STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146198	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
All American Vlge Nrsg & Rhb	5448 North Broadway Street Chicago, IL 60640

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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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on interview and record review, the facility failed assert the right of the resident by searching a residents' room and personal property without the residents' knowledge and consent. This failure affects one (R33) resident in a total sample of 27 residents reviewed. Findings include: R33's facesheet documents R33 is a [AGE] year-old male admitted to the facility on [DATE], with diagnoses not limited to: Hemiplegia, cerebral infarction, schizoaffective disorder, glaucoma, lack of coordination, unsteadiness on feet, heart failure, and malignant neoplasm of prostate. R33's MDS/Minimum Data Set, dated dated [DATE], documents R33 has a BIMS/Brief Interview for Mental Status of 11/15, indicating R33 is cognitively impaired. On 04/08/2025 at 11:32 AM, V8 (Certified Nursing Assistant/CNA) was sitting on R33's bed, and V8's right hand inside of R33's nightstand located adjacent to R33's bed. V9 (CNA) was sitting in a chair at the foot of R33's bed, with a water container placed on R33's bedside table. R33's closet was open, and R33's clothing was exposed. R33 wass not located inside of his room at this time. V8 stated he is inside of R33's room because he is taking his lunch break. V8 was asked why his hand was located inside of R33's nightstand. V8 stated he was only looking, and stated he did not take any of R33's items. V9 stated this is her very first day working in the facility, and she is assigned to be trained by V8, and is shadowing V8's schedule. V9 stated R33's closet door was already open prior to V8 and V9 going inside of R33's room. V9 stated she was only drinking her water and sitting down waiting on further direction from V8. V8 stated he is aware that he should not be inside of any of the residents' rooms without their knowledge and while the residents are not located in their rooms. V8 stated he is not assigned to care for R33 today. V8 stated going inside of R33's nightstand is a violation of R33's rights. On 04/08/2025 at 11:53 AM, R33 was observed sitting in the dining room located on the second floor of the facility. (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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/08/2025 at 11:47 AM, V3 (Licensed Practical Nurse/LPN) stated all staff members have a designated break area located on the fourth floor of the facility. V3 stated staff should go to that break room whenever they take their assigned lunch breaks. On 04/10/2025 at 12:45 PM, V2 (Director of Nursing/DON) stated staff members should not be inside residents' rooms during their assigned breaks. V2 stated staff members should not be searching through residents' personal belongings without permission. V2 stated this is a violation of R33's resident rights. Facility policy, dated 10/2024, titled Resident Rights Guideline documents, Our facility will treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each residents' individuality. The facility protects and promotes the rights of the residents.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on observation, interview, and record review, the facility failed provide privacy and confidentiality of personal information for one (R33) resident reviewed in a total sample of 27. Findings include: R33's facesheet documents R33 is a [AGE] year-old male admitted to the facility on [DATE], with diagnoses not limited to: Hemiplegia, cerebral infarction, schizoaffective disorder, glaucoma, lack of coordination, unsteadiness on feet, heart failure, and malignant neoplasm of prostate. R33's MDS/Minimum Data Set, dated dated [DATE], documents R33 has a BIMS/Brief Interview for Mental Status of 11/15, indicating R33 is cognitively impaired. On 04/08/2025 at 11:53 AM, R33 was sitting in the dining room located on the second floor of the facility. R33 was sitting in a wheelchair wearing a white hospital wristband on his right wrist, which displayed R33's full name, date of birth, age, and medical record number. Record review of R33's electronic health record documents R33 was last admitted to the hospital on 03/18/2025, and returned to the facility on [DATE]. On 04/08/2025 at 12:31 PM, V2 (Director of Nursing/DON) observed the white hospital wristband on R33's right wrist. V2 was made aware of R33's full name, date of birth, age, and medical record number being displayed for anyone to see. V2 stated the wristband was placed on R33 in the hospital, and it should have been removed once R33 was admitted back to the facility. V2 stated R33 should not still be wearing the hospital wristband with his private health record information displayed. V2 stated this is a violation of HIPAA/Health Insurance Portability and Accountability Act, and V2 will get some scissors to cut R33's wristband off. Facility policy, undated, titled Health Information Management- Resident Information Privacy Protection documents, Policy: To assure that all resident-identifiable information maintained by the facility shall be confidential and disclosed only to authorized individuals. 45111

