STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146145	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mather Evanston, The	425 Davis Street Evanston, IL 60201

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718 Based on observations, interviews, and record reviews the facility failed to follow their care planning policies by not ensuring a residents baseline care plan included safety/fall interventions. This failure applies to one (R1) of four residents reviewed for accidents on the total sample of 20. Findings include: R1 is a [AGE] year-old female with a diagnoses history of Prosthetic Heart Valve, Chronic Diastolic Congestive Heart Failure, Presence of Artificial Hip Joint, Primary Osteoarthritis of Hip, Dizziness, and Lack of Coordination who was readmitted to the skilled nursing unit on 02/25/2025. On 03/17/25 at 10:57 AM R1 stated she fell a couple of weeks ago and fractured her pelvis. R1's current physician orders includes an active order effective 03/03/2025 for Fall Risk Assessment Weekly for four weeks every day shift every 7 day(s) for fall precautions management for 4 Weeks. R1's Admission Baseline Care Plan assessment dated [DATE] documents her vision is impaired, cognitively impaired, uses a walker, has a history of falls, her last fall was 2 months prior to admission which resulted in a fractured pelvis, she receives psychotropic, diuretic, and anticoagulant medications, and it does not include fall interventions. R1's current care plan does not include falls interventions and documents she sometimes has pain or feels weak and might require extensive assistance to transfers. R1's fall risk assessments dated 02/25/2025, 03/10/2025, and 03/17/2025 document she is at high risk for falls, and her fall risk assessment dated [DATE] documents she is at moderate risk for falls. On 03/19/25 at 11:37 AM V2 (Assistant Director of Nursing/Registered Nurse) stated R1 was admitted to the facility from assisted living on 02/25/2025 and did have falls while in assisted living. (continued on next page)

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/19/2025 at 1:19 PM V8 (Certified Nursing Assistant) stated she's always assigned to R1 when she works, and she thinks R1 might be a fall risk. V8 stated usually R1 doesn't get up on her own without assistance but sometimes when she arrives to work in the morning R1 is already dressed and in her chair. V8 stated R1 walks sometimes but tires easily and has an unsteady gait. V8 stated R1 hunches over and doesn't stand up straight. V8 stated R1 mostly walks in her room and doesn't like coming out of her room. V8 stated she assumes R1 is a fall risk but was never actually informed that she was. V8 stated she is normally notified of residents being a fall risk when they come in to the unit. On 03/19/2025 at 1:24 PM V9 (Certified Nursing Assistant) stated he wouldn't say R1 is a fall risk but he hasn't worked with her since she's come back to the skilled nursing unit. On 03/19/2025 at 1:25 PM V10 (Certified Nursing Assistant) stated she believes R1 is a fall risk and she uses a gait belt to raise R1 up and follows her to the bathroom. V10 stated other fall precautions for R1 include low bed with a mattress on one side of the bed and at times raising her bedrails to keep her sideways so she won't roll out of bed. On 03/19/2025 at 1:34 PM V11 (Certified Nursing Assistant) stated she works with R1 and tries to check on her every hour and assists her with ambulating. On 03/19/2025 at 1:37 PM Observed R1 lying in her room in her bed raised to knee height and not in the lowest position, with no mats on the floor and without bedrails raised. On 03/19/2025 at 2:07 PM V2 (Assistant Director of Nursing) stated R1 needs fall interventions including regular checks from Certified Nursing Assistants and nurses, call light within reach, proper footwear, her walker always within reach, reminders to call for assistance when needed especially when toileting, and bed in low position when in it. V2 stated the facility does not use bed rails for fall precautions. On 03/19/2025 at 3:07 PM V12 (Registered Nurse) stated she has 21 days to complete a comprehensive care plan which would have been Monday 03/17/2025. V12 stated she isn't sure what other information staff would use to identify fall interventions besides the baseline and comprehensive care plans. V12 stated R1's baseline care plan assessment provided to the surveyor is considered their baseline care plan. V12 stated the baseline care plan does include fall risk information and could not explain where the fall interventions were located in R1's baseline care plan assessment. On 03/20/2025 at 1:20 PM V1 (Administrator) reported R1 went to the hospital on March 1, 2025 after her readmission to Skilled Nursing unit on 02/25/2025 and returned from the hospital on 03/03/2025. V1 stated R1 fractured her hip in November of 2024 when she was a resident in the assisted living unit of the facility. The facility's Care Plan Policy received 03/18/2025 states: The goal of the baseline care plan is to provide an initial set of instructions needed to provide effective and person-centered care of the resident. An initial baseline personalized plan of care addresses the transfer information sent on admission and initial nursing assessment information. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The baseline care plan should include the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care and the minimum healthcare information necessary to properly care for each resident immediately upon their admission. This may include but is not limited to resident-specific safety concerns to prevent injury and would identify needs for supervision, behavioral interventions, and assistance with activities of daily living as necessary.