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	IL6008213	A. BUILDING: _____ B. WING _____	06/11/2025

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SANDWICH LIVING & REHAB CENTER	902 EAST ARNOLD STREET SANDWICH, IL 60548

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Second Probationary Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations: 1 of 9 300.696b)3) Section 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. 3) Facility activities shall be monitored on an ongoing basis by the Infection Preventionist to ensure adherence to all infection prevention and control policies and procedures. (Source: Amended at 46 Ill. Reg. 6033, effective April 1, 2022) This REQUIREMENT was not met as evidenced by:	S9999		

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Based on observation, interview and record review, the facility failed to ensure staff wore the required personal protective equipment when providing care for residents on enhanced barrier precautions, failed to prevent cross-contamination by not removing the gloves used for incontinence care prior to touching the resident and the resident's environment, and failed to perform hand hygiene after removing soiled gloves for 3 of 3 residents (R4, R1, R3) reviewed for infection control in the sample of 7.

The findings include:

1. R4's face sheet, provided by the facility on 6/11/2025, showed she had diagnoses including, but not limited to hereditary and idiopathic neuropathy, edema, obesity, cerebrovascular disease, and generalized anxiety disorder. R4's 4/1/2025 facility assessment showed she had severely impaired cognitive skills for daily decision making. The assessment showed R4 was dependent on staff for toilet hygiene, bed mobility, lower body dressing, and transfers.

On 6/10/2025 at 10:18 AM, V8 and V9 (Certified Nursing Assistants-CNAs) were in R4's room providing incontinent care. A sign on R4's door showed she was on enhanced barrier precautions (EBP). The sign showed staff must clean their hands before entering and when leaving the room. The sign also showed staff must wear gloves and a gown for the following high-contact resident care activities: Dressing, bathing, transferring, changing linens, providing hygiene, changing briefs, assisting with toileting, and when doing wound care: Any skin opening requiring a dressing.
The only PPE V8 and V9 were wearing were gloves. Neither V8, nor V9 had a gown on, and

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both were observed leaning over while providing care, and their shirts and pants were touching R4's bedding. V8 ran out of wet wipes during care and started opening the drawers in both nightstands in R4's room, looking for more wipes. V8 was still wearing the gloves used for incontinent care. V8 removed the gloves and said she had to go out to get some more wipes. V8 did not wash her hands or use alcohol-based hand rub prior to grabbing the sling from one of the chairs and placing the sling at the end of R4's bed. V8 touched R4's bedside table to move it out of the way, then touched the doorknob to go out of R4's room. V8 re-entered R4's room, with a pair of gloves on. She touched R4's door to close it, then walked over and continued to provide incontinent care to R4. V8 wiped R4's right groin area, then folded the wet wipe, wiped in a downward motion from R4's pubic area towards the middle, folded the wet wipe again and wiped R4's left groin area. V9 was assisting by holding R4's legs, and pulling back the inner thigh skin near R4's right groin area, so V8 could clean the groin area. Both V8 and V9 left the soiled gloves on and touched R4's dress to pull it down, touched the incontinent pad under R4, touched R4's sheet, and R4's arms and legs while rolling her left, then right, then left again, to pull her dress down and place the sling for the mechanical lift under R4. R4's right leg was visibly weeping due to edema. V9 removed R4's pressure-relieving boots and commented that they were wet due to R4's right leg weeping. Both V8 and V9 removed their gloves. Neither V8, nor V9 performed hand hygiene. V8 left the room to get the mechanical sling lift. V9 touched R4's oxygen concentrator, and both chairs that were in R4's room. V8 returned to R4's room with the mechanical lift. V8 and V9 transferred R4 to her wheelchair. Neither CNA had gloves or a gown

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on. V9 was making R4's bed. She picked up R4's sheet, rolled it up and put it on the floor. V9 picked the sheet back up and asked V8 if the sheet felt wet to her. V8 grabbed the sheet with her bare hands and said they would just change it. V9 exited R4's room with the mechanical lift. No hand hygiene was performed prior to exiting the room. V8 propelled R4 down to V4 (Licensed Practical Nurse-LPN) to inform her of R4's weeping right leg. No hand hygiene was performed by V8 prior to touching R4's wheelchair and exiting the room with R4. V4 instructed V8 to take R4 back to her room and she would grab supplies needed to wrap R4's right leg. V4 brought the needed supplies, set them on her cart, performed hand hygiene and put on a gown and gloves before entering R4's room. V8 was not observed performing hand hygiene. V8 assisted V4 with the treatment by holding R4's right leg, while V4 put an abdominal pad over the area and wrapped it with rolled gauze. V8 only wore gloves during the treatment. V8 did not wash her hands or perform hand hygiene after the treatment was completed and propelled R4 down the hall to the dining room.

On 6/11/2025 at 12:56 PM, V5 (Registered Nurse-RN) said if a resident is on enhanced barrier precautions staff should wear gloves, a gown, and a mask if splashing is an issue, for any kind of direct-care activity. Hands should be cleaned before you go in the room and before you leave the room. Alcohol gel is okay if no blood is involved. Gloves should be removed after incontinent care and hands washed or use alcohol-based hand rub to clean hands before touching the resident, their environment or equipment to prevent cross-contamination and the spread of infection. V5 said it is important to wear gloves, so you are not contaminating your

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hands and then moving onto the next resident. V5 said when performing wound care for a resident on enhanced barrier precautions, staff should wear a gown, gloves, and a mask if splash is anticipated.

