STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide timely incontinence care for residents who require extensive assistance with activities of daily living for 2 of 18 residents (R4 and R42) reviewed for activities of daily living in the sample of 18. This failure resulted in R4 developing MASD (Moisture Associated Skin Damage) with open wounds to the sacral area. The findings include: 1.R4's Minimum Data Set assessment dated [DATE] shows that his cognition is severely impaired, is always incontinent of urine and stool and is dependent on staff for toileting and personal hygiene. On 4/13/26 at 10:44 AM, V16 (Certified Nursing Assistant/CNA) went in to provide incontinence care to R4. R4's incontinence brief was saturated and the sheet underneath R4 was wet. R4's buttock was reddened and had multiple open wounds present. V16 said that R4 was last changed with the help of the night shift around 6:45-7:00 AM. On 4/14/26 at 2:06 PM, V17 (CNA) said that all incontinent residents should be checked and changed every two hours. R4's Skin Check from 4/7/26 shows that R4 has generalized redness to his coccyx but does not document any open wounds or MASD. R4's Wound Evaluation and Management Summary dated 4/15/26 shows that R4 has Moisture Associated Skin Damage measuring 7.0 centimeters (cm) x 6 cm x 0.1 cm (Surface Area of 42 cm squared) with open areas with exposed dermis of 21 cm squared.On 4/15/26 at 10:35 AM, V18 (Wound Physician) said that he just saw R4 and R4 has a cluster of wounds on his bottom that were caused by MASD. V18 said that they were not present when he saw him the week prior. V18 said that R4 is incontinent, and the wounds are caused by prolonged moisture. V18 said that the wounds could have developed from R4 being wet for a long period of time. V18 said that the facility needs to make sure that R4 is being provided incontinence care and repositioned frequently.2. R42's Minimum Data Set assessment dated [DATE] shows that she is cognitively impaired, incontinent of urine and stool and is dependent on staff for toileting and personal hygiene. On 4/13/26 at 2:58 PM, V16 (CNA) provided incontinence care to R42. R42's incontinence brief was saturated and the sheet under her was wet. R42's buttock was reddened and had an open wound present. V16 said that she last changed R42 at breakfast time. On 4/14/26 at 2:06 PM, V17 (CNA) said that all incontinent residents should be checked and changed every two hours. R42's current Care Plan shows, [R42] has bowel and bladder incontinence and is dependent on staff for toileting hygiene. Provide incontinence care in a timely manner.The facility's Activities of Daily Living Policy shows, Residents who are unable to carry out activities of daily living independently receive the services necessary to maintain good nutrition, grooming, and personal and oral hygiene. Appropriate care and services are provided for residents who are unable to carry out ADLs independently, with the consent of the resident, and in accordance with the plan of care, including appropriate support and assistance with: hygiene.elimination.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure discharge MDS (Minimum Data Set) assessments were completed for discharged residents. This applies to 4 of 4 residents (R29, R54, R81, R83) reviewed for resident assessments in the sample of 18. The findings include: 1.R29's face sheet shows she was admitted to the facility on [DATE] and discharged on 12/28/25. On 4/15/26, R29's MDS shows her discharge assessment was not completed (greater than 100 days). 2. R54's face sheet shows she was admitted to the facility on [DATE] and discharged on 03/16/26. 3. R81's face sheet shows she was admitted to the facility on [DATE] and discharged on 3/20/26. 