/Skin Breakdown policy last revised Aril 2018 shows, the physician will order pertinent treatments including dressings and topical agents to manage pressure injuries.</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40085</p> <p>Based on observation, interview, and record review the facility failed to ensure dietary supplements were provided for 2 of 5 residents (R28, R5) reviewed for weight loss in the sample of 12.</p> <p>The findings include:</p> <p>1.) R28's face sheet shows he was admitted to the facility on [DATE] with diagnoses including protein-calorie malnutrition and muscle weakness. R28's active care plan shows he has malnourishment and will be consulted by the dietician.</p> <p>R28's Weight Summary shows his weight was 110.2 on 8/27/24 and was 101.4 on 9/6/24 which is a 7.99% and 8.8 pound (lb.) significant weight loss in 10 days.</p> <p>R28's Nutrition note completed on 9/6/24 by V4 (Dietician) shows he has sustained a significant weight loss and Magic Cup a dietary supplement had been ordered to be given with lunch. R28 declined any additional supplements.</p> <p>R28's active Physician Order Summary and meal ticket both show he should receive magic cup with lunch effective 9/1/24.</p> <p>On 9/9/24 the noon meal service was observed and R28 was in the dining room he did not receive a magic cup during the meal service. At 12:33 PM, V6 (Cook) confirmed that all trays had been passed and the noon meal service was complete.</p> <p>On 9/10/24 at 1:07 PM, V4 said R28 was admitted to the facility with poor nutrition and is underweight and she is concerned about it. V4 said she personally adds supplement orders to the resident meal tickets herself and then the kitchen staff pass the supplements with the trays.</p> <p>2.) R5's Weight Summary shows she weighed 160.2 lbs. on 8/21/24 when she was admitted to the facility. Her weight on 9/5/24 was 146.0 lbs. Which is a significant weight loss of 8.9% and 14.2 lbs. in 15 days.</p> <p>R5's Nutrition note completed on 9/6/24 by V4 shows had a significant weight loss and will be given Mighty Shake two times a day for weight support which began on 8/27/24.</p> <p>R5's active Physician Order Summary shows she should receive mighty shakes 2 times a day at lunch and dinner.</p> <p>R5's meal ticket shows she should receive 6 ounces of vanilla mighty shake at lunch.</p> <p>On 9/9/24 R5 was eating lunch in her room. At 12:20 PM, and again at 12:35 PM and 12:40 PM, R5 was observed and finished with her meal and had not been given her mighty shake with lunch.</p> <p>On 9/10/24 at 1:07 PM, V4 said she provides supplements for residents with weight loss, and she expects them to be given.</p> <p>(continued on next page)</p>

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility provided Supplement policy dated 2021 shows nutritional supplements should be given as ordered.</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37232</p> <p>Based on interview and record review the facility failed to ensure there was no delay in obtaining a medication from the pharmacy and failed to obtain a medication from the pharmacy for 2 of 5 residents (R235 and R11) reviewed for pharmacy services in the sample of 12.</p> <p>The findings include:</p> <p>1. R235's Face Sheet showed R235 had a primary diagnosis of polyneuropathy (a nerve disease that affects many nerves).</p> <p>On 09/09/24 at 12:05 PM, R235 said he had neuropathy (nerve pain) in his hands and feet. R235 described the pain as if his hands and feet were on fire. R235 said there was a delay in starting medication for the nerve pain. R235 said it took the facility over a day to get the medication. R235 was not sure why there was a delay. R235 said the facility did provide other interventions while waiting for the pain medication to treat the neuropathy.</p> <p>R235's Progress Notes dated 9/4/24 entered by V10 (Nurse Practitioner) showed R235 reported he had neuropathy and was agreeable to try pregabalin (medication to treat the nerve pain).</p> <p>R235's Progress Note dated 9/4/24 at 12:49 PM showed a nurse practitioner gave an order for pregabalin.</p> <p>R235's Progress Note dated 9/4/24 at 12:59 PM, showed a nurse practitioner was informed a prescription needed to be sent to the pharmacy for the pregabalin.</p> <p>R235's Clinical Physician Orders showed an order for pregabalin with a start date of 9/4/25 at 8:00 PM.</p> <p>R235's Progress Note dated 9/4/24 at 10:11 PM, showed the pharmacy had not received the prescription for the pregabalin.</p> <p>On 09/09/24 at 01:22 PM, V17 (Licensed Practical Nurse- LPN) said she went to give R235 his pregabalin on 9/4/24 at 8:00 PM and it was not available. V17 said she contacted pharmacy and was informed the pharmacy had not received the prescription for the pregabalin. V17 said the medication was not available in the medication dispensing machine at the facility.