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	02/05/2026

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 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** Based on observation, interview, and record review, the facility failed to ensure walk-in cooler, refrigerator (Reach In cooler) and freezer maintained a daily log tracking of temperatures; failed to maintain refrigerated foods within normal ranges; failed to label foods with open and use by dates; and failed to discard foods with expired dates. This has the potential to affect all residents residing in the facility. Upon initial kitchen observation at 9:15 am, refrigerator, freezer, and walk-in cooler (walk-in cooler tracking log on a clip board) had a January Tracking log affixed to the outside doors; refrigerated foods with no open or use by date; refrigerated foods with expired use by dates; walk-in cooler with an out of range temperature; and foods temperature measuring at warmer temperatures than normal range. On 2/1/2026 at 9:18 am, V7 (Dietary Cook) verified with surveyor the temperature tracking log on the freezer, Reach in Cooler, and Walk in Cooler was dated January 2026 and the last documented temperature tracking date was 1/31/2026. V7 stated the Dietary Supervisor reloads the new tracking log monthly, but today is Saturday. V7 stated she checked the temperature of the freezer, Reach in Cooler, and Walk in Cooler, and all three were within normal temperature ranges. Surveyor verified with V7 there was no February temperature tracking log affixed to the refrigerator. Thermometer reading was 38 degrees Fahrenheit; the freezer with a temperature reading was -9 degrees Fahrenheit; and the Walk in cooler with a temperature reading of 48 degrees Fahrenheit. V7 verified cheese partially wrapped in saran wrap with no open label date and no expiration date; large roast beef in a metal pan with soaking in a brown liquid covered with saran wrap with an open date of 1/28/2026 and a use by date 1/30/2026; hamburger buns with no open or use by date; and turkey breast sandwich meat wrapped covered with saran wrap and an open date of 1/28/2026 expiration date of 1/30/2026. V7 verified the milk temperature was 46 degrees Fahrenheit; turkey sandwich meat temperature was 48 degrees Fahrenheit; and the roast beef temperature was 47 degrees Fahrenheit. V7 stated the Walk in Coolers temperature had dropped because dietary staff are in and out of the Walk in Cooler frequently. V7 verified the cooling fan in the Walk in Cooler was blowing warm air. V7 stated the safe temperature in the Walk in Cooler should be about 40 degrees Fahrenheit. V7 stated the purpose of maintaining cold foods Walk in Cooler temperature at 40 degrees Fahrenheit is to prevent spoilage of the food and prevent foodborne illnesses. V7 stated she (V7) will discard all of the food in the Walk in Cooler. On 2/1/2026 at 12:06 pm, V10 (Dietary Supervisor) verified the Walk in Cooler thermometer temperature reading was 48 degrees Fahrenheit. V10 stated the dietary cook is responsible for affixing new temperature tracking logs monthly to the Walk in Cooler, Reach-In Cooler (refrigerator), and the Freezer. V10 stated the temperatures are tracked twice a day, and if they are out of temperature range, the Dietary staff should notify the Dietary supervisor and Maintenance immediately. V10 stated the Dietary staff did not notify her the Walk in Cooler temperature was out of range. V10 verified the temperature of the milk was 46 degrees Fahrenheit; turkey sandwich meat temperature was 48 degrees Fahrenheit with open date of 1/28/2026 and use by date of 1/30/2026; and the roast beef temperature was 47 degrees Fahrenheit with open date of 1/28/2026 and use by date of 1/30/2026. V10 stated all Dietary cooks, and Dietary Aides are responsible for applying open (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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and use by dates on foods stored by them. V10 stated cold foods should be held at 32 degrees Fahrenheit and hot foods should be held at 165 degrees Fahrenheit to prevent food borne illnesses. V10 stated she (V10) will contact an outside HVAC company for maintenance to the Walk in Cooler.On 2/1/2026 at 1:24 pm, Walk in Cooler and all food and beverages had been discarded. V10 stated she was purchasing milk from the local grocery store and ordering food to replace discarded food from Walk in Cooler. HVAC repairman had just arrived to repair the walk-in cooler. On 2/4/2026 at 1:13 pm, V20 (Acting Maintenance Director) stated, The Dietary Director must check refrigerator temperatures twice daily and report any out-of-range readings to Maintenance; Refrigerators should be at 40 F or below, and freezers at 0 F; if temperatures fall below normal ranges a plan b is to add ice to the