On 6/11/2025 at 1:39 PM, V3 (Director of Nursing-DON) said staff should have been wearing gown and gloves when providing direct-care for a resident on enhanced barrier precautions. V3 said staff should remove gloves and clean their hands, before touching anything in the environment. V3 said staff are not supposed to reuse wipes. The mechanical lift should have been cleaned before going in and out of the room. V3 said gloves and gown should be worn when changing a resident's sheets. V3 said V8 and V9 should not have touched the sheet with their bare hands. V3 said after incontinence care, staff should remove gloves and clean their hands before touching the resident or their environment. It is important to do these things to protect yourself (staff), the resident, and the other residents from cross-contamination.

2. R1's face sheet printed on 6/11/25 showed diagnoses including but not limited to multiple sclerosis, schizophrenia, and neuropathic bladder. R1's June 2024 physician order report showed orders renewed dated 4/5/25 for an indwelling urinary catheter.

On 6/10/25 at 9:45 AM, an enhanced barrier precaution sign was posted on the door of R1's room. The signage showed staff must wear gloves and a gown for high-contact resident care activities, including the use of a urinary catheter, transferring, providing hygiene, dressing, and changing briefs.

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On 6/10/25 at 10:00 AM, V6 and V7 (CNAs-Certified Nurse Aides) donned gloves and gowns and provided incontinence care to R1. V6 exited the room during the care to obtain a clean sling. Upon return, V6 did not put on a new gown. V6 and V7 continued to remove R1's night gown and dress him. V7 removed her gown and assisted V6 while a mechanical lift was used to transfer R1 to the wheelchair. R1's catheter bag was moved and repositioned throughout the process. V6 and V7 were not wearing gowns during the transfer or while dressing R1.

3. R3's face sheet printed on 6/11/25 showed diagnoses including but not limited to aftercare following digestive system surgery, cerebral palsy, dysphagia (difficulty swallowing), and the use of a gastrostomy tube (g-tube/feeding tube).

On 6/10/25 at 1:15 PM, an enhanced barrier precaution sign was posted on the door of R3's room. The signage showed staff must wear gloves and a gown for high-contact resident care activities, including the use of a feeding tube, transferring, providing hygiene, and changing briefs.

On 6/10/25 at 1:20 PM, V8 and V9 (CNAs) transferred R3 using a mechanical lift from the wheelchair to the bed. V8 and V9 provided incontinence care, changed his brief, dressed him, and repositioned him on the bed. The aides knelt on the bed, leaned against R3, rolled him from side to side, and moved the g-tube repeatedly during the processes. At no time did V8 and V9 don a gown.

On 6/10/25 at 1:39 PM, V4 (Licensed Practical Nurse) entered the room and administered R3's afternoon medications via the g-tube. V4 did not

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don a gown during the process.

On 6/11/25 at 12:05 PM, V3 (DON) stated enhanced barrier precautions (EBPs) are used so staff don't give germs to residents and residents don't give germs to staff. PPE stops cross contamination. Staff need to wear gowns and gloves in a EBP room. They need to have it on during all direct care with catheters and feeding tubes, just like it shows on the door signs.

4. On 6/10/25 at 11:33 AM, V12 (CNA) was observed exiting a resident room while holding the soiled bed linens directly against her body. V12 was asked if she always transports dirty linens in the same method. V12 said she should have put the linens in a bag before leaving the room. It prevents the germs from getting on her clothes and going onto other residents she cares for.

On 6/11/25 at 12:05 PM, V3 (DON) stated aides should be bagging dirty linens immediately and before exiting the room. There is the potential to cross contaminate other residents when soiled linen is against the body.
The facility's Soiled Contaminated Laundry and Bedding policy revision dated October 2024 states: "To ensure soiled laundry/bedding are handled to prevent microbial contamination. 1. Place contaminated laundry in a bag or container at the location where it is used."

The facility's policy titled Enhanced Barrier Precautions, with a revision date of 10/2024, showed Enhanced Barrier Precautions involve gown and glove use during high-contact resident care activities for residents known to be colonized or infected with a multi-drug-resistant organism (MDRO), as well as those at increased risk of

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acquiring an MDRO. Examples include, but are not limited to, wounds and indwelling medical devices. The policy showed before care staff should wash their hands with soap and water or alcohol-based hand rub before entering room. During Care staff should wear gown and gloves for the following resident care activities: ADL care (activities of daily living)/Hygiene, changing linen, toileting/incontinent care, wound care, central lines, urinary catheters, tracheostomy, mealtimes/passing of trays. The policy showed after care staff should discard the gown and gloves in the resident's room and perform hand hygiene with soap and water or alcohol-based hand rub when leaving the room.

The facility's policy titled GLOVES, with a revision date of 1/2012 showed it is the policy of this facility that gloves be worn when handling blood or body fluids, mucous membranes, and non-intact skin. PROCEDURE: 1. Gloves shall be used for touching excretions, secretions, blood, body fluids, mucous membranes, and non-intact skin. 2. When gloves are indicated, they shall be used once and discarded into the appropriate receptacle.