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on interview and record review, the facility failed to initiate a new PASARR screening for one (R79) resident reviewed for Pre-Admission Screening and Record Review (PASARR) in a total sample of 27. Findings include: R79's facesheet documents R79 was admitted to the facility on [DATE]. R79's PASARR Notice of SLP/Supportive Living Program Setting Appropriateness outcome letter, dated [DATE], documents an SLP setting is appropriate for R79. R79's SLP Setting Appropriateness Outcome Explanation Notice documents, This SLP initial screen and SLP comprehensive assessment is good for up to 90 calendar days of the Notice Date listed on the Notice of SLP Setting Appropriateness Outcome If you do not go to a SLP setting within that time, you must have an updated SLP initial screen and SLP comprehensive assessment. On [DATE] at 11:15 AM, V20 (Business Office Manager/BOM) stated she has been working at the facility for only 11 days, and is responsible for inputting resident information into the PASARR screening system when a resident is admitted to the facility. V20 stated whenever a residents' PASARR screening is about to expire, the facility needs to request a new screening to be completed. V20 stated she is unsure of R79's PASARR screening results for his living setting. V20 stated the facility is responsible for initiating R79's transition to a SLP. V20 stated the facility has to contact the screening agency to come to the facility and assess R79 to see if he is appropriate for the nursing home setting. V20 stated Social Services is also responsible for inputting resident screening information and ensuring that screening is performed and updated. V20 stated Social Services will also get a notification via email about appropriate resident living settings and a residents' need for transitioning to another setting. On [DATE] at 11:28 AM, V22 (Social Services Director) stated he has been working at the facility for 5 months and is responsible for updating resident PASARR screenings. V22 stated he checks the screening agency system every other day, or when he has time to do so. V22 stated the screening agency system shows the list of residents who require updates to their screening. V22 stated this is how he is made aware of which screenings are expiring and needs an update. V22 stated he is not aware of R79's PASARR SLP screening having an expiration date. V22 stated based on the documentation, R79's PASARR SLP screening is expired because it is now past 90 days. V22 stated he has not received any email notification for R79's PASARR SLP screening expiring. Facility policy, dated ,d+[DATE], titled, Pre-Admission Screening and Resident Review (PASRR) documents, IDPH (Illinois Department of Public Health) rules mandate that it is the transferring (not receiving) facility's responsibility to send the correct PASRR paperwork or make sure that it is located in the screening agency system.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314 Based on interview and record review, the facility failed to initiate a new Level I screen for a resident with known mental illness for one (R40) of five residents reviewed for Pre-Admission Screening and Record Review (PASRR) in a total sample of 27. Findings include: R40's face sheet documents R40 was admitted to the facility on [DATE], with diagnoses not limited to: Hypertensive heart disease without heart failure, schizoaffective disorders, seizures, bipolar disorder, major depressive disorder, recurrent, unspecified, other obsessive-compulsive disorder. R40's Interagency Certification of Screening Results OBRA (Omnibus Budget Reconciliation Act)-I Initial Screen, dated 06/02/2004, indicates R40 has reasonable basis for suspecting MI (mental illness). R40's Minimum Data Set (MDS) Section I, dated 04/03/2025, indicates active diagnoses of depression and bipolar disease. On 04/10/2025 at 9:46 AM, V1 (Administrator) was asked about level I pre-admission screening and resident review (PASRR) screening for R40, who was admitted to the facility with a diagnosis of a psychiatric mental health illness. V1 stated the facility does not have a PASRR screening for R40. V1 stated R40 was admitted to the facility many years ago, when PASRR screenings were not required. V1 informed the surveyor V1 asked V20 (Business)Office Manager) to