cooler until repairs are made by maintenance typically within an hour. This is why the company had the walk-in cooler was serviced on Sunday. Proper temperature control is critical to protect residents' health.On 2/4/2026 at 2:21 pm, V1 (Administrator) stated monthly temperature log must be maintained for all refrigerator, cooler, and freezers in the kitchen. The cook is required to check and record the temperatures at the start of each shift. The walk-in cooler temperature should read 41 degrees Fahrenheit or below; If temperature is out of range, notify manager immediately. The manager contacts HVAC for service and informs Maintenance. An improper temperature can cause food spoilage and health risks (e.g., upset stomach from milk) to the residents.On 2/4/2026 at 2:25 pm, V1 (Administrator) stated Dietary staff must label all food items and discard any expired or spoiled products. V1 stated consuming outdated food poses health risks and must be avoided to prevent foodborne illnesses.HVAC repair work order invoice, dated 2/1/2026, documents walk-in cooler running warm topped of system with 1.5 pounds of R-404A verified operation. Head pressure was high cleaned condenser. Temperature is 38 degrees Fahrenheit. HVAC repair work order invoice, dated 2/2/2026, documents [NAME] Cooler not working and upon inspection a new junction box and contactor was added along with a power switch was only cutting out 1 leg on 208V. Proper 208V switch was installed.HVAC repair work order invoice, dated 2/3/2026, documents warm walk-in cooler picked up parts replaced 1 breaker with proper 2 pole 20-amp breaker, tested breaker and found good.On 2/4/2026 at 2:15 pm, walk-in cooler temperature is 34 degrees Fahrenheit.Facility Food Service Supervisor Job Description undated documents, qualifications and essential functions include. Supervise and direct all food service components. This includes, but is not limited to, sanitation procedures, proper food and chemical storage procedures, proper operation of facility equipment (dishwasher, stove, oven, etc.), . monitoring of refrigerator and freezer temperatures. Facility policy titled Storage of Refrigerated Foods, dated 2015 revised 2017, documents Policy: Refrigerated food is stored in a manner that ensures food safety and preservation of nutritive value and quantity.Refrigerated foods are stored at 41 degrees Fahrenheit or below. Air temperature inside the refrigerator is checked and recorded twice daily. The reading on both the external and internal thermometers is recorded.The temperature of a PHF/TCS food is taken and recorded each day.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to ensure the linen chute was secured to prevent unauthorized access. This failure has the potential to affect all 47 residents on the third-floor unit.Findings include:On 2/1/26 at 10:27 am, residents were walking throughout the third-floor unit. The third-floor laundry chute unlocked and accessible.On 2/1/26 at 10:34 am, V18 (Registered Nurse), stated the laundry chute should be locked at all times so the residents do not fall down the chute. V18 further explained if a resident falls down the laundry chute, it could cause death to the resident. V18 stated she does not have a key to lock the third-floor laundry chute. V18 stated she does not know who has a key to lock the laundry chute.On 2/2/26 at 12:22 pm, V20 (Building Engineer Consultant) observed the third-floor laundry chute remain unlocked and accessible. V20 stated all the laundry chutes should be kept locked at all times to prevent the risk of residents from throwing themselves done the laundry chute and causing an injury or death. V20 stated the third-floor laundry chute lock was broken and V20 does not know how long the third-floor laundry chute lock has been broken. The facility document, dated February 2025, and titled Equipment Reporting- Failures and Malfunctions documents: Policy: To provide a mechanism for reporting medical equipment failures malfunctions. Policy Specifications: 2. A reporting form to identify and document medical equipment failures and uses errors that may have an adverse effect on resident safety is completed by the department who owns/maintains the equipment. This report, forwarded to the Maintenance Department, includes the problems identified and the actions taken to resolve these problems.The facility document, dated February 2025, and titled General Safety Precautions documents, Policy: To assure that all personnel are aware of necessary and appropriate safety expectations when performing tasks associated with their positional responsibilities. Policy Specifications: 21. Report all unsafe acts or conditions to your supervisor as soon as practical . 34. Follow established safety precautions as well as those that may become necessary and appropriate.

