STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146197	A. Building B. Wing	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jennings Terrace	275 South Lasalle Aurora, IL 60505

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389 Based on observation interview and record review, the facility failed to assess a resident's wound during a course of treatment and document the status of the wound weekly and revise the care plan interventions for wound care. This applies to 1 of 2 residents (R5) reviewed wound care in the sample of 12. The findings include: R5's electronic medical record showed a [AGE] year old female admitted to the facility on [DATE] with diagnoses that include Osteoarthritis, Congestive Heart Failure, Obesity, Difficulty Walking, Weakness, Cognitive communication deficit, Type 2 Diabetes, and Diarrhea. R5's annual Minimum Data Sheet dated August 12, 2024 showed her to be cognitively intact. On November 18, 2024 11:23 AM, R5 was observed to be alert and oriented and stated that the facility took her air mattress and she has buttocks pain. Later, on November 19, 2024 1:40 PM, R5 stated her bottom hurts and she has an open wound on her bottom. R5 stated it has been there for a couple months. V19 (Wound Care Doctor) note dated November 20, 2024 showed R5 presented with moisture associated and excoriations and possible concomitant candida to sacrum with scattered openings in the fragile inflamed skin. V19 then prescribed an antifungal treatment for R5's wound. On November 19, 2024 at 1:43 PM V12 (Certified Nursing Assistant/CNA) confirmed that R5 has a wound to her sacrum and V14 (Licensed Practical Nurse/LPN) stated that R5 has wound on her sacrum ant they are treating it with medi-honey and calcium alginate. V14 also stated that the wound was noted on October 23, 2024. Nursing progress notes document that V18 (LPN-Nurse) obtained orders for wound care for R5 on October 23, 2024. R5 has an order dated October 23, 2024 that showed the following: Sacrum: Cleanse with wound cleanser, apply calcium alginate with medi-honey, and cover with border foam. Two times a day for opening in the sacral area. V16 (Nurse) stated on November 20, 2025 at 9:43AM, that V16 has provided wound care to R5 in the past. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5 skin care plan showed she was at risk for impaired skin integrity related to bowel and bladder incontinence, need for assist with repositioning and impaired mobility. R5's skin goal was for her skin to remain intact, free of redness, blisters, or discoloration through the next review date. The skin care plan was not updated to reflect R5's sacral wound and had not been updated since August 23, 2023. On November 20, 2024 at 9:19 AM, V2 (Director of Nursing/DON) stated, R5 does not have a wound. V2 was unable to provide any assessment or documentation of R5's wound on November 20, 2024. V2 stated she was not aware that R5 had a wound and V2 could not locate a wound assessment. V2 stated when a wound is found it should be care planned, put on the wound care system that the wound care doctor can see, assessed and documented, and the resident should be seen by the wound care doctor. V2 stated the wound care doctor has not seen R5 nor are they currently seeing R5. V2 stated that wounds should be in their Wound care system and then they flow into electronic medical record. The wound care system is what V19 (Wound Care Physician) checks when she comes in to see residents that have wounds. V2 confirmed that R5's name does not appear anywhere on the October 2024 or November 2024 list to be seen by V19. R5 was observed on November 20, 2024 with a wound to her sacrum about the size of a silver dollar. The wound bed was red and missing a layer of skin. R5 stated that the area hurt when touched. V2 stated she is waiting for the wound care doctor to see R5. V19 (Wound Care Physician) assessed R5 later and charted R5's wound as moisture associated excoriation. The facility's Pressure Ulcer/Injury Risk Assessment Policy dated July 2017 showed the following: Steps in the procedure 4. Conduct a comprehensive skin assessment with every risk assessment. b. once inspection of skin is completed document the findings on a facility-approved skin assessment tool. c. if a new skin alterations noted, initiate a (Pressure or non-pressure) form related to the type of alteration in skin. 5. Develop the resident-centered care plan and interventions based on the risk factors identified in the assessment, the condition of the skin, the residents stated wishes and goals. Documentation: The following information should be recorded in the resident's medical record utilizing facility forms: 1. The type of assessment(s) conducted. 5. The condition of the resident's skin (ie., the size and location of any red or tender areas identified. The Facility's Pressure Ulcer/Skin Breakdown- Clinical Protocol policy dated April 2018 showed the following 2. The nurse shall describe and document/report the following: a. Full assessment of the pressure sore including, location, stage, length, width, and depth, presence of exudates or necrotic tissue. 3. The physician will assist the staff to identify the type (for example, arterial or stasis ulcer) and characteristics (presence of necrotic tissue, status of wound bed, etc) of an ulcer.