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344 Based on interview and record review, the facility failed to ensure effective fall interventions were in place and fall interventions were being followed, resulting in multiple falls. This failure applies to one (R2) of four residents reviewed for falls on the total sample of 20. Findings include: R2 is a [AGE] year-old female who originally admitted to the facility on [DATE] and continues to reside in the facility. R2 has multiple diagnoses including but not limited to the following: CHF, respiratory failure, Parkinson's disease, dementia, lack of coordination. Per facility fall log R2 had a fall on 11/26/2024, 1/15/2025, and 2/16/2025. It is to be noted that R2 experienced these three falls during transferring. R2's Progress Note dated 11/26/2024 states in part but not limited to the following: Observed R2 sitting on the floor in the room. V5 (Certified Nursing Assistant) said she was transferring R2 to the wheelchair when R2's legs buckled, and she was lowered to the floor. R2's Progress Note dated 1/15/2025 states in part but not limited to the following: V5 was transferring R2 from the wheelchair to the bed. V5 said that R2's knee gave out and R2 was lowered to the floor. Fall Risk Assessment Post Fall Evaluation dated 1/15/2025 states in part but not limited to the following: R2 will have two-person assistance during transfers. R2's Progress Note dated 2/16/2025 states in part but not limited to the following: V6 (Certified Nursing Assistant) stated while transferring R2, R2 was unable to support her weight and subsequently V6 had to slide R2 to the floor. Fall Risk Assessment Post Fall Evaluation dated 2/16/2025 states in part but not limited to the following: Any commonalities with previous falls: Had a fall prior with similar incident. It is to be noted that on 2/16/2025, V6 was the only staff present when transferring R2. On 3/19/2025 at 1:15PM, V6 was interviewed regarding R2's fall on 2/16/2025. V6 said I was providing assistance while toileting R2. I was helping R2 pull her pants up and when she was standing up, her knees buckled, and I brought her down to the floor. V6 said after the fall, the nurse on duty let me know that she required two-person assistance with transfers due to a fall prior to this. However, I was never made aware of this. At 2:25PM, V2 (Director of Nursing) was interviewed regarding R2's falls. V2 said R2's falls on 11/26/2024, 1/15/2025, and 2/16/2025 all happened during transferring. After 1/15/2025, we recommended that R2 have two-person assistance during transferring. However, on 2/16/25, V6 was not aware of this and transferred R2 with one person assistance. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility Fall Prevention Protocol states in part but not limited to the following: This protocol outlines procedures for implementing fall precautions. Post Fall Actions: The resident's care plan is reviewed after a fall event and new interventions are considered.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. 40718 Based on interview and record review the facility failed to designate a registered nurse to serve as the director of nursing on a full-time basis. This failure applies to all 22 residents within the skilled nursing unit of the facility. Findings include: On 03/17/25 at 10:45 AM V2 (Assistant Director of Nursing) reported the facility does not currently have a Director of Nursing. On 03/19/25 at 10:38 AM V1 (Administrator) stated the skilled nursing team responsible for recruiting staff, and they have placed ads, and gone to schools but has been unsuccessful and hiring a Director of Nursing. , V1 stated the skilled nursing unit has had applicants without enough experience, and people filled the position but have not stayed. V1 stated V2 (Assistant Director of Nursing) is not comfortable with being in the Director of Nursing position. V1 stated all facility's need a nursing director and a person responsible for coordinating nursing services. The facility's staffing list provided during the survey does not include a Director of Nursing.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46344 Based on interview and record review, the facility failed to ensure that all residents were offered the pneumococcal booster vaccine. This failure applied to four (R9, R11, R12, and R19) of five residents reviewed for vaccines on the total sample of 20. Findings include: R9 is a [AGE] year-old female with multiple diagnoses including but not limited to the following: COPD (Chronic Obstructive Pulmonary Disease), anxiety, dysphagia, and need for assistance with personal care. R11 is a [AGE] year-old male with multiple diagnoses including but not limited to the following: CVD (CardioVascular Disease), dementia, and dysphagia. R12 is a [AGE] year-old female with multiple diagnoses including but not limited to the following: CVD, dementia, and macular degeneration. R19 is an [AGE] year-old male with multiple diagnoses including but not limited to the following: AFib, CAD (Coronary Artery Disease), HTN (Hypertension), heart failure, dementia, and legal blindness. On 3/18/2025 at 1:57PM, V2 (Director of Nursing/Infection Preventionist) said residents should receive the pneumococcal vaccination booster every five years. V2 said when a resident is admitted I check to see if they have any historical history of the pneumococcal vaccine. If they do not, I will order the vaccination, however if they do, I do not order anything. V2 says we offer a vaccination clinic almost twice a year for the influenza and COVID+ vaccine, but not the pneumonia vaccine. Vaccination history shows R11 last received their pneumococcal vaccine on 8/13/2018, R9 on 4/7/2015, R12 on 10/8/2015, and R19 on 3/16/2018. It is to be noted that R9, R11, R12, and R19 all received their last pneumococcal vaccination >5 years ago and were not offered a booster shot. Facility policy titled Immunization Program with revision date of 05/2024 states in part but not limited to the following: For adults [AGE] years or older, if PPSV23 is administered, use shared clinical decision-making to decide whether to administer one dose of PCV20 at least 5 years after the last dose of PPSV23 dose.