STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146174	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Circle	3659 West 99th Street Chicago, IL 60655

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure that one resident (R1) had an informed signed consent prior to administering a psychotropic medication. Findings include:R1 is an [AGE] year old with diagnosis including but not limited to: Alzheimer's disease, Delirium due to known physical condition, unspecified lack of coordination, difficulty in walking and essential hypertension. R1 has a BIMS (Brief Interview of Mental Status) score of 7, which indicates severe cognitive impairment. On 9/17/25 at 12:57 pm, R1 was observed sitting in his room with his daughter. At that time, V9 (R1's Family) said the following, They (facility) were giving my father Trazadone and I asked that they discontinue the Trazadone because once, I came here and he (R1) was very lethargic and looked like a zombie. When I asked what he had, I was told that he had Melatonin and Trazadone for sleep the previous night. Melatonin alone is just fine for my father to sleep. He is [AGE] years old. Why would they give my father both medications to sleep? I never consented for Trazadone and I am his POA (Power of Attorney).On 9/17/25 at 4:15 pm, V6 (Nurse Manager) stated the following, We do not have any psychotropic consents for R1.The purpose of doing the informed consent is to let them know if there are any adverse effects to the medication and to get signed consent to give the medication.On 9/18/25 at 12:40 pm, V7 (Registered Nurse) stated the following, R1 has dementia and is here for rehabilitation. His daughter (V9) is here almost daily and oversees his care. She had concerns about his sleeping medication (Melatonin) and stated that she did not want it scheduled. She (V9) also wanted the Trazodone discontinued and complained that she didn't like the way that her father looked when she visited. I don't give any psychotropic medication without consent from either the patient or the family.R1's MAR (Medication Administration Record) for the period of 8/1/25- 8/31/25 documents both Melatonin 3 mg (milligrams) and Trazadone 50 mg administered to R1 on 8/6/25. R1's Order Report documents the following orders that started on 8/6/24 and ended on 8/9/25: Melatonin 3 mg and Trazadone 50 mg.Facility policy titled Psychotropic medication use documents the following: Facility should comply with the Centers for Medicare and Medicaid Services (CMS) State Operations Manual Appendix PP, and all other Applicable Laws relating to the use of psychopharmacologic medications including gradual dose reductions; Facility staff should inform the resident and/or resident representative of the initiation, reason for use, and the risks associated with the use of psychotropic medications, per facility policy or applicable state regulations.

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
	146174	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Circle	3659 West 99th Street Chicago, IL 60655

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement and revise the resident-centered care plan for a resident with a diagnosis of urinary tract infection and hernia which affected one resident (R1) in the sample of 20 residents reviewed for care plan revision. Findings include:R1's admission Record documents, in part, diagnoses of urinary tract infection (UTI), Delirium, Benign Prostatic Hyperplasia with lower urinary tract symptoms Muscle weakness, difficulty in walking, chronic kidney disease stage 3, Essential hypertension, Unspecified Glaucoma, Alzheimer's, Anxiety, Malignant neoplasm of splenic.R1's Minimum Data Set (MDS), dated [DATE], documents, in part, a Staff Assessment for Cognitive Skills for Daily Decision Making is coded at 7 which is severe cognitive impairment. R1's Care Plan Report dated 8/5/2025 has no documentation stating care of UTI or hernia was observed in chart. On 9/18/25 at 10:56am, V6 (MDS coordinator/Nurse) stated all diagnosis are care planned to ensure that staff is aware of plan of care for each resident, and if a resident is admitted with a diagnosis of infection such as urinary tract infection this diagnosis should be care planned to ensure staff will be able to plan the care of the resident and monitor sign and symptoms and monitor for adverse reactions and be able to perform appropriate assessments. I reviewed R1's admission paperwork, med list and diagnosis, but I do not read the information under the main diagnosis sheet, and if a resident was still being treated for UTI it is the nurse's responsibility to clarify that in nurse-to-nurse report prior to the resident transferring over to the facility. It is part of my responsibility to have care planned the diagnosis of UTI and Hernia. Hernia should be a focus on a care plan because the nurses can assess for size and monitor for pain and be able to report off to the physician for any changes to site.Facility job description undated and titled (Registered Nurse) documents, in part, . Position Summary: Responsible for the independent supervision of the delivery of care to a group of residents on a nursing unit. Assesses residents' needs, develops care plans, administers nursing care, evaluates nursing care, and supervises CNA and other personnel in the delivery of nursing care; Develops and implements Plan of Care for each resident.Facility policy titled Baseline Care Plan dated November 1, 2019, documents, in part, Purpose Statement: The community must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident. The community must provide the resident and representative a summary of the baseline care plan in a language and conveyed in a manner the resident and or representative can understand.2). The baseline /admission care plan will include information for the provision of effective person- centered care and will include the minimum healthcare information necessary to properly care for each resident immediately upon admission.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146174	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Circle	3659 West 99th Street Chicago, IL 60655