4. R83's face sheet shows she was admitted to the facility on [DATE] and discharged on 3/20/26. The facility's MDS report provided on 4/15/26, shows R54, R81, R83's discharge assessments were not completed/submitted within 14 days of discharge. On 4/15/26 at 10:05 AM, V10 (MDS Nurse) said the facility has certified 84 beds. If there are more residents listed in IQES it's probably because residents are not being discharged timely. We have to submit MDS discharge assessments within 14 days. There's been a miscommunication issue not discharging residents timely. She runs a monthly report of the missed assessments, and she is in the process of completing the missed discharge assessments. We have to be more diligent completing the discharge assessment in the MDS. V10 confirmed R54, R81 and R83's discharge assessments were not completed within 14 days of discharge and said she was not aware of R29's discharge not being completed. The facility's Discharge Assessments Policy dated 2023 states, A discharge MDS assessment is completed whenever a resident is physically discharged from the facility.a discharge assessment is completed when a resident is discharged from the facility and the resident is not expected to return.is completed within 14 days after the discharge 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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. Based on observation, interview and record review the facility failed to identify, assess and implement treatment after a resident developed a stage two pressure ulcer, failed to ensure pressure ulcer prevention interventions were in place and failed to ensure low air loss mattresses were functioning and set to the appropriate settings for 4 of 7 residents (R1, R4, R11 and R42) reviewed for pressure ulcers in the sample of 18. The findings include: 1.On 4/13/26 at 2:58 PM, V16, (Certified Nursing Assistant/CNA) and V17 (CNA) went provided incontinence care to R42. R42 had an open wound on her coccyx. There was no dressing present on the wound or in the incontinence brief. On 4/14/26 at 2:00 PM, V21 (Registered Nurse) and V9 (Clinical Nurse Manager) went into R42's room to do a skin check. R42 still had the open wound to her coccyx with no dressing in place. V21 stated, That must be new because it was not there earlier. This surveyor notified V21 that it was there on 4/13/26. V21 stated, No one told me about it. There was no documentation regarding R42's coccyx wound from when it was first observed on 4/13/26 at 2:58 PM and when it was observed on 4/14/26 at 2:00 PM. R42's Hospice Notes dated 4/15/26 shows, Patient has new opening to coccyx or sacral region stage 2. Wound measures 1 cm (centimeter) x 3.5 cm x 0.1 cm, no drainage, 100 percent granulation tissue. On 4/15/26 at 9:50 AM, V2 (Director of Nursing) said that if a CNA sees a new wound, they should notify the nurse right away. V2 said that the nurse would then immediately assess the wound and call the provider for treatment orders. 2.On 4/13/26 at 10:03 AM, R4 was laying in bed sleeping. R4's heels were directly on the mattress and the bottoms of his feet were touching the foot board. R4's heel protector boots were sitting in a chair in R4's room. At 10:44 AM, R4 was in the same position and his heel protector boots were still on the chair. On 4/14/26 at 1:45 PM, V9 (Clinical Nurse Manager) said that R4 has a wound to his foot. V9 said that R4 is at risk for pressure and has pressure relieving boots that should be worn at all times when he is in bed. V9 said that R4 does not refuse to wear his pressure relieving boots. R4's Care Plan shows, [R4] is at risk for alteration in skin integrity due to bed-chair confinement, need for assistance with transfers/repositioning. off-load heels as applicable R4's Wound Evaluation and Management Summary dated 4/15/26 shows that R4 has a dry blister to his right lateral foot measuring 1.5 centimeters (cm) x 1.1 cm with an etiology undetermined or unknown. The same report shows that the support surface for R4's feet is off-loading. 3. R1's wound report dated 4/8/26 showed R1 had a stage 3 pressure injury to her left buttock and a stage 2 pressure injury to her right buttock. A physician order dated 3/11/26 showed an order for R1 to be on a low-air-loss mattress (LAL) due to her pressure injuries. On 4/13/26 at 9:36 AM, R1 was in bed, lying on a LAL mattress; however, the LAL mattress was powered off. The mattress appeared deflated. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 4/14/26 at 8:30 AM, R1 was asleep in bed. R1's LAL mattress was powered off and appeared deflated. On 4/14/26 at 8:45 AM, V8 (Licensed Practical Nurse/LPN) stated R1 requires a LAL mattress because of the pressure injuries she has to her buttocks. V8 stated nurses should be checking to make sure LAL mattresses are turned on and functioning every shift. V8 stated, If the mattress is not turned on, it's just a regular mattress. It won't off-load areas of pressure or take pressure off areas with injuries. The facility's Support Services Guidelines policy dated September 2025 showed, Redistributing support services are to promote comfort for all bed- or chairbound residents, prevent skin breakdown, promote circulation and provide pressure relief or reduction. 