STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E247	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 41384 Based on observation, interview, and record review, the facility failed to maintain dignity and privacy for 2 residents (R17 & R71) in a sample of 26. Findings include: 1. On 06/12/24 at 10:13 AM, R17 was in her room. R17, who's cognition is intact, said she has anxiety and panic attacks, and staff will knock on her door and just walk in. R17 said the staff will not wait for her to give them permission to come in before they enter. R17 said this makes her feel like she is not respected, and she feels like she is being invaded. At 10:25 AM, V13, CNA (Certified Nurse's Assistant) knocked on the door while opening it, entered the room and said, room check. V13 entered the room without waiting for permission to enter. 2. On 06/12/24 at 09:33 AM, R71 was in her room and R71, who's cognition is intact said, Some staff will knock and come in without getting permission to come in, and some don't even knock, especially at night so you don't even have time to cover up. R71 said many of the staff have seen her naked. At 09:48 AM, V12 (Nurse) came in to R71's room to give her her medication and did not knock before entering. V12 was asked why she did not knock before entering and she said, I knocked earlier. R71 said staff give her her incontinence briefs in the dining hall in front of people and it makes her feel bad. R71 showed the surveyor the dresser she shares with her roommate. R71 pulled open the top drawer, and the drawer beside it opened. So when the roommate opens her drawer, she also opens R71's drawer. R71 said this makes her feel anxious because everyone is seeing her belongings. On 06/13/24 at 11:03 AM, V2, DON (Director of Nursing), opened R71's dresser and said this is a dignity concern, and R71 should have privacy to her personal items. V2 said the staff should not be giving incontinence brief to the residents in a public area for dignity issues, and staff should knock and wait to be invited in. The facility's Resident' Rights information in the Admission packet (no date) from the Illinois Department of Aging showed under privacy, facility staff must knock before entering your room. The facility's Resident Rights policy, dated 3/2021, showed residents have a right to privacy. The facility's Resident Rights policy, dated 4/2020, showed residents have a right to a dignified existence, and be treated with respect, kindness, and dignity.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on interview and record review, the facility failed to maintain proper documentation for Advanced Directives for 3 residents (R76, R293, and R243) in a sample of 26. Findings include: 1. On [DATE] at 12:00 PM, R76's health records were reviewed. The facility's book titled Advanced Directives showed R76 was to receive CPR (cardiopulmonary resuscitation) full treatment. The document was signed on [DATE]. R76's electronic record showed his code status as DNR (do not resuscitate). R76's [DATE] physician's orders showed Do Not Attempt Resuscitation/DNR. On [DATE] at 11:25 AM, V2, DON (Director of Nursing), said the staff will use the resident's electronic health record to determine treatment when a resident goes into cardiac arrest or is found unconscious. V2 said if the electronic health record shows R76 is a DNR, and the Advanced Directives book shows R76 is a full code, the staff will not be giving him CPR. V2 said this would be against R76's wishes. The facility's Advance Directives policy, dated ,d+[DATE], showed, all residents will have the right to establish advanced directives, advanced care planning, and the right to accept or refuse treatment and be educated on the rights. The policy showed under Procedure, The residents physicians should be informed of advanced directives and copies should be placed in the medical record. Physicians' orders to support the advanced directive should be obtained by the nursing personnel. Social services will review the residents' advance directives with the physician and or compare with the physician's documentation in order to ensure all documentation is congruent with the resident patient's wishes. The social service designee will conduct a periodic review when there is a change in condition and at least quarterly of DNR orders and advanced directives with the resident and representative to allow the opportunity for revocation or amendment. 48526 2. R293 was [AGE] years old. R293 was admitted to the facility on [DATE], with multiple diagnoses which included schizophrenia, combined systolic and diastolic congestive heart failure, hyperlipidemia, atherosclerotic heart disease, asthma, gastro-esophageal reflux disease, and hypertension, per the face sheet. R293's MDS (Minimum Data Set), dated [DATE], showed R293 was cognitively intact. R293 did not have an Advanced Directive care plan. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:09 AM, R293 did not have an order in the electronic medical record for a code status. R293 did not have a POLST (Physician Order for Life Sustaining Treatment) form uploaded into the electronic medical record. There were no sections in the electronic medical record containing any information regarding Advanced Directives or code status. On [DATE] at 11:43 AM, an order was put in the electronic medical record for POLST A: Attempt Resuscitation/CPR (Cardiopulmonary Resuscitation). The Illinois Department of Public Health Uniform Practitioner Order for Life-Sustaining treatment form was uploaded into the electronic medical record. The POLST form was signed and completed by R293 and the physician on [DATE]. On [DATE] at 11:43 AM, V11 (Registered Nurse) said resident's code status and Advanced Directives are found in the electronic medical record. V11 said she did not know where else to access a resident's code status/Advanced Directives if it was not in the electronic medical record. On [DATE] at 11:51 AM, V2 (Director of Nursing) said the Psych Social department has the paper copy of all Advanced Directives/code status that is kept in their office. The paper copy is uploaded into the electronic health record. All code statuses are uploaded into the resident's chart. There would be no need for the staff to access to the paper copy. The facility's Advance Directives Policy, effective date ,d+[DATE], stated, Procedure: 2. The resident's/patient's physician should be informed of advance directives and copies should be placed in the medical record. Physician's orders to support the advance directive should be obtained by nursing personnel, as appropriate. 46003 3. R243 was admitted to the facility on [DATE]. R243 did not have any code status orders entered until [DATE]. On [DATE], an order was entered attempt resuscitation / CPR (Cardiopulmonary Resuscitation). R243 did not have a POLST (Practitioner Order for Life Sustaining Treatment) in the facilities Advanced Directives binder. R243's current care plan, dated [DATE], states resident has chosen the DNR (Do Not Resuscitate) and completed a POLST Advanced Directive regarding treatment. On [DATE] at 4:44 PM, V3, PSRD (Psych Rehab Services Director) stated she is responsible for uploading the POLST in the EMR (Electronic Medical Record) and placing a copy in the Advanced Directives binder. V3 stated nursing is responsible for obtaining the physician order. On [DATE] at 12:06 PM, R243 stated he was a DNR, but signed a new POLST to be a full code on [DATE] after staff talked to him. On [DATE] at 12:08 PM, V2, DON (Director of Nursing), stated code status orders should be obtained on admission with admitting orders. The admitting nurse is responsible for getting the code status orders. The facility policy Advanced Directives, dated ,d+[DATE], states all residents shall be presumed as having consented to CPR unless there is documentation in the medical record that the resident has specified that DNR order be written. upon admission nursing is to clarify the advanced directive order that have accompanied the resident.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to provide a safe, clean, and comfortable environment. This applies to 8 residents (R34, R72, R53, R193, R75, R59, R71, and R42) reviewed for homelike environment in a sample of 26 residents. The findings include: 1. R34's MDS (Minimum Data Set), dated 3/4/24, shows his cognition is intact. On 6/11/24 at 10:48 AM, R34 said his bathroom door gets stuck when he is trying to open or close it, and he feels like he is going to throw his back out trying to open it. R34 said when he is in the bathroom it is even worse trying to open it; he has to kick the bottom of the door to get it to open. R34 then demonstrated opening the door, and he had to pull hard on the knob, rocking his body back and forth, 3-4 times to get the door to open, and when it finally did open, it scraped against the floor making a loud noise. R34 said he mentioned the door needing to be repaired to V9 (Maintenance Director) 3-4 months ago, and V9 told him he would have to take the door off and clean the bottom of it but he had not fixed it yet. 2. R72's MDS, dated [DATE], shows his cognition is intact. On 6/11/24 at 12:45 PM, R72 said we (R34 and himself) do have a problem with our bathroom door, and R72 has a hard time pulling the door open. R72 said he has to use both of his hands on the door knob to pull the bathroom door open, and he knows R34 has told V9 (Maintenance Director) that it needed to be fixed. R34 and R72 are roommates and share the same bathroom/enter through the same bathroom door. On 6/13/24 at 11:04 AM, R34 and R72's bathroom door was observed again. The doorknob was loose, no screws holding the knob were in place, and surveyor was unable to close the door all the way because of the resistance between the bottom of the door and the floor. 