</p> <p>On 09/09/24 at 12:35 PM, V18 (Pharmacist) said the pharmacy received the prescription for pregabalin on 9/4/24 at 11:27 PM. V18 said the medication was filled on 9/5/24 and it was delivered to the facility on [DATE] at 2:29 AM. V18 said the pharmacy makes one daily routine delivery to the facility. V18 added that the daily pharmacy delivery leaves the pharmacy at midnight. According to V18, the pregabalin prescription came in too late to make the delivery on 9/5/24. V18 said the normal time frame for a medication to be delivered to the facility is 24 hours.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R235's Medication Administration Record (MAR) indicated R235 received the first dose of pregabalin on 9/5/24 at 7:00 PM (before the medication was delivered to the facility).</p> <p>On 9/9/24 at 2:21 PM, V19 (LPN) said she was the one that documented on the MAR that R235 received a dose of pregabalin on 9/5/24 at 7:00 PM. V19 said she made an error on R235's MAR by marking that the pregabalin was given. V19 said she did not give R235 the pregabalin on 9/5/24 at 7:00 PM because the medication was not available.</p> <p>R235's Controlled Drug Receipt/Record/Disposition Form for the pregabalin indicated R235 received his first dose on 9/6/24 at 8:00 AM (about 43 hours after the Progress Note dated 9/4/23 at 12: 49 PM indicating an order for pregabalin was given).</p> <p>On 09/09/24 at 01:48 PM, V2 (Director of Nursing) said a new medication is usually started the next day. V2 said when a medication is ordered the pharmacy will deliver the medication the next day in the early morning.</p> <p>The facility's Pharmacy Policy and Procedures Manual showed medications and related products are received from the dispensing pharmacy in a timely basis.</p> <p>40085</p> <p>2.) On 9/9/24 at 12:08 PM, R11 said she has had a problem with thrush in her mouth and had previously been on a medication she swished in her mouth. R11 said the nurses told me several days ago she was going to get it again but has yet to see it.</p> <p>R11's Electronic Medical Record (EMR) shows a note documented on 9/6/24 at 10:06 PM, by V10 (Nurse Practitioner), for R11 to start on Miracle mouth wash 4 times a day for 10 ten days.</p> <p>R11's Medication Administration Record (MAR) and Physician Order Summary (POS) both show an order for Miracle mouth wash (Hydrocortisone, Benadryl, and Nystatin) equal parts 10 ml (milliliters) swish and spit QID (4 times a day) for oral thrush for 10 days. The order has a start date of 9/7/24 and a stop date of 9/9/24. The MAR shows no doses were given 9/7/24 or 9/8/24. The MAR and POS next show the order was restarted on 9/10/24 and discontinued on 9/10/24 with no doses signed off in the MAR.</p> <p>A nursing note completed by V12 (Licensed Practical Nurse) on 9/10/24 at 9:47 AM states, Pharmacy did not send patient's miracle mouth wash. NP (Nurse Practitioner) notified and assisted with updating order. Order faxed to pharmacy, will send tonight. Patient to start medication tomorrow morning. NP verified and patient aware of order.</p> <p>On 9/10/24 at 10:36 AM, V13 (Pharmacist) said they had no order request from the facility for R11 to receive Miracle mouth wash. V13 said if the facility does not properly enter the order into the computer correctly as a pharmacy order they pharmacy will not get it unless the facility prints the order off and faxes it to them. V13 said had he gotten this order they would have sent the medication out to the facility with the next delivery.</p> <p>On 9/10/24 at 10:40 AM, R11 was in the hallway talking with V11 (Nurse Practitioner) V11 told R11 the hold up with starting her mouth rinse was due to the order not being sent to the pharmacy.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 9/10/24 at 10:47 AM, V11 said R11 did not get the medication that was ordered due to the facility not entering it correctly, so the order was just faxed to the pharmacy today by V12 (LPN). V11 said R11 does have oral thrush and a small sore inside her mouth.</p> <p>On 9/10/24 at 11:05 AM, V2 (Director of Nursing) said she was also not aware until today that orders have to be faxed to the pharmacy if they are not entered as a pharmacy order. V2 said this was the reason R11 did not receive her mouth wash yet.</p> <p>The facility Ordering and Receiving Non-Controlled Medications from The Dispensing Pharmacy dated 10/25/24 shows a nurse should promptly report any discrepancies of omissions of medications to the pharmacy and charge nurse supervisor.</p>		

