STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0054957	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK PARK OASIS	625 NORTH HARLEM , OAK PARK, Illinois, 60302

(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) COMPLETION DATE
S0000	Initial Comments Annual Licensure and Certification Survey.	S0000		01/05/2026
S9999	Final Observations Statement of Licensure Violations: (1 of 6) 300.230e) Section 300.230 Information to Be Made Available to the Public by the Licensee e) All Cook County facilities with Colbert Class Members shall conspicuously display, in a public and accessible location, a Department-provided poster informing residents of their right to explore or decline community transition, and their right to be free from retaliation, regardless of their decision on transition. This poster shall include a telephone number for reporting retaliation to the Department and shall include the steps a resident should take if retaliation does occur. The display of the poster will be included as a compliance measure in the Department's survey process. These REQUIREMENTS were not met as evidenced by: Based on observation, interview and record review, the facility failed to display the Retaliation Hotline poster for the residents in the building. This failure has the potential to all 111 residents residing in the facility. On 12/15/25 around 11:54 am, facility tour was conducted on both floors and Surveyors were unable to locate any postings for the Williams Colbert Retaliation Hotline poster on any of the floors in the facility. On 12/16/25 at 10:55am, V24 (Social Service Director) was asked by the surveyor to locate the bulletin board posting for the Williams Colbert Retaliation Hotline poster. V24 came back after about one hour and stated that the poster is not currently being displayed in the facility. V24 added, “I don’t think we have the sign,	S9999		01/05/2026

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

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S9999	Continued from page 1 but I can get it as soon as possible and post it at each nursing station." After V24 came back and told the surveyor that she (V24) would find it, the Surveyor went with V24 to meet with V29 (Regional Director of Operations) to ask about Colbert Decree Posters. V29 stated that some time ago, the posters were available but maybe residents pulled them down from the walls. The surveyor then explained the need for the poster information to be on the wall on every floor at the nursing station where residents can read it but would not have access to tear down the posters. V24 later presented a list of 4 residents who currently participate in the program through an agency. Facility's document titled "DHS Comprehensive Class Member Transition Program: Consent Decree Fact sheet" states: Class Members Who participate in William Colbert activities keep all of their rights and services. Class members can report retaliation, discrimination, or other similar actions to their William Colbert staff, the facility's assigned ombudsman, or the Illinois Department of public health nursing home hotline. (C) (2 of 6) 300.1060 f) Section 300.1060 f) Vaccinations f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act) These REQUIREMENTS were not met as evidenced by: Based on interview and record review, the facility failed to screen residents for risk factors associated with hepatitis B, hepatitis C, and HIV. This failure affects 4 residents (R37, R56, R94, and R104) reviewed for immunization. Findings include: Record review of R37, R56, R94 and R104's electronic health records do not indicate that R37, R56, R94 and R104 were screened for risk factors of hepatitis B, hepatitis C, and HIV. On 12/16/2025 at 1:08 PM, surveyor requested evidence	S9999		

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S9999	Continued from page 2 of screening for risk factors of hepatitis B, hepatitis C, and HIV. V28 (Regional Director of Clinical Services) reviewed R37's, R56's, R94's, and R104's electronic health records and affirmed that there was no documentation that the residents' hepatitis/HIV screening was completed. V28 affirmed that the facility's policy is that hepatitis/HIV screening should be completed within 7 days of admission. No further evidence was provided prior to the exit of the survey that indicates that the facility screened R37, R56, R94 and R104 for hepatitis b, hepatitis c, or HIV risk factors. Facility policy titled, "HEPATITIS" (dated 9/2014) documents in part, "...Screening to be done within 7 days of new admission..." (C) (3 of 6) 300.690a) 300.690b) 300.690c) 300.1210 a) 300.1210 b) 300.1210 c) 300.12010 d) 6) Section 300.690 Incidents and Accidents a) The facility shall maintain a file of all written reports of each incident and accident affecting a resident that is not the expected outcome of a resident's condition or disease process. A descriptive summary of each incident or accident affecting a resident shall also be recorded in the progress notes or nurse's notes of that resident. b) The facility shall notify the Department of any serious incident or accident. For purposes of this Section, "serious" means any incident or accident that causes physical harm or injury to a resident. c) The facility shall, by fax or phone, notify the Regional Office within 24 hours after each reportable incident or accident. If a reportable incident or accident results in the death of a resident, the facility shall, after contacting local law enforcement pursuant to Section 300.695, notify the Regional Office	S9999		

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S9999	Continued from page 3 by phone only. For the purposes of this Section, "notify the Regional Office by phone only" means talk with a Department representative who confirms over the phone that the requirement to notify the Regional Office by phone has been met. If the facility is unable to contact the Regional Office, it shall notify the Department's toll-free complaint registry hotline. The facility shall send a narrative summary of each reportable accident or incident to the Department within seven days after the occurrence. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 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. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure	S9999		

