STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146164	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspyre of Bronzeville	4314 South Wabash Avenue Chicago, IL 60653

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 0688 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to (a) provide treatment or services, equipment or device and (b) develop comprehensive care plan to address contractures for two (R4 and R34) of two residents reviewed for limited range of motion in sample of 29. This failure resulted to left hand contracture of one (R34) resident admitted with full range of motion and / or mobility status. The findings include:R4's admission record showed admit date on 5/7/24 with diagnoses not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Dysarthria following unspecified cerebrovascular disease, Personal history of traumatic brain injury, Pain in left upper arm. On 9/2/25 at 11:35AM Observed R4 sitting on the side of the bed, alert and oriented x 3, responsive, nonverbal, communicate through gestures, nodding and shaking head. Observed with left hand contractures, no device in place. R4 was shaking his head side to side indicating no or he was not wearing device or splint, and range of motion exercises were not provided for his left-hand contracture. MDS (Minimum Data Set) dated 8/12/25 showed R4's cognition was intact. He had functional limitation ROM (Range of Motion) or impairment on one side of upper and lower extremities. R4 needed supervision or touching assistance with eating, oral and personal hygiene, shower / bathe self, upper and lower body dressing, chair / bed and toilet transfer; Partial / moderate assistance with toileting hygiene. MDS showed R4 received restorative nursing program for dressing and / or grooming, Communication. OT (Occupational Therapy) evaluation note dated 5/10/24 showed R4's LUE (Left upper extremity) ROM (Range of Motion) assessment was Impaired. R4's OT Discharge summary dated [DATE] showed recommendations not limited to Restorative range of motion program.Functional abilities and goals assessment dated [DATE] showed R4 had Impairment on one side of the upper extremity ROM.Restorative observation and planning assessment dated [DATE] showed R4's LUE (Left upper extremity) ROM (Range of Motion) deficit. Restorative programs: Communication, Dressing / Grooming.R4's EHR (Electronic Health Record) did not reflect R4 was provided with restorative nursing program for ROM.Reviewed R4's care plan, did not reflect plan of care for left hand contracture.R34's admission record showed initial admit date on 3/21/24 with diagnoses not limited to Peripheral Vascular Disease, Thrombosis of atrium, Hypertensive heard disease, Acquired absence of left leg below knee, Human immunodeficiency Virus (HIV) disease, Unspecified mental disorder. On 9/2/25 at 11:42AM Observed R34 sitting up on wheelchair, alert and oriented x 3, verbally responsive, with left below knee amputation. Observed left hand contracture, not able to open middle, ring and little fingers on left hand. No device or splint on left hand. R34 said he has been residing in the facility for over a year, and he developed contracture on left hand about 6 months ago while residing in the facility. He said left hand contracture started when he had a fracture from a fall incident in the facility. MDS admission assessment dated [DATE] showed R34's cognition was severely impaired. R34 had no functional limitation in ROM or no impairment on both upper extremities. MDS dated [DATE] showed R34's cognition was moderately impaired. He had functional limitation in ROM or impairment on one side of the upper extremity. He needed supervision or touching assistance with eating, upper body dressing; Substantial / maximal assistance with oral, toileting and (continued on next page)

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 0688 Level of Harm - Actual harm Residents Affected - Few	personal hygiene, shower / bathe self, lower body dressing, chair / bed and toilet transfers. MDS showed R34 received restorative nursing program for Active ROM and dressing and / or grooming. OT (Occupational Therapy) evaluation and plan of treatment report dated 3/22/24 showed R34's left upper extremity ROM was within functional limits or no impairment. OT evaluation and plan of treatment report dated 4/22/24 showed R34's left upper extremity (LUE) ROM was impaired, no contracture.R34's OT discharge summary report dated 7/17/24 showed recommendations not limited to restorative program for LUE PROM (Passive Range of Motion) and RUE AROM (Active Range of Motion). R34's EHR reviewed, no documentation found that PROM (Passive Range of Motion) to LUE was provided to R34.OT evaluation and plan of treatment report dated 10/16/24 showed R34's left upper extremity (LUE) ROM was impaired, left-hand contracture (middle, ring and little finger). R34's OT discharge summary report dated 11/26/24 showed recommendations not limited to: Restorative program for left hand PROM. Splint and brace program. Left hand contracture cushion to be worn daily (evening) or as tolerated. R34's EHR (electronic health record) reviewed, no documentation found that PROM and splint or brace to left hand were provided to R34.OT evaluation and plan of treatment report dated 6/16/25 showed R34's LUE ROM was impaired, left-hand contracture. R34's OT discharge summary report dated 7/11/25 showed recommendations not limited to: Restorative ROM program. PROM to left hand. R34's EHR reviewed, no documentation found that PROM to left hand was provided to R34.Care plan reviewed, no plan of care found to address or focus R34's left hand contracture. Functional abilities and goals assessment dated [DATE] showed R34's ROM had no Impairment. Functional abilities and goals assessment dated [DATE] showed R34's ROM had Impairment on one side of the upper extremity. On 9/3/25 at 2:42PM V20 (Restorative Nurse, Registered Nurse / RN) stated she started working in the facility in July 2025. She said if resident has limited ROM or contractures, should provide restorative programs such as AROM / PROM or rehab evaluation and treatment if appropriate. V20 said the goal is to maintain resident's functional mobility, prevent contractures or further contractures. She said if resident has hand contracture, palm protector / splint could be provided. V20 said care plan should be developed for limited ROM or Contracture so staff would know the plan of care or what to focus on the resident. She said the purpose of splint or brace is to prevent further contracture or possible injury. V20 said resident's care plan should be individualized to address concern / problem and would include goals, interventions / approaches. Stated does not know if R4 and R34 have limited ROM or contracture because she is new to the facility. Surveyor reviewed R4 and R34's EHR with V20. She said R4 is on restorative program for communication and dressing / grooming. She said if there is limited ROM / Contracture, PROM or AROM could be provided to resident. V20 was not able to find documentation if AROM / PROM was provided to R4's LUE impairment. Stated she could not find care plan for R4's LUE impairment or left-hand contracture. V20 said R34 has limited ROM / impairment on one side of the upper extremity. She is not sure if R34 has left hand contracture. V20 said could not find care plan for left hand contracture on R34's EHR. Stated she does not know if PROM or splint was provided to R34's left hand because she is new to the facility and she was not able to find documentation in R34's EHR.On 9/4/25 at 10:21AM Surveyor and V20 checked R4 and R34. V20 said R4 and R34 have contractures to left hand, no device / splint in place to affected area. On 9/4/25 at 10:34AM V30 (CEO of ARC Rehab, OT / Occupation Therapist) was interviewed via phone and reviewed R4 and R34's EHR. She said R4's last OT evaluation and treatment was on 5/10/24 until 6/7/24. V30 said per documentation R4's LUE ROM was impaired, with contractures. She said R4's treatment goal was splinting on LUE / left hand. V30 said R34's initial OT eval and treatment was on 3/21/24 to 4/3/24. She said R34 was evaluated by OT on 3/21/24, documentation showed both upper extremities ROM within functional limits, no impairment on right and left UE, No contracture. V30 said R34 had another OT eval and treatment on 10/2024 to 11/2024. She said R34's LUE with impairment and contracture to left hand. V30 said treatment goal included donning and doffing of splint on the left hand and wearing hand splint finger contracture and decreasing pain. She said R34 last OT eval and treatment was on (continued on next page)

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F 0688 Level of Harm - Actual harm Residents Affected - Few	6/16/25 to 7/11/25. V30 said R34 had LUE impairment or left-hand contracture. Stated R34's treatment goal included wear palm roll or hand splint on left hand.On 9/4/25 at 11:25AM V2 (Director of Nursing / DON) stated if there are limited ROM / contractures, resident should have Restorative nursing program like ROM as appropriate. She said it should be a team effort and what is best for the resident. V2 said the goal is to maintain resident's ROM, prevent contractures or further contractures, if possible, by giving or providing resident with necessary or appropriate services or care best for the resident. On 9/4/25 at 12:08PM V27 (MD / Medical Doctor) was interviewed via phone and stated contractures could be preventable by giving resident necessary services such as hydration, nourishment, therapy, restorative nursing programs. Stated he knows R34, and he is the attending physician. V27 said R34 has multiple comorbidities, he has HIV and muscle weakness / wasting that could possibly lead to limited ROM or contractures. He said the goal is to prevent contracture or further contracture by giving appropriate services or care needed for the resident. Facility's Restorative Nursing policy dated 3/2021 showed in part: The facility shall ensure that restorative care approaches and principles aimed at improving, preventing decline or maintaining a resident's functional level and quality of life are integrated into the individualized plan of care. If therapy department determines that skilled therapy is not indicated, Restorative nursing recommendations will be forwarded to the Restorative Nurse. The Restorative Nurse will initiate individualized goals and objectives based on therapy recommendations and monitor the implementation of the plan of care. Care plan will be individualized and specific to the resident needs. Evaluation and reevaluation fo the resident's status is ongoing and at least quarterly.