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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 observation, interview, and record review, the facility failed to discard expired medications for four residents (R61, R87, R96 and R124), failed to label multiuse medications for six residents (R9, R23, R55, R106, R132, and R133),and failed to monitor the temperature of the medication refrigerator that included medications for three residents (R30, R102 and R12. This failure affected 13 residents in a total sample of 50 residents reviewed. Findings include: 1.On 02/02/25 at 8:45am, V19 (Licensed Practical Nurse) reviewed the fourth-floor medication cart, noted the following observations with R23,R61,R87,R96,R132 : R132: No open date on the eye drops listed. Brimonidine Tartrate 0.15% ophthalmic solution , manufacture exp date of 2/28.No open date and No discard date. Prednisolone Acetate ophthalmic suspension 1%, manufacture exp date of 8/28.No open date and No discard date. Timolol maleate ophthalmic solution 0.5% ,manufacture exp date of 3/27.No open date and No discard date. Moxifloxacin solution hcl 0.5%, manufacture dispense date of 1/8/18/26 manufacture label states last for 30 days no open date on medication. No open date and No discard date. Latanoprost solution 005%, manufacture instructions on label states to discard medication after 6 weeks of use. No open date and No discard date. R96: Fluphenazine decanoate 125mg/5ml, medication vial observed in medication in top drawer with date on medication box of 6/7/25.Manufacture instructions to discard medication after 30 days. No open date and No discard date. R87: Fluphenazine decanoate 125mg/5ml, medication vial observed in medication in top drawer with date on medication box of 12/18/25.Manufacture instructions to discard medication after 30 days. No open date and No discard date. R61: Fluphenazine decanoate 125mg/5ml, medication vial observed in medication in top drawer with date on medication box of 8/4/25.Manufacture instructions to discard medication after 30 days. No open date and No discard date. R23: Breo Ellipta inhaler 100-25,manufacture label reads to discard medication after 6 weeks .No open date and No discard date. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 02/02/2026 at 9:33 am, V19 stated R23 is no longer a resident on the fourth floor and she is not sure why R23's medication was still on the cart.V19 stated medications should have an open date written on the medication box or bottle so that all nurses who are administering the medication would know when the medication should no longer be used and discarded. Administering expired medication may not have the same effect as unexpired medication. 2.On 02/02/2026 at 9:38 am, the 4th floor medication storage room was reviewed with V19. Upon opening the refrigerator, V19 observed there was no thermometer present in the refrigerator. There were medications inside the refrigerator including unopened insulin, tubersol , and a med pass supplement drink. V19 stated the refrigerator temperature should be kept below 46F to ensure the potency of the medication is maintained. V19 stated there is no thermometer in the refrigerator at this time because the refrigerator was just replaced, and she was not aware where they put the old thermometer.V19 recorded the temperature on the refrigerator temperature log as 40F time 7-3 shift, and stated she did this because she just followed the previous temperature reading from the day before. On 2/2/26 at 9:42 am, V2 (Director of Nursing) stated, Eye drops should have open dates on them. The nurses need to know when the medications expire to ensure medications are not administered after discard date. This is to decrease risk of administering expired medication because it may decrease the effectiveness of the medication. The nurses are aware to make sure the temperature and fridge logs are accurately checked on their shifts. The thermometer is not present in fridge because we just replaced the fridge, and they must have forgot to put the thermometer back in. 3.On 02/02/26 at 9:54am, R9's ophthalmic solution had no open date, R124's haloperidol injection had an expiration date of 01/2026, R55's, R106's, and R133's albuterol sulfate inhalation had no open date. Medication refrigerator had no temperature log for February 2026 and multiple missing temperature dates for January 2026. R9's R102's and R121's ophthalmic solution were in the medication refrigerator that stated refrigerate until open label and R30's pneumovax 23 injection. On 02/02/26 at 9:54am, V24 (Licensed Practical Nurse/LPN) stated R9's medication is expired and should not be used. V24 stated expired medication