3. The use of gloves will vary according to the procedure involved. The used of disposable gloves is indicated for procedures where body fluids are handled and includes the following circumstances: If it is likely that the employee's hands will come in contact with blood or body fluids, mucous membranes, or non-intact skin while performing the procedure ...D. If handling soiled linen or items that may be contaminated ...H. During all cleaning of blood, body fluids, and decontaminated procedures. The policy showed handwashing is necessary even if gloves are used.

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S9999	Continued From page 8 (B) 2 of 9 300.697a) 300.697b)1)A)B)C)D)E)F)G)H)I)2) 300.697c) Section 300.697 Infection Preventionists A facility shall designate a person or persons as Infection Preventionists (IP) to develop and implement policies governing control of infections and communicable diseases. The IPs shall be qualified through education, training, experience, or certification or a combination of such qualifications. The IP's qualifications shall be documented and shall be made available for inspection by the Department. (Section 2-213(d) of the Act). The facility's infection prevention and control program as required by Section 300.696(e) shall be under the management of an IP. a) IPs shall complete, or provide proof of completion of, initial infection control and prevention training, provided by CDC or equivalent training, covering topics listed in subsection (b)(1) to the facility, within 30 days after accepting an IP position. Documentation of required initial infection control and prevention training shall be maintained in the employee file. b) Effective July 1, 2022, a qualified IP candidate shall: 1) Have completed at least 19 hours of training in infection prevention and control including, but not limited to, training in the following areas: A) Principles of Standard Precautions	S9999		

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S9999	Continued From page 9 B) Principles of Transmission-Based Precautions C) Prevention of Healthcare-Associated Infections D) Hand Hygiene E) Environmental Cleaning, Sterilization, Disinfection, and Asepsis F) Environment of Care and Water Management G) Employee/Occupational Health H) Surveillance and Epidemiological Investigations I) Antimicrobial Stewardship 2) Have clinical work experience related to infection prevention and control in health care settings including, but not limited to, hospitals or long-term care settings. c) A facility shall have at least one IP on-site for a minimum of 20 hours per week to develop and implement policies governing prevention and control of infectious diseases. This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure the infection preventionist completed the required Centers for Disease Control (CDC) or equivalent infection control and prevention training within 30 days of accepting	S9999		

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the position. This has the potential to affect all 23 residents currently residing in the facility.

The findings include:

The Facility Data Sheet and resident roster dated 6/10/2025 indicated that 23 residents were currently residing in the facility.

The facility provided documentation upon entrance that indicated one resident had an indwelling urinary catheter, one resident had a peripherally inserted central catheter, seven residents had wounds, and one resident with a gastrostomy tube, and two residents on isolation for blood and/or urine infections, all of which required these residents to be placed on transmission-based precautions.

On 06/10/2025, the facility's infection control policy and procedures binder was provided by V3 (Director of Nursing) for review by survey team. At this time, V3 also identified herself as the facility's current infection preventionist.

Review of survey binder provided by V1 (Administrator) revealed no certificate that indicated V3, or any other staff member had completed the required infection control and prevention training course.

On 06/11/2025 at 01:01 PM, surveyor requested V3's infection preventionist certification from facility.

On 06/11/2025 at 01:53 PM, V3 (DON) said she started working at the facility on 12/02/2024 as the Director of Nursing and the Infection Preventionist. V2 then said that she enrolled in the required training course today, and after

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S9999	Continued From page 11 surveyor requested her certificate. On 06/11/2025 at 01:56 PM, V2 (Regional Nurse Consultant) said V3 is the designated Infection Preventionist and was previously sent a link to complete the required training. V2 then said is it important for the Infection Preventionist to be certified due to the ongoing changes and updates with infection control and it is V3's responsibility to educate staff on this and the facility's infection control policy and procedures. Infection Control Policy Review and Updating policy revised October 2024 reads in part: the facility's infection control policies and procedures shall be reviewed and revised or updated as needed ...The infection preventionist is conjunction with the director of nursing and quality assurance committee will be responsible for keeping the facility infection control program and practices current ...Facility staff will be in-serviced on changes in the infection control program policies and procedures. (C) 3 of 9 300.700a) 300.700b)1)2)3) Section 300.700 Testing for Legionella Bacteria a) A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests and corrective actions taken shall be made available to the Department upon request. (Section 3-206.06 of the Act) b) The policy shall be based on the ASHRAE Guideline "Managing the Risk of Legionellosis	S9999		

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Associated with Building Water Systems" and the Centers for Disease Control and Prevention's" Toolkit for Controlling Legionella in Common Sources of Exposure". The policy shall include, at a minimum:

1) A procedure to conduct a facility risk assessment to identify potential Legionella and other waterborne pathogens in the facility water system.

2) A water management program that identifies specific testing protocols and acceptable ranges for control measures; and

3) A system to document the results of testing and corrective actions taken.
(Source: Added at 46 Ill. Reg. 10460, effective May 31, 2022)

This REQUIREMENT was not met as evidenced by:

Based on interview and record review, the facility failed to perform a facility risk assessment to identify potential Legionella and other waterborne pathogens in the facility's water system and failed to perform Legionella testing. This has the potential to affect all 23 residents residing in the facility.