4. On 4/13/26 at 9:51 AM, and again on 4/14/26 at 10:02 AM, R11 was lying in bed on top of a low air loss mattress. At the end of the bed was the mattress control box which controlled the mattress being on and off and the weight settings. R11's mattress was set for 200 pounds (lbs.) R11 presented as very thin and fragile. R11's care plan shows she has a pressure injury to her coccyx. R11's weight summary shows R11s weight on 3/7/26 was 76.2 lbs. On 4/14/26 at 1:39 PM, V9 (Clinical Nurse Manager) said the air mattress should be set to a residents weight and the nurses are the people responsible to make sure the settings are correct and the device is powered on. On 4/14/26 at 2:01 PM, V13 (LPN) said when the mattresses are put on, they are set up. And R11 is on hospice so the bed was set by them. V13 also said she knows nothing about the pressure reducing mattress settings.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. Based on observation, interview and record review the facility failed to follow the menu during the noon meal for residents on a pureed diet. This applies to 5 of 5 residents (R11, R23, R42, R91 and R6) reviewed for dietary services in the sample of 18. The findings include: On 4/13/26 at 10:55 AM, V5 (Cook) prepared the pureed meal using the food processor including bean soup, BBQ chicken, cowboy beans, pea onion salad and coffee cake. On 4/13/26 at 12:38 PM, the lunch service began on the second floor. Staff came to the serving window and verbally requested a resident's tray (pureed/regular). V5 was plating and serving the meals. The puree residents were served BBQ chicken, cowboy beans and mashed potatoes. The puree soup was not served to all the puree residents. The puree pea salad and coffee cake were not served. The puree pea salad and puree coffee cake were sitting on the prep table behind the serving table with plastic wrap in place during the noon meal service. At 1:37 PM, V4 (Dietary Manager) said the puree meal should receive what's on the menu including puree soup, BBQ chicken, cowboy beans, pea salad and coffee cake. The soup and salad should be served first. Staff should automatically serve what is listed unless the resident requests something else. V5 confirmed the puree salad and dessert were not offered or served to the puree residents. On 4/14/26, a list provided by the facility shows R11, R23, R42, R91 and R6 on a puree diet. The menu dated 4/15/26 shows barley soup, green pea and red onion salad, BBQ chicken, cowboy beans and assorted desserts are listed for the noon meal. The facility's Dietary Services for the Health Care Policy dated 2015 states, The community will provide a comprehensive dining program to meet the resident's individual nutritional needs and enhance quality of life.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. Based on observation, interview and record review the facility failed to ensure the puree noon meal was a smooth consistency for residents on a pureed diet. This applies to 5 of 5 residents (R11, R23, R42, R91 and R6) reviewed for therapeutic diets in the sample of 18. The findings include: On 4/13/26 at 10:55 AM, V5 (Cook) prepared the noon puree meal adding cubed chicken adding eight ladles of BBQ sauce, one ladle of hot water and unmeasured amount of thickener in the food processor and blended. V5 then placed the puree BBQ chicken in the steam pan it appeared thick and lumpy. V5 then pureed the cowboy beans in the food processor and added unmeasured amount of thickener. On 4/13/26 at 11:44 AM, V5 said the puree consistency should be smooth like pudding. If you add too much thickener, it will be thick. On 4/13/26 at 1:50 PM, this surveyor sampled the puree meal including the pureed BBQ chicken and cowboy beans. Both items appeared lumpy on the plate. The puree BBQ chicken and cowboy beans were not a smooth consistency. Small gritty pieces that required chewing were present. On 4/13/26 at 2:10 PM, V4 (Dietary Manager) said I can already tell what's wrong. V4 said the puree meals normally don't