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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. 29562 Based on observation, interview, and record review the facility failed to label and date medications once opened to determine the expiration date. The facility failed to remove expired medications, and remove or dispose narcotic medications that were in a broken sealed container. In addition, the facility failed to store suppository medications in a sanitary manner. This applies to 8 residents (R3, R8, R16, R19, R29, R30, R40, R41) reviewed for medication storage and labeling in the sample of 12. The findings include: On November 18, 2024, from 3:27 PM through 3:58 PM, observation of medication carts and medication rooms' refrigerator were conducted with V15 and V16 (Both Nurses). 1. R40's Latanoprost 0.005% (ophthalmic solution) label showed that it was opened on September 20, 2024, and expired on November 1, 2024. 2. R19's Latanoprost .005% (ophthalmic solution) label showed that it was opened on September 22, 2024, and expired on November 3, 2024. 3. R8's Latanoprost 0.005% (ophthalmic solution) opened on July 8, 2024. Pharmacy recommendation showed to discard 6 weeks after it was opened. 4. R16's Breo Ellipta (inhaler) was opened and not dated. Pharmacy recommendation showed to discard 6 weeks after opening of foil tray. 5. R41's Fluticasone Furoate/Vilanterol Ellipta (inhaler) was opened and not dated. Pharmacy recommendation showed to discard 6 weeks after opening of foil tray. 6. R30's Tramadol 50 mg tablet blister pack/container had a seal broken and taped over for tablets number 34 and 35. 7. R3's Hydrocodone Acetaminophen 7.5/325 mg tablet blister pack/container had a seal broken and taped over for tablets number 1, 2, 3, 7, 9, and 10. 8. R29's Lorazepam 0.5 mg tablet blister pack/container had a seal broken and taped over for tablets number 1. 9. There was a vial of Tuberculin Purified Protein in the South medication room refrigerator which shows that it was opened on September 26, 2024. The pharmacy guidelines show to discard this medication 30 days after it was opened. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	10. There was a vial of Tuberculin Purified Protein in the North medication room refrigerator which showed that it was opened on July 1, 2024. The pharmacy guidelines show to discard this medication 30 days after it was opened. This same refrigerator stored two boxes of Bisacodyl Suppositories and one box of Tylenol Suppositories. The box containers of these suppositories were drenched with water which came from the leaking freezer. There was a puddle of water on the base floor of the refrigerator where they stored these suppositories. On November 21, 2024, at 10:33 AM, V2 (Director of Nursing) stated that if a narcotic medication container is already broken or the medication was already removed from its container and the resident refused to take the narcotic medication, the staff nurse should discard or waste it with the presence of another nurse as a witnessed to prevent potential diversion of this medications. On November 21, 2024 at 1:52 PM, V20 (Registered Pharmacist) stated that their controlled medication policy shows that once the narcotic medication is removed from its container, but the patient refused to take it, the controlled medication should not be returned to its container and should be destroyed, with a witness. The facility's Storage of Medications policy and procedure with revised dated of April 2007, shows: Policy Interpretation: 2. The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner.

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. 16746 Based on observation, interview and record review the facility failed to prepare the green peas to pureed consistency for residents on pureed diets. This applies to 5 of 5 residents (R3, R6, R13, R17, R23) reviewed for pureed diet in the sample of 12. The findings include: On November 19, 2024 at 10:30 AM, the pureed green peas preparation done by V5 (cook) was observed in the facility kitchen. V5 stated that she was preparing for five residents who are on pureed diets. According to V5, the green peas were frozen, and she had cooked it. V5 placed eight scoops of 4 ounces (total of 32 ounces) green peas inside the food processor, added 4 ounces of butter and pureed the mixture for about three minutes. V5 then opened the food processor and transferred the processed green peas inside a small metal pan. According to V5, she was done processing the green peas and she will place the small metal pan inside the warmer because the processed green peas was ready to be served to the residents on pureed diet. V5 was asked why she did not test the processed green peas to make sure it was the right consistency. V5 did not respond. On tasting the processed green peas, lots of fibrous casings (pea pods) was visible in the mixture. The fibrous casings were unable to be chewed and got stuck in the throat when swallowed. During this time V4 (Dietary Manager) was notified of the concern with regards to the consistency of the processed green peas and V4 tasted the product. V4 agreed that the green peas still had lots of fibrous casings. V4 stated that the pureed product should be pudding-like consistency and should be smooth without the need to chew. The facility's diet list as of November 19, 2024 showed that R3, R6, R13, R17 and R23 were on pureed diet consistency. On November 20, 2024 at 1:23 PM, V7 (Registered Dietitian) stated that for pureed food, the expected and appropriate consistency should be pudding-like, without chunks, clumps or fibrous casings and should be smooth. V7 added that if the processed food did not reach the pureed consistency, it should not be served to the residents on pureed diet, to prevent choking or swallowing problem. The facility's recipe for pureed green peas showed in-part, 2. Place in food processor and process until fine in consistency. Review of the facility policy and procedure regarding pureed/dysphagia diet dated 2010 showed, Food will be provided in a form designed to meet individual needs. The texture of the food may be altered to pureed consistency. Pureed/dysphagia diets will be served as ordered by the physician. The same policy under procedure showed in-part, Whole food will be pureed in a blender or a food processor to a semi-solid consistency (i.e. (for example), the consistency of pudding-like).