The findings include:

The facility data sheet, provided by the facility on 6/10/25, showed 23 residents resided in the facility.

On 6/10/2025 at 8:40 AM, during the entrance conference with V3 (Director of Nursing-DON), the facility was asked to provide the facility's

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Legionella testing/Assessment policy and any documentation they have showing an assessment was completed of the facility's risk of Legionella and other waterborne pathogens, and any testing that had been done.

On 6/10/2025, V1 (Administrator) provided an email dated 6/10/2025 at 11:36 AM, from a water management company showing they will do a water management survey including Legionella testing for the facility before the end of June 2025.

On 6/11/1015 at 1:24 PM, V1 and V13 (Maintenance Director) were asked if the facility did an assessment to evaluate the water flow throughout the system to determine any areas that are vulnerable for legionella and other pathogen growth. V1 and V13 said the facility did not have an assessment. V1 said the only thing he had was the email he already provided showing that someone was coming out before the end of June 2025 to do a water management survey and legionella testing.

The facility's policy and procedure titled Water Management Program, with a revision date of 5/01/2024, showed in the event of an outbreak, or a suspicion of a possible outbreak, or as directed by Public Health Officials, it is the policy of this facility to establish procedures to reduce risk of Legionella and other opportunistic pathogens in the facility's water system. 1. The Maintenance Director will maintain documentation that describes the facility's water system. 2. A risk assessment of water system components will be conducted to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility's water system. 3. The risk assessment will be completed by facility

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leadership and the infection preventionist with collaboration from other facility team members such as maintenance employees, safety officers, risk and quality management staff, and the Director of Nursing. The policy lists examples of water system components including hot and cold-water storage tanks, water heaters, water-hammer arrestors, pipes, valves, fittings, expansion tanks, water filters, electronic and manual faucets, aerators, faucet flow restrictors, showerheads and hoses, ice machines, and eyewash stations, among other system components. The policy showed 5. data to be used in the risk assessment may include, but is not limited to: Lab reports, environmental culture results, water temperature logs, water quality reports from drinking water (i.e. municipality, water company), rounding observation data, and community infection control surveillance data from the local health department. The policy showed 6. Based on the risk assessment, control measures will be established to address potential hazards ... 7. Testing protocols and acceptable ranges (control limits) will be established for each control measure ...b. When control limits are not maintained, corrective actions will be taken and documented accordingly.
(C)

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300.1210b)

Section 300.1210 General Requirements for Nursing and Personal Care

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care

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plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident.

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review the facility failed to verify placement of a gastrostomy tube (G-tube) prior to use for 1 of 1 resident (R3) reviewed for feeding tubes in the sample of 7.

The findings include:

R3's face sheet printed on 6/11/25 showed diagnoses including but not limited to aftercare following digestive system surgery, cerebral palsy, dysphagia (difficulty swallowing), and the use of a G-tube.

R3's June 2025 physician order report showed an order renew dated 6/1/25 for: valproic acid 250 milligrams by g-tube route every 8 hours". The same report showed an order renew dated 6/1/25 for: "phenobarbital 16.2 milligrams by g-tube route 3 times per day".

On 6/10/25 at 1:39 PM, V4 (Licensed Practical Nurse) prepared R3's afternoon medications. V4 flushed the g-tube with water, gave the phenobarbital, and flushed the tube again. V4 gave the valproic acid and flushed the g-tube. V4 did not verify placement of the g-tube prior to administering the water flushes or medications.

On 6/11/25 at 12:05 PM, V3 (Director of Nurses) stated feeding tube residents need to have the placement of the tube verified before anything

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goes into it. Nurses should be pulling back and checking for residual stomach fluid first. It is important to ensure the tube is still in the stomach. If the tube has moved, the abdominal cavity could fill up and make the resident sick.

R3's care plan showed a focus area: "Resident requires tube feeding due to inability to intake nutrition orally related to diagnosis of cerebral palsy." Interventions included: "Check gastric residuals before each feeding & document amount. Hold feed if greater than 100cc." (start dated 4/4/25)

The facility's Gastrostomy Tube Medication Administration policy (undated) was reviewed and did not include any procedure related to verifying tube placement prior to use.
(B)
5 of 9
300.1620a)

Section 300.1620 Compliance with Licensed Prescriber's Orders

a) All medications shall be given only upon the written, facsimile, or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

This REQUIREMENT was not met as evidenced by:

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Based on observation, interview, and record review the facility failed to ensure medications were administered as ordered for 1 of 1 residents (R7) reviewed for medication administration in the sample of 7.

The findings include:

On 6/10/25 at 12:13 PM, V4 (Licensed Practical Nurse) prepared R7's noon medications. V4 stated the tramadol (pain medication) was not available. V4 said it ran out and she has missed four doses so far. V4 said the weekend nurse sent a refill request. V4 said the physician just sent clarification today that the refill request has been received. V4 said they are still waiting for it to be delivered.

R7's June 2025 physician order report showed an order renew dated 6/1/25 for: "tramadol 50 milligrams every 6 hours".