can be harmful to the residents. V24 stated there is no open date on the albuterol inhalation medications for R55, R106 and R133, but there should be. V24 stated the facility has not started a February refrigerator log. V24 stated it is important to check the refrigerator temperature to make sure that the refrigerator is at the right temperature. V24 stated if the refrigerator is not the right temperature, the medication can spoil. On 02/02/26 at 11:55am, V2 (Director of Nursing/DON) stated the medication refrigerator should be checked daily to make sure the medication is at the right temperature. V2 stated, If the medication is not at the right temperature, the medication can go bad. Multidose medication should have an open date because the medication has a certain lifespan. Expired medication has the potential to lose its potency and should be discarded. Facility's policy titled Storage of Medications, revision date 02/2025, documents, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only by licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Procedures: C. All medications dispensed by the pharmacy are stored in the container with the pharmacy label. H. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	procedures for medication disposal. Temperature: A. Medications and biologicals are stored at their appropriate temperatures and humidity according to the United States Pharmacopeia guidelines for temperature ranges. C. Medications requiring refrigeration are kept in a refrigerator at temperatures between 2 degrees Celsius (59 degrees Fahrenheit) and 8 degrees Celsius (46 degrees Fahrenheit) with a thermometer to allow temperature monitoring. E. The Facility should maintain a temperature log in the storage area to record temperatures at least once a day. F. The Facility should check the refrigerator or freezer in which vaccines are stored, at least two times a day, per CDC Guidelines. Expiration Dating: A. Expiration dates of dispensed medications shall be determined by the pharmacist at the time of dispensing. B. Drugs dispensed in the manufacturer's original container will be labeled with the manufacturer's expiration date. C. Certain medications or package types, such as IV (intravenous) solutions, multiple dose injectable vials, ophthalmic, nitroglycerin tablets, blood sugar testing solution and strips, once opened, require an expiration date shorter than the manufacturer's expiration date to insure medication purity and potency. E. When the original seal of a manufacturer's container or vial is initially broken, the container or vial will be dated. 1. The nurse shall place a date opened sticker on the medication and enter the date opened and the new date of expiration. H. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light for two residents (R7, R85) was within reach. This failure affected 2 residents out of a sample size of 50.Findings include:1.R7 has a diagnosis of but not limited to Bilateral primary Osteoarthritis of Hip, Hemiplegia and Hemiparesis, Type 2 Diabetes Mellitus, Cerebral Infarction, and Hypertensive Heart Disease.R7 has a Brief Interview of Mental Status score of 15, indicating cognition is intact.R7's Minimum Data Set, dated 1/1/2026, documents, Roll left and Right: 02 Substantial/maximal assistance-helper does MORE THAN HALF the effort.R7's care plan focus: Falls, dated 10/01/2025, documents, keep call light in reach at all times.2.R85 has a diagnosis of but not limited to Chronic Obstructive Pulmonary disease, Schizophrenia, Hypertensive Heart Disease, Dementia, and Major Depressive disorder.R85 has a Brief Interview of Mental Status score of 07, indicating severe cognition impairment.R85's R7's Minimum Data Set, dated [DATE], documents, roll left and Right: 05-Setup or clean-up assistance: Helper sets up or cleans up.R85's care plan focus: Falls, dated 09/22/2025, documents, keep call light in reach at all times.On 2/01/2026 at 10:12am, R7's and R85's call light strings were hanging behind the bed on the wall where the residents could not reach it.On 2/01/2026 at 10:41am, V22 (Licensed Practical Nurse-LPN) stated call lights should be within reach of the resident.On 2/04/2026 at 9:34am, V2 (Director of Nursing) stated, Call light should be within reach of the resident so they can let us know if they need assistance.Policy titled Answering the Call Light, with a revised date of October 2025, documents, the purpose of this procedure is to respond to the resident's requests and needs, and when the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.Undated Job description titled Certified Nursing Assistant documents, Ensure that all residents have access to call lights throughout each shift.