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S9999	Continued from page 4 that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These REQUIREMENTS were not met as evidenced by: Based on interview and record review, the facility failed to develop, implement, and ensure staff knowledge of a comprehensive resident care plan and failed to provide necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being of residents. This failure caused harm as evidenced by R14 accessing a razor blade and self-inflicting injury to R14's neck and face, requiring emergency intervention and psychiatric hospitalization. The facility also failed to notify the Regional Office within the required 24-hour timeframe after a serious injury for one resident (R14) reviewed for hazards and supervision. Findings include: On 12/15/25 at 10:48am, R14 said, "The staff caught me (R14) in the nick of time. About a month or two ago, I had a razor, took the razor apart, and used the blade to try to stab my carotid. I was having trouble because the blade was cutting my (R14) fingers, so I got even more mad, and took the blade to my face. I just wanted to die. I kept hearing voices telling my to just end my (R14) life. I was hearing voices for about 2 weeks and just couldn't take it. They (facility staff) got me to the hospital, and I was put on new meds. I'm doing better now. I know I'm a woman, but I get hairs on my face and have to shave. I can't be sure where I got the razor, I wasn't in my right mind. I usually just go leave the facility with staff to smoke. I don't really go anywhere." R14's face sheet documents diagnoses that include but are not limited to suicidal ideations, major depressive disorder, schizophrenia, anxiety disorder, PTSD (post traumatic stress disorder, bipolar disorder, and brief psychotic disorder. R14's BIMS (brief interview mental status) scored, dated 9/25/25, is 15 which indicates R14 is cognitively intact. R14's care pan, dated 4/05/24, documents, in part, "(R14) have a history of self-harmful ideation	S9999		

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S9999	Continued from page 5 (thoughts) and/or behavior. This appears to be related to a history of mental abuse., Current needs are manifested by admitting to having thoughts of self-harm." R14's "PETITION FOR INVOLUNTARY/JUDICIAL ADMISSION," dated 3/11/25. Documents, in part, "Resident (R14) expressed that she is having suicidal ideation and feel that she will self-harm herself and others. Resident (R14) is very anxious." R14's hospital records, dated 3/18/25, documents, in part, "(R14) is a 68 year old female who presents from Nursing facility with suicidal ideation. She states that she has had these feelings for the past 3 months and have been trying to ignore them. She endorses that she has been hearing voices during this time also telling her to "get it over it" indicating to end her life. Pt. reports she had a plan to cut her carotid artery with a razor blade. The constant voices and feelings made her talk to social worker at her nursing facility. Pt. endorses that she is the only one of her friends whom are still living. Pt. also states that she does not have any family with whom she communicates with. When asking pt. to describe her mood she states, "I am not sure where I am going" is the way that she described it. Pt. reports that she has been having trouble sleeping over the past year. She endorses that she tends to sleep only about 15-30 minutes at a time. She denied feelings of hopelessness. (R14) does endorse one command auditory hallucination telling her to "just get It over with". She denies visual hallucination, suicidal and homicidal ideation." R14's progress note, per V26 (Licensed Practical Nurse/LPN), dated 9/11/25 at 10:22pm, documents, in part, "Resident (R14) walked to the nursing station while writer was sitting at the desk had blood coming from right side of her face with scratches coming from her neck stated that she wants to kill herself she had took blade from razor that was taken from her by writer towel compress on bloody area." R14's progress note, per V26 (Licensed Practical Nurse/LPN), dated 9/11/25 at 10:34pm, documents, in part, "911 arrived less than 10 mins with 2 policeman all information given with paperwork she (R14) told them that she wants to kill herself she was taken to (hospital)." R14's progress note, per V26 (Licensed Practical Nurse/LPN), dated 9/11/25 at 10:55pm, documents, in part, "Called (hospital) stated that she (R14) will be going to psyche facility in will call facility with	S9999		

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S9999	Continued from page 6 update of what facility." R14's hospital records, dated 9/13/25, documents, in part, "Patient (R14) is a 68yo female with a history of schizoaffective disorder and PTSD (post-traumatic stress disorder) who presents with worsening depression, suicidal ideation s/p (status post) self-inflicted Injury to her right neck with a razor. Reports worsening depression and labile moods. Pt (patient) states she has ongoing auditory hallucinations telling her to hurt herself." On 12/16/25 at 1:17pm, V26 (Licensed Practical Nurse/LPN) said, "Hmmm… I was working at the time (9/11/25). I was at the nurses' station charting when the resident (R14) came out with a bloody face and scratches. I asked her (R14) what had happened, and she (R14) stated that she (R14) had tried to kill herself (R14). I assessed the resident (R14) and immediately dialed 911. I remained with the resident (R14) while waiting for emergency services to arrive. I notified the physician, the supervisor on duty (V27), and the Director of Nursing. I believe the supervisor was V27 (LPN/Supervisor). Regarding razors, some residents may have them, but not all. She (R14) should not have had a razor. Residents on the psychiatric unit are not usually given razors because it is not considered safe. Yes, R14's unit is the psychiatric unit. We (facility staff) typically do not provide razors in order to maintain resident safety." On 12/16/25, V27 (LPN/Supervisor) said, "Yes, yes I was called about the R14 and the razor. We (staff) called 911 immediately and sent her (R114) out. I have no idea how she (R14) for the razor. I was wondering that myself. I asked her (R14) and R14 said she (R14) couldn't remember. I asked all the staff too if they gave her (R14) a razor and they said no. No way! She (R14) cannot have a razor. She's (R14) a suicide risk. I know her (R14) her history. No, she (R14) should not have a razor unsupervised. Razor supervision is to make sure the residents are kept safe." On 12/16/25 at 3:20pm, V1 (Administrator) said (in part) yes, this appears to be an incident that required medical care. We (facility staff) do not know how she (R14) obtained the razor. I do not know. We (facility staff) did search the room to see if she (R14) had any type of sharps. I cannot say what interventions were put in place, after the incident. I would think those interventions would be included in the care plan. There are in-services that were done regarding razors. . V1 (Administrator) said "I did not (notify the Department of R14's suicide attempt at the facility). When it	S9999		