3. R53's MDS, dated [DATE], shows his cognition is intact. On 6/13/24 at 10:58 AM, R53 said he needs a more powerful shower head in his bathroom shower because the water pressure is too low coming through it, and it does not rinse the soap off his body. R53 said he previously had a more powerful shower head, but it broke about 6 months ago, and V9 (Maintenance Director) replaced it with the current one, but the pressure is too low and is not getting the soap off his body. R53 said he told V9 the shower head was not sufficient shortly after he replaced it, six months ago, and V9 has not fixed the problem. R53 said he was going to go buy a new shower head himself because he has seen the good shower heads for about 20 dollars at the store. R53 then turned on the shower and showed surveyor how lightly the water was coming out of the shower head. 4. R193's MDS, dated [DATE], shows her cognition is intact. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/11/24 at 10:23 AM, R193 said her room is a concern for her because there is a piece of brown gum stuck under her bedside table, the baseboard behind the door to her room is falling off, there is a missing drawer to her built in closet, and another one of the drawers is not on the track and doesn't come in and out without pulling hard on it. R193 said she did mention her concerns to the staff. R193 said the facility is falling apart, and many rooms have the same problems as hers, and it makes her feel scared to be in the facility when it looks the way it does. On 6/13/24 at 11:08 AM, R193's room was again observed in the same condition. R193 said she mentioned the gum to two different staff members in the past week, and they told her they were working on it. R193 said she is using both of the dressers in the room because of the broken and missing drawers in the closet, but if she got a roommate she would have to remove her things from one of the dressers. R193 said she doesn't feel at home in the facility because of all the concerns she has with her room. 5. R75's MDS, dated [DATE], shows his cognition is intact. On 6/11/24 at 10:34 AM, R75 said the drawers in his built in closet are broken and not on the track. R75 said because the top two drawers are not on the track, they slide out when he is trying to open the bottom drawers. On 6/13/24 at 11:15 AM, R75's concerns were again observed. R75's dresser was observed with peeling on top and built in cabinet with broken drawers. Surveyor was unable to open bottom drawers without the top drawers pulling out on top of the bottom drawers. The drawer on the right bottom side was missing a drawer pull/knob and there was just a screw sticking out where the knob should've been. On 6/13/24 at 9:32 AM, V9 (Maintenance Director) said he has worked at the facility for two years and he does rounds on resident rooms twice a week to look for concerns. V9 said he sometimes writes down what concerns he finds in addition to concerns that have been entered as work orders. On 6/13/24 at 12:52 PM, V9 was shown all of the concerns mentioned above for residents R34, R72, R53, R193, and R75. V9 said he did know the door knob was falling off on R34 and R72's bathroom door, and he was notified about two weeks ago by R34 the bathroom door was difficult to open and close. V9 said he told R34 he might have to shave the bottom of the door to get it to close. V9 said he was not aware the water pressure was too low with R53's new shower head. V9 said he was aware that a drawer was missing in R193's built in cabinet, but he did not know there was gum stuck under her bedside table or that the baseboard on the wall behind her door was falling off. V9 said he was not aware about broken drawers or peeling dresser in R75's room. V9 said all of these observations are concerning because they effect the residents' quality of life. V9 said the facility is not homelike for these residents when their rooms are in disrepair. V9 said the whole facility should be like his own home where things are in working order. On 6/13/24 at 2:15 PM, V9 was questioned regarding hand written notes he had provided from resident rounds. V9 said all of the hand written notes he provided were from March 2024. V9 said his note from March states rust stopper on bathroom door for R34 and R72's room is in regards to the bathroom door not opening and closing correctly. V9 said he thinks it is not opening and closing because of rust on the bottom of the door and the swelling of the floor underneath the door. V9 said he thinks he will have to get a new door and he has to speak to his boss about it. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/13/24 at 12:13 PM, V1 (Administrator) said fixes like the gum, loose door knob, and shower head, she would expect to be fixed same day as they are reported. V1 said the facility should be homelike for the residents and it is not homelike if the resident is unable to open and close their bathroom door without difficulty and the door knob is loose and missing screws. V1 said the facility is not homelike if the shower water pressure is so low that the resident reports not being able to rinse soap off their body. The facility provided list of work orders were reviewed from 6/2023 through 6/2024. No work orders have been entered for any of the resident reported concerns, including R34 and R72's bathroom door knob and door or R193's missing drawer, which V9 said he knew about. Resident Council Meeting notes as far back as 10/27/23 report residents needing new dressers. The facility's policy, dated 4/2020, titled, Maintenance states, Guideline: Maintenance service shall be provided to all areas of the building, grounds, and equipment. Process: 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards .Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order . Establishing priorities in providing repair service . Providing routinely scheduled maintenance service to all areas 8 .The Maintenance Director will respond to each work order and alert the Administrator if additional resources are necessary for completing the work order . 41384 6 & 7. On 06/11/24 at 10:31 AM R42 and R59 were in their room with the surveyor and the room was observed with the walls dirty, paint missing and peeling, & a large square area behind the bedroom door about 2 1/2 feet by 2 feet that was patched with spackle but not painted. R59 said that that all of the walls have been like that for 3 years since he moved into the room. R42, who's cognition is intact, said that it bothers him that the walls need to be painted and repaired and that it makes him feel down. R42 said that he pays a lot of money to live here and it should not look like this. R59, who's cogntion is intact said, it looks ghetto in here. Then R59 said that they can not use the bath or the shower in their room because the water leaks into the room if they do. R59 said that V9 (Maintenance Director) told him that the pipes are busted. R59 said that because of that they have to use the communal shower room to shower and that there is no bathtub in there if they wanted to bathe. R59 then showed that the soap dispenser was not on the wall in the bathroom. R59 said that V9 said that he does not want to put holes in the wall so that is how it has to stay. Then R59 showed the toilet. It was very unsteady and wobbly. R59 said that when the toilet is flushed water and urine leaks onto the floor. R59 said that the toilet has been this way for over 2 years, and he has reported it to V9. On the door to the bathroom the wood is peeling off of the door in 2 areas one is a six inch by 6 inch area and the second area is about 8 inches by 4 inches. R59 said, This all makes me feel discouraged and disappointed. R42 said It makes me feel sad, very sad. On 06/13/24 at 09:39 AM V9 went into R42 and R59's room and the light above R59's bed was not covered and there was a piece of bent metal on the light frame sticking out. Then V9 and the surveyor went into the bathroom and the knob to the cold water on the bathtub was observed missing. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/13/24 at 09:32 AM, V9 said that he has work at the facility for 2 years and he does rounds of the facility twice a week. V9 said the rooms he looks at is random when he does his rounds and sometimes he writes down the work that needs to be done. V9 said that he was not aware of the concerns in R42 and R59's room. At 9:58 AM, V9 said that while he was not aware of the work that needed to be done in R42 and R59's room, after looking at the room he agreed that the work needed to be done because of safety issues and for quality of life. On 06/13/24 at 10:58 AM, V2 DON (Director of Nursing) went into R42 & R59's room with the surveyor and said she was not aware that the room was in the condition it was in. V2 said that no one should be living like this for safety concerns, dignity, and for mental health. 8. On 06/12/24 09:33 at AM R71 was in her room with the surveyor and R71 showed the surveyor her dresser that she shares with her roommate. R71 pulled open the top drawer and the drawer beside it opened. So, when the roommate opens her drawer, she also opens R71's drawer. The same happened with the other 4 drawers on the dresser. R71 said that she hates that everyone can see her personal items and it makes her feel anxious. Then R71 showed the surveyor her toilet. R71's said, It is wobbly and leaning and I have OCD and it bothers me. The toilet was observed leaning and was wobbly. R71 said the drawer and toilet have been like that since she moved into the room a year ago. On 06/13/24 09:50 AM, V9 said that he thought R71's dresser was fine and that he was unaware that there was something wrong with it. On 06/13/24 at 02:26 PM, V9 looked at his maintenance log and it showed a work order for R71's toilet dated for 5/24/24 the document showed wobbly toilet, the log showed that the work was completed on 6/4/24 at 11:21am by V9. The facility's Maintenance policy dated 4/2020 showed, maintenance service shall be provided to all areas of the building, grounds, and equipment. Under Process: The maintenance department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of maintenance personnel include but not limited to maintaining the building and compliance with current federal, state, and local laws, regulations, and guidelines. Maintaining the building in good repair and free from hazards. Providing routinely scheduled maintenance service to all areas. The maintenance director is responsible for maintaining the following records and reports inspecting building, & maintenance schedules, .