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F 0847 Level of Harm - Potential for minimal harm Residents Affected - Many	Inform resident or representatives choice to enter into binding arbitration agreement and right to refuse. 41855 Based on interview and record review, the facility's Arbitration Agreement failed to have the required language in the Arbitration Agreement Contract. This applies to all 46 residents residing at the facility. The findings include: The facility's Long Term care facility application for Medicare and Medicaid (CMS (Centers for Medicare & Medicaid Services)-671 form) dated November 18, 2024 showed that there were 46 residents residing at the facility. On November 20, 2024, at 2:02 PM, V8 (Community Relations Coordinator) said when there is a new admission, she sit downs and goes paragraph by paragraph through the contract with the resident and/or their representative. There have been situations where V8 said she has gone over the contract paragraph by paragraph over the phone with a resident's representative who was not able to come into the facility. On November 20, 2024, at 12:18 PM, facility provided their undated admission packet titled, Contract Between Resident and [facility name] which included the arbitration agreement. Under Section X. Miscellaneous Provisions N. Mediation/Arbitration asked the resident and or their representative to enter into mediation for all claims, disputed, and controversies arising in relation to the performance, interpretation, applications, or enforcement of this contract, including but not limited to the breach thereof, or relating to care and treatment of any other dispute relating to the resident's residency The mediator will be selected in good faith by both parties .Should the parties fail to reach a resolution of the claim, dispute, or controversy by way of mediation, the dispute shall be arbitrated in accordance with the American Arbitration Association (AAA) 'Commercial Dispute Resolution Procedures' . The facility contract was lacking the language that showed that neither the resident nor their representative are required to sign the agreement for arbitration as a condition of admission to, or as a requirement to continue to receive care at the facility. It was also lacking the language that showed the resident or their representative have the right to rescind the agreement within 30 day calendar days of signing the contract. On November 20, 2024, at 2:25 PM, V8 said she has re-read the agreement and the contract does not have the required language in it. V8 said this will be addressed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 43389 Based on interview and record review, the facility failed to ensure the facility had an assessment performed that identifies where Legionella and other opportunistic waterborne pathogens could grow. This applies to all 46 residents that reside in the facility. The findings include: The facility's Long Term care facility application for Medicare and Medicaid (CMS (Centers for Medicare & Medicaid Services)-671 form) dated November 18, 2024 showed that there were 46 residents residing at the facility. On November 20, 2024 at 11:12 AM, V6 (Maintenance Director) stated the facility does not have an assessment for Legionella or other opportunistic water borne pathogens. V6 stated he is not aware of any Legionella assessment being done in the last 3 years that he has been working at the facility. V6 stated, they will be using a specific company to do the facility's assessment for Legionella and other waterborne pathogens. V6 stated that they have not utilized the company yet. V6 stated the facility does not have an assessment that shows where specifically Legionella or other waterborne pathogens can potentially grow. V6 stated that there has not been any testing for Legionella since he has been working at the facility. The facility's Infection Prevention & Control - Legionnaires Disease policy dated November 1, 2018 showed the following: Procedure: the water management program is maintained by the Maintenance and Environmental Services staff. Facility plan: Identifies building water systems for which Legionella control measures are needed- Utilizing the facility layout to describe the building water systems using text. b. Assesses how much risk the hazardous conditions in those water systems pose-developing a building flow diagram per the CDC toolkit. c. Control measures will be applied as needed to reduce the hazardous conditions, whenever possible to prevent Legionella growth and spread.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. 