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S9999	Continued from page 7 happened, we (facility staff) received direction from the doctor to send her (R14) out, and she (R14) was then sent to the hospital. We (facility staff) did search her (R14) room to see if she (R14) had anything in there. Social Services completed their follow-up as well. I believe we (facility staff) followed the doctor's directions to ensure she (R14) was taken care of. Yes, there is a state requirement for accident and injury reporting within 24 hours. Types of accidents include injuries that require medical care. Yes, this appears to be an incident that required medical care. We (facility staff) do not know how she (R14) obtained the razor. I do not know. A history of suicide attempts should be documented. If something is not documented, then there is no record that it was completed. The care plan should be updated with interventions following the suicide attempt in September (9/2025). After the incident occurred, it was discussed in the morning meeting. I do not recall having a meeting in QAPI. Quality measures and root cause analysis should be completed, and actions taken to ensure the safety of other residents." On 12/16/25 at 3:44pm, V24 (Social Services Director) said, "I have been here since July 27 (2025), and I am familiar with R14. When we (social services department) became aware of the incident (R14's suicide attempt on 9/11/25) that next morning, we (social services department) initiated a 72-hour behavioral assessment and made a referral for psychotherapy. Nursing staff completed an in-service regarding the proper disposal of razors and ensuring that razors are not kept at the bedside. I do not know how the resident (R14) obtained a razor. The investigation is being handled by upper management. Absolutely not, the resident should not have had access to a razor. Prior to my tenure, I am not aware of any similar issues. I cannot speak to events in March (March of 2025); however, following this incident (9/11/25), the resident (R14) was placed on 72-hour behavioral monitoring, and social services made daily rounds. (Behavioral Psychiatric Services) is now involved in the resident's (R14) care for psychotherapy. We (facility staff) did not hold a separate meeting regarding this incident, but we (facility staff) discussed it during the morning meeting and made appropriate referrals for when the resident (R14) returned from hospitalization. I will take a deeper dive into the matter and follow up. The 72-hour monitoring should be documented in the clinical record and thoroughly followed for the next three days. The care plan should be updated to reflect a significant change. A suicide attempt is a suicide attempt. If the resident was able to self-harm, it raises the question of whether the care plan was	S9999		

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S9999	Continued from page 8 effective. That is a good question (Was R14's care plan updated), and I would need to review the records myself and confer with the social worker before providing a definitive response. I do know that appropriate referrals were made. Yes, the issue would fall under the QAPI committee; however, to my knowledge, it has not yet been discussed in QAPI. Regarding other residents, I personally did not conduct audits of rooms, and I do not know if anyone else audited rooms. Other residents at the facility have diagnoses of depression and suicidal ideation." On 12/16/25 at 4:11pm, V24 (Social Services Director) affirmed that R14's care plan was not updated after R14's March of 2025 hospitalization or after R14's 9/11/2025 suicide attempt. On 12/16/25 at 3:56pm, V41 (Certified Nursing Assistant/CNA) said, "I was not in the room when the incident (R14's suicide attempt on 9/11/25) happened, and I do not know how it occurred. I did see the resident's (R14) face after she (R14) injured herself (R14) and observed scratches on her (R14) face. I did not speak with her (R14) at all. I saw multiple scratches on the side of her (R14) face, and I believe I also saw a couple on her (R14) neck. The nurse (V26/ Licensed Practical Nurse/LPN) placed the razor in the sharp's container. The resident (R14) grows facial hair and shaves independently. I am not fully aware of the specific protocol, but when residents ask for supplies, we (facility staff) provide them. We (facility staff) know which residents to give items to base on the activities they participate in, and it is generally left to my (V41) discretion. Yes, I did receive an in-service on razors, although I do not recall who conducted it. We (facility staff) were taught that we (facility staff) must supervise the resident the entire time they have access to razors." On 12/17/25 ay 9:48am, V2 (Director of Nursing/DON) said, "Social Services makes the decision if residents can have razors unsupervised. The supervision of razors is based off of the resident is alert and oriented, BIMS (brief interview mental status) score, and safety. The CNA (certified nursing assistant) does not make that decision." On 12/17/25, V42 (Psychiatric Nurse Practitioner) said, "Yes, I am aware of R14's suicide attempt on 9/11/25. She (R14) reported that she (R14) was doing better. She (R14) had been stable in the facility for a very long time and had not been hospitalized for several years. We (facility staff) recognized that something was wrong in March (March of 2025) because she (R14) had been	S9999		