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146174	A. Building B. Wing	09/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mercy Circle	3659 West 99th Street Chicago, IL 60655

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide showers to a resident. This failure affected one resident (R1) reviewed for ADLs (activities of daily living) in a sample size of 20 residents. The findings include:On 9/17/25 at 12:52 PM, R1's white board in room displayed the dates that he was assigned to receive showers from facility staff, the dates listed were every Sunday and every Wednesday. R1 was eating his lunch at time of observation, his hair presented as oily and food debris were observed on his clothing.On 9/17/2025 at 12:57 PM, V9 (family member of R1) was in the room with R1 and stated that the facility has only provided R1 a shower once since admission and she knows this because she is always at the facility or has a caregiver present as a companion for R1 when she is not available.On 9/17/2025 at 1:24 PM, V8 (Certified Nursing assistant, CNA) entered the room of R1 to collect the food tray of R1, V8 stated he did not give R1 a shower. V8 stated I gave R1 a bed bath because I did not have any assistance from team members and the last time I gave R1 a shower was about two weeks ago. V8 stated he could not remember which team members he asked for assistance from, but V8 stated I was too busy to provide R1 a shower because I was assigned to provide a shower to another resident. V8 stated he informed his nurse that a bed bath was given.On 9/17/2025 at 1:27pm, V7 (Registered nurse) stated she was the nurse assigned to R1 and that V8 informed her that R1 refused his shower, I did not get a chance to go and speak to R1 because V8 had informed me after he provided R1 with the bedbath.V7 stated the staff is aware to come and get the nurse when a resident refuses care so the nurse has the opportunity to speak with the resident to assess the reason for refusal of care and try and encourage the resident to receive treatment. If the resident continues to refuse showers the responsible power of authority (POA) is notified, and documentation is placed in the chart regarding the refusal. V7 provided copies of R1's shower review sheets and stated that the 7 sheets provided were the only shower review sheets available for R1.On 9/17/25 at 1:50 pm, V6 (MDS Nurse) stated the following, Our showers are documented via shower sheet at the nurse's station. We have demented residents who will refuse showers at times. We will attempt to shower the resident and it is documented on the shower sheet. The nurse and the CNA will document on the shower sheet. On 9/18/2025 at 2:45 PM, V2 (Director of Nursing) stated the following the nurse is responsible to ensure that residents showers are completed. The nurse is the direct supervisor of the certified nursing assistants and supervises the day-to-day care provided to the residents on the units each shift and if a resident refuses a shower a call should be placed to the POA because the POA must be made aware that the resident is declining showers to give the POA an opportunity to try and encourage the resident to shower, the refusal behavior should also be care planned in chart, so all staff are aware. I was made aware that R1 refuses showers by one of the staff members and I have never spoke with V9 to inform her that R1 has been refusing staff assistance to have showers taken, I signed R1's bed bath sheet one day but I cannot remember the day.R1's face sheet dated September 17,2025 states that R1 admitted to facility on 8/5/2025 with diagnosis of Urinary tract infection, Delirium, Benign Prostatic Hyperplasia with lower urinary tract symptoms, muscle weakness, difficulty in walking, chronic kidney disease #3, essential hypertension, unspecified glaucoma, Alzheimer's, anxiety, malignant neoplasm of splenic. R1's MDS (Minimum Data Set) dated August 12, 2025, shows R1 has a score of 7 which means R1 has severe cognitive impairment; Functional abilities score is 1 which means R1 is dependent on staff to provide all care for shower/bath; Transfer to tub/shower staff provides more than half of the effort for task to be completed.R1's care plan dated and revised on August 13,2024 shows R1 has a self-care performance deficit requires assistance with personal hygiene and ADLs including brushing teeth, washing/drying face, and hands, combing hair, cutting nails, shaving etc. due to Dementia, Impaired balance, and Fatigue. Intervention/Task: staff will provide [R1] with sponge bath when a full bath or shower cannot be tolerated.On 9/17/2025 reviewed R1's Shower/laundry/AD cleaning schedule, documents that R1 is scheduled to have showers on Sundays and Wednesdays.Skin monitoring: Comprehensive CNA shower review, there were seven sheets to review with listed dates:8/6/25 bed bath completed, 8/31/25 shower completed, 9/3/25 bed bath completed, 9/12/25 refused, asked three times in front of daughter too, refused nurse too, 9/14/25 bed bath, decline shower offered bed bath,9/15/25 bed bath, given bed bath, refused shower,9/17/25 Declined shower, no new skin areas observed, bed bath offered this was signed by V8 and V7.Since admission on [DATE] R1 was scheduled to receive 13 showers and only received one shower per document. Dates of scheduled showers that were to be given are listed below:8/10/25; No