look like this. V4 sampled the puree BBQ chicken and cowboy beans and said it's not a smooth consistency. It should be smooth like pudding. On 4/14/26, a list provided by the facility shows R11, R23, R42, R91 and R6 are all on a puree diet. The facility's BBQ Chicken Quarters Recipes dated 2026 states, place the number of servings needed in the food processor and blend until smooth. check product consistency until smooth, lump free and extremely thick. The facility's Pureed Cowboy Beans recipe dated 2026 states, Place prepared beans and tomato juice in the food processor; blend until smooth.adjust liquid needed to create a smooth pudding consistency.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure daily weights were performed as order for residents with congestive heart failure and failed to perform and document a wound assessment for a resident with a new wound. This applies to 3 of 18 residents (R4, R13 and R108) reviewed for quality of care in the sample of 18.The findings include:1.On 4/13/26 at 2:22 PM, R4 had a dressing on his upper back dated 4/13/26. R4's Nursing Notes dated 4/8/26 shows, Resident noted to have a small open area to midback. Cleaned with NS (normal saline), patted dry, covered with clean and dry dressing. Resident denies pain to area. The facility was unable to provide any additional wound assessment documentation for R4's back wound that provided characteristics of the wound and measurements. R4's Wound Evaluation and Management Summary dated 4/15/26 shows that R4 has a non-pressure wound of his left upper back measuring 0.6 centimeters (cm) x 0.6 cm x 0.1 cm with moderate serous exudate. On 4/14/26 at 1:45 PM, V9 (Clinical Nurse Manager) said that if a resident develops a wound at the facility, the nurse should assess the wound and call the provider for orders. V9 said that the documented assessment should include the characteristics of the wound and measurements. On 4/14/26 at 2:00 PM, V21 (Registered Nurse) said that if a resident develops a new wound, the nurse should assess the wound and call the provider for orders. V21 said that it should be documented in the resident's record. V21 said that she is not sure if they are supposed to do measurements. The facility's Wound Assessment Protocol shows, Nursing will complete and document a focused skin and wound assessment when concerns are identified and is clinically indicated which may include: Skin integrity status, including presence of open areas.wound location and general appearance.wound measurements.wound bed characteristics (e.g. granulation, slough, eschar, epithelialization), drainage characteristics.condition of surrounding skin.pain or discomfort.signs and symptoms of infection.Assessment findings will be documented at the time of the observation. 2. R13's admission record showed R13 was admitted to the facility on [DATE] with a diagnosis of congestive heart failure (CHF). R13's April 2026 Summary Order Report showed R13 received a diuretic medication (Torsemide) once a day for treatment of CHF. A physician order dated 12/17/25 showed, Record weight daily. notify MD (physician) if difference is greater than 2 pounds in one day or 5 pounds in one week. On 4/13/26 at 9:46 AM, a sign that showed Daily Weight hung on the door frame to R13's room. R13 was in bed. When R13 asked when she had last been weighed, R13 stated, It's been a couple of days. I don't get weighed every day. R13's weight records dated March 2026-April 2026 showed R13 was not weighed on 4/2, 4/3, 4/5-4/7, 4/9, 4/11, or 4/12/26. R13 was not weighed on 3/1-3/3, 3/5-3/10, 3/15, 3/16, 3/18, 3/19, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/23, 3/24, 3/26, 3/27, or 3/29-3/31/26. R13's current care plan reviewed on 4/13/26 showed no documentation of R13 refusing to be weighed. 3. R108's admission record showed R108 was admitted to the facility on [DATE] with diagnoses of respiratory failure and CHF. R108's April 2026 Order Summary Report showed R108 received a diuretic medication (Furosemide) once a day for treatment of CHF. A physician order dated 4/9/26 showed, Record weight daily. notify MD (physician) if difference is greater than 2 pounds in one day or 5 pounds in one week. On 4/13/26 at 10:00 AM, a sign that showed Daily Weight hung on the door frame to R108's room. R108 was in bed with supplemental oxygen in place to her nares via nasal cannula. R108 stated she had not been weighed daily while in the facility. R108's weight record dated April 2026 showed R108 was not weighed on 4/10, 4/11, or 4/12/26. 