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S9999	Continued from page 9 stable for years. She (R14) likely should not have had access to a razor, and closer monitoring should have been in place. For a period of time following the hospitalization, she (R14) should not have had access to a razor; however, it would not necessarily be withheld forever. Ongoing monitoring is important, and if there is a change in her (R14) condition, then access to razors should be restricted. Social workers also see and assess her (R14) regularly. Depending on her (R14) mood and how she (R14) is feeling, and if she (R14) is doing much better, she (R14) may have the right to use a razor. However, just because she (R14) has a history of suicidal ideation does not mean she (R14) should have unsupervised access to a razor forever. If she (R14) had engaged in self-harm at the facility using a razor, then access should be restricted. If she (R14) is not suicidal and has only made threats of suicide in the past, continued assessment and monitoring would be appropriate." On 12/17/25 at 10:41am, V33 (Assistant Director of Nursing/ADON) said, "Regarding shavers, those are in locked cabinets and nurse's carts. We (facility staff) check the resident's BIMS score, ensure they (residents) are alert and oriented, and allow them to shave themselves. Afterward, they return the shaver to a CNA (certified nursing assistant) or nurse for disposal. I would need to review the actual process (shavers for residents with history of suicidal ideation and self-injurious behavior), as I am not actively involved and do not know the full details. I would really like to understand it better myself." On 12/17/25 at 11:18am, V2 (Director of Nursing/DON) said," As for R14, I would need to speak with other staff further to clarify. Typically, once an suicide incident occurs, the patient may have thoughts but no plan. This particular situation happened in March (March of 2025 R14's suicidal ideation with a plan to R14's carotid artery with a razor). She (R14) went out for treatment, came back with no issues, and was reassessed. At that time, there was no reason she (R14) could not have a razor. Razor access is determined on an individual basis. Although she (R14) has had continual suicidal ideations in the past, she (R14) had no current issues at that time. Razors should be collected regularly for residents' safety. Those who are able may come to the nurse and place the razors in the sharps box. Razors are kept behind the nurse's station in locked cabinets and locked med carts. If too much time has passed since a resident was given a razor, the nurse or CNA (certified nursing assistant) should retrieve them."	S9999		

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S9999	Continued from page 10 On 12/17/25 at 12:26pm, V36 (Restorative Aide) said, “Regular routine. I did not do any razor care with her (R14). R14 went for a smoke after breakfast. She (R14) does it (shaving with a razor) on her (R14) own. She (R14) still would have to ask for the razor. Any razors given to residents have to give back and disposed of.” Record review of facility policy titled, “Suicide Observation & Prevention,” dated 5/14, documents, in part, “Purpose: To protect resident from self-injury or death. To increase resident's control of self-destructive impulse. Policy: It is the policy of the facility to implement interventions for residents who exhibit suicidal tendencies: Pre-admission assessments should be sufficiently thorough to identify care needs or need for active treatment which the facility may or may not be able to provide. Continuous monitoring includes mental and psychosocial status as well as physical. Confer with Social Service and Interdisciplinary Team to assess mental status behavior and appropriate interventions. Explain purpose of monitoring to resident/family and indicate concern and interest in his/her safety welfare. In the event safety concerns exceed the facility's ability to provide services, the resident will be transferred to an acute care psychiatric unit. In the event there are behavior symptoms which indicate a suicide emergency, safety interventions will be promptly initiated. Conduct a search of resident room, clothing, for any harmful objects, and remove. Discuss with team members daily the continuance of close observation with direction by physician or mental health professional. Staff to provide ongoing recording and reporting of behavioral observations and verbalizations.; Rationale/Amplification: To ensure facility admits only those residents it can meet their needs. All changes in condition require prompt notification of physician and sponsor/family member. Nurse needs to actively participate in the team decision about the need for continuances. All staff members need to be informed about changes in suicide precautions.; Behavioral Manifestations - Potential and Actual Psychiatric/Suicidal Emergency: Suicidal 1. Threatened - verbalization of wish to die. 2. Attempted - recent injury to body (cutting, burning, hitting, drug overdose, jumping off (bridge) with intent to kill self. 3. Indirect self-destructive behavior - rejects food, medication, and/or treatment.; To Provide Protection: 1. Remove sharp objects such as sharp scissors, razor blades, or knives. 2. Observe resident closely, emphasize protection, not punitive or critical attitude. 3. Evaluate with team members the necessity for close observation area restriction procedures, or one-to-one observations for suicide prevention. 4. With	S9999		

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S9999	Continued from page 11 mental health professional, work toward establishing contract with resident so he/she will contact certain staff when feelings of self-harm are felt. Inform/reassure of staff availability and readiness to help stay with, etc. 5. Set limits in relation to destructive behavior toward self or others. 6. Permit expression of anger and hostility within these limits. 7. Offer support against self-destruction impulses and suggest alternative behaviors. 8. Prevent isolation - seek out resident. 9. DO NOT DARE resident to carry out a suicidal threat. 10. Assess impact of resident on staff or other residents." Record review of facility policy titled, “Supervision and Safety,” dated 3/15, documents, in part, “Policy: Our policy strives to make the environment as free from hazards as possible. Resident safety and supervision are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through employee training conducted upon hire, annually and as needed. Staff will use various sources to identify resident risk factors. Resident supervision is a core component to resident safety. The type and frequency of supervision is determined by the individual resident assessment needs. Staff to decrease safety risk factors as much as possible. Staff to make visual rounds on residents minimally every two hours and more often if necessary based on resident's assessment needs.” Record review of facility policy titled, “Shaving Male and Female Residents,” undated, documents, in part, “Place disposable safety razor in bio-hazardous sharps container.” Record review of facility policy titled, “Care Plan,” dated 3/15/22, documents, in part, “All residents will have comprehensive assessments, and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. 5. Care plans are reviewed and discussed individually. a. Concerns, problems, needs, and/or strengths are listed based on resident's individual needs. Physicians' orders and personal care and nursing needs are also listed based upon comprehensive assessments. b. Approaches are written clearly to be understood by all. Approaches include specific departments and staff member(s) responsible. Approaches must reflect Interdisciplinary Team involvement. c. All concerns, problems, needs and/or strengths have a corresponding goal. The format for a goal is who, what, how, and when. Goals are resident oriented, specific problem-oriented goals relative to medical and nursing diagnosis, realistic, measurable, and directed towards increased functional	S9999		