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to develop a discharge plan that reflects the residents post discharge needs, goals, and treatment preferences. This failure effected one (R70) in a sample size of 50 residents reviewed for discharges. Findings include: R70's face sheet, dated 2/4/2026, documents R70 was admitted to the facility on [DATE], with diagnoses of Diabetes mellitus, multiple myeloma, paroxysmal atrial fibrillation, hypertensive heart disease with heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, hyperlipidemia, and gastro esophageal reflux disease. R70's minimal data set section C cognitive patterns, dated 12/11/2025, documents R70 has a score of 15, which means R70 is cognitively intact; section GG functional abilities documents R70 has a score of 02 for shower/bathe self, meaning R70 requires staff substantial/maximal assistance to complete the task. R70's care plan, dated 12/06/2025, documents R70's discharge planning: R70's discharge plan is to return to community after completion of skilled treatment; Goal: R70 will be transitioned to home/community after completion of skilled treatment; Interventions: staff to assess availability support system for discharge to community. R70's care plan, dated 02/02/2026, documents; return to community referral; discharge planning: R70 plan is to return to the community/assisted living. Goal: R70 will discharge to the community/assisted living; Intervention: assess available support system for safe discharge back into the community. On 02/01/2026 at 10am, R70 was alert and responsive; able to make needs known to staff; no acute distress or pain expressed; she can transfer herself from bed to wheelchair; and reports that she is here from Arkansas. R70 states this placement in the nursing facility was supposed to be temporary but the last Social Worker she spoke to informed her she did not qualify to be transferred to another facility such as senior living because she was unable to walk. She stated it's not that she is unable to walk, but she is afraid to walk because she has had falls in the past prior to admission and she utilizes a mobility device for ambulation. She states she spoke to one Social Worker when she admitted that informed her that she would be able to transition back into the community when appropriate, but I'm being informed that the person is no longer working here and no one else has spoken to me about being discharged even though I ask frequently. R70 stated she is in her right state of mind and should be allowed to leave because she desires to have her own space. R70's resident progress notes, dated 12/05/2025 at 4:06pm, documents; resident's goal includes eventually transitioning back into the community when appropriate. On 02/02/2026 at 11:35 am, V6, Social Service Director stated, I was not aware (R70) wanted to discharge to senior living because the Social Worker who was working with (R70) no longer works here and never informed me prior to leaving there was a discharge discussion for (R70). I did meet with (R70) one time but cannot remember the conversation and did not document the meeting. V6 stated she is the Social Service Director and responsible for all the Social Workers in the facility, and it should have been reported to her that R70 desired to discharge. After interviewing V6, she stated she will now start making calls and sending out referrals to various agencies for R70 to be screened and evaluated for assistive living facilities. R70's resident progress notes, dated 02/02/2025 at 3:43pm, documents; R70 expressed interest in assisted living facility. V6 reached out to a facility and the representative was able to come out and complete and in person interview with R70 at 1:00 pm, tour of the assistive living facility has been scheduled at 11:00 am on 02/02/2026. R70's resident progress notes, dated 02/04/2025 at 12:05 pm, documents; R70 has returned from her tour of assistive living facility. On 02/04/2026 at 2:11 pm, V1 (Administrator) stated, When a resident admits to the facility, upon initial assessment, staff ask the resident do they have a place to discharge when the time comes, and if they have been working with any agency. We continue with the process and set up care plan meetings. If the resident has a team that they are working with we collaborate with the outside (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	vendor to ensure the resident receives whatever care, equipment or supplies they may need for a smooth transition. V1 stated she was made aware on 02/03/2026 by V6 that R70 desired to transition to an assistive living facility and V6 sent out referrals to agencies. (R70) went out to one facility today to tour, but (V6) informed me that the resident did not qualify because (R70) demonstrated profound behaviors that the facility was unable to redirect at time of the tour. If (R70) wants a staff member to escort her on the tours, then the facility will assign her with an escort to accompany her. V1 stated she never spoke with R70's family regarding her inability to transfer to an assistive living facility. On 02/04/2026 at 2:29 pm, V6 (Social Service Director) stated, The discharge discussion starts at the beginning with admission process. When a resident wants to be discharged , a care plan meeting is scheduled that includes the vendors and resident, a discharge date is given, and the needs are set up if the resident requires equipment. V6 stated the last care plan for R70 was 12/16/25 and progress notes were written about the meeting. There is only an attendance sheet with staff names that V6 states attended the meeting. V6 states the care plan admission meeting topics that are discussed are orientation to the facility and discharge plan goals. V6 stated the boxes for agree/disagree with plan of care were not checked and she is not sure why, but V6 doesn't check any of those boxes ever. V6 stated the care plan meeting discussion was not documented because it is optional to document because if there is an attendance sheet that displays proof that the care plan was done that is all that is required. V6 stated, (R70) went out today to tour an assistive living facility but returned because (R70) did not like the facility. When asked where the documentation was for the visit, V6 stated she normally does her charting at the end of the day. V6 stated R70 requested for her to search for other facilities that she could tour for possible transition to assistive living. When V6 was asked why a facility escort or Social Service worker did not accompany R70, V6 stated, It's up to the resident if they ask staff to accompany them to an appointment. V6 stated she suggested it to R70, and she said she will think about it for next tour visit.Job description titled Social Service Director; direct service and programming: assist as a liaison with outside agencies as needed to facilitate communication and services ;assist in coordination of discharge planning services, job training and employment services and housing; 2) Record keeping: Maintains concise comprehensive case records by following established agency policies and procedures.Facility's policy titled Discharge summary and plan, with revised dated of February 2025, documents: Policy statement: when a resident's discharge is anticipated ,a discharge summary and post discharge plan will be developed to assist the residents to adjust to his/her new living environment; Policy interpretation and implementation:1) when the facility anticipates a residents discharge to a private residence or another nursing care facility, a discharge summary and a post discharge plan will be developed which will assist the resident to adjust his or her new living environment,4) social service department will review the plan with the resident and family before the discharge is to take place.