R7's June 2025 medication administration report showed R7 to receive the tramadol daily at 6 AM, noon, 6 PM, and midnight. The report showed the last four doses were not given. The report showed under the reason section: "pharmacy to deliver, awaiting delivery, and not available".

On 6/10/25 at 3:05 PM, V3 (DON-Director of Nurses) stated nurses should be requesting medication refills when three- or four-days' worth are still on hand. Refills should be obtained before a medication runs out. V3 said no one told her R7 was missing her tramadol and had she known she would have immediately followed up with the pharmacy. V3 said R7 needs the pain medication as scheduled to stop any pain. It is easier to stop her pain from starting versus trying

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to stop it once it is elevated. She needs it routinely and as ordered.

On 6/10/25 at 3:21 PM, V3 provided a convenience box of backup medications. The box did contain six doses of 50 milligram tramadol. V3 said this has been here the whole time. I have no idea why the nurses didn't give her a dose out of here until her refills arrived.

On 6/11/25 at 12:05 PM, V3 said the nurses should have gone to the convenience box and called me as soon as R7's tramadol was not available. They (nurses) need re-education to go and find a medication if something isn't readily available while awaiting refills.

The facility's Medication Administration Policy last updated January 2024 states: "1. Drugs will be administered in accordance with orders of licensed medical practitioners of the State in which the facility operates. 10. Medications shall be administered one (1) hour before/after of the medication schedule unless specifically ordered otherwise."
(B)
6 of 9
300.1630a)
300.1630b)

Section 300.1630 Administration of Medication

a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting

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if their duties include administering medications to residents.
b) The facility shall have medication records that shall be used and checked against the licensed prescriber's orders to assure proper administration of medicine to each resident. Medication records shall include or be accompanied by recent photographs or other means of easy, accurate resident identification. Medication records shall contain the resident's name, diagnoses, known allergies, current medications, dosages, directions for use, and, if available, a history of prescription and non-prescription medications taken by the resident during the 30 days prior to admission to the facility.

This REQUIREMENT was not met as evidenced by:

Based on interview and record review the facility failed to administer intravenous medication as ordered by a physician and failed to ensure that qualified staff were administering intravenous medications. This failure applies to one resident (R2) reviewed for intravenous therapy in a sample of seven.

Findings include:

R2's progress note dated 06/02/2025 at 09:30 AM documented that pharmacy was called due to resident not receiving teflaro (ceftaroline fosamil) 600 mg IV solution and had missed three doses.

R2's progress noted dated 06/05/2025 at 02:00 PM documented MD (medical doctor) ordered teflaro (ceftaroline fosamil) administration time to 11:00 AM and 11:00 PM due to pharmacy issues.

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Upon entrance on 06/10/2025, the facility provided an employee list that identified both V4 and V16 as Licensed Practical Nurses (LPN).

On 06/10/2025 at 10:17 AM, observed R2 lying in bed watching television. Noted an intravenous (IV) pole/pump next to R2's bed. R2 indicated that he had a "heart infection" and receives antibiotics. When asked if he receives the antibiotic every day, R2 said "I think so".

Review of R2's current physician orders showed the following: ceftaroline fosamil (teflaro) 600 mg IV solution, infuse 600 milligrams by IV route every 12 hours and daptomycin 500 mg IV solution, infuse 500 milligrams by IV route once daily for 31 days.

Review of R2's electronic medication administration record for May 2025 showed the ceftaroline fosamil 600 mg IV solution medication with a start date of 05/31/2025 was not administered as scheduled on 05/31/2025 at 05:00 AM or 05:00 PM. Both administration times were documented with an asterisk which indicates "not administered" per legend.

Review of R2's electronic medication administration record (MAR) for June 2025 (page two) showed the ceftaroline fosamil 600 mg IV solution medication with a start date of 05/31/2025 was not administered as scheduled at 05:00 AM or 05:00 PM on 06/01/2025 and was not administered at 05:00 AM on 06/02/2025. Missed administration times for both days were documented with an asterisk. Page one of R2's MAR showed the ceftaroline fosamil 600 mg IV solution with a start date of 06/05/2025 and administration times of 11:00 AM and 11:00 PM was documented with an asterisk as not

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administered on 06/10/2025 at 11:00 AM.

Review of R2's MAR2 also documented that V4 (LPN) administered R2's daptomycin 500 mg IV solution on 05/31/2025, 06/01/2025, 06/04/2025-06/05/2025, 06/09/2025-06/10/2025 at 09:00 AM and R2's ceftaroline fosamil 600 mg IV solution on 06/04/2025 at 05:00 PM and 06/09/2025 at 11:00 AM.

Review of R2's MAR2 also documented that V16 (LPN) administered ceftaroline fosamil 600 mg IV solution on 06/03/2025 at 05:00 AM and 06/06/2025-06/08/2025 at 11:00 PM.

On 06/10/2025 at 01:02 PM, V4 (LPN) said she did not administer R2's IV antibiotic at 11:00 AM because the medication "was not available again". V4 added that R2 receives two different IV antibiotics and that she administers them to R2 when she is working then said, "is that not okay".

On 06/10/2025 at 01:16 PM, V3 (Director of Nursing) said the floor nurses administer R2's intravenous (IV) antibiotics daily. At 03:15 PM, V3 said R2 has missed doses of his "teflora" antibiotic because the pharmacy wasn't sending enough doses with each delivery, they were sending enough for one daily dose and not for two doses.