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S9999	Continued from page 12 levels. e. Notation is made on the care plan when a goal is resolved and changed. f. Notation is made on the care plan when a goal is changed. The goals may be changed for many reasons. A Few examples are: resolved, unrealistic, deterioration in condition. 8. Care conferences for review and revision of resident's care plan are scheduled at a conducive time for residents and their families. a. Skilled and intermediate residents every 90 days and PRN b. When a change occurs in a resident's condition the Care Plan Coordinator is notified by a member of the Interdisciplinary Team. The care plan is then reviewed and updated. c. The Care Plan Coordinator reads report books and makes rounds daily and updates care plans as needed. 9. The Care Plan Coordinator has responsibility for each resident's care plan. a. The Care Plan Coordinator is responsible for coordinating each resident's care plan and for ensuring that the appropriate information is available to all staff and is transmitted at time of discharge or transfer. b. The Interdisciplinary Team is responsible for the implementation of resident care management. 10. All interdisciplinary Team departments are responsible for charting that reflects the care plan concerns, problems, needs and/or strengths, approaches, progress or lack of progress with possible reasons for and any new problems. 11. The Care Plan Coordinator is responsible for in-service training for all departments and shifts to assure understanding of the care plan process and each person's responsibility and participation in the care plan. 12. All Interdisciplinary Team members are expected to participate in the care conference and to have input into each resident's care plan. a. Communication of goals and approaches developed are communicated to all care givers b. Certified Nurse Assistants are responsible for reporting to the charge nurse at the end of the shift any progress or lack of progress seen in their assigned residents. 13. After care conference, all Interdisciplinary Team members are responsible for communication of the care conference information to staff, resident, and family when appropriate. 14. If resident is found to need services not provided by facility, the Social Service Director, Director of Nursing and Care Plan Coordinator will work together by: a. Obtaining service, if feasible. b. Recommending to resident/family appropriate facility. c. Arranging for transfer. 15. When appropriate, resident teaching is planned and coordinated with interdisciplinary team members. The care plan reflects the problem, need or concern, approach (es) to be taken, Interdisciplinary Team members responsible, and goals. 16. If there has not been a significant change in resident condition upon readmission, the care plan can be used from previous admission. 17. Care plans must be	S9999		

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S9999	Continued from page 13 person-centered inclusive of skilled therapy needs." Record review of pamphlet titled, "RESIDENTS' RIGHTS' For People In Long-Term Care facilities," revised date 11/18, documents, in part, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life… Your facility must provide equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care." Record review of facility policy titled, "Change In Condition Physician Notification Overview Guidelines," dated 4/14, documents, in part, "These guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record. 2.Medical care non-emergency problems are communicated to the attending physician and family in a timely, concise, and thorough manner (generally with twenty-four (24) hours or sooner). 3. Medical care emergency problems are communicated to attending physician and family immediately. The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgment requires immediate medical intervention. Should the physician not be available, the alternate physician should be contacted. If neither of these physicians are available, the Medical Director should be notified. A. Any calls to or from physician will be documented in the nurse's notes indicating information conveyed and received. B. All orders taken from the physician, the Physician's Assistant or Nurse Practitioner to be carried out. C. The nurse receiving telephone verbal orders should write it on the POS. Acute and subacute problems are to be communicated shift-to-shift by verbal report and highlighting or discussing the problems listed on the 24 Hour Shift Report to facilitate communication and Quality Assessment and Improvement follow-up. E. The nurse shall indicate in the nurses notes ongoing conversations with the physician regarding response to	S9999		

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S9999	Continued from page 14 notification(s) (faxes, phone calls, and verbal conversations) of changes in condition, laboratory. F. Responsible Party is to be notified of change in condition. The attending physician is responsible for responding in a timely manner to nurses regarding prompt notification calls, or emergencies. In addition, the physician is responsible for communicating the results of assessments and medical plans to a licensed nurse when appropriate." (B) (4 of 6) 300.2230 a)2)A)E) Section 300.2230 a)2)A)E) Laundry Services a) Every facility shall have an effective means of supplying an adequate amount of clean linen for operation, either through an in-house laundry or a contract with an outside service. 2) If an in-house laundry service is provided then the following conditions shall exist: A) The laundry area shall be maintained and operated in a clean, safe and sanitary manner. No part of the laundry shall be used as a smoking or dining area. E) Soiled linen shall be handled, transported and stored in a manner that protects facility residents and personnel. These REQUIREMENTS were not met as evidenced by: Based on observation, interview and record review the facility failed to handle soiled linen in a manner that prevents contamination. This failure has the potential to affect all 111 resident that reside within the facility. Findings include: Facility census for 12/15/2025 documents in part that 111 residents reside within the facility. On 12/16/2025 at 11:17 AM, a tour of the laundry room was conducted with V1 (Administrator) and V21 (Housekeeping Manager). V1 and V21 affirmed that V7 is responsible for supervising the housekeeping and laundry department. Observed the soiled linen area and observed loose clothing items including shirts and jackets unbagged within the bin underneath the chute.	S9999		