4/14/26 at 11:05 AM, V2 (Director of Nursing) stated residents should be weighed as per their physician order. V2 stated, Most residents are weighed once week but residents with CHF and that are on diuretics are weighed daily because that's how we monitor those residents for increased fluid retention which could mean their CHF is worsening.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on interview and record review the facility failed to ensure a resident was assessed by a dietician after a significant weight loss for 1 of 3 residents (R11) reviewed for weight loss in the sample of 18. The findings include: R11's face sheet shows she has diagnoses including Alzheimer's Disease with early onset and dysphagia. R11's current Care Plan shows she is dependent on staff for feeding assistance, she is at risk for nutritional deficit and should be seen by the dietician. The Care Plan also shows R11 has transitioned to hospice care. R11's weight summary shows she weighed 89.4 pounds (lbs.) on 1/28/26 and on 2/22/26 she weighed 83.0 lbs. which is a 6.4 lb. 7.16% weight loss in less than 1 one month.On 3/1/26 R11 weighed 87.6 lbs. and on 3/7/26 she weighed 76.2 lbs. which is a 11.4 lb. 13.01% weight loss in one week. On 4/14/26 and 4/15/26 all dietary notes and assessments for the past 6 months for R11 were requested. The facility provided dietary progress notes completed by V15 (Registered Dietician) which shows R11 was assessed on 10/24/25 and the next dietary/nutrition note was not done until 3/26/26 (5 months later). That note states, Pt. [Patient] is in hospice care r/t [related to] decline 2/2 [secondary] to Alzheimer's. Last known weight @ 76.2#. Remains on Pureed diet with (Brand name supplemental drink) TID [three times per day] as tolerated. CPM. The note does not address R11's significant weight loss or any recommendation that maybe implemented. On 4/14/26 at 11:46 AM, V15 said I see residents with significant weight loss, and with wounds, or that have tube feedings. I do admission and quarterly assessments, however, when a resident is on hospice I do not normally see them unless there is a consult request done. Usually hospice takes over, and even when I recommend a supplement it is often denied. On 4/15/26 at 9:55 AM, V2 (Director of Nursing) said assessments of residents with significant weight loss should still be done by the facility even if someone is in hospice care.On 4/15/26 at 11:55 AM, V14 (R11's hospice nurse) said We do not do nutritional assessments for residents with significant weight loss that should be done by the facility dietician unless they do not have one and then the facility can ask if they can consult our hospice dietician. V14 said R11 has been on hospice since 12/17/25 and the facility has not asked about consulting their dietician for the required assessments. V14 said R11 does currently receive (Brand name supplemental drink) but unfortunately due to her overall status and diagnosis, weight loss is probable. The facility provided Weight Assessment and Intervention policy dated 2001 identified significant weight loss as an unplanned and undesired weight loss of greater than 5% in 1 month, greater than 7.5% in 3 months, or greater than 10% in 6 months. The policy also shows that the dietician will review residents with significant weight loss. R11's face sheet shows she has diagnoses including Alzheimer's Disease with early onset and dysphagia. R11's current Care Plan shows she is dependent on staff for feeding assistance, she is at risk for nutritional deficit and should be seen by the dietician. R11's weight summary shows she weighed 89.4 pounds (lbs.) on 1/28/26 and on 2/22/26 she weighed 83.0 lbs. which is a 6.4 lb. 7.16% weight loss in less than 1 one month. On 3/1/26 R11 weighed 87.6 lbs. and on 3/7/26 she weighed 76.2 lbs. which is a 11.4 lb. 13.01% weight loss in one week. On 4/14 and 4/15/26 all dietary notes and assessments for the past 6 months for R11 were requested. The facility provided dietary progress notes completed by V15 (Registered Dietician) which shows R11 was assessed on 10/24/25 and the next dietary/nutrition note was not done until 3/26/26.