On 06/11/2025 at 10:16 AM, V3 (Director of Nursing) said a licensed practical nurse (LPN) administering an intravenous medication is within their scope of practice if that LPN is IV certified. V3 then said that V4 (Licensed Practical Nurse) had previously indicated to her that she was IV certified. V3 provided IV therapy with central lines certificate for V16 dated 06/06/2005 from the Florida Board of Nursing and provided a

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transcript for V4 that did not indicate completion of an IV therapy with central lines course.

R2's progress note dated 06/10/2025 at 02:09 PM documented R2's IV ATB (antibiotic) was not available at 10:30 AM and a call was placed to pharmacy to "find out where it is".

On 06/11/2025 at 10:52 AM, V2 (Regional Nurse Consultant) said LPNs have to be certified, in their current state to administer IV medications. V2 added that V4 is not IV certified, and V16 is IV certified for the state of Florida but not for the state of Illinois. V2 then said both LPNs need to be IV certified and should not administer any IV medications until they are IV certified. V2 added that she was informed by V3 (DON) that V4 and V16 were certified but their certifications were not verified by the facility prior to this day. V2 provided a communication email addressed to the corporate office which she requested IV certification class be done as soon as possible due to "one resident on IV ATB (antibiotic) therapy and LPNs have been administering the IV with no proper documentation that they are certified.

Undated IV Administration Policy indicated to administer medications per MD (medical doctor) orders.
(B)
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300.1640a)2)

Section 300.1640 Labeling and Storage of Medications

a) All medications for all residents shall be properly labeled and stored at, or near, the nurses' station, in a locked cabinet, a locked medication room, or one or more locked mobile

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medication carts of satisfactory design for such storage.

2) All mobile medication carts shall be under the visual control of the responsible nurse at all times when not stored safely and securely.

This REQUIREMENT was not met as evidenced by:

Based on observation, interview, and record review the facility failed to ensure medications were stored in a secure manner and failed to maintain a temperature log for refrigerated medications. These failures have the potential to affect all residents in the facility.

The findings include:

The resident Census Detail Report dated 6/10/25 showed 23 residents residing at the facility.

1. On 6/10/25 at 8:15 AM, the south hall medication cart was unlocked and there was no nurse present. This surveyor had full access to every drawer of the cart (exception of the double locked narcotics drawer). Residents were seated and ambulating in the immediate area.

2. On 6/10/25 during the noon medication pass, V4 (Licensed Practical Nurse) walked away from the medication cart multiple times to provide resident medications in the dining room. The cart was unlocked several times during the medication pass. V4 was questioned about the locking system and stated the cart locks with an electronic code. The cart should lock automatically with just one button pushed. The battery has been acting up and pharmacy has been told. V4 said they are still having issues with

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it. Multiple staff and residents were passing the unlocked cart during the medication pass.

3. On 6/11/25 at 8:30 AM, the nurses station/medication room was observed with V5 (Registered Nurse) present. An overhead cabinet was unlocked and held a box labeled "emergency IV (intravenous) supplies and fluid kit". The label showed the contents including but not limited to sodium chloride, dextrose, IV syringes, and Levaquin (antibiotic). V5 stated the cabinet should be locked so residents or a family member don't get into it. Multiple staff and residents were passing the room during the survey.

4. On 6/11/25 at 8:45 AM, the director of nurse's office (DON) was observed with V3 (DON) present. A waist high file cabinet was unlocked and contained all the stock over the counter medications used in the facility. V3 stated the cabinet doesn't have a lock so she just keeps her room door locked. The DON's office was observed the day prior (6/10) and today (6/11) with the door opened during the survey. Staff were eating lunch in the office, seated just outside the door, and residents were watching TV just outside the door. The DON was not in the office to supervise the medications.

5. On 6/11/25 at 8:45 AM, the director of nurse's office was observed with V3 (DON) present. A locked refrigerator was in her office. The refrigerator contained tuberculin testing solution, several pneumonia vaccines, multiple residents' insulin vials and pens, and a resident's IV antibiotic. There was no temperature log posted at the refrigerator. The current temperature of the refrigerator showed 50 degrees Fahrenheit. V3 said the medications were moved to her office a few days ago. The refrigerator on the south hall

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broke down and a new one hadn't been set up yet. V3 said she checks the temperatures every morning but doesn't write them down. V3 said they should be running between 30 and 40 degrees.

On 6/11/25 at 12:20 PM, V3 (DON) stated medication carts should always be locked when a nurse is not in sight. That south cart has been giving us trouble. The electronic lock isn't working quite right, and nurses are probably forgetting to lock it with a key for now. V3 said the IV kit should be locked so no resident drinks the fluids in there. There is the potential for supplies to get stolen and a resident injury from a sharp IV needle. Levaquin is a medication and needs to be locked all the time. V3 said someone needs to get me a lock for this stock medication cabinet in my office. An open cabinet is a risk for someone to eat or take the medicines. V3 said the refrigerators need to be checked daily and logged. Medication can lose efficacy if not stored at the correct temperature.