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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 Based on interview and record review, the facility failed to refer one resident (R71) who has a serious mental illness was referred to the appropriate state agency for a Level 1 PASRR (Pre-admission Screening and Resident Review) evaluation and failed to refer one resident (R12) to the appropriate State Agency for evaluation after being diagnosed with a serious mental illness. This deficient practice affected two residents (R12 and R71) in a total sample size of 50 residents.Findings Include: 1.On 2/2/2026 at 10:43 am, R12's Preadmission Screening and Resident Review (PASRR) I and II were not noted in R12's electronic health record. R12's PASRR Level I and Level II were requested from V4 (Admissions Director/Business Office Manager). On 2/4/2026 at 11:38 am, V4 (Admissio. Director/Business Office Manager) stated R12 has a serious mental health condition of schizoaffective disorder; has a Preadmission Screening and Resident Review (PASRR) Level I with a determination to refer for a PASRR Level II onsite; and was referred to the referral agency for level II but the referral agency cancelled the level II. V4 stated she is responsible for PASRR's during admission and if a required level II is triggered, Social Services is responsible; R12 should have had a PASRR Level I and Level II on admission and when the required PASRR Level II is not completed, a resident may not receive the needed services. V4 stated R12's PASRR Level II was completed today, 2/4/2026. On 2/4/2026 at 11:49 am, V6 (Social Services Director-(SSD) stated currently, the admission Director handles Preadmission Screening and Resident Review screenings (PASRR). The facility is behind on several tasks; another SSD from a sister facility will be training her soon on PASRR screenings. PASRR screenings ensure residents with mental health diagnoses are appropriate for the facility and the facility can provide appropriate care according to the resident's diagnosis. On 2/4/2026 at 2:17 pm, V1 (Administrator) stated R12 should have both a Preadmission Screening and Resident Review (PASRR) Level I and Level II for his diagnosis of Schizoaffective Disorder. PASRR Level I is completed by the Business Office Manager to identify mental health needs before admission or a few days after admission; PASRR Level II is completed by the Social Service worker or Director. If level I triggers it is based on diagnosis and behavioral history. The purpose is to ensure appropriate care and services for residents with serious mental illness. 2.R71's medical diagnoses include but are not limited to schizoaffective disorder, depression, generalized anxiety disorder, cocaine abuse, and hypertensive heart disease with heart failure. R71's admission date to the facility is documented as 02/28/19. R71's PASSR I provided by the facility is dated 02/02/26. R71's PASSR II provided by the facility is dated 02/02/26. On 02/04/26 at 10:41am, V4 (Business Office Manager/Admissions Director) stated R71's PASRR was submitted on 02/02/26 after surveyor requested to review R71's PASRR. V4 stated she is responsible for making sure that residents have a PASRR done prior to or on admission. V4 stated the PASRR evaluation is important because it tells the facility how to assess and treat the resident. On 02/02/26 at 11:55am, V2 (Director of Nursing/DON) stated every resident should have a PASRR done to make sure the resident is appropriate for the facility. V2 stated PASRR's give the facility (continued on next page)

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	direction on how to care for the residents. Facility's policy titled Pre-admission Screening and Resident Review), revised date 12/2023, documents, Background: In accordance with Federal and State of Illinois regulatory standards and recommended practices, this organization requires each resident to be screened for Level I prior to or shortly thereafter admission. The facility will expect Maximus to properly complete the Level 2 is a PASRR condition (SMI (Serious Mental Illness)/ID (Intellectual Disability) exists. The facility works to obtain Pre-admission Screening documents prior to the individual's arrival at the facility. Facility staff, as indicated, will provide information to help Maximus complete the Level 2 interview/screen. Policy: it is the policy of this facility to: 1. Comply with Federal, State and the appointed screening agency, maximus, in standards addressing the PASRR assessment/screening process. 2. Request full and complete PASRR materials (Level 1 and 2) from each referral source prior to or soon following admission. Procedure: 1. A facility representative shall request the complete screening from the referral source. 3. The hospital/screening agency/referral source may be contacted, as indicated and asked to provide any missing or incomplete documents.