43389 Based interview and record review the facility failed to utilize the McGeer Criteria from March 2024 through November 19, 2024 for residents with suspected infections based on their policy. This applies to 9 of 9 residents (R1, R5, R6, R7, R11, R12, R20, R37, R46) reviewed for antibiotic stewardship in the sample of 12. The findings include: On November 20, 2024 at 11:38 AM, V3 (Infection Preventionist/Assistant Director of Nursing) stated that the facility is using the McGeer Criteria to ensure residents are not prescribed unnecessary antibiotics. V3 stated that in March of 2024, she stopped utilizing the McGeer Criteria. Surveyor reviewed the facility's infection tracking binder and there were McGeer Criteria filled out for residents in January and February of 2024, but there were no McGeer Criteria for residents for the remainder of the year (from March 2024 to present). V3 stated there was no McGeer Criteria documentation stating whether residents who were prescribed antibiotics from March 2024 to present, either met or did not meet standards for antibiotic utilization. V3 stated, she wears a lot of hats and she is not able to get everything done. V3 stated infection control has suffered because of this. Review of the facility's infection prevention and control monthly log from March through November 19, 2024 showed that R1, R5, R6, R7, R11, R12, R20, R37, and R46 had used antibiotic therapy at a given time for suspected/confirmed infections. The facility's Antibiotic Stewardship Protocol dated April 2016 showed the following: Action, a. The facility utilizes McGeer Criteria to improve the evaluation and communication of clinical signs and symptoms when a resident is first suspected of having an infection.

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on interview and record review the facility failed to provide dementia training for the CNAs (Certified Nurse Assistants) working in the facility and who were required to care for residents with dementia. This applies to 26 of 26 residents (R1, R3, R4, R6, R8, R11, R12, R14, R15, R16, R19, R20, R21, R23, R24, R26, R27, R28, R33, R36, R38, R40, R42, R44, R45 and R46) identified by the facility as having a diagnosis of dementia. The findings include: On November 20, 2024, at 10:03 AM, V9 (CNA (Certified Nursing Assistant) Supervisor) said that as the CNA Supervisor she does the CNAs annual evaluations and does the in-services for the CNAs. V9 said when needed, she will do re-education along with return demonstration on skills provided to the residents. V9 said she does not do dementia training and cannot remember having attended a training on dementia. V9 said V8 (Community Relations Coordinator) does dementia, resident rights, abuse and neglect trainings. The facility trainings are all done as in-services and the documentation is the sign in sheet. On November 20, 2024, at 10:56 AM, V2 (Director of Nursing) said she started working at this facility in April 2024. V2 said they have not done dementia training since she has been here. V2 pulled the in-service binder to see if she could locate a dementia training and provided the surveyor with an in-service V8 did on June 6, 2024. The in-service sign in sheet showed; In a facility that practices Person-Centered Care, listening skills and customer service are important skills. This is a reminder to let the resident finish their thought, sentence, or paragraph, before you offer a solution to them. Let them finish, do not cut them off when they are trying to tell you something. If you don't do it right the first time, you will have to find the time to fix it the second time! We are here to serve the needs of residents. Many of our residents' struggle with symptoms that are overwhelming to them and make their lives difficult, painful, or frustrating. Be conscious that as a staff member, you always have the power to leave, whereas the resident may not. Please remember that you can change your perspective of your job and the work you do here, where as the resident may not be able to do so. V2 was not able to provide any documentation to show dementia training had been provided to the CNAs. On November 20, 2024, 2:25 PM, V8 said she does not do dementia training for the staff. On November 20, 2024, at 1:12 PM, V10 (CNA) said she has worked here since September 2024, and had taken care of residents with dementia at the facility. V10 stated that she was not given dementia training during her orientation. On November 20, 2024, at 1:20 PM, V11 (CNA) said she has worked at this facility for [AGE] years, [AGE] years as a CNA, and had taken care of residents with dementia at the facility. V11 said she has not had dementia training and cannot remember when she had dementia training last. (continued on next page)

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On November 20, 2024, at 1:42 PM, V12 CNA) said she has been working at this facility for five months, and had taken care of residents with dementia at the facility. She was able to explain her orientation process but said she did not have dementia training. On November 20, 2024, at 1:47 PM, V13 CNA) said she has been working at the facility for about five months, and had taken care of residents with dementia at the facility. V13 stated that she did not get dementia training with orientation. The facility provided list of residents with diagnosis of dementia. The list identified 26 residents which included R1, R3, R4, R6, R8, R11, R12, R14, R15, R16, R19, R20, R21, R23, R24, R26, R27, R28, R33, R36, R38, R40, R42, R44, R45 and R46.