The facility's Medication Administration and Storage Policy revision dated 07/23 states: "Policy-To ensure medications are administered and stored in accordance with Standard of Practice" and "10. The key to the medication room must be carried by the licensed/registered nurse at all times". The policy did not state how to secure medication carts.

The Med Room Refrigerators Policy review dated 09/2024 states: "5. A thermometer will be kept in the med room refrigerator and the temperature will be taken and recorded daily". The policy did not show what temperature range is required. (C)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 26 8 of 9 300.2220d) Section 300.2220 Housekeeping d) All cleaning compounds, insecticides, and all other potentially hazardous compounds or agents shall be stored in locked cabinets or rooms. (Source: Amended at 13 Ill. Reg. 4684, effective March 24 1989) This REQUIREMENT was not met as evidenced by: Based on observation, interview and record review, the facility failed to secure hazardous chemicals. This has the potential to affect all 23 residents currently residing in the facility. The findings include: The facility data sheet, provided by the facility on 6/10/2025, showed 23 residents resided in the facility. On 6/11/2025 at 9:32 AM, the door to the laundry room, soiled linen side, was not locked. No staff were present in the laundry room. Chemicals, and products containing chemicals were visible upon opening the door, including a bottle of bleach sitting on a trash can, a container of micro-kill germicidal wipes, a container of bleach wipes was on the sink, and a bucket labeled third-shift wheelchair cleaning supplies containing cleaner with bleach in. At 9:40 AM, the door to the soiled utility closet was unlocked. 2 unlocked housekeeping carts were stored in the room. Chemicals were visible on top of the housekeeping carts. Both carts were unlocked	S9999		

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	IL6008213	A. BUILDING: _____ B. WING _____	06/11/2025

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with multiple bottles of chemicals inside the carts. At 12:24 PM, the same laundry room door was unlocked. No laundry staff were in the room. The jug of bleach and the before mentioned items with chemicals that were observed on the first observation, were observed again. In an unlocked closet area on the clean laundry side were 5-gallon containers of laundry oxygen bleach. one container was full and the other was 1/4 full. there was a 5-gallon bucket of laundry emulsion detergent that was half full and one full one. there was a full 5-gallon bucket of laundry softener/sanitizer. V15 (laundry aide) had entered the room while surveyor was documenting observations and said when no one is in the laundry room, the door should be locked because there are chemicals in there. A sign on the door showed the door must be closed and locked when staff leave the room.

On 6/11/2025 at 12:38 PM, V14 (Housekeeper) said he was just informed that keys were put in the nurse's station to unlock the soiled utility room. V14 said he started working at the facility on 4/28/2025 and the door to the soiled utility closet has never been locked. V14 said the items stored in the housekeeping carts are the chemicals that are normally stored in there every time he works. The chemicals are used to clean the facility. The items in and on the housekeeping carts were: Claire germicidal cleaner, multi-shine glass and surface cleaner, foaming acid disinfectant, mean green cleaner and degreaser, Martin Brother's shower power mild acid, and stainworx enzyme erase.

On 6/11/2025 at 1:03 PM, V5 (Registered Nurse) said a key was provided today for the soiled utility room. I have never seen that door locked. V5 said chemicals are kept in that room in the

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housekeeping carts. V5 said the laundry room should be locked when the laundry staff are not in there. Chemicals are stored in there. We do have wanderers in the facility that could go in there. V5 said not only are the residents that wander affected, but you also never know what a resident would do if they went in there and grabbed something.

On 6/11/2025 at 1:17 PM, V1 (Administrator) said it is important to make sure the laundry and the soiled utility rooms are locked when staff are not present in there because chemicals are kept in there and we do not want the residents to be able to get to it.

The facility's undated policy titled Safe Storage of Cleaning Chemicals showed the purpose of the policy was to establish a policy that ensures the safe handling, storage, and access control of cleaning chemicals to protect residents, staff, and visitors from chemical exposure, poisoning, or accidents. This policy applies to all employees, contractors, and third-party service providers involved in the handling, use, or storage of cleaning chemicals within the facility. Policy Statement: All cleaning chemicals must be stored in accordance with manufacturer guidelines, OSHA Hazard Communication Standard (29 CFR 1910.1200), and applicable federal/state regulations to prevent harm and ensure a safe environment for residents. 4. Storage Requirements 4.1 Designated Storage Areas: Cleaning chemicals must be stored only in designated, secure janitorial closets or chemical storage rooms. Storage areas must be clearly labeled and have restricted access (locked when unattended).