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F 0689 Level of Harm - 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** Based on observation, review of records and interviews facility failed to provide supervision, assistance, assessments and interventions to maintain the right of every resident to be free from accidents, hazards and injuries for 1 out of 1 resident (R6) for a total sample of 29 residents. These failures affected 1 resident (R6) who sustained multiple falls resulting to right arm fracture on 05/21/2025 and right hand/finger fracture on 06/14/2025.Findings include: On 09/02/2025 at 10:56 AM, R6 seen alert but had a hard time elaborating when questions asked. R6 stated he had recent fall and went to hospital by nodding his head and short statements when asked. R6 was seen with bed about 2 feet high. R6 was not able to move both extremities well more on right side grimacing upon slight movement. R6's head was positioned opposite of the wall far from bedside table where items out of reach. Review of R6 fall clinical notes and care plan documents multiple falls: R6 had an actual fall (1/30/25) with no injuryR6 had an actual fall (1/31/25) with no injuryR6 had an actual fall (3/15/25) with no injuryR6 had an actual fall (5/21/25) with injuryR6 had an actual fall (6/02/25) with no injuryR6 had an actual fall (06/12/25) with injury R6's clinical notes related to falls are as follows:Dated 03/15/2025 by V35 (Registered Nurse) R6 fell when reaching TV remote. Clinical notes document, I was trying to reach my TV remote, and I fell. R6's fall care plan dated 03/15/2025 reads, determine and address causative factors of the fall. No intervention on the care plan was done to determine or address the cause of R6's fall. Dated 05/21/2025 by V16 (Licensed Practical Nurse), R6 fell in the bathroom. Transferred to hospital admitted with closed right humeral fracture. R6 now uses right cast/wrap mold and sling. Hospital records dated 05/27/2025 documents that R6 sustained closed right humeral fracture. Dated 06/02/2025 by V9 (Registered Nurse) documents that R6 fell in his bedroom. Per V9 notes, R6 able to ambulate with assistance. Per MDS (Minimum Data Set) assessment R6 dependent to facility staff on transfers and unable or not attempted to walk due to medical condition or safety concerns. Dated 06/12/2025 by V31 (Registered Nurse) documents that R6 fell in his bedroom in front of his wheelchair. After two days on 06/14/2025 V32 (Licensed Practical Nurse) clinical notes reads right hand with large swelling, pain 9 out of 10. V34 (Nurse Practitioner) medical notes dated 06/14/2025 documents that R6 wearing soft cast on right arm / hand with pain and swelling, X-Ray pending. The same date 06/14/2025, V33 (Licensed Practical Nurse) noted X-Ray done with result of right fracture of the fifth metacarpal. R6 was sent to hospital. R6's fall care plan does not address each fall that occurred on 05/21/2025, 06/02/2025 and 06/12/2025 when R6 sustained injuries by providing interventions. Most current care plan intervention was dated 04/21/2025. R6 was assessed as high risk of fall dated 05/27/2025 the only fall assessment done since 11/24/2020. On 09/03/2025 at 2:05 PM, V20 (Restorative Nurse / Registered Nurse) after review of R6 clinical records confirmed that R6 have multiple falls. V20 stated that all falls of R6 were not addressed in his plan of care. V20 stated that most current intervention for R6 was dated 04/21/2025 which does not address repeated falls on 05/21/2025, 06/02/2025 and 06/21/2025 which R6 sustained injuries. V20 stated that R6 sustained closed right humerus fracture due to fall on 05/21/2025 and right 5th metacarpal (finger) due to fall on 06/12/2025. V20 stated that interventions needed every time R6 fall to prevent R6 from recurrent falls. V20 stated that care plan interventions should be based on assessments that needs to be reviewed from time to time to prevent falls to reoccur. On 09/04/2025 at 09:49 AM, V2 (Director of Nursing) denies any knowledge that R6 have fractures. V2 said, I don't know if there was history of fracture. V2 stated that there needs to have fall interventions because interventions are there to prevent falls. Decline of R6's functional abilities were noted based on Minimum Data Set (MDS) assessment dated [DATE] compared to 06/04/2025). 05/16/2025 assessment documents that R6 needs partial moderate assistance on transfers and ambulation. 06/04/2025 assessment after the fall dated 05/21/2025 when R6 sustained (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	fracture injury. R6's MDS assessment documents dependent on transfers where facility staff needs to help R6 totally and unable or not attempted to walk due to medical condition or safety concerns. Per clinical notes dated 09/02/2025 by V20, R6 was transferred to hospital due to uncontrolled pain with highest pain score of 10 out of 10 and swelling of right arm. Fall Program Policy dated 03/2021provide guidance to facility staff. Per policy all residents need evaluation for falls on admission, at least quarterly after admission, change in condition and after a fall. Upon completion of the fall evaluation, residents that are identified at risk for falls develop a care plan or update. Falls will be reviewed with the Interdisciplinary Team discussions will include any trends, education needed or recommendations. Review of interventions and care plan occurs.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview and record review, the facility failed to follow their policy and procedure for preventing foodborne illnesses to ensure dairy in the main cooler was discarded by the best by date, and to ensure staff was wearing hair restraint while in the kitchen. These failures have the potential to affect all 143 residents in the facility who are receiving oral diet.Findings Include: On 9/2/25 at 9:54 AM, during the initial tour in the kitchen with V4 (Dietary Manager), surveyor found a carton of 2% milk labeled with best by date of 6/11/25. V4 stated it should have been discarded and not be stored in the main cooler.On 9/3/25 at 11:07 AM, surveyor observed V25 (Director of Rehab) entered the kitchen with no hair restraint on. V4 stated that everyone entering the kitchen should wear hair restraint to prevent hair contaminating the food.On 9/3/2025 at 12:01 PM, V4 further stated that foods or dairies stored in the main cooler should be discarded the day of the best by date because it may not be any good and should not be given to the residents. V4 stated nothing spoiled should be given to the residents because it could cause food poisoning or food borne illness.The facility's 9/2/25 residents' roster documents 144 residents in the facility with 1 resident who is NPO (Nothing By Mouth).The facility's Personal Hygiene and Attire (no date) documents in part: Incorporate appropriate personal habits and hygiene that minimize the risk of food-borne illness. Hair restraints acceptable in your operation (hair net, visor, cap or hat, other). The facility's Kitchen/Dietary Guidelines dated 4/20 documents in part: Hairnets, caps, or other approved coverings are mandatory for all staff working in food preparation, storage, or service areas.The facility's Storage, Rotation, and Disposal of Foods dated 4/20 documents in part: Food items past their expiration date, use-by date, or showing signs of spoilage (e.g., odor, discoloration, texture changed must be removed.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview and record review, the facility failed to ensure the dumpsters and garbage bins were properly covered and not overflowing to prevent the harborage and feeding of pests. This deficient sanitation practice has the potential to affect all 144 residents residing in the facility. Findings Include: On 9/2/25 at approximately 10:00 AM, V4 (Dietary Manager) brought surveyor outside to inspect the facility's dumpsters. Surveyor observed two dumpsters with the lid not fully closed due to overflowing of garbage. V4 stated that all dumpsters should be fully closed to prevent rodents and other pests' infestation. V4 stated, They did not pick up the garbage this morning. V4 stated that pest will be all over the overflowing garbage and residents will be at risk to get sick. V4 stated, They called me yesterday saying garbage was overflowing. [V1 (Administrator)] called the company, and they said they will pick them up this afternoon. Surveyor also observed in the basement hallway by the kitchen one black garbage bin and two gray garbage bins with no covers filled with waste from the kitchen, and one yellow cart with no cover overflowing with black garbage bags. V4 stated they were garbage collected by housekeeping from all floors. The facility's Garbage Disposal policy dated 4/20 documents in part: To prevent odors, minimize breeding places for insects and rodents, maintain sanitary conditions, and ensure service areas remain lean and safe. Use garbage cans that are leak-proof, non-absorbent, and have tight-fitting lids. Empty garbage cans as they become full. Do not allow overflow. Keep garbage can lids closed. Keep open garbage cans away from food production areas. The facility's roster dated 9/2/25 documents 144 residents residing in the facility.