request a PASRR screening yesterday (referring to date of 04/09/2025). On 04/10/2025 at 9:51 AM, V20 (Business Office Manager) stated, The facility does not currently have a pre-admission screening and resident review (PASRR) for (R40) because he was admitted to the facility on [DATE]. At the time that (R40) was admitted to the facility, PASRR screenings were not required. The facility received an OBRA screening from a previous facility where (R40) resided, so the only thing we have is (R40's) OBRA screen. I submitted a request for an OBRA screen for (R40) yesterday. We have been doing a lot of cleaning up and auditing the charts for the residents who have been residing in the facility for a long time, prior to the PASRR being required. The PASRR screening became a requirement about 3 to 4 years ago. The PASRR screen for (R40) should have been done by now, but it fell through the cracks and the facility never requested a PASRR screening. I am new here and have only worked here for 13 days. I am trying to catch up with the documents that fell through the cracks. I am auditing the charts to make sure that the residents have PASRR screenings, as per the state requirement. (R40) has a mental illness. Pre-Admission Screening and Resident Review (PASRR) (revised 12/2023) states: In accordance with Federal and State of Illinois regulatory standards and recommended practices, this organization requires each resident to be screened for Level 1 prior to or shortly thereafter admission. The facility makes reasonable efforts to make sure the required screening documents are in the AP/PT system prior to admission or shortly after the time of the individual's arrival.

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F 0691 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate colostomy, urostomy, or ileostomy care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314 Based on observation, interview, and record review, the facility failed to follow physician orders by not monitoring a resident's stoma site (Ileostomy site) every shift for one resident (R70) out of 7 residents reviewed for nursing care in a total sample of 27 residents. Findings include: R70's face sheet documents R70 was admitted to the facility on [DATE], with diagnoses not limited to: Chronic obstructive pulmonary disease, unspecified, bipolar disorder, current episode depressed, severe, with psychotic features, and Ileostomy status. Minimum Data Set Section (MDS) section C (dated 04/01/2025) documents R70 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R70's cognition is intact. Care plan (dated 04/10/2025) documents R70 has an ostomy related to Ileostomy status. R70's physician order (dated 04/10/2024) states: Monitor the Stoma Site (Ileostomy site) for any signs of infection or changes in skin issues every shift (day, evening, night). For any concerns notify medical doctor. On 04/10/25 at 10:30 AM, R70 expressed having concerns with the nurses not providing ileostomy care as they should per the physician's order. R70 had a ostomy bag. R70's Treatment Administration Record (TAR) documents in the month of April 2025, R70's stoma site was not being monitored by the nurses, as per the physician order. R70's Treatment Administration Record indicated R70's stoma was not monitored on 04/01/2025, 04/02/2025, 04/03/2025, 04/04/2025, 04/05/2025 (night shift), 04/06/2025 (day and night shift), 04/07/2025 (day and evening shift) and 04/08/2025 (evening and night shift). On 04/09/2025 at 12:43 PM, V17 (Nurse Consultant) stated, In the physician orders for (R70), the nurses are to monitor the stoma site every shift for signs of infection and changes and skin issues. According to the treatment administration record (TAR), there are days that are missed by the nurses. Facility policy regarding Colostomy/Ileostomy Care (undated) documents: The following information should be recorded in the resident's medical record: 1. The date and time the colostomy/ileostomy care was provided. 2. The name and title of the individual(s) who provided the colostomy/ileostomy care. 3. Any breaks in resident's skin, signs of infection (purulent discharge, pain, redness, swelling, temperature), or excoriation of skin.