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observation, interview, and record review, the facility failed to invite 4 residents (R55, R65, R76 and R31) to their care plan meetings that were reviewed for care plans, in a sample of 26 Findings include: 1. On 06/11/24 at 2:31 PM, R55, who's cognition is intact, said he had never been invited or attended a care plan meeting. On 6/13/24 at 1:51 PM, R55's electronic health record showed no documentation for any care plan meeting or invitation to any care plan meetings. 2. On 06/11/24 at 11:23 AM, R65, who's cognition is intact, said he has never attended a care plan meeting. On 6/13/24 at 1:51 PM, R65's electronic health record showed no documentation for any care plan meeting or invitation to any care plan meetings. 3. On 06/11/24 12:43 PM, R76, who's cognition is intact, said he has never attended a care plan meeting. On 06/13/24 at 1:58 PM, R76' electronic health records did not show any documentation for any care plan meetings or invitations to any care plan meetings. On 06/13/24 at 3:01 PM, V1 (Administrator) said the facility has no documentation for any residents being invited to their care plan meetings, and the facility has no documentation for any residents' attendance sheets to their care plan meetings. 46003 4. R31 was admitted to the facility on [DATE]. R31 has diagnoses that includes paranoid schizophrenia, gout, major depressive disorder. Type 2 diabetes, hyperlipidemia, hypertensive heart disease, and chronic obstructive pulmonary disease. R31's MDS (Minimum Data Set), dated 3/22/24, shows he has moderate cognitive impairment with BIMS (Brief Interview for Mental Status) score of 12. On 6/11/24 at 1:01 PM, R31 stated he has not been invited to a care plan meeting in over a year. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/12/24 at 4:44 PM, V3, PSRD (Psych Rehab Services Director), stated her department is responsible for inviting residents and their families to care plan meeting 7 to 14 days in advance. V3 stated she did not have any documentation to show R31 participated in a care plan / IDT (Inter Disciplinary Team) meeting. V3 stated she did not have any documentation to show R31 was invited to care plan meeting. V3 stated she did not have any documentation to show who participated in any care plan / IDT meetings for R31. On 6/13/24 at 11:07 AM, V1, Administrator, stated residents are invited to care plan / IDT meeting verbally. V1 stated the facility only recently started documenting residents' acceptance or refusal to participate in the meetings. On 6/13/24 at 12:08 PM, V2, DON (Director of Nursing), stated psych social is responsible for inviting residents to their care plan / IDT meetings. V2 stated residents are required to be invited to their care plan / IDT meetings. The facility's Care Plan policy, dated 3/2021, showed, The facilities interdisciplinary team in consultation with the resident and his or her representative develops and implements a person centered care plan for each resident. The resident has the right to refuse to participate in the development of his or her care plan and medical and nursing treatment. When such refusals are made the appropriate documentation will be entered into the residence clinical record in accordance with established policies. The facility's Care Planning - Interdisciplinary Team (IDT) policy dated 3/2021 showed, a comprehensive care plan for each resident is developed within seven days of completion of the residence assessment. The resident, the residence family and or the residence legal representative or guardian surrogate or responsible party are encouraged to participate in the development of and revisions to the care plan.