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, interviews and record review the facility failed to label/date medications when opened and remove expired medications from the medication carts and medication room during review of medication storage and labeling.Findings Include:On 09/02/25 at 12:52PM the third floor A medication cart was reviewed with V7 (Registered Nurse) R100's Breo Ellipta Inhalation Aerosol Powder Breath Activated 200-25 MCG/ACT 1 inhalation inhale orally one time a day dispensed 08/15/25 was observed in the medication cart with no label/open date. V7 said when the inhalers are opened, they are supposed to be dated. One multi dose vial of Lantus insulin 100/units/ml was observed in the medication cart drawer open with no date with a label indicating discard after 28 days. Surveyor asked V7 what could potentially happen if the Lantus insulin was used passed the 28 days. V7 responded, it does not have the potency. R101's multi dose vial of Lispro insulin 100 units sliding scale was observed in the medication cart drawer labeled with an open date of 06/25/25, expires 07/23/25. V7 said it was supposed to be discarded on 07/23/25. When medication expires, we put it in the discard bin, and it gets sent back to pharmacy. On 09/03/25 at 10:47 AM the 2ND floor team b medication cart was reviewed with V16 (Licensed Practical Nurse). Docusate Sodium 100 MG with an expiration date of 07/25, Senna Plus 100 tablets with an expiration date of 06/25 100 and Vitamin C 500 MG with an expiration date of 08/25 were observed in the top drawer of the medication cart. V16 said I will toss those; they should have been taken out of the medication cart.On 09/03/25 at 10:57 AM the second-floor medication room was reviewed with V16 (Licensed Practical Nurse). One vial of Tuberculin Purified Protein Derivative 5 tu/0.1 ml was observed in the medication room refrigerator open/undated. R112's multidose vial of Lantus insulin and R112's multidose vial of Humulin R insulin 100 unit sliding scale was observed in the medication room refrigerator open/undated. (R112's Humalog Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 150 - 200 = 2 units; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units if above 401 call md, subcutaneously two times a day for was Discontinued on 07/19/25). Floor stock Vitamin C 250 MG with an expiration date of 12/24 and Vitamin D 10 MCG 400 iu with an expiration date of 05/25 was observed on a shelf in the medication room.On 09/03/25 at 11:06 AM the 1st floor medication cart was reviewed with V17 (Registered Nurse). Senna plus 100 tabs with an expiration date of 06/25 and One Daily Multi Vitamin with an expiration date of 08/25 was observed in the top drawer of the medication cart. V17 stated they should have been taken out of the medication cart.On 09/04/25 at 09:06 AM V2 (Director of Nursing) stated Expired medications should be removed from the cart and medication room then discarded. Expired medications should not be administered. If expired medications are administered, they could have an adverse reaction. If the nurse does not have a certain stock medication on the cart, they should come downs stairs and get it. Medication should not be taken from the original container and stored in a medication cup for administration, so we don't make mistakes. My expectations when a multidose insulin vial, multidose Tuberculin vial or inhaler is opened is that it need to be dated and stored in the proper place. Insulin and Tuberculin good for 28 days after opening. If the insulin or Tuberculin is given passed the expiration date, there can potentially be adverse reactions.PolicyTitled Medication Storage effective date 03/21 document in part: The facility maintains proper store of a variety of medications in accordance to the pharmacy recommendations and regulatory guidelines. PROCEDURE: 4. Medications that have a different route form oral are kept separated and when appropriate in labeled and dated bags in the cabinets. 7. Medications are routinely checked for expiration dates. 8. Discontinued medications are disposed of per facility policy.Titled Medication Administration effective date 03/24 document in part: To ensure that the administration of medications is performed in a safe manner to prevent medications errors. STANDARD: Medications are administered according to state and federal law. PROCEDURE: 1. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Infection control practices. b. Medications are administered in a manner to prevent contamination. 2. General: No discontinued or unlabeled drugs remain on the medication cart. Multi-dose solutions/vials labeled with date opened. b. Verify the expiration date. 6. Medications are not prepared ahead of time.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure reusable medical equipment (blood pressure monitor) was cleaned and sanitized between residents use and failed to ensure proper PPE (Personal Protective Equipment) was worn during care of one (R1) resident on Enhanced Barrier Precautions with a Nephrostomy tube. The facility also failed to perform hand hygiene during and after performing direct care and catheter care for 1 (R41) resident on Enhanced Barrier Precautions. This failure has the potential to affect all residents residing on the second and third floors of the facility.Findings Include:Findings include: R41 is [AGE] years old with initial admission date of 07/17/2024. R41 diagnosis includes type 2 diabetes and kidney transplant. R41 has a BIMS of 15 dated 06/24/2025 that means resident cognition is intact. R41 has an order for enhanced barrier precautions due to urinary catheter and wounds. On 09/02/2025 at 10:10 AM inside R41's room, V13 (Certified Nursing Assistant) was preparing R41 for appointment. R41 said that he is going to his kidney appointment. V13 was seen changing clothes of R41, performing care of R41's urinary catheter. V13 stated that he gave R41 bed bath when asked about why moving side table was wet. V13 then transferred R41 from bed to wheelchair in a hugging position. Urinary catheter bag was seen on R41's bed. V13 then attached urinary bag to R41's right leg. During all these care, handwashing or hand hygiene was not performed. V13 uses single glove not changing and without gown. On 09/02/2025 at 10:23 AM, V14 (Registered Nurse) stated that nursing staff needs to use gown and gloves when performing patient's care. Pointing to the poster that reads: Enhanced Barrier Precautions. Everyone must: Clean their hands, including before entering and when leaving the room. Staff must also wear gloves and gowns for the following high-contact resident care activities that includes dressing, bathing, transferring, providing hygiene, device care or use that includes urinary catheter. V14 stated that the purpose is to prevent the spread of infections. V13 stated that the purpose of using PPE for residents on transmission barrier precaution is prevent potential infection. V13 said, I forgot to use gown and change gloves during care. On 09/04/2025 at 09:49 AM V2 (Director of Nursing) stated that gloves and gown, catheter care needs gloves and gown. Nursing staff needs to perform handwashing before and after performing care. Enhanced Barrier Precautions dated 12/2019 policy purpose is to prevent the spread of infections in facilities. To use PPE based on anticipated exposure. Hand Hygiene Policy dated 08/01/2015: All personnel are responsible for hand hygiene. Wash hands with a non-antimicrobial soap and water or an antimicrobial soap and water when hands are visibly dirty or contaminated. If hands are not visibly soiled, use an alcohol-based waterless antiseptic agent for routinely decontaminating hands. After moving from a contaminated body site to a clean body site during patient care. R109 has diagnosis not limited to Cerebrovascular Disease, Hypertensive Heart Disease with Heart Failure and Hyperlipidemia. 0n 09/02/2025 at 09:37 AM V5 (Registered Nurse) entered R109 room and said to R109, come out and take your blood pressure. At 09:40 AM V5 placed the blood pressure cuff on R109's right arm while (continued on next page)

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	146164	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspyre of Bronzeville	4314 South Wabash Avenue Chicago, IL 60653

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	standing at the medication cart with a blood pressure reading of 81/54 pulse 100. V5 placed the blood pressure cuff on R109 left arm and rechecked R109's blood pressure with a reading of 104/75 pulse 101. V5 placed the blood pressure cuff on top of the medication cart without cleaning/sanitizing it. R96 has diagnosis not limited to Anemia, Malignant Neoplasm of Upper Lobe, Right Bronchus or Lung, Hypertensive Heart Disease, Facial Weakness Following Unspecified Cerebrovascular Disease, Primary Generalized (Osteo)Arthritis, Lack of Coordination, Constipation, Chronic Pain, Sleep Disorder, Neuralgia and Neuritis, Simple Chronic Bronchitis, Sciatica, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side and Major Depressive Disorder. On 09/02/25 at 09:51 AM V5 (Registered Nurse) picked up the blood pressure monitor from the medication cart, entered R96's room, placed the blood pressure cuff on R96's right arm, placed the blood pressure monitor on R96's bed and obtained a reading of 130/69 pulse 75. V5 exited R96's room and placed the blood pressure monitor on top of the medication cart without cleaning/sanitizing it. R92 has diagnosis not limited to Acute on Chronic Diastolic (Congestive) Heart Failure, Atrial Fibrillation, Hypertensive Heart Disease with Heart Failure, Nonrheumatic Aortic Valve Disorder, Cardiomegaly, Peripheral Vascular Disease, Atherosclerosis of Native Arteries of Right Leg and Hypertrophic Cardiomyopathy. On 09/02/25 at 10:04 AM V5 (Registered Nurse) told R92 you