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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. Based on observation, interview, and record review, the facility failed to ensure the development of a care plan focused on a serious mental health illness to maintain proper disease management and continuance of care. This failure affected 1 of 1 resident (R12) in the sample of 50. R12's Face Sheet, dated 2/4/2026, documents a diagnosis of but not limited to for schizoaffective disorder on 3/2020.R12's Minimum Data Set Section C documents a BIMS (Brief Mental Interview Status) Score of a 15, which is indicative of an intact cognition. R12's care plan, dated 11/18/2025, does not document a focus for a severe mental illness of schizoaffective disorder.On 2/4/2026 at 11:51 am, V6 (Social Services Director) stated, (R12) should have a care plan for schizoaffective disorders to manage the condition effectively. Social Services is responsible for ensuring this care plan exists and without a care plan, we cannot properly monitor or manage the diagnosis.On 2/4/2026 at 2:27 pm, V1 (Administrator) stated R12 and other residents with schizoaffective disorder must have a care plan outlining behavioral history and interventions because this ensures proper management and continuity of care.Facility Policy titled Care Plan, with an effective date of April 2015- Updated October 2025, documents, an individualized Comprehensive Care Plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and /or psychological needs is developed for each resident:#3. Each resident's Comprehensive Care Plan has been designed to:Incorporate identified problem areasIncorporated risk factors associated with identified problemsBuild on the residents' strengthsReflect treatment goals and objectives in measurable outcomesIdentify the professional services that are responsible for each element of care.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide necessary foot care, treatment, or professional referrals to maintain skin integrity on the foot. This failure affects one resident(R70) in a sample size of 50 reviewed for podiatric/foot care. R70's face sheet, dated 2/4/2026, documents R70 was admitted to the facility on [DATE] with diagnoses of Diabetes mellitus, multiple myeloma, paroxysmal atrial fibrillation, hypertensive heart disease with heart failure, atherosclerotic heart disease of native coronary artery without angina pectoris, hyperlipidemia, and gastro esophageal reflux disease. R70's Minimal Data Set section C cognitive patterns, dated 12/11/2025, documents R70 has a Brief Interview for Mental Status score of 15, which means R70 is cognitively intact; section GG functional abilities documents R70 has a score of 02 for shower/bathe self, meaning R70 requires staff substantial/maximal assistance to complete the task. R70's physician order report, dated 01/04/2026- 02/04/2026 with a start date of 12/05/2025, documents R70 may receive services from podiatrist. On 02/01/2026 at 10:00 am, R70 was observed in her room sitting at bedside. She can make her needs known to staff. R70 stated, My toenails have not been cut since August 2025, and my toenails are so long and bending over they are uncomfortable in my shoes. I told the nurse, but nothing happened. On 02/01/2026 at 10:03 am, R70's toenails were observed to be long and curled over towards her toes. On 02/04/2026 at 1:06pm, V25 (Medical records) stated, (V2, Director of Nursing) just gave me the task a few seconds ago to record and maintain the list of residents who will need to be seen by the podiatrist. The facility just started with this new group in December 2025. The task was previously assigned to Social Service, but Social Service did not seem to know about the podiatrist list. V25 stated she will have the nurses to create a list of which patients need to be seen by the podiatrist. V25 stated she took the appointment request sheet forms to each nursing unit for nurses to be able to place resident's names on the sheet who need to be seen also for better tracking. V25 stated the podiatry group will begin evaluating residents on 02/12/2026.On 02/04/2026 at 1:23pm, V8 (Wound care/IP nurse) assessed R70's toenails. V8 stated R70's toenails definitely need to be cut. V8 stated R70's feet should be assessed by podiatry because she is a diabetic and nurses should be assessing the nail care and feet three times a week during showers. R70 receives showers on Monday-Wednesday-Friday on 11-7am shift. V8 stated she was not made aware R70 had any concerns with her toenails. On 02/04/2026 at 1:29pm, V12 (Licensed practical Nurse) stated, The shower report sheet is for body assessments and open areas after completion of shower or bed baths, and the toenail care box was not checked on the sheet so that means the staff did not check the toenails. The nurse should be reviewing the whole skin report sheet to assess if there are any opening skin concerns or nail care concerns that need to be further assessed and addressed with our wound care nurse or call placed to the physician.On 02/04/2026 at 1:33pm, V29 (Certified nursing assistant/CNA) stated she supervised R70 with her shower on 02/03/2026.V29 stated she did not check the box for toenail care and was not aware of how R70's toenails appeared. V29 