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on observation, interview, and record review, the facility failed to discard medication without an expiration date in a cart serving 42 residents on the third floor; failed to follow pharmacy instructions on medication administration while administering an inhaler for one (R31) resident; failed to document medications as given for one (R55) resident; and failed to contact provider while administering late medications to one (R84) resident in a sample of 27. Findings include: 1. On [DATE] at 10:10 AM, V3(Licensed Practical Nurse-LPN) residents eMAR (Electronic Medication Administration) profile showed red on R55's medication profile for medications: Furosemide 40 Mg, Finasteride 5mg, Lisinopril 5mg, Memantine 10mg. V3 stated she gave the medication earlier, but forgot to sign as given. V3 stated the nurse administering medications should sign as soon as it is given to prevent medication error because another nurse might give the resident medication thinking it was not given, and it can also confuse the nurse giving the medication and not know if she/he gave the resident medications. V3 stated this can affect the resident if given medications double. V3 stated signing the medication as given prevents confusion and medication error. 2. On [DATE] at 10:20 AM, V4 (Licensed Practical Nurse-LPN) was administering Symbicort inhaler-two puffs to R31 back-to-back, and did not wait between puffs. V4 read the instructions on the medication label that documented, wait ,d+[DATE] seconds between puffs. V4 stated she waited two seconds before giving the second puff, and stated she should have waited between puffs as noted on the medication instructions to let the medication get absorbed properly in R31's body, so R31 can get the full benefits of the medication. 3. [DATE] at 11:00 AM, V5 (Licensed Practical Nurse-LPN) was administering medications to R84: Biktavy 200mg oral, Olanzapine 200mg oral, Folic Acid 1 tablet oral, Amantadine 100mg oral, Vit B-1(Thiamine) one tablet. V5 stated R84's medications were being administered late because R84 refused to wake up this morning. V5 stated medications should be given on time so that the resident can have therapeutic levels to promote management of their illnesses. V5 stated he should have notified the doctor when R84 refused his medications so that new orders can be given, or new administrations times can be given. 4. On [DATE], at 10:45 AM, 3rd floor medication cart and medication room reviewed with V11(LPN), and V2 (Director of Nursing). Observed in the cart: -A bottle of Ferrous Sulfate with open date of [DATE] written on the bottle. No expiration date was observed on the bottle. V2 stated medications without expiration dates should be taken out of the medication cart because it is not known if they are expired, and might not be therapeutic if given to the residents and can cause bad side effects. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 12:00 PM, V2(Director of Nursing) stated if a resident refuses medication, the nurse is supposed to notify the doctor, so the doctor can give orders and/or adjust the medications time, so that the resident can maintain therapeutic levels. V2 further stated nurses should read the instructions by pharmacy on the inhalers so that they can administer the medications as instructed on the medications label, so that the medication can be therapeutic to the resident. Medication Administration Policy dated [DATE] documents: -Medications shall be administered one (1) hour before/after of the medication schedule unless specifically ordered otherwise. -Medications shall be recorded on the MAR (Medication Administration Record) promptly after each administration by the individual who administered the drug. -Clarifications and/or questions related to administering medications will be directed to the next highest authority in the nursing service, and if needed the attending physician or pharmacist.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314 Based on observation, interview, and record review, the facility failed to ensure that residents are free from expired food for one resident (R102) out of 7 residents reviewed for nutrition in a sample of 27 residents. Findings include: R102's face sheet documents R102 was admitted to the facility on [DATE], with diagnoses not limited to: Hypertensive heart disease without heart failure, major depressive disorder, recurrent, unspecified, anxiety disorder, unspecified, lymphedema, not elsewhere classified, and gastro-esophageal reflux disease without esophagitis. Minimum Data Set Section (MDS) section C (dated [DATE]) documents R102 has a Brief Interview for Mental Status (BIMS) score of 15, indicating R102's cognition is intact. R102's Care plan (dated [DATE]) documents R102 is on a therapeutic diet regular, with no added salt. On [DATE] at 12:11 PM, R102 stated, This morning for breakfast, I received a milk that was expired. The date of expiration on the milk carton is [DATE]. The milk was spoiled. I just want to bring this to your attention because they should be checking the dates on the milk before they serve spoiled milk to the residents. R102 showed the milk carton, and surveyor noted an expiration date of [DATE]. After the surveyor inspected the milk R102 received for breakfast, the milk carton was discarded. On [DATE] at 9:53 AM, V1 (Administrator) stated, The staff are supposed to check the dates on the milk carton before placing the milk on