are on blood pressure medications so let me take you blood pressure. V5 picked up the blood pressure monitor from the medication cart, placed blood pressure cuff on R92's left arm, placed the monitor in R92's lap and obtained a blood pressure reading of 112/48 pulse 63 then placed the blood pressure monitor on top of the medication cart without cleaning/sanitizing it. On 09/02/25 at 10:14 AM V5 (Registered Nurse) said when cleaning the blood pressure monitor, I clean it when I first start, in the middle and when I'm done. It should be cleaned between each resident with the minute wipes for infection control, to avoid passing things from one resident to the other. On 09/02/25 at 11:42 AM R1 was observed lying in bed with the urinary drainage leg bag wrapped in a brief. R1 began unwrapping the drainage bag from the brief then threw it on the floor near the garbage can and said I don't know why they wrapped it in the diaper because it is not leaking. The brief was observed to be wet with a large yellow stain. The urinary drainage bag was observed without the blue screw cap on it. R1 was observed twisting on the white extension then picked up the blue cap from the bed and tried to screw it on the extension to the urinary drainage leg bag. R1 said the leg bag is not closed, I am trying to put the blue cap on here. On 09/02/25 at 01:50 PM Enhanced Barrier Precaution signage was posted on R1's entry door. Surveyor asked V7 (Registered Nurse) to assess R1's urinary drainage leg bag. V7 said let me get some gloves and maybe I can put the blue cap back on. V7 reentered R1's room at 01:51 PM put on gloves and attempted to screw the blue cap back on the urinary drainage leg bag. V7 said I fixed it for you, and I put the cap back on it. V7 emptied the urine from the drainage bag into a urinal. V7 removed her gloves then picked up the soiled brief from the floor and placed it in the garbage can. V7 did not have the required PPE (Personal Protective Equipment). V7 said I have worked here since December. R1 gets up out of the bed and is on Enhance Barrier Precautions. I should have had on gloves, mask and a gown when doing care. I am not sure why R1 urinary drainage leg bag was wrapped in a diaper. I put the blue cap back on there, made sure it was working and not leaking. There is a potential for (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	infection. On 09/04/25 at 09:06 AM V2 (Director of Nursing) stated my expectations of the staff when using the blood pressure monitor is to use the proper size and cleaned it between residents with the antibacterial wipes. If the blood pressure monitor is not clean/sanitizing between residents, there is a potential to transmit anything from one resident to another. My expectation for the care of a resident with a nephrostomy tube is that all care is to be given as ordered. For the resident on EBP (Enhanced Barrier Precautions I expect the precautions to be followed when providing care for the resident. Gloves and gowns should be worn. If the PPE (Personal Protective Equipment) is not worn there is a potential for cross contamination. If the urinary drainage is leaking, it should not be wrapped in a brief. The urinary drainage leg bag should be connected to R1's leg. If the urinary drainage leg bag screw cap was off it is the best interest to change the leg bag. There is a potential for contamination that can possibly lead to a urinary tract infection. Enhanced Barrier Precautions signage indicated Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident care activities: Device care or use: central line, urinary catheter, feeding tube. Policy: Titled Cleaning Titled Enhanced Barrier Precautions effective date 12/19 document in part: 1. Enhanced Barrier Precautions are a new approach for preventing the spread of infections in facilities. 3. Enhanced Barrier Precautions are focused on residents with MDRO (Multi Drug Resistant Organisms) colonized and infected residents. 4. Enhanced Barrier Precautions will be in place for residents with wounds, indwelling medical devices (catheter) regardless of MDRO status to address the issue of unknown colonization status and silent spread of MDRO's. Standard: 1. Enhanced Barrier Precautions expand the use of PPE (Personal Protective Equipment) beyond standard precautions and in situations when Contact Precautions do not apply. Procedure: Gloves and gowns should be used when providing the following High-Contact activities: g. Device care or use of a device: catheter. Titled Cleaning and Disinfection of multi-use equipment effective dated 03/21 document in part: To prevent inadvertent contamination and ensure surfaces and equipment may be cleaned per the manufacturer's recommendations. Procedure: Wipe the item thoroughly following the manufacturer's recommended contact time and cleaning instructions.

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F 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Put firmly secured handrails on each side of hallways. Based on observation and interviews facility failed to ensure 3rd floor corridor handrails used by residents are firmly secured. These failures have the potential to affect 63 residents' safety when using handrails for support.Findings include: On 09/02/2025 at 11:15 AM In the hallway near the nurse station, resident using a wheelchair was using handrails when locomotion. Handrails was seen moving when resident holds to move his wheelchair. Close view of handrails shows that it easily wobbles with slight pressure. Brackets are loose that may detach upon further pressure. On 09/02/2025 at 12:32 PM with V12 (Walker Maintenance Director) went to check the handrails. V12 held and moved the rail that was loose. V12 saw that there was one bracket missing and 2 brackets that has one loose screw instead of 2 screws. Handrails has a total of 4 brackets to support its structure. V12 stated, yea, this is loose. this is located at northwest area of the nurse station. V12 said that handrails are required because it gives support to those that needs to get up while using a wheelchair. Handrails needs to be maintained and checked for safety. V1 (Administrator) was made aware of concern, stated that facility does not have policy specific to handrails and only has maintenance policy. Maintenance policy dated 04/2020, maintenance service shall be provided to all areas of the building, grounds and equipment. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in safe and operable manner at all times. The Maintenance Director is responsible for developing and maintaining a schedule of preventative maintenance service to assure that the buildings, grounds, and equipment are maintained in a safe and operable manner.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and review of records the facility failed to maintain resident rights to access personal funds in timely manner for 1 out of 1 resident (R41). These failures affected 1 resident (R41) in his ability to support his wants and/or needs due to lack of financial funds.Findings include: R41 is [AGE] years old with initial admission date of 07/17/2024. R4 diagnosis includes type 2 diabetes and kidney transplant. R41 has a BIMS of 15 dated 06/24/2025 that means resident cognition is intact. On 09/02/2025 at 10:05 AM, R41 stated that he asked for his monthly allowance of 30 dollars on August 1 and 2. Facility staff told him (R41) that it was not yet available. R41 stated that he asked multiple times for his monthly allowance from activity staff but still have the same answer. R41 stated it was very hard because he does not have any money at all. R41 stated that because of his frustration he told the facility that he would report to the State. It was only then that facility gave him his monthly allowance. On 09/03/2025 at 10:28 AM, V15 (Business Manager) stated that facility give residents their personal funds or monthly allowance between day 2 to 5 of each month. V15 stated that itemization of personal funds is being done by corporate office. Every time resident received personal fund, a receipt will be made with residents' signature. Review of R41 July itemization documents that 30-dollar allowance was debited on July 18. V15 stated that it may be recorded but it is not the actual date of disbursement depending on the receipt. Review of R41's receipt for 30-dollar allowance for the month of August was dated on the 27 of August almost September. V15 stated that if it was available, it should have been given to R41. V15 was made aware that based on R41's itemization record of funds, R41 has enough balance to cover 30-dollar allowance at the start of August. V15 saw the record and did not comment. 09/03/2025 11:28 AM V18 (Activity Director) stated that when resident asked for trust fund it will be given right away. Once business office gave her (V18) the money, I gave it right away. V18 stated that what she received for resident's monthly allowance is always cash. V18 stated that for the current month (September 2025) business office will give her the money on Thursday (September 4) and will give it to the resident on Friday (September 5). V18 stated that monthly allowance of 30 or 60 dollars is the only money given to residents by the facility through Activity Department. V18 when made aware that R41 received his monthly allowance on August 27 almost September. V18 said, It's not that late. Under Resident Rights Policy dated 03/2021, residents will be assured of the following rights including rights regarding their money. And the right of every resident to manage their own money.