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observation, interview, and record review, the facility failed to follow physicians' orders for 1 resident (R71), and failed to monitor 1 diabetic resident's blood glucose levels (R293) in a sample of 26. Findings include: 1. R71's electronic health records showed diagnoses including spinal stenosis, muscle weakness, and perforation of intestines. R71's 5/17/24 physician orders showed Tylenol oral tablet (acetaminophen) 1000 milligrams every four hours as needed for pain. On 06/12/24 at 9:48 AM, R71 was in her room and V12 (Nurse) gave R71 her morning medications. R71 looked at all of the medications, and informed V12 she had given her two 325mg of Tylenol instead of two 500mg of Tylenol that was ordered. V12 said she only had the 325mg of Tylenol on her cart. V12 said, I just substituted the 325mg for the 500mg. I gave 650mg instead of the 1000mg. I did not have the 1000 in the cart and I am allowed to do that. V12 then said, I am going to get her the 1000 mg now because she asked for it. R71 said, This happens a lot. I have to go over my medications every time. On 6/13/24 at 10:58 AM, V2, DON (Director of Nursing), said the nurse should have given her 1000 milligrams of Tylenol as the doctor ordered, because that is what the doctor ordered. V2 said by giving only 650 milligrams of Tylenol, the facility is not managing her pain. The facility's Physician Orders Verbal or Faxed policy, dated 3/2021, showed, follow through with orders as required. 48526 2. R293 was [AGE] years old. R293 was admitted to the facility on [DATE], with multiple diagnoses which included schizophrenia, combined systolic and diastolic congestive heart failure, hyperlipidemia, atherosclerotic heart disease, asthma, gastro-esophageal reflux disease, and hypertension, per the face sheet. R293's MDS (Minimum Data Set), dated 06/06/24, showed R293 was cognitively intact. R293's physician orders or face sheet did not show a diagnosis for diabetes. R293's discharge summary/transition record from her previous facility, dated 05/31/24, showed a diagnosis for NIDDM (Non-Insulin Dependent Diabetes Mellitus). On 06/11/24 at 10:27 AM, R293 said she is not getting her blood sugar checked daily. R293 said a nurse told her she does not have an order to get her blood sugar checked. (continued on next page)

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	14E247	A. Building B. Wing	06/14/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Joliet Terrace	2230 McDonough Joliet, IL 60436

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/13/24 at 12:09 PM, R293 said she has been in the facility for two weeks and has not had her blood sugar checked. R293 said she was a diabetic and she takes diabetic medications. R293 said she did not want to have any reactions related to diabetes. R293 said her previous facility was monitoring her blood sugar daily. R293 said she told the nurses she is supposed to get her blood sugar checked daily. R293 said a nurse told her she does not have an order to get her blood sugar checked. R293 said she asked the nurse if she could get an order to check it. On 06/13/24 at 10:37 AM, V14 (Registered Nurse) said R293 receives Glipizide 5 mg, Linagliptin 5 mg and Metformin 500 mg. V14 said R293 did not have any orders for blood glucose monitoring, or orders for an A1C (Glycosated Hemoglobin test). V14 said there was not a diabetes diagnoses in the electronic medical record. On 06/13/24 at 11:37 AM, V2 (Director of Nursing) said the admitting nurse puts in the diagnoses, and the MDS (Minimum Data Set) Coordinator reviews the diagnoses and makes changes if needed. V2 said R293's blood sugar or A1C should be checked. V2 said since R293 is receiving diabetic medications, she should have a diagnosis for diabetes. V2 said, If (R293's) blood sugar or A1C is not checked, she could go into diabetic ketoacidosis, hyper or hypoglycemia or even death, since we are not monitoring her levels. We would not know if her medications would need to be adjusted. The nurses are expected to put in the correct orders and diagnoses for medications. R293's current physician's order sheet showed R293 receives Glipizide 5 mg tablet by mouth two times per day, Linagliptin 5 mg tablet by mouth one time per day, and Metformin 500 mg one tablet three times per day. R293's MAR (Medication Administration Record) for 06/2024 showed she was administered the medications as ordered. R293's progress notes showed R293's primary physician and/or nurse practitioner had not been to the facility to assess her. The facility's Blood Glucose Testing Policy, effective date 03/2021, showed, Standard: Blood glucose resting is performed according to the order and as appropriate. Blood glucose levels for residents/patients with diabetes vary, depending on food intake, medication, and exercise. Target glucose levels should be determined by the attending physician.