stated, (R70) prefers to give herself a shower but I stand close by shower room to give her supplies and assistance if required, and after (R70) completed her shower I completed the skin check but forgot to check her toenails and feet. On 02/04/2026 at 1:40 pm, V2 (Director of Nursing) stated, The podiatrist comes in for toenail care monthly. The list is kept with Social Service Director. The staff should place residents on the list to be seen by podiatrist. V2 expectations of the nursing staff is for the CNA and nurse to check, inspect, and assess the toenails during showers or baths, and if any concerns, this needs to be brought to the attention of the wound care nurse and the physician for further orders.V2 stated she was not made aware R70 had any concerns with her toenails. On 02/04/2026 at 3:00 pm, V25 submitted a list of residents that were to be seen by the podiatrist on these dates 12/10/2025,12/12/2025,12/18/2025, R70's name was not on any of the residents list and V25 stated she was never given R70's name to be added. Facility (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	document, dated 02/04/2026 titled Skin report sheet, documents R70 received a shower on 02/03/2026 and skin was reviewed by V29 (Certified Nursing Assistant), and toenail care was left blank with no documentation for yes or no. Facility's policy titled care of Fingernails/Toenails, with revised dated of February 2025, documents, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections; General guidelines:2).proper nail care can aid in the prevention of skin problems around the nail bed,3).Unless otherwise permitted, do not trim the toe nails of diabetic residents or residents with circulatory impairments,4).trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin,6) stop and report to the nurse supervisor if there is evidence of ingrown nails, pain, or if nails are too hard or thick to cut with ease; Documentation: the following information should be recorded in the resident's medical record,3)the condition of the residents nails and nail bed including pain, breaks or cracks especially between toes, corns or calluses, ingrown nails, any problems or complaints made by the resident with his/her feet,6).if the resident refuses treatment, the reason why and the intervention taken,7)the signature and title of the person recording the data.

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F 0914 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide bedrooms that don't allow residents to see each other when privacy is needed. Based on observation, interview, and record review, the facility failed to ensure a residents had a privacy curtain that extended around the bed. This failure affected one resident (R77) in the total sample of 50 residents. Findings include: R77's face sheet documents R77 has diagnoses which include but not limited to anxiety, cerebral infarction, bipolar disorder, hemiplegia, paroxysmal atrial fibrillation, benign prostatic hyperplasia, syphilis, and headaches.R77's Brief Mental Status Interview (BIMS), dated 01/13/26, indicates R77 is cognitively intact. On 2/1/26 at 10:18 am, R77's room was without a privacy curtain that extended around R77's bed. R77 was out on pass from the facility during this observation.On 2/2/26 at 2:28 pm, R77's room was without a privacy curtain that extended around R77's bed. V20 (Building Engineer Consultant) explained all residents should have a privacy curtain, so the residents are not exposed. V20 stated, The privacy curtains are to give the residents privacy.On 2/2/26 at 2:28 pm, R77's room was without a privacy curtain that extended around R77's bed. R77 was out on a pass at a doctor's appointment during this observation.The facility's undated document titled Residents Rights Protocol for All Nursing Procedures documents: Purpose: To provide guidelines for residents rights while caring for the resident. Preparation: 1. b. Resident dignity and respect . General Guidelines: 1. f. close the room entrance door and provide for the resident's privacy.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to include the required elements (date and census) on the daily nursing staffing post. This failure affected all the 134 residents residing in the facility.Findings include:On 2/1/26 at 9:18 am, surveyor observed the facility daily staff posting displayed in a clear case, on the wall, with no date and census.On 2/04/2026 at 11:04am, V28 (Licensed Practical Nurse) stated he s responsible for completing and posting the daily staff posting daily. V28 stated it should include the date and the census. V28 stated on the weekends, no one posts it because he doesn't work on the weekends. Policy Posting Direct Care Daily Staffing Numbers, with a revised date of February 2025, documents, our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents and at the beginning of each shift facility shall post the nurse staffing data as required by state and federal regulations, and Staff staffing information shall be recorded on the form provided by the facility's Administrative for each shift. The information recorded on the form shall include: b. the date for which the information is posted, and c. the resident census at the beginning of the shift for which the information is posted.