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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** Based on observation, interview, and record review, the facility failed to ensure a baseline care plan was developed within 48 hours - 72 hours of admission for 3 (R11, R103, R125) of 3 residents reviewed for baseline care plans in a sample of 29.Finding Include:R11 was admitted to the facility on [DATE] with diagnosis not limited to Hypertensive Heart Disease, Atherosclerotic Heart Disease of Native Coronary Artery, Gastro-Esophageal Reflux Disease, Primary Open-Angle Glaucoma, Bilateral, Stage, Polyosteoarthritis, Schizophrenia, Hyperlipidemia and Major Depressive Disorder, Recurrent. R11's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15 indicating intact cognitive response. R11's Care Plan Report document No Data Found.R11's Care Plan Report presented to the surveyor areas of Focus/Goals/ Interventions/Tasks document Cancelled and/or resolved. 40 of 40 pages document in part: Care Plan Closed Date: 08/24/23, Reason for Close: Discharge. There are no marked areas on R11's Initial Nursing Assessment interim care plan dated 08/23/25. R103 was admitted to the facility on [DATE] with diagnosis not limited to Major Depressive Disorder, Recurrent, Schizoaffective Disorder, Hypertensive Heart Disease with Heart Failure, Unspecified Psychosis, Dysphagia, Oral Phase, Constipation, Secondary Osteoarthritis, Hyperlipidemia and Alcohol Dependence with Alcohol-Induced Persisting Dementia. R103's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 06 indicating severe cognitive impact.R103's Care Plan Report with one Focus, Goal and Interventions/Task document in part: Focus: The resident is Moderate risk for falls r/t (related to) Date Initiated: 08/24/25. Goal: The resident will be free of falls through the review date. Date Initiated: 08/24/25. Interventions/Task: Anticipate and meet the resident's needs. Date Initiated: 08/24/25. There is one marked area on R103's Initial Nursing Assessment interim care plan dated 08/24/25 document in part: B. Fall Focus: The resident is Moderate risk for falls r/t. Goal: The resident will be free of falls through the review date. Intervention: Anticipate and meet the resident's needs. R103's Care Plan Report presented to the surveyor areas of Focus/Goals/ Interventions/Tasks document Cancelled and/or resolved. 45 of 45 pages document in part: Care Plan Closed Date: 08/29/23, Reason for Close: Discharge. R125 has diagnosis not limited to Paranoid Schizophrenia, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Hypertensive Heart Disease, Schizoaffective Disorder, Bipolar Disorder, Anemia, Gastro-Esophageal Reflux Disease and Hyperlipidemia.R125's Care Plan Report is incomplete and document in part: Focus: The resident has a behavior problem (SPECIFY) r/t (related to) Date Initiated: 08/27/25. Goal: The resident will have fewer episodes of (SPECIFY: behavior) (SPECIFY: daily/weekly) by review date. Date Initiated: 08/27/25. Interventions/Task: Anticipate and meet the resident's needs. Focus: The resident is (SPECIFY High, Moderate, Low) risk for falls r/t Date Initiated: 08/27/25. Goal: The resident will be free of falls through the review date. Date Initiated: 08/27/25. Focus: The resident has a psychosocial wellbeing problem (actual or potential) r/t Date Initiated: 08/27/25. Goal: The resident will demonstrate adjustment to nursing home placement by/through review date. Date Initiated: 08/27/25. Interventions/Task: Encourage participation from resident who depends on others to make own decisions. Date Initiated: 08/27/25.On 09/04/25 at 12:45 PM per telephone interview V29 (MDS/Care Plan Coordinator) stated initially the nurses on admission within 48 to 72 hours after admission is responsible for completing the baseline care plan. I review the baseline care plan and within 14 days I do the comprehensive care plan. Bowel and bladder, amount of assistance the resident needs, pain, skin, diet, if they have any medication, diagnosis pertinent, if any oral issues vision issues and behaviors should be included in the baseline care plan. The baseline care plan should be more specific than just one Focus, Goal and intervention. The purpose of the initial nursing assessment interim care plan is just to get an overall ideal of the resident needs and status so we can provide appropriate care. The information transfer from the nursing assessment interim care plan (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to the actual baseline care plan and they should have filled in more information.Policy:Titled Care Plan Development effective date 03/21 document in part: A person-centered care plan that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs, that are identified in the evaluation process, is developed and implemented for each resident. Procedure:1. The facility's Interdisciplinary Team, in consultation with the resident and his/her representative, develops and implements a person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs, that are identified in the evaluation process. 7. The resident comprehensive care plan is developed within 72 hours of admission.Titled Care Plan Use effective date 03/21 document in part: The care plan is one of the tools used in developing the resident's daily care routines and will be available to staff personnel who have responsibility for providing care or services to the resident. Procedure: Complete care plans are available in the medical record and assessable by all care givers.Titled Care Planning-Interdisciplinary Team (IDT) effective date 03/21 document in part: The facility Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility staff failed to follow professional standards of practice with regards to medication administration by storing medication outside of its original packaging for administration. The facility also failed to ensure the physician was notified when blood pressure medications were not administered for 2 (R92, R109) of 3 (R96) residents during medication administration.Findings Include: On [DATE] at 09:37 AM V5 (Registered Nurse) entered R109's room and said to R109, come out and take your blood pressure. At 09:40 AM V5 placed the blood pressure cuff on R109's right arm while standing at the medication cart with a blood pressure reading of 81/54 pulse 100. V5 placed the blood pressure cuff on R109 left arm to recheck R109's blood pressure with a reading of 104/75 pulse 101. V5 said let me look to see if you have some blood pressure medications because your blood pressure is a little too low. V5 stated I am not giving Amlodipine; I am going to hold it because the blood pressure is a little low. R109 gets three blood pressure medications that I am going to hold. I will revisit R109 blood pressure after lunch to see if R109 needs them referring to (The blood pressure medications: Amlodipine Besylate 10 MG (Milligram) Daily, Hydrochlorothiazide 25 MG Daily and Losartan Potassium Tablet 50 MG Daily were held and not given). 1. Amlodipine Besylate 10 MG Daily (Not given) 2. Hydrochlorothiazide 25 MG Daily (Not given) 3. Losartan Potassium Tablet 50 MG Daily (Not given) On [DATE] at 09:51 AM V5 (Registered Nurse) took a medication cup stored in the medication cart drawer with Folic Acid written on it and stated I took a couple of folic acid 100 mcg from the other medication cart because when I checked the medication cart there was no folic acid, and I knew some of the residents get folic acid. V5 administered the medication to R96. 4. Folic Acid Tablet 1 MG Daily (Stored in a medication cup and not in the original packaging) R92 has diagnosis not limited to Acute on Chronic Diastolic (Congestive) Heart Failure, Atrial Fibrillation, Hypertensive Heart Disease with Heart Failure, Nonrheumatic Aortic Valve Disorder, Cardiomegaly, Peripheral Vascular Disease, Atherosclerosis of Native Arteries of Right Leg and Hypertrophic Cardiomyopathy. On [DATE] at 10:04 AM V5 (Registered Nurse) stated I need to write a note why I did not give R109 his blood pressure medications. R92 was in a wheelchair in the hallway. V5 told R92 you are on blood pressure medications so let me take you blood pressure. V5 picked up the blood pressure monitor from the medication cart, placed the blood pressure cuff on R92's left arm, placed the monitor in R92's lap and obtained a blood pressure reading of 112/48 pulse 63. V5 said R92's blood pressure is a little low for my liking, I think I am going to hold your blood pressure medications. On [DATE] at 10:09 AM V5 (Registered Nurse) stated I am holding R92's blood pressure medications. I held the blood pressure medications, and I will check the blood pressure again after lunch referring to: (Lisinopril 10 MG Twice a day and Metoprolol Tartrate 25 MG Twice a day were held and not given). 5. Lisinopril 10 MG Twice a day (Not given) 6. Metoprolol Tartrate 25 MG Twice a day (Not given) On [DATE] at 10:14 AM V5 (Registered Nurse) stated when giving medications we check to make sure it is the right medication, right date, right time, right person and make sure it is not expired. We are not supposed to transfer the medication from the original packaging. I am going to toss the rest of the folic acid. On [DATE] at 09:06 AM V2 (Director of Nursing) stated The nurse should hold blood pressure or any medications if the blood pressure is outside of the parameters, using nursing judgement then consult with the doctor immediately to get directions if there are any abnormal blood pressures. My expectations when holding blood pressure medications is to consult with the doctor for further orders and instructions. V5 (Registered Nurse) said she notified the doctor but if it is not documented it did not happen. Potentially it depends on the patient, it is different risk for all diagnosis. I cannot say what would happen with that particular resident. The blood pressure could have potentially dropped lower or went higher depending on the resident condition. V2 was asked by the surveyor, if there is a missed dose or medication is held without a doctor order is that a medication error. V2 responded, it depends on what the documentation says, if documented it would (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be considered a late documentation, not a missed dose. If the nurse does not have a certain stock medication on the cart, they should come downs stairs and get it. Medication should not be taken from the original container and stored in a medication cup for administration, so we don't make mistakes. Policy: Titled Medication Administration effective date 03/24 document in part: To ensure that the administration of medications is performed in a safe manner to prevent medications errors. STANDARD: Medications are administered according to state and federal law. PROCEDURE: 4. Medication preparation/Administration. a. Five Rights: Right Medication, Right Dose. Right Time - Right Route, Right Resident/patient/guest identification by way of, photo, verbal Affirmation by staff or resident, or birth date.). c. Additional assessments are obtained prior to medication administration, such as pulse, blood pressure or oxygen level. 6. Medications are not prepared ahead of time. Document medication administration after delivering. 3. If the medication is not given or given late notify the provider for additional orders. Titled Medication Storage effective date 03/21 document in part: The facility maintains proper store of a variety of medications in accordance to the pharmacy recommendations and regulatory guidelines. Titled Physician Orders-Verbal and Fax effective date 03/21 document in part: The physician or extender retains control of the resident's medical plan of care and is consulted when changes in condition occur, outpatient appointments with orders or any other situation that requires an alteration to prescribed treatments, medications, or additional test.