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<p>F 0758</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>40085</p> <p>Based on interview and record review the facility failed to ensure PRN (as needed) psychotropic medication had a stop date not greater than 14 days for 1 of 5 residents (R11) reviewed for psychotropic medications in the sample of 12.</p> <p>The findings include:</p> <p>R11's Physician Order Summary and Medication Administration Record both show an active order prescribed by V11 (Nurse Practitioner) on 9/5/24 for Ativan 0.5 MG (milligrams) every 12 hours as needed for anxiety with no stop date.</p> <p>On 9/10/24 at 2:25 PM, V2 (Director of Nursing) said PRN orders for psychotropic medications including Ativan should have a stop date of 14 days.</p> <p>The facility provided Time Limited Orders policy effective 10/25/24 shows PRN Anxiolytics (Ativan) should have a stop date of 14 days.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>37232</p> <p>Based on observation, interview, and record review the facility failed to ensure staff wore the required personal protective equipment for a resident on enhanced barrier precautions for 1 of 12 residents (R15) reviewed for infection control in the sample of 12.</p> <p>The findings include:</p> <p>R15's Clinical Physician Orders showed R15 had an order for enhanced barrier precautions because R15 had an indwelling urinary catheter.</p> <p>On 09/09/25 at 9:20 AM, on the outside of R15's room was a sign indicating R15 was on enhanced barrier precautions. The sign indicated staff were to wear gloves and gown for high-contact resident care activities. High-contact activities included transferring and care of a medical device such as a urinary catheter.</p> <p>On 09/09/24 at 09:29 AM, R15 was in his room sitting in a wheelchair. R15's indwelling urinary catheter drainage bag was hanging on the wheelchair. V14 (Physical Therapist Assistant) was in the room. V14 moved R15's indwelling urinary catheter drainage bag from the wheelchair to a walker. V14 did not have on gloves or a gown. V14 assisted R15 to stand and walk.</p> <p>On 09/10/24 at 11:58 PM, V15 (Certified Nursing Assistant- CNA) assisted R15 to stand and walk. V15 hung R15's indwelling urinary catheter drainage bag on a walker. V15 did not have on gloves or a gown.</p> <p>On 09/10/24 at 10:03 AM, V16 (CNA) said for a resident on enhanced barrier precaution for an indwelling urinary catheter staff should put on gloves and a gown before handling the indwelling urinary catheter. V16 said enhanced barrier precautions are infection control interventions to limit the spread of infections.</p> <p>The facility's Enhanced Barrier Precautions policy with a reviewed date of 4/1/24 showed enhanced barrier precautions is an approach of targeted gown and glove use designed to reduce transmission of bacteria. Enhanced barrier precautions apply to residents with indwelling medical devices such as an indwelling urinary catheter. The same policy showed when a resident is placed on enhanced barrier precautions gown and gloves will be used during high contact resident care activities such as transferring and device care/use.</p>

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<p>F 0908</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Keep all essential equipment working safely.</p> <p>40798</p> <p>Based on observation, interview, and record review, the facility failed to ensure the walk in freezer was repaired and in safe working condition. This failure has the potential to affect all 24 residents residing in the facility.</p> <p>The findings include:</p> <p>The CMS-671 form completed by the facility on 9/9/24, shows there are 24 residents residing in the facility.</p> <p>During the kitchen tour on 9/9/24 at 9:10 AM, thick frost was noted on the packages of food in the walk in freezer and frozen water was pooled on a box of cookies and a box of diced turkey on the shelf below the fans. A large puddle of water was on the floor between the walk in freezer and the walk in cooler coming from water dripping from the connecting door. V5, Dietary Manager, said the freezer was down and they had a repair company out to fix it about a month ago. V5 said they are waiting on a part to fix the freezer.</p> <p>On 9/9/24 at 12:46 PM, V20, Freezer repair company representative, said they provided an estimate to fix the facility's freezer on 7/30/24. V20 said they have not been waiting for parts to fix the facility's freezer since they provided the estimate on 7/30/24; they needed the facility to approve the estimate before they could order the parts.</p> <p>On 9/10/24 at 2:27 PM, V1, Administrator, said she has been aware there was a problem with the walk in freezer since July when the repair company was in the facility.</p> <p>The freezer repair company's estimate dated 7/30/24 shows they arrived to find the walk in freezer not temping and the condenser short cycling due to a compromised pressure transducer. The thermostat was in rough shape and the door closer was not working as intended. They provided a quote to remove and replace the electronic control, transducer, and temperature control on the walk in freezer.</p>		