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview, and record review, the facility failed prevent a resident from accessing medications for which they were not prescribed, and failed to monitor smoking residents. This applies to 4 of 4 residents (R17, R59, R68, and R76) reviewed for accidents and hazards in a sample of 26 residents. Findings include: 1. R76 admitted to the facility on [DATE]. R76 has diagnoses that includes major depressive disorder, anxiety, insomnia, psychoactive substance abuse and suicidal ideations. R76's MDS (Minimum Data Set), dated 5/1/24, showes he is cognitively intact with a BIMS (Brief Interview for Mental Status) score of 15. R76's care plan, dated 5/9/24, states a history of self harmful ideations and behaviors. On 6/12/24 at 12:31 PM, R76 stated he sees things that are not right all the time. R76 stated he finds medications on the floor all the time. R76 took surveyor to his room and provided five pills from the top of his night stand. Two round white pills, one white oval pill, one round red pill, and one round orange. On 6/12/24 at 12:44 PM, V15, RN (Registered Nurse), stated nurses are supposed to stay with residents and until they swallow their medications and check their mouth to make sure it was swallowed. On 6/12/24 at 12:50 PM, V2, DON (Director of Nursing), stated she would have to look the medications up to determine who they belonged to. V2 stated, The concern is the nurses didn't watch the resident take their medications. A resident could have taken them medications not meant for them and had an allergic reaction or overdose if they had already taken that medication or a resident may have missed their medications and suffer a negative outcome. On 6/13/24 at 11:07 AM, V1, Administrator, stated, (R76) should not have been in possession of those medications. The nurses should have been more cognizant of their surroundings and when they are dropping medications or if a resident is pocketing them. Residents getting a hold of medications that are not theirs pose a risk for harm. The resident that missed their medications could also have a negative outcome. On 6/13/24 at 12:08 PM, V2, DON (Director of Nursing), stated, (R76) would not be in possession of the medication if nurses had been paying attention and picked them up to dispose of them. V2, DON, stated 4 of 5 of the medications were identified and included psychotropics; Risperidone 3mg (milligrams), famotidine 40mg, benztropine 1mg, and a multivitamin. The persons that missed their medications could have an increase in behaviors from missing the risperidone or an increase in tremors from missing the benztropine. 41384 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. 06/12/24 at 10:13 AM, R17, who's cognition is intact, said during smoking breaks the staff will sometimes come out, and sometimes the staff stays inside. R17 said the residents light their own cigarettes. R17 said the staff leaves the lighter outside, and sometimes the lighter will come up missing, because no one is watching. R17 said the staff hardly ever gets the lighter back. 3. On 06/11/24 10:31 AM, R59, who's cognition is intact, said during smoking breaks, the staff watch from the inside, and they don't come outside at all. R59 said sometimes it is one staff monitoring, and sometimes it is 2 staff, but nobody goes outside to monitor when the residents are smoking. On 06/12/24 3:29 PM, V3 (Psych Services Rehab Director) said, The facility is short staffed, and they don't have two staff to monitor during smoking breaks. The facility's lighter will come up missing when they don't have staff to monitor during smoking breaks outside. On 06/13/24 11:18 AM, V2 DON (Director of Nursing) said staff are to go outside to monitor during smoking breaks. V2 said staff should be holding the lighter and lighting the cigarettes for the residents. The facility's smoking policy, dated 4/2020, showed it is against facility policy to carry a lighter (and other smoking materials ie. cigarettes). Staff are available to light cigarettes for residents during designated smoking times. Being caught in possession of a lighter and or cigarettes smoking materials will be considered a violation of the policy and consequences will be reviewed on an individual case by case basis. 48526 4. R68 was [AGE] years old. R68 was admitted to the facility on [DATE], with multiple diagnoses which included paranoid schizophrenia, pancytopenia, osteoarthritis, bipolar disorder, gastro-esophageal reflux disease, chronic pancreatitis, and alcohol abuse per the face sheet. R68's MDS (Minimum Data Set), dated 04/17/24, showed R68 cognition was moderately impaired. On 06/12/24 at 10:56 AM, residents were observed outside on the patio. The residents were on their assigned smoke break. There was a cigarette lighter on top of the air conditioning unit. The residents were seen lighting their own cigarettes. On 06/12/24 at 2:43 PM, R68 said she was a smoker. R68 said when she goes out to smoke, she lights her own cigarettes. The staff does not light the resident's cigarettes. R68 said there is not a staff member outside monitoring the smokers when they go out to smoke. R68 said there is always a lighter available outside for residents to use. On 06/12/24 at 10:56 AM, V10 (PRSA/Psychiatric Rehab Services Assistant) said there is normally one staff member inside and not outside watching the residents while they smoke. V10 said residents light their own cigarettes. V10 said the lighter comes up missing often. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/12/24 at 3:54 PM, V3 (PRSD/Psychiatric Rehab Services Director) said R68 is not a safe smoker. V3 said R68 smokes outside of scheduled smoke breaks. V3 said R68 has been caught in possession of a cigarette lighter. V3 said there should be a staff member outside while residents are smoking. V3 said the resident's should not light their own cigarettes outside, however, the lighter is placed in an area where the residents can light their own cigarettes.