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S9999	Continued from page 15 V7 observed the bin and affirmed that confirmed there was loose clothing items in the bin, indicating that the clothing was not bagged prior to putting it in the chute. V7 affirmed that all clothing that comes down the laundry chute must be bagged to prevent contamination. On 12/16/2025 at 12:50 PM, V28 (Regional Director of Clinical Services) explained that all soiled linen must be bagged when going down the chute. V28 stated, "soiled linen can contain urine or feces that can then stick to the sides of the chute, contaminating it. Also, bagging the laundry helps to protect laundry staff from potential exposure to bodily fluids". Facility policy titled, "LINEN AND LAUNDRY HANDLING FOR LAUNDRY DEPT" (10/2014) documents in part, "Purpose: To Ensure proper handling of soiled and clean linen and personal laundry to prevent the spread of microorganisms. Standards: ...4. Soiled linen shall be placed in plastic bags by nursing personnel. 5. Labels shall be placed on the exterior of soiled linen bags to indicate specific precautions or instructions when appropriate..." (C) (5 of 6) 300.610a) 300.1210a) 300.1210b) 300.1210d)1) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care	S9999		

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S9999	Continued from page 16 a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 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. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.These REQUIREMENTS were not met as evidenced by: Based on observation, interview, and record review the facility failed to follow policy procedures, failed to document medication administration, failed to ensure prescribed medications were administered timely to three residents (R10, R37, R102) residing on 2nd floor in a sample of 25 residents. The facility further failed to ensure timely and appropriate emergency medical response and failed to follow facility's hypoglycemic protocol. These facility failures affected one (R116) of one resident reviewed for quality of care and resulted in R116 experiencing a blood sugar level of 40 (critical) and hospitalization requiring intensive care services.Findings include: R116 is a closed record. R116 was transferred to the hospital on 10/19/25. R116's diagnoses include but are not limited to adult	S9999		

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S9999	Continued from page 17 failure to thrive, chronic respiratory failure, dependence on supplemental oxygen, type 2 diabetes, hypertension, chronic obstructive pulmonary disease, malignant neoplasm of unspecified part of unspecified bronchus or lung, and obesity. R116's BIMS (brief interview mental status) score, dated 9/22/2025, is 13 which indicates R116 is cognitively intact. R116's physician order, ordered date 6/10/25, documents, in part, "POLST: Attempt resuscitation/CPR (selecting CPR means intubation and mechanical ventilation)." R116's progress note, per V23 (Registered Nurse), dated 10/19/25 at 6:11am, documents, in part, "Writer entered room around 4:30 am. Resident (R116) would not respond to any verbal or physical stimuli. Writer called residents (R116) name loudly while shaking her shoulders, no response. Pupils dilated round and reactive to light assessed after raising eyelids. Mucus membranes moist. O2 NC 3LPM patent. Foley draining amber colored urine. Bowel sounds hypoactive. Lung sounds clear bilaterally. Compromised skin integrity, dryness, breakdown over arms, legs and perineal area. BP 132/64, P 65 T 95.4 O2 Sat 94% without 3L NC, 98% w/ 3L NC. BS 59 initially, Sugar given by mouth BS 63, Writer & Supervisor unable to get IV access for dextrose. 911 called around 4:50 am. MD (medical doctor) called no answer NP (nurse practitioner) called no answer. BS dropped down to 40 before EMS (emergency medical services) arrived. EMS arrived around 5:05 am, (R116) taken to hospital." R116's progress note, per V18 Licensed Practical Nurse/LPN), dated 10/19/25 at 1:27pm, documents, in part, "Called (hospital) and spoke to with nurse in emergency department she (R116) is admitted in the ICU (intensive care unit), who then transferred me to ICU and spoke with nurse, she (R116) is still hypoglycemic and having some respiratory issues as well." R116's hospital records, admission date 10/19/25, documents, in part, “Pt (R116) arrives via EMS (emergency medical services) from Nursing Home, pt (R116) was unresponsive on arrival in NH (nursing home) reported to have sugar of 50. Blood sugar 25 by EMS and given glucagon repeat 20. Not responsive on arrival. In the ED (emergency department), pt (R116) was initially hypothermic to 96.1F. Pt (R116) on 3L Nasal Cannula for COPD (chronic obstructive pulmonary disease). Initial labs were remarkable f glucose 42, Albumin 1.5, lactate 2.5 -> 3.8, WBC 14.95K. Arrived with foley placement,	S9999		