On 6/11/2025, V1 (Administrator) provided Safety

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S9999	Continued From page 29 Data Sheets for the chemicals observed in the unlocked laundry room and soiled utility room. The Data Sheets showed the following: Multi-Shine Glass and Surface Cleaner may cause damage to the central nervous system. May be harmful if swallowed. Maya cause eye irritation on contact. Claire Germicidal Cleaner Country Fresh Scent may cause serious eye damage/eye irritation. May cause an allergic skin reaction. If on skin wash with plenty of water. If skin irritation or rash occurs, get medical advice/attention. If ingested call a poison center/doctor if you feel unwell. Rinse mouth. Martin's Shower Power may be harmful if swallowed. Causes severe skin burns and eye damage. Causes damage to organs (kidney, liver). Laundry Emulsion Detergent may be harmful if swallowed. Harmful in contact with skin. Causes severe skin burns and eye damage. Liquid Oxygen Bleach may be harmful if swallowed. Harmful in contact with skin. Causes serious eye damage. Laundry Soft & Sour is harmful if swallowed. Harmful in contact with skin. Causes severe skin burns and eye damage. Clorox Commercial Solutions Germicidal Bleach causes severe skin burns and eye damage. Stainworx Enzyme Erase Laundry Pre-spotter is harmful if swallowed. May be harmful in contact with skin. Causes mild skin irritation. Causes eye	S9999		

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S9999	Continued From page 30 irritation. Medline Microkill Germicidal Wipes causes serious eye irritation, and microdot bleach wipes cause moderate eye irritation. (C) 9 of 9. 300.340c)3)C)iii) Section 300.340 Incorporated and Referenced Materials c) The following statutes and State regulations are referenced in this Part: 3) State of Illinois rules: C) Department of Public Health: iii) Food Code (77 Ill. Adm. Code 750) This REQUIREMENT was not met as evidenced by: Based on interview and record review the facility failed to ensure the dishwasher reached the required washing, rinse and sanitizing temperatures per manufacturer guidelines and facility policy. This has the potential to affect all 23 residents currently residing in the facility. The findings include: The Facility Data Sheet and resident roster dated 6/10/2025 indicated that 23 residents were currently residing in the facility. On 6/10/2025 at 09:10 AM, during kitchen tour, V10 (Food Service Supervisor) said the dish	S9999		

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machine wash and/or rinse temperatures should be at 120 or higher and sanitizer level should be between 50-100 ppm (parts per million).
V10 (Food Service Supervisor) provided Dishwasher Temperature/Sanitizer logs from March 2025 through June 2025 that indicated to "report inappropriate temperatures or test strip results to the supervisor". V10 did not indicate that any inappropriate temperatures were recently reported.

Dishwasher Temperature/Sanitizer log for March 2025 showed wash and/or rinse temperatures of less than 120 degrees Fahrenheit for breakfast on 03/20/2025-03/22/2025, 03/27/2025 and 03/30/2025; for lunch on 03/19/2025-03/20/2025; and for dinner on 03/19/2025-03/21/2025 and 03/23/2025-03/25/2025. Dinner sanitizer test strip results on 3/23/2025 documented a result of "25" with all other logged strip results at either 50 or 100 [parts per million].

Dishwasher Temperature/Sanitizer log for April 2025 showed wash and/or rinse temperatures of less than 120 degrees Fahrenheit for breakfast on 04/28/2025; and for dinner on 04/05/2025-04/07/2025, 04/09/2025-04/10/2025, 04/13/2025-04/14/2025, 04/20/2025, 04/22/2025, 04/27/2025-04/28/2025, and 04/30/2025. Dinner sanitizer test strip results on 4/30/2025 documented a result of "25" with all other logged strip results at either 50 or 100 [parts per million].

Dishwasher Temperature/Sanitizer log for May 2025 showed a rinse temperature of less than 120 degrees Fahrenheit for dinner on 05/05/2025. May log also documented that "wash and rinse temp must be 120 degrees or hotter".

Dishwasher Temperature/Sanitizer log for June

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2025 showed a rinse temperature of less than 120 degrees Fahrenheit for dinner on 06/02/2025. Water and rinse entries for breakfast and dinner on 06/01/2025 were illegible.
On 6/10/2025 at 11:48 AM, V1 Administrator said the facility dishwasher was a low temperature dishwasher.

The facility provided Machine Washing and Sanitizing (low temperature dishwashing machine) policy provided by V1 (Administrator) last revised in 2017, reads in part: dishwashing machine will be operated in accordance with manufacturer's instructions. Dishwashing machines may be used for cleaning and sanitizing tableware, utensils, equipment, pots and pans. Low Temperature Dishwashing Machine: dishwashing machines using chemicals (typically chlorine) for sanitizing may be used if the temperature of the wash water is not less than 120 degrees Fahrenheit. . .the final rinse will be tested with the appropriate test strip and the results will be recorded on the Low Temperature Dishwashing Machine log.

Chlorine Sanitizer Test Procedure for Low Temperature Machines provided by V10 (Food Service Supervisor) on 06/11/2025 indicated to use micro chlorine test strips (item #180070), tear off 1-2" strip. At the end of the rinse cycle, immerse strip into final rinse water of dish machine. Compare to color chart at once. Test strip range should be 50-100 ppm (parts per million).

Low Temp Dish Machine Guidelines provided by V10 (Food Service Supervisor) on 06/11/2025 reads in part: typical wash and rinse temperatures for Low Temp Machine 120-145 degrees Fahrenheit ...Check Low Temp Sanitizer

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S9999	Continued From page 33 level minimum of once a day. Acceptable range 50-100 ppm chlorine ... Low Temp vs High Temp guidelines provided by V10 (Food Service Supervisor) on 06/11/2025 reads in part: Wash temperature 120-150 degrees Fahrenheit ...Rinse temperature 120-150 degrees Fahrenheit ... Chlorine Sanitizer 50-100 ppm ... (C)	S9999		