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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. Based on interviews and record reviews, the facility failed to follow a physician's plan of care for a resident (R71) with history of significant weight loss for one resident out of a total sample of 29 residents.Findings include:F71's ?admission Record' documents in part a diagnosis of abnormal weight loss. This was acquired during R71's stay at the facility with an onset date of 3/07/2025.R71's ?Progress Notes' document in part a nutrition/dietary note from 6/04/2025. R71 lost 11.6% of body weight over six months (R71 weighed 191 pounds on 12/02/2024 and 168.8 pounds on 6/01/2025). Multiple progress notes by V27 (Physician) note R71's abnormal weight loss. Plan of care includes weekly weights. This was noted on multiple progress notes by V27 dating back to July (7/03/2025, 7/25/2025, 8/13/2025, and 8/29/2025). R71's ?Weight Summary' documents in part monthly weights. No weekly weights done in July or August. R71's ?Order Summary Report' documents in part diet orders, supplement drinks, and frozen nutritional treats but no orders for weekly weight monitoring.R71's ?Care Plan Report' documents in part unplanned/unexpected weight loss related to poor food intake and is at risk for complications (initiated 2/20/2025). Interventions do not include weekly weight monitoring.On 9/03/2025 at 3:04 PM, V20 (Restorative Nurse) stated the restorative department does the weights for the residents. V20 stated they were not doing weekly weights for R71 because there was no order for it. V20 stated no one communicated to [V20] that R71 needed weekly weights. When asked about V27's progress notes, V20 stated [V20] did not review V27's progress notes.On 9/04/2025 at 10:05 AM, V28 (Nurse) stated progress notes are there to communicate with the rest of the team. It helps everyone know what's going on with the resident and stay up to date with the plan of care. V28 stated nurses should be reading the progress notes including the physician notes. If the physician notates an intervention that is not in the orders, then the nurse should call the physician and confirm it. During a joint interview on 9/04/2025 at 10:15 AM, V5 (Nurse) and V14 (Nurse) stated progress notes help maintain an open communication with the rest of the interdisciplinary team. V14 stated progress notes contain any updates and suggestions to the residents' plan of care. If the physician updates the plan of care but it is not transcribed to the order, V5 and V14 stated the nurse should call the physician to verify the change and put it in the orders. V5 and V14 stated that the nurse should also document that they clarified the plan of care with the doctor.Facility's Physician Orders - Verbal and Fax policy (effective 3/2021) documents in part: The Physician or extender retains control of the resident's medical plan of care and is consulted when changes in condition occur, outpatient appointments with orders or any other situation that requires an alteration to prescribed treatments, medications, or additional tests.Facility's Care Plan Development policy (effective 3/2021) documents in part: The facility's Interdisciplinary Team, in consultation with the resident and his/her representative, develops and implements a person-centered care plan for each resident that includes measurable objectives and timeframes to meet the resident's medical, nursing, mental and psychosocial needs, that are identified in the evaluation process.Facility's Weight Management Protocol (effective 3/2021) documents in part that care plans should reflect current individualized interventions and risks. Nursing monitors completion of weights and for significant weight changes.

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	146164	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspyre of Bronzeville	4314 South Wabash Avenue Chicago, IL 60653

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on observation, interview, and record review the facility staff failed to provide care and services for a catheter bag for one resident. Observations of R1 revealed the attached urinary drainage leg bag was wrapped in a brief with the closure cap not in place for a resident at risk for urinary tract infections in a sample of 29.Findings include:R1 has diagnosis not limited to Gastro-Esophageal Reflux Disease, Gout, Osteoarthritis, Hypothyroidism, Pain in Left Upper Arm, Rheumatoid Arthritis, Chronic Viral Hepatitis, Hydronephrosis with Ureteropelvic Junction Obstruction, Chronic Kidney Disease, Calculus of Kidney, Major Depressive Disorder, Recurrent, Delusional Disorders, Hallucinations, Anxiety Disorder, Hypertensive Heart Disease with Heart Failure, Atherosclerotic Heart Disease of Native Coronary Artery, Hyperlipidemia, Artificial Openings of Urinary Tract Status, Presence of Urogenital Implants, Elevated [NAME] Blood Cell Count, Myocardial Infarction Type 2, Type 2 Diabetes Mellitus, Chronic Obstructive Pulmonary Disease, Systemic Lupus Erythematosus, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Pain In Thoracic Spine, Low Back Pain, Calculus of Gallbladder, Disease of Pancreas, Migraine, Schizophrenia, Iron Deficiency Anemia and Neuromuscular Dysfunction of Bladder.Care Plan document in part: Focus: R1 has a nephrostomy tube and is at risk for complications. Date Initiated: 02/05/25. Focus: R1 is on enhanced barrier precautions, which includes gowning and gloving for transferring, bathing, providing hygiene, changing linens, changing briefs or assisting with toileting, Incontinent care, and providing care for Nephrostomy tube. Date Initiated: 05/16/25. Interventions: Gown and glove for every time if/when R1 requires assist with transfers/bathing/dressing/hygiene care, changing linens, changing clothes and/or briefs, incontinent care, or any device care (Nephrostomy Tube). Date Initiated: 05/16/25.On 09/02/25 at 11:42 AM R1 was observed lying in bed with the urinary drainage leg bag wrapped in a brief. R1 began unwrapping the drainage bag from the brief then threw it on the floor near the garbage can and said I don't know why they wrapped it in the diaper because it is not leaking. The brief was observed to be wet with a large yellow stain. The urinary drainage bag was observed without the blue screw cap on it. R1 was observed twisting on the white extension on the urinary drainage leg bag then picked up the blue cap from the bed and tried to screw it on the extension of the urinary drainage leg bag. R1 said the leg bag is not closed, I am trying to put the blue cap on here.On 09/02/25 at 01:50 PM Enhanced Barrier Precaution signage was posted on R1's entry door. Surveyor asked V7 (Registered Nurse) to assess R1's urinary drainage leg bag. V7 said let me get some gloves and maybe I can put the blue cap back on. V7 reentered R1's room at 01:51 PM put on gloves and attempted to screw the blue cap back on the urinary drainage leg bag. V7 said I fixed it for you, and I put the cap back on it. V7 emptied the urine from the drainage bag into a urinal. V7 removed her gloves then picked up the soiled brief from the floor and placed it in the garbage can. V7 did not have on the required PPE (Personal Protective Equipment). V7 said I am not sure why R1 urinary drainage leg bag was wrapped in a brief. I put the blue cap back on there, made sure it was working and not leaking. There is a potential for infection. R1 has a nephrostomy, and this urinary bag was not broken. The drainage bag is connected to the tubing from her, and everything would have to be changed.On 09/04/25 at 09:06 AM V2 (Director of Nursing) stated My expectation for the care of a resident with a nephrostomy tube is that all care is to be given as ordered. For the resident on EBP (Enhanced Barrier Precautions I expect the precautions to be followed when providing care for the resident. Gloves and gowns should be worn. If the PPE (Personal Protective Equipment) is not worn there is a potential for cross contamination. If the urinary drainage is leaking, it should not be wrapped in a brief. The urinary drainage leg bag should be connected to R1's leg. If the urinary drainage leg bag screw cap was off it is the best interest to change the leg bag. There is a potential for contamination that can possibly lead to a urinary tract infection.Policy:Titled Nephrostomy Tube Management effective date 03/21 document in part: To (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provide a comprehensive approach to managing care of a resident with a Nephrostomy tube. Changing Drainage Bags: 1. Drainage bags should be changed at least every 7 days and dated. 2. If the drainage bag becomes dirty, foul smelling, or punctured, it is changed sooner.Titled Foley Catheter Use and Management Effective date 05/24 document in part: Indwelling urinary catheters should be used only when specific medical condition exists requiring the use of the catheter. PROCEDURE: 4. Proper management of resident with a Foley catheter include the following: b. A closed drainage system should be maintained. c. Urinary drainage bags should be kept below the bladder level to promote free flow of urine, by gravity. 5. Urinary leg bags should be evaluated for use, if used the following should be done. a. If a leg bag is determined appropriate, it should be only used when out of bed. b. A leg bag will be considered for discontinuation if a UTI (Urinary Tract Infection) pattern is identified. c. A leg bag should be positioned below the bladder. d. When connecting the catheter to the leg bag, follow these steps: iv. Uncap the top of the leg bag and wipe top with alcohol wipe. vi. Attach the leg bag to the catheter. vii. Apply leg straps -secure so that they are comfortable. ix. Check leg bag often and empty when needed. 7. Urinary catheter leg drainage bags are changed twice (2) a month. 10. Cleaning of Leg bags: a. Night shift will be responsible for cleaning the leg bags. e. Cleaning of the leg bag should be done every 24 hours.