the tray before serving it to the residents. When the milk is expired, staff are to immediately discard the milk and replace it with a milk with the appropriate date that is not expired. On [DATE] at 10:15 AM, V10 (Dietary Manager) stated, I put the old milk in the refrigerator to the left side and the new milk to the right side. We checked the dates on the milk before the milk is served to the residents. Every day, before the milk carton is served, the dates on the carton are checked to make sure that the milk is not old. When the milk is expired, it is tossed out and not served to the residents. Labeling and Dating Foods Policy (dated 2021) documents: To decrease the risk of food borne illness and to provide the highest quality, foods labeled with the date received, the date opened and the date by which the item should be discarded.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44314 Based on observation, interview, and record review, the facility failed to ensure food is labeled, dated, and discarded after use by date/expiration date and failed to ensure reach-in refrigerator temperature, walk in refrigerator temperature and walk-in freezer temperatures were monitored 2 times per day. These failures have the potential to affect 138 residents living in the facility. The findings include: On 04/08/2025 at 9:22 AM, the reach-in refrigerator was inspected, and the following food items were found inside the refrigerator: *A container of nacho jalapeno peppers (1 gallon) with an open date of 02/08/25, and expiration date of 03/20/2025. V10, Dietary Service Director, said it should have been discarded. *A container of giardiniera mild pepper mix (1 gallon) with no open date and expiration date of 10/08/2025. *A container of sweet relish (1 gallon) marked with an open date of 04/07/2025, and no use by date. *A jar of creamy peanut butter (5lb) with no open date and the use by date was not readable. *A container of red western dressing (1 gallon) with an open date of 04/06/2025, and the use by date was not readable. *A container of silver source salad dressing (1 gallon) with an open date of 04/07/2025, and no use by date. *A container of yellow mustard (1 gallon) with an open date of 04/07/2025, and no use by date. *A jar of grape jelly (4 lb.) with no open date and no use by date. *A jar of red [NAME] (24 oz.) with the open date and the use by date smeared and not readable. Inspection of the dry foods/spice pantry was conducted with V10 (Dietary Service Director). The following food items were found: *A container of Cajun Chef Louisiana Hot Sauce (1 gallon) with the open date of 03/25/2025, and no use by date. *A container of Liquid Smoke Concentrated Sensory Hickory Sauce (1 gallon) with the open date of 02/18/2025, and no use by date. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*A bottle of [NAME] Vinegar (1 gallon) with the opened date of 02/11/2025, and no use by date. *A bottle of Liquid Smoke Concentrated Sensory Hickory Sauce (1 gallon) with an open date of 10/02/2024, and no use by date. *A container of Black Pepper Ground (5 lbs.) with an open date of 03/25/2025, and no use by date. *A container of Parsley Flakes (1 lb.) with the open date of 10/29/2024, and no use by date. *A container of Light Chili Powder (80 oz.) with the open date of 09/03/2024, and no use by date. *A container of Italian Seasoning (2 lbs.) with the open date of 02/18/2025, and no use by date. *A container of Ground Nutmeg (16 oz.) with the open date of 03/18/2025, and no use by date. Inspection of the reach-in refrigerator temperature logs for the month of April 2025 documented no entries on evening temperature on days 04/01/2025 to 04/08/2025. The temperature log had no entries for the morning temperature for the date of 04/09/2025. Inspection of the walk-in refrigerator temperature logs for the month of April 2025 documented no entries on evening temperature on days 04/01/2025 to 04/08/2025. The temperature log had no entries for the morning temperature for the date of 04/09/2025. Inspection of the walk-in freezer temperature logs for the month of April 2025 documented no entries on evening temperature on days 04/01/2025 to 04/08/2025. The temperature log had no entries for the morning temperature for the date of 04/09/2025. On 04/08/2025 at 10:21 AM, V10 stated the cooks check the temperatures of the refrigerators and the freezers once per day, in the morning at the start of shift. V10 stated the cook documents the temperatures on the log only for the morning temperatures. V10 stated the cooks should be checking the temperatures 3 times per day, and not only once per day. Labeling and Dating Foods Policy (dated 2021) states: To decrease the risk of food borne illness and to provide the highest quality, food is labeled with the date received, the date opened and the date by which the item should be discarded. Refrigerated Foods Policy (revised 2017) states: Refrigerated food prepared in the healthcare community is labeled with the date to discard or to use by. Storage of Refrigerated Foods Policy (revised 2017) states: Air temperature inside the refrigerator is checked and recorded twice daily. The reading on both the external and internal thermometers is recorded.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146198	A. Building B. Wing	04/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