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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. 50858 Based on observation, interview, and record review, the facility failed to maintain cleanliness in the food preparation area and equipment storage. This applies to all residents in the facility for a total 92 residents. The findings include: On 06/11/2024 9:54 AM, during initial kitchen tour with V4 (Dietary Manager), two staff were preparing food for the lunch meal and snack. V5 (Cook) was wearing a hair restraint, with hair dangling to their earlobe on both sides of the face. While wearing gloves, V5 was chopping red peppers and onions. Without removing gloves, V5 went to the cooler to retrieve additional vegetables and resumed chopping. V5 did not change gloves or perform hand hygiene before she resumed chopping vegetables. V6 (Dietary Aide) was wearing a hair restraint with hair dangling to their earlobe on both sides of the face while preparing peanut butter jelly sandwiches. An air vent on the ceiling in between the food preparation area was covered with black dust build up. The floor behind the shelving, which was holding the plates, bowls, plastic storage bins, stainless steel food pans and lids, had black substance. On 06/11/2024 at 12:08 PM, during lunch service V5 (Cook), was preparing resident lunch meal plates from a steam table. Five of the six pans used during meal service were stained with a black build up dry grease around the rims. Directly above the steam table, the ceiling spattering of fuzzy gray dust particles and food stains. Behind V5 were three metal and one black plastic storage racks. The black plastic storage rack held the food serving plates and bowls. All of the shelves were covered with a fuzzy buildup of dust. The other three chrome wire storage racks had three shelves, five shelves and four shelves. Those three racks stored clean steam table pans and plastic food storage and lids. A cobweb was noted near the floor and the wall next to steam table. On 06/11/2024 at 12:19 PM, V5 took one steam table pan from the dusty shelf, stating she needed it for the gravy, then returned it with gravy and placed in the steam table. On 06/11/2024 at 12:40 PM, V8 (Dishwasher) took one plastic storage container from the dust covered shelves. V8 stated she was going to put the grapes into it for storage. At 12:45 PM, V8 was placing grapes in the plastic storage. On 6/12/2024 at 12:19 PM, V7 (Cook), was serving food from the steam table. V7 had a full beard and mustache. Only the bottom part of the beard from the chin down was covered by the hairnet. Mustache, hair, and sideburns from the hairline to the jaw line were exposed. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 6/13/2024, V4 said the vents above the stove are cleaned every six months by an outside company. With V4 present, V7 said the beard covering doesn't go up enough, even though he tries to put it up. V4 agreed, but wasn't sure how to get it to cover all the beard. The facility's Nutrition Care System Safe Food Preparation and Handling policy, dated 2014, provided by V4 (Dietary Manager) shows food will be prepared to conserve maximum nutritive value in a safe and sanitary environment. It includes hands will be washed properly, frequently, and at appropriate times proper hand washing techniques will be used. Suitable and effective hair restraints will be worn while in the kitchen. The facility Nutrition Care System Cleaning Scheduled policy, dated 2014 provided by V4, included the Food Service Manager is responsible for developing a cleaning schedule for the department. She/He will also monitor compliance and overall cleanliness and sanitation of the department.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review, the facility failed to update the EMR (Electronic Medical Record) to include R243's medical diagnoses. Findings include: R243 was admitted to the facility on [DATE]. During review of R243's medical record, no diagnoses were noted listed in the EMR. On 6/13/24 at 12:08 PM, V2, DON (Director of Nursing), reviewed R243's EMR and did not find his diagnoses. V2 stated the admitting nurse is responsible for entering the residents' diagnoses list and the MDS (Minimum Data Set) Coordinator should have reviewed them. The resident's diagnosis list is obtained from the discharge summary or admission packet received from the hospital. If the resident needed to be sent out, we would not have a diagnoses list to provide for the transfer. The facility did not provide a policy or procedure guide for resident record updating.