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to (a) follow oxygen liter flow as ordered by physician, (b) provide humidification for oxygen use, (c) properly stored oxygen tubing when not in use and (d) develop care plan for oxygen use for 1 (R33) of 2 residents reviewed for respiratory care in a sample of 29. The findings include: R33's admission record showed admit date on 2/11/25 with diagnoses not limited to Acute on chronic systolic (congestive) heart failure, Hypertensive heart disease with heart failure, Chronic kidney disease stage 3, Chronic obstructive pulmonary disease, Nicotine dependence. MDS (Minimum Data Set, dated [DATE] showed R33's cognition was intact. On 9/2/25 at 11:20 AM Observed R33 up and about, ambulatory with steady gait, alert and oriented x 3, verbally responsive. Observed oxygen tubing and nasal cannula placed on the bed and not properly stored, oxygen concentrator was on at 3L/min, no humidification bottle on the oxygen concentrator. R33 said he has been using oxygen most of the time. On 9/2/25 at 11:22 AM Surveyor requested V5 (RN / Registered Nurse) to R33's room and V5 said oxygen is on at 3L/min. She said if oxygen is not being used, oxygen tubing should be stored in a clear plastic bag. V5 said humidification bottle should be available, not sure why it was not available. On 9/4/25 at 11:25AM V2 (DON / Director of Nursing) said Oxygen should be administered as ordered by physician, following the liter flow. Stated oxygen tubing and nasal cannula should be stored properly in a bag when not in use. V2 said humidification should be available and should be changed weekly and as needed or as ordered by physician. Stated oxygen use should be care planned.R33's physician order summary report dated 9/3/25 showed active order not limited to: OXYGEN - Change tubing and humidifier weekly every night shift every Sunday for Weekly tubing change. Oxygen - PRN (as needed) via nasal cannula @ 2L/min. Reviewed R33's electronic health record, no care plan found for oxygen use. Facility's Oxygen therapy administration dated 3/2021showed in part: Verify order. When oxygen is not in use, store oxygen tubing and nasal cannula in labeled plastic bag. Facility's care plan policy dated 3/2021 showed in part: A person- centered care plan that includes measurable objectives and timeframes to meet the resident's medical, nursing needs that are identified in the evaluation process, is developed and implemented for each resident.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on observation, interview and record review, the facility staff failed to reconcile and account for controlled medications accurately in 1 of 3 medication carts reviewed for medication labeling and storage.Findings Include:On 09/02/25 at 12:52PM the third floor A medication cart was reviewed with V7 (Registered Nurse). When checking the controlled substances with V7 said R100 has 25 Vimpat Oral Tablet 100 MG (Lacosamide) Twice a day for Seizure. The Controlled Drug Receipt/Record/Disposition Form document dated dispensed 08/30/25, Lacosamide Tab 100 MG take 1 tablet by mouth twice daily. Quantity dispensed, 30 amount left 26. R100's Lacosamide 100 MG medication punch card has a remaining count of 25 pills. V7 said I did not sign for the Lacosamide, 26 is documented on the sheet. It was given at 9am. R105 Phenobarbital 64.8 MG Twice a day for seizures should have 13 and there is 14 documented on the sheet. The Controlled Drug Receipt/Record/Disposition Form document dated dispensed 08/06/25, Phenobarbital Tab 64.8 MG Take 1 tablet by mouth twice daily. Quantity dispensed 30, amount left 14. R105's Phenobarbital 64.8 MG medication punch card has a remaining count of 13 pills. V7 said the Controlled Substances Check Form is signed at the beginning and end of each shift. Review of the Controlled Substances Check Form has no initials for the date of 09/01/25 7-3 on, 3-11 off, 11-7 on or 09/02/25 7-3 on. On 09/04/25 at 09:06 AM V2 (Director of Nursing) stated When administering medications the nurse should sign that the medication is given after it is given unless it is a narcotic, it should be signed before it is given. If the resident refuses the medication the nurse has to come back and waste any medications. The medication on the Medication Administration Record should be signed for after it is given. My expectations when administering narcotics and narcotic accountability is for the nurses to count the narcotics during shift change, sign accordingly and sign when the medication is given.Policy: Titled Medications-Controlled effective date 03/21 document in part: Controlled substances are signed out upon dispensing of the medication. A count of controlled drugs is maintained by nurses of the off-going and oncoming shifts. Any irregularities are reported to the director of nursing. 1. Storage of all controlled schedule II or higher substance drugs incudes: b. Nurse on duty are responsible for controlled drugs for their shift; and d. Verified by inventory every 8 hours, and/or each shift change. 2. Controlled medication documentation: a. A separate controlled substance administration control record is kept on all scheduled II or higher drugs. It contains the amount verifiable inventory. 3. Administration: a. Remove the medication from the locked container. b. Verify medication and dosage with medication sheet. c. Remove proper dose from container and place in medication cup. d. Sign out full name in appropriate space provide. e. Subtract amount given from total and verify amount remaining.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to ensure a medication error rate was less than 5%, by making 9 errors out of 30 opportunities with an error rate of 30%.Findings Include:On 09/02/2025 at 09:37 AM V5 (Registered Nurse) entered R109's room and said to R109, come out and take your blood pressure. At 09:40 AM V5 placed the blood pressure cuff on R109's right arm while standing at the medication cart with a blood pressure reading of 81/54 pulse 100. V5 placed the blood pressure cuff on R109 left arm to recheck R109's blood pressure with a reading of 104/75 pulse 101. V5 said let me look to see if you have some blood pressure medications because your blood pressure is a little too low. I am not giving Amlodipine; I am going to hold it because the blood pressure is a little low. R109 gets three blood pressure medications that I am going to hold. I will revisit R109 blood pressure after lunch to see if he needs them. (The blood pressure medications). There are 7 pills in the medication cup. (Amlodipine Besylate 10 MG Daily, Hydrochlorothiazide 25 MG Daily and Losartan Potassium Tablet 50 MG Daily) were held and not given. V5 administered:1. Aspirin Tablet Chewable 81 MG (milligram) Daily2. Metoclopramide HCl (hydrochloric acid) Tablet 10 MG Three times a day3. Sinemet Tablet 25-100 MG (Carbidopa-Levodopa) Three times a day4. Docusate Sodium Capsule 100 MG Daily5. Vitamin B-1 (Thiamine HCl) 1 tablet Daily6. Sertraline HCl Tablet 50 MG Daily7. Multivitamin Tablet 1 tablet Daily8. Polyethylene Glycol 3350 Powder 17 GM (gram)/SCOOP Daily9. Amlodipine Besylate 10 MG Daily (NOT GIVEN)10. Hydrochlorothiazide 25 MG Daily (NOT GIVEN) 11. Losartan Potassium Tablet 50 MG Daily (NOT GIVEN) On 09/02/25 at 09:51 AM V5 (Registered Nurse) said there is one more resident in R109's room. V5 took a medication cup stored in the medication cart drawer with Folic Acid written on it and said I took a couple of folic acid 100 mcg from the other medication cart because when I checked the medication cart there was no folic acid, and I knew some of the residents gets folic acid. There are 10 pills in the medication cup. V5 administered:1. Aspirin Tablet Chewable 81 MG Daily (ASPIRIN EC TABLET DELAYED RELEASE 81 MG WAS ORDERED)2. Ferrous Sulfate Tablet 325 (65 Fe) MG Daily3. Vitamin B12 Oral Tablet 1000 MCG (Microgram) Daily (EXPIRED 07/25)4. Folic Acid Tablet 1 MG Daily (STORED IN A MEDICATION CUP AND NOT IN THE ORIGINAL PACKAGING)5. Multivitamin Oral Tablet 1 tablet Daily6. Amlodipine Besylate Tablet 5 MG Daily7. Metoprolol Tartrate Tablet 25 MG Twice a day8. Gabapentin Tablet 600 MG three times a day9. Psyllium Oral Packet 1 packet Daily (NOT GIVEN)10. Sertraline HCl Tablet 100 MG Daily11. Vitamin D3 Oral Tablet 25 MCG 2 tablet Daily On 09/02/25 at 10:04 AM V5 (Registered Nurse) stated I need to write a note why I did not give R109's his blood pressure medications. Resident #92 was in a wheelchair in the hallway. V5 told R92 you are on blood pressure medications so let me take your blood pressure. V5 picked up the blood pressure monitor from the medication cart, placed the blood pressure cuff on R92's left arm, placed the monitor in R92's lap and obtained a blood pressure reading of 112/48 pulse 63. V5 said R92's blood pressure is a little low for my liking, I think I am going to hold your blood pressure medications.On 09/02/25 at 10:09 AM V5 (Registered Nurse) said I am holding R92's blood pressure medications. V5 (Registered Nurse) said there are 6 pills in the medication cup. I held the blood pressure medications, and I will check the blood pressure again after lunch. (Lisinopril 10 MG Twice a day and Metoprolol Tartrate 25 MG Twice a day were held and not given). V5 administered:1. Cholecalciferol Oral Tablet 25 MCG (1000 UT) Daily2. Ferrous Sulfate Oral Tablet 325 (65 Fe) MG Daily3. Apixaban Oral Tablet 5 MG every 12 hours4. Pentoxifylline ER 400 MG Three times a day5. Furosemide Oral Tablet 40 MG Daily6. Jardiance Oral Tablet 10 MG Daily7. Lisinopril 10 MG Twice a day (NOT GIVEN)8. Metoprolol Tartrate 25 MG Twice a day (NOT GIVEN)On 09/02/25 at 10:14 AM Surveyor asked V5 (Registered Nurse) to remove the bottle containing the Vitamin B 12 1000 MCG from the medication cart. V5 removed the bottle from the medication cart and while looking at the bottle V5 said it is not labeled, and it is expired. It should not have been given. When giving medications we check to make sure it is the right medication, right date, right time, right person and make sure it is not expired. If giving a resident expired medication, there is a potential it (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	can cause toxicity. I will have to call the doctor. We are not supposed to transfer the medication from the original packing. I am going to toss the rest of the folic acid. acid. On 09/03/25 while conducting record review there was no documentation of V5 (Registered Nurse) notifying the physician for the medications that were held and the administration of the expired medication for R92, R96 or R109. Review of the blood pressure monitoring, there was no recheck of R96 and R109 blood pressure after the medications were held. On 09/03/25 at 11:40 AM Surveyor requested the blood pressure readings for R92 and R109. Surveyor informed V2 (Director of Nursing) that V5 (Registered Nurse) held both residents blood pressure medications but failed to notify the doctor or document the occurrence. V2 stated I talked to V5 about that this morning.On 09/04/25 at 09:06 AM V2 (Director of Nursing) stated The nurse should hold blood pressure or any medications if the blood pressure is outside of the parameters, using nursing judgement then consult with the doctor immediately to get directions if there are any abnormal blood pressures. My expectations when holding blood pressure medications is to consult with the doctor for further orders and instructions. V5 (Registered Nurse) said she notified the doctor but if it is not documented it did not happen. Potentially it depends on the patient, it is different risk for all diagnosis. I cannot say what would happen with that particular resident. The blood pressure could have potentially dropped lower or went higher depending on the resident condition. My expectations when staff are administering medications is for them to go by doctor orders, right resident, right time, right dose, right medication and check the expiration dates. Expired medications should be removed from the cart and medication room then discarded. Expired medications should not be administered. If expired medications are administered, they could have an adverse reaction. Surveyor asked V2, If the order reads enteric coated aspirin can chewable aspirin be given instead of the enteric coated. V2 responded, you should follow the doctor orders but if unavailable call the doctor to see what the doctor wants to do. The enteric coated aspirin is extended release, and the chewable aspirin acts immediately. If the chewable aspirin is given instead of the enteric coated aspirin, there is a potentially it will not last as long and there is a possibility it will not give the expected effect that the enteric coated aspirin would give. V2 was asked by the surveyor, if there is a missed dose or medication is held without a doctor order is that a medication error. V2 responded, it depends on what the documentation says, if documented it would be considered a late documentation, not a missed dose. If the nurse does not have a certain stock medication on the cart, they should come downs stairs and get it. Medication should not be taken from the original container and stored in a medication cup for administration, so we don't make mistakesTitled Physician Orders-Verbal and Fax effective date 03/21 document in part: The physician or extender retains control of the resident's medical plan of care and is consulted when changes in condition occur, outpatient appointments with orders or any other situation that requires an alteration to prescribed treatments, medications, or additional test.Titled Medication Storage effective date 03/21 document in part: 7. Medications are routinely checked for expiration dates.Titled Medication Administration effective date 03/24 document in part: To ensure that the administration of medications is performed in a safe manner to prevent medications errors. STANDARD: Medications are administered according to state and federal law. PROCEDURE: b. Medications are administered in a manner to prevent contamination. 2. General: 4. Medication preparation/Administration. a. Five Rights: Right Medication, Right Dose. Right Time - 60 minutes before or after the scheduled time unless otherwise specified, Right Route, Right Resident/patient/guest identification by way of, photo, verbal Affirmation by staff or resident, or birth date.). b. Verify the expiration date. c. Additional assessments are obtained prior to medication administration, such as pulse, blood pressure or oxygen level. 6. Medications are not prepared ahead of time. 10. Document medication administration after delivering. 1. If the medication you are to pass is not available, check the first dose machine/convenience box to see if the medication is there and administer if available. 3. If the medication is not given or given late notify the provider for additional orders. This includes any input from pharmacy on suggested alternatives if the medication cannot be supplied for any reason. 4. Alert the DON (Director of Nursing) or designee if you are not able to obtain the medication.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure medications were administered as ordered by the residents' Physicians orders resulting in significant medication errors for 2 (R92, R109) of 3 (R96) residents reviewed during medication administration.Findings Include:R109 has diagnosis not limited to Cerebrovascular Disease, Hypertensive Heart Disease with Heart Failure and Hyperlipidemia.0n [DATE] at 09:37 AM V5 (Registered Nurse) entered R109 room and said to R109, come out and take your blood pressure. At 09:40 AM V5 placed the blood pressure cuff on R109's right arm while standing at the medication cart with a blood pressure reading of 81/54 pulse 100. V5 placed the blood pressure cuff on R109 left arm and rechecked R109's blood pressure with a reading of 104/75 pulse 101. V5 said let me look to see if you have some blood pressure medications because your blood pressure is a little too low. I am not giving Amlodipine; I am going to hold it because the blood pressure is a little low. R109 gets three blood pressure medications that I am going to hold. I will revisit R109 blood pressure after lunch to see if he needs them. (The blood pressure medications). There are 7 pills in the medication cup. (Amlodipine Besylate 10 MG Daily, Hydrochlorothiazide 25 MG Daily and Losartan Potassium Tablet 50 MG Daily were held and not given). 1. Amlodipine Besylate 10 MG Daily (Not given)2. Hydrochlorothiazide 25 MG Daily (Not given)3. Losartan Potassium Tablet 50 MG Daily (Not given)R92 has diagnosis not limited to Acute on Chronic Diastolic (Congestive) Heart Failure, Atrial Fibrillation, Hypertensive Heart Disease with Heart Failure, Nonrheumatic Aortic Valve Disorder, Cardiomegaly, Peripheral Vascular Disease, Atherosclerosis of Native Arteries of Right Leg and Hypertrophic Cardiomyopathy.On [DATE] at 10:04 AM V5 (Registered Nurse) stated I need to write a note why I did not give R109's his blood pressure medications. R92 was in a wheelchair in the hallway. V5 told R92 you are on blood pressure medications so let me take your blood pressure. V5 picked up the blood pressure monitor from the medication cart, placed the blood pressure cuff on R92's left arm, placed the monitor in R92's lap and obtained a blood pressure reading of 112/48 pulse 63. V5 said R92's blood pressure is a little low for my liking, I think I am going to hold your blood pressure medications.On [DATE] at 10:09 AM V5 (Registered Nurse) said I am holding R92's blood pressure medications. V5 (Registered Nurse) said there are 6 pills in the medication cup. I held the blood pressure medications, and I will check the blood pressure again after lunch. (Lisinopril 10 MG Twice a day and Metoprolol Tartrate 25 MG Twice a day were held and not given). 4. Lisinopril 10 MG Twice a day (Not given)5. Metoprolol Tartrate 25 MG Twice a day (Not given)On [DATE] at 10:14 AM V5 (Registered Nurse) said when giving medications we check to make sure it is the right medication, right date, right time, right person and make sure it is not expired. On [DATE] while conducting record review there was no documentation of V5 (Registered Nurse) notifying the physician for the blood pressure medications that were held for R92 or R109. Review of the blood pressure monitoring, there was no recheck of R92 and R109 blood pressure after the medications were held.On [DATE] at 11:40 AM Surveyor requested the blood pressure readings for R92 and R109. Surveyor informed V2 (Director of Nursing) that V5 (Registered Nurse) held both residents blood pressure medications but failed to notify the doctor or document the occurrence. V2 stated I talked to V5 about that this morning.On [DATE] at 09:06 AM V2 (Director of Nursing) stated The nurse should hold blood pressure or any medications if the blood pressure is outside of the parameters, using nursing judgement then consult with the doctor immediately to get directions if there are any abnormal blood pressures. My expectations when holding blood pressure medications is to consult with the doctor for further orders and instructions. V5 (Registered Nurse) said she notified the doctor but if it is not documented it did not happen. Potentially it depends on the patient, it is different risk for all diagnosis. I cannot say what would happen with that particular resident. The blood pressure could have potentially dropped lower or went higher depending on the resident condition. My expectations when staff are administering medications is for them to go by (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146164	A. Building B. Wing	09/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aspyre of Bronzeville	4314 South Wabash Avenue Chicago, IL 60653

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	doctor orders, right resident, right time, right dose, right medication and check the expiration dates. Medication Administration Record should be signed for after it is given. Policy:Titled Medication Administration effective date 03/24 document in part: To ensure that the administration of medications is performed in a safe manner to prevent medications errors. STANDARD: Medications are administered according to state and federal law. PROCEDURE: 4. Medication preparation/Administration. a. Five Rights: Right Medication, Right Dose. Right Time - 60 minutes before or after the scheduled time unless otherwise specified, Right Route, Right Resident/patient/guest. c. Additional assessments are obtained prior to medication administration, such as pulse, blood pressure or oxygen level. 10. Document medication administration after delivering. Titled Physician Orders-Verbal and Fax effective date 03/21 document in part: The physician or extender retains control of the resident's medical plan of care and is consulted when changes in condition occur, outpatient appointments with orders or any other situation that requires an alteration to prescribed treatments, medications, or additional test.