All American Vlge Nrsg & Rhb	5448 North Broadway Street Chicago, IL 60640

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 45000 Based on observation, interview, and record review, the facility failed to implement a plan to prevent Legionella (a bacteria that can cause a serious type of pneumonia/lung infection) growth in the facility's water system. This failure has the potential to affect all 137 residents residing in the facility. Findings include: On 04/08/2025 at 1:56 PM, V21 (Maintenance Director/Housekeeping Director) stated he has been working at the facility for approximately 5 months. V21 stated he does not have a plan in place to check the facility's water system for Legionella. V21 stated he does not have any documentation to show the facility has a plan in place to prevent Legionella in the facility. V21 stated he has been searching, and is unable to find any previous documentation to show the facility's water system has been tested for Legionella. V21 stated at his previous employment, he implemented Legionella water testing, but has not implemented Legionella testing and prevention at the facility. Facility census, dated 04/08/2025, documents a total of 137 residents reside in the facility. Facility policy, dated 2023, titled Prevention of Legionella and Other Waterborne Pathogen Outbreak documents, It is the policy of this facility to reduce Legionella Risk in the facility water systems to prevent cases and outbreaks of Legionnaires' Disease and other Waterborne Pathogens. Legionella can grow in parts of building water systems that are continually wet Facilities must be able to demonstrate its measures to minimize the risk of Legionella and other opportunistic pathogens in building water systems such as by having a documented water management program. To reduce cases of Legionnaires' disease in health care facilities, the Centers for Medicare & Medicaid Services (CMS) announced that Medicare certified healthcare facilities must develop and maintain water management policies and procedures to reduce the risk of growth and spread of Legionella and other opportunistic pathogens in building water systems. The directive has an immediate effective date. (https://www.ashrae.org/about/news/2017/cms-issues-directive-requiring-medicare-certified-healthcare-facilities-to-implement-and-maintain-legionella-prevention-policies)Legionella, the bacterium that causes Legionnaires' disease, .Legionella can pose a health risk when it gets into building water systems. Legionella first must grow (increase in numbers). Then it has to spread through small water droplets (aerosolization) that people can breathe in. (https://www.cdc.gov/legionella/wmp/overview/growth-and-spread.html) Seven key elements of a Legionella water management program are to: Establish a water management program team, describe the building water systems using text and flow diagrams; identify areas where Legionella could grow and spread; decide where control measures should be applied and how to monitor them; establish ways to intervene when control limits are not met; make sure the program is running as designed (verification) and is effective (validation) and document and communicate all the activities. (https://www.cdc.gov/legionella/wmp/overview.html) 45111

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	146198	A. Building B. Wing	04/11/2025

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement a program that monitors antibiotic use. 45000 Based on interview and record review, the facility failed to monitor and review antibiotic use for three (R79, R81, and R102) residents reviewed for antibiotic stewardship in a total sample of 27. Findings include: On 04/09/2025 at 2:53 PM, V6 (Infection Preventionist/IP/LPN) stated she has been the IP at the facility for approximately one month now. V6 stated she generated the antibiotic tracking/monitoring list today, with the help of other staff members. V6 stated this is the first time she has generated the tracking/monitoring list for residents on antibiotics. V6 stated prior to today, there was not a system in place to track and trend antibiotic use for residents in the facility. V6 stated she has been trying to clean up some things as much as she can since she's been working at the facility. V6 stated now that she is aware, she can now keep