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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 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. Based on observation, interview and record review the facility failed to ensure a resident's head of bed was elevated while tube feeding was being administered for 1 of 3 residents (R4) reviewed for tube feeding management in the sample of 18.The findings include:On 4/13/26 at 10:44 AM, V16, (Certified Nursing Assistant/CNA) went into R4's room to provide incontinence care. R4 had tube feeding running. V16 lowered R4's head of the bed to a flat position. V16 then started incontinence care. At 10:49 AM, V16 left the room to get help with care and left R4's head of the bed lowered. At 11:04 AM, V16 returned to the room and continued providing incontinence care with the head of the bed still in the flat position and the tube feeding still running.On 4/14/26 at 2:06 PM, V17 (CNA) said that if a resident is getting tube feeding, the head of the bed should always be elevated. V17 said that if the head of the bed needs to be lowered to provide care, the CNA should notify the nurse so they can stop the feeding while the care is being provided. R4's Current Care Plan shows that he requires tube feeding with interventions of, The resident needs the HOB (head of bed) elevated 45 degrees during and thirty minutes after tube feeding.The facility's Enteral Feedings-Safety Precautions Policy shows, Preventing aspiration.Always elevate the head of bed (HOB) at least 30-45 degrees during tube feeding and at least 1 hour after.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146136	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Radford Green	960 Audubon Way Lincolnshire, IL 60069

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to ensure the required Personal Protective Equipment (PPE) was worn when providing care to residents on Enhanced Barrier Precautions (EBP) and failed to handle oxygen tubing in a manner to prevent cross contamination for 3 of 18 residents (R24, R4, R107) reviewed for infection control in the sample of 18. The findings include: 1. R24's face sheet shows she has diagnoses including dementia and dysphagia. R24's active Care Plan shows she is incontinent of both bowel and bladder and is dependent on staff for care. R24 has a pressure injury to her coccyx which requires wound care, and is on Enhanced Barrier Precautions due to having a wound. On 4/13/26 at 9:35 AM, there was a sign posted on R24's door indicating that providers and staff must wear gloves and gowns for high contact resident care including dressing, changing linen, providing hygiene and changing briefs. There was a plastic bin outside of R24's doorway that had PPE supplies inside including gowns and gloves. At 9:37 AM, V11 and V12 both Certified Nursing Assistants (CNAs) applied only gloves and entered R24's room with the surveyor. V11 and V12 used a mechanical lift and put R24 to bed. Once R24 was in bed and without ever applying gowns, they removed R24's incontinent brief and provided incontinence care to R24 and applied a new brief. There was a bandage on R24 lower back. V12 said that R24 is on EBP due to her having the pressure wound. On 4/14/26 at 9:19 AM, V13 (Licensed Practical Nurse/LPN) said that when a resident is on EBP precautions and direct patient care is being done staff are required to wear both gowns and gloves. The facility provided Enhanced Barrier Precautions policy dated March 22, 2024 shows that EBP precautions are used to prevent infection and to reduce the spread of drug resistant organisms to residents. The policy also identifies gloves and gowns should be worn during high contact care including changing linens and briefs. 2. On 4/13/26 at 10:44 AM. R4's room door had a sign on it that said, Enhanced Barrier Precautions, Everyone must:.Wear gloves and gown for the following high contact care activities.providing hygiene.changing briefs. On 4/13/26 at 10:44 AM, V16 (CNA) entered the room to provide incontinence care. V16 did not put a gown on. V16 cleaned R4's front perineal area. On 4/14/26 at 2:06 PM, V17 (CNA) said that if a resident is on enhanced barrier precautions, staff should wear a gown and gloves when providing care to the resident. R4's Current Care Plan shows, Potential for the spread of multi-drug resistant organisms (MDROs) to other residents or staff during high contact related to: feeding tube.Apply gloves and gown before performing the high contact resident care activity. 3. R107's admission record showed R107 was admitted to the facility on [DATE] with diagnoses including acute respiratory failure and COPD (chronic obstructive pulmonary disease). A physician order dated 4/3/26 showed R107 was prescribed one liter of continuous supplemental oxygen via nasal cannula related to her diagnoses. (continued on next page)

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	146136	A. Building B. Wing	04/15/2026

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Radford Green	960 Audubon Way Lincolnshire, IL 60069

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/13/26 at 9:43 AM, V6 (CNA) provided cares to R107 in bed. R107's nasal cannula was off R107's face, lying on the bed next to R107. As V6 repositioned R107, R107's nasal cannula fell off the bed, onto the floor. V6 picked the cannula off the floor and immediately placed the cannula in R107's nares and secured it to R107's face. On 4/14/26 at 9:02 AM, V7 (CNA) stated staff are to immediately dispose of a resident's nasal cannula that appears dirty and/or falls on the floor because the nasal cannula is considered contaminated and could potentially cause an infection.