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S9999	Continued from page 18 scant urine output, cloudy and clumpy output. Foley bag was noted to have grossly tenacious component. Foley leaking purulent urine malodorous. Her (R116) Foley catheter was exchanged that also had thick clumps debris and dark urine with concern for infectious etiology. Spoke to the patient's daughter and updated her in regards to her being at Rush Oak Park. She specifies that she would like her mother to be full code and receive chest compressions as well as intubation if she decompensates. During the ICU (intensive care unit) stay the patient (R116) was treated for ESBL (Extended-Spectrum Beta-Lactamase) bacteremia and UTI (urinary tract infection) with meropenem and MRSA bacteremia with vancomycin and pneumonia, as well as candida intertrigo with fluconazole. Patient mental status remained poor with severe pain given diffuse skin wounds. Patient family ultimately made a decision to make the patient DNR (Do Not Resuscitate) and today made a decision to transition the patient to inpatient hospice here in the unit. Presents with toxic metabolic encephalopathy. Admitted with PNA (pneumonia) and Sepsis= 2/2 complicated UTI. See past medical history below. Extensive skin breakdown and? Abrasions present on admission-see photos. Moaning/crying throughout care. Four-eye skin assessment completed: under abdominal folds, breasts, back, bilateral outer and inner thighs, Left heel DTI and cracked and dry, sacrum, and perineal area. Report to IDPH (Illinoi Department of Public Health) for concerns of neglect from (nursing home) where patient has been a resident since June 10th, 2025. Pt appears un-cared for. Unbathed and skin was extremely dirty and dry. Back side reddened and with multiple areas of skin break down. Foley appears unchanged and extremely dirty. Sepsis--hypothermia, leukocytosis: Likely 2/2 R-sided PNA (pneumonia), suspect aspiration component; +/- component of GU infection, at risk given indwelling foley catheter though pyuria and mixed flora colonization expected. During the ICU stay the patient was treated for ESBL bacteremia and UTI with meropenem and MRSA bacteremia with vancomycin and pneumonia, as well as candida intertrigo with fluconazole. Patient family ultimately made a decision to make the patient DNR and today made a decision to transition the patient to inpatient hospice here in the unit. This patient has a high probability of sudden, clinically significant deterioration, which requires the highest level of physician preparedness to intervene urgently." R116's MAR (Medication Administration Record), dated October 2025, documents, in part "Accu-Chek QID (4 times a day) AC & HS before meals and at bedtime for DMII (Diabetes Mellitus II)."	S9999		

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S9999	Continued from page 19 R116's care plan, dated 7/09/25, documents, in part, "(R116) has diabetes mellitus & the potential for complications related to: Elevated blood sugar., History of uncontrolled diabetic status., The resident is: Insulin dependent," with interventions that document, in part, "Assess for signs of hyperglycemia or hypoglycemia; Provide medication as ordered." On 12/16/25 at 2:14pm, V23 (Registered Nurse/RN) stated, "Yes, I was familiar with the patient (R116). During my rounds, the patient (R116) was found unresponsive. I was unable to obtain vital signs, and the patient's (R116) blood sugar was low. I attempted to administer dextrose but was unable to obtain IV (intravenous access). The patient (R116) was sent out. V40 (Registered Nurse/RN) tried to give R116 sugar in her (R116) mouth to bring up R116's blood sugar. The sugar was regular table sugar. R116 wasn't given a lot of sugar because the patient's (R116) mouth was not open. I am not sure why this method (oral table sugar to an unresponsive resident) was used, and I understand that administering anything orally to an unresponsive patient is unsafe due to the risk of choking. When a patient is unresponsive, the first action should be to call 911, and it should be done in a timely manner. The patient felt cold to the touch, and a temporal thermometer was used. I was a new nurse at the time and was doing my best to the best of my ability. I immediately called for help by contacting my supervisor to determine the next plan of action." On 12/17/25 at 10:46am, V40 (Medical Director) said, "For an unresponsive resident, the resident should be sent to the hospital immediately. The first step is for another nurse to evaluate the resident, and another nurse call 911, and ensure the resident is transported to the emergency room without delay. Administering oral sugar to an unresponsive resident who cannot swallow is ineffective and should not be done. A Foley catheter not being changed routinely can increase the risk of developing a urinary tract infection if not properly managed. Sorry, I am not familiar with R116." On 12/17/25 at 11:18am, V2 (Director of Nursing/DON) said," R116 was in and out of the hospital. She (R116) came in June 2025), but I didn't start until September (2025). Before my time. Based on the documentation, she (R116) came in June (2025) with a Foley catheter. The Foley was never changed in-house and there is no documentation that she (R116) refused to have the foley changed. Not changing a foley can cause infection. I would need to review her (R116) notes for more details."	S9999		