track of resident antibiotic use. V6 reviewed the antibiotic order report, dated 04/2025. V6 stated she is not sure why some residents are prescribed antibiotics without an end date. V6 stated she will follow up on this. V6 stated all antibiotics should have an end date, even if it is an ointment or eye drop. V6 stated if residents are continuously receiving antibiotics without an end date, then the residents could potentially develop a compromised immune system that will not respond to antibiotics any longer. V6 stated additional complications related to other infections could also arise. The facility's antibiotic order report, dated 04/2025, documents the following: *R79 has an order for antibiotic tobramycin-dexamethasone drops, suspension with start date 12/19/2024 and no end date. R79 has an order for antibiotic ofloxacin drops, with start date 12/19/2024 and no end date. R79 has an order for antibiotic moxifloxacin drops, with start date 03/31/2025 and no end date. *R81 has an order for antibiotic neomycin-bacitracnzn-polymyxnb topical ointment, with start date 03/08/2025 and no end date. *R102 has an order for antibiotic ciprofloxacin 500mg tablets, with start date 04/09/2025 and no end date. Facility policy, dated 04/29/2024, titled Antibiotic Stewardship Program Guideline documents, The purpose of an antimicrobial stewardship is to promote the appropriate use of antimicrobials by selecting the appropriate agent, dose, duration, and route of administration to improve patient outcomes, while minimizing toxicity and the emergence of antimicrobial resistance. The purpose of an antimicrobial stewardship program is to improve antimicrobial stewardship practices and to monitor outcomes and antimicrobial use. Tracking: The facility will monitor antibiotic use and outcomes from antibiotic use.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure that a working call system is available in each resident's bathroom and bathing area. 45001 Based on observation, interview, and record review, the facility failed to provide a functioning call light system for eleven (R14, R22, R34, R47, R59, R64, R112, R118, R119, R133, R139) residents of 27 reviewed for call light. Findings include: On 4/8/25 at 12:55 PM, R133 was asked to activate the call light. The light bulb above R133's door did not light up, and there was no audible sound heard. On 4/8/25 at 12:58 PM, V18 (Certified Nursing Assistant) stated, There is a call light in each resident room. When it is pulled, it should light above the resident's door, and you should hear a sound. It also lights up at the nursing station panel. The call light is for emergency purposes; for the assistance of the resident. V18 pull the call lights in three resident rooms. Writer verified with V18 that no light came on over the door of the resident rooms. There was no audible sound heard, and the panel at the nursing station did not light up. On 4/8/25 at 1:10 PM, V2 (Director of Nursing) stated, The purpose of the call light is so the patient can get assistance when needed, to accommodate the patient's needs. If the resident feels sick, they can get assistance. The call light is kept in reach for emergencies and non-emergency purposes. If the call light system is not operating, then the patient cannot call to get help. I was not aware the system is not working. There must be a glitch in the system. V2 pulled the call lights in (3 resident rooms). No light came on over the door of the resident rooms, and no audible sound was heard when the call light system was activated from each room. On 4/8/25 at 1:22 PM, the call light system was activated in (resident room). The light over the door did not light up, and no audible sound was heard. On 4/8/25 at 1:32 PM, the call light system was activated in (resident room). The light over the door and the nursing station panel lit up, however, no audible sound was heard. On 4/8/25 at 1:40 PM, V19 (Certified Nursing Assistant) stated, Somebody was here last week looking at the call light system. We noticed there were no lights coming on and there was no sound. Currently there still is no sound from the system. The purpose of the call light system is if the resident gets sick and needs assistance. The CNAs (Certified Nursing Assistants) round hourly. On 4/8/25 at 1:51 PM, V5 (Licensed Practical Nurse) stated, Last week they were working on the system. We only saw the light on, with no audible sound. The purpose of the call light system is if someone needs help, we assist. We have to go quick to answer the call light. On 4/9/25 at 9:48 AM, V1 (Administrator) stated, My expectation is that staff are to do continuous check-ins in those areas identified with call light issues, and immediately notify maintenance in order to resolve the issue. Facility Call Light policy, 5/2024, documents: Equipment: Functioning call light.