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S9999	Continued from page 20 On 12/17/25 at 12:05pm, V40 (Registered Nurse/RN) said, “I was called V23 (Registered Nurse/RN) who stated that she (V23) went to do routine care and found her (R116) unresponsive. At that moment I knew she (R116) was diabetic and check sugar and tried placing sugar in her (R116) mouth. Checked her (R116) sugar and sugar went up but then came right back down. Yes, I tried putting in and IV (intravenous) in her (R116) and was unsuccessful. When a resident is unresponsive, you do an assessment and call a code immediately. Yes, Call 911 immediately, but I knew it was hypoglycemia, so we (V40 and V23) were trying to get sugar up. If glucagon was available I would have given it to her (R116). If I remember, I don’t recall exactly, I usually call 911 from my cellphone. I don’t recall exactly. I do agree that 911 should be called immediately. Oral sugar is not safe when a resident is unresponsive, but I placed the sugar in between her (R116) lips and gums, because time was of the essence, and we were trying to bring the sugar up. We do have glucagon in the emergency carts, but we just didn’t have it (glucagon) that morning. All I know is I asked V23 for some glucagon and V23 said V23 didn’t have none. Each emergency cart has glucagon, so I don’t know why she (V23) said she (V23) have any.” On 12/17/25 at 12:43pm, V2 (Director of Nursing/DON) said, “Glucagon is in the emergency kit. Yes, glucagon is always available. It (glucagon) should be given for hypoglycemia. Glucagon should have been given for a blood sugar less than 60 if the resident was unresponsive.” The 12/14/25 census includes 72 (2nd floor) residents. On 12/15/25 at 10:50am, twenty (20) residents were affirmed to be highlighted red (indicating late administration) on the (2nd floor) EMAR (Electronic Medication Administration Record). Surveyor inquired why 20 residents were highlighted red on the EMAR V6 (LPN/Licensed Practical Nurse) stated “Its highlighted red cause it needs signed out. I (V6) have to sign the medications that I give as I give it out, it got kinda busy today. We (staff) normally sign em out as we go. 12 of em (residents) are mine.” Surveyor inquired which residents did not receive their 9am medications V6 responded “Everybody got they’re 9am meds.” Surveyor inquired whose medications were in the cup - that V6 was holding V6 replied “(R10’s name).” On 12/15/25 at 11:11am, V6 administered R10’s medications (scheduled for 9am administration) therefore not within regulatory requirements (within	S9999		

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S9999	Continued from page 21 one hour; before or after the scheduled time). On 12/16/25 (the following day) at 9:41am, surveyor relayed that AM medication administration was being observed today V19 (LPN) stated "I'm (V4) finished with my morning meds already." Surveyor inquired why R11's name was highlighted red on the EMAR V19 responded "I (V19) just need to check her (R11) blood sugar before I give it." Surveyor inquired why R11's insulin (scheduled for 8am administration) was not administered V19 replied "This is my second day working here." Surveyor inquired about the regulatory requirement for medication administration V19 stated "An hour before and an hour after, so yes, I'm late to her (R11)." On 12/16/25 at 10:01am, R37 and R102 were highlighted red on the 2nd floor EMAR. V6 affirmed that medications (scheduled for 9am administration) were not administered to R37 and R102 therefore late. R116's urinalysis (10/19/25) includes the following out of range results: Urine color: Red; Urine Clarity: Turbid; Urine Protein: greater than 300; Urine Blood: Large: Urine Nitrite: Positive; Urine Bacteria: Many which affirms UTI findings. R116's physician order, ordered date 7/31/2025, documents, in part, "Catheter: change urinary drainage bag monthly on 11-7 shift on the 15th and as needed." R116's physician order, ordered date 6/10/2025, documents, in part, "Catheter Care: change foley cath as needed for blockage, leaking or malfunctioning." R16's care plan, dated 6/03/2025, documents, in part, "(R116) has Indwelling Catheter: d/t (due to) wound," with interventions that document, in part, "Monitor/record/report to MD for s/sx UTI: pain, burning, blood tinged urine, cloudiness, no output, deepening of urine color, increased pulse, increased temp, Urinary frequency, foul smelling urine, fever, chills, altered mental status, change in behavior, change in eating patter." R16's care plan, dated 6/03/2025, documents, in part, "(R116) has an alteration in skin integrity related to: foley cath," with interventions, that documents, in part, "Urinary catheter per Physician order." On 12/17/25 at 10:46am, V40 (Medical Director) said, "A Foley catheter not being changed routinely can increase the risk of developing a urinary tract infection if not properly managed. Sorry, I am not familiar with R116."	S9999		

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S9999	Continued from page 22 The (8/15) medication administration policy states medications must be administered in accordance with a physician's order ant his/her discretion (the right resident, right medication, right dosage, right route, and right time). Documentation of medication administration is recorded on the MAR (Medication Administration Record) and includes the date, time and initials of the licensed nurse who administered the medication. Record review of facility policy titled, "Hypoglycemia," dated 9/14, documents, in part, "Nursing Intervention: Give some form of glucose if resident is conscious: Mild reaction -small amount of food 10-15 gm carbohydrates (such a 4 oz. orange juice 6 oz. regular soda, 8 oz. 2% skim milk) repeat in 10-15 minutes if needed. Moderate reaction (drowsy, profuse perspiration, blood glucose 30-50 below normal) 20-30 gm. Carbohydrate, 4 oz. orange juice followed by food in 10 – 15 minutes. May give orange juice instead of food if still symptomatic. Contact physician if blood sugar is below 60 unless there are specific call parameters. Take vital signs Repeat finger-stick fifteen (15) minutes after first item of food is given. If unable to swallow notify physician and prepare glucagon from emergency drug kit for administration as ordered. Prepare to send to Emergency Room if condition worsens per MD order. Document findings, interventions, and M.D. contact in resident's clinical record." Record review of facility document titled, "(Name of Facility) (Medication Dispensing Cabinet) List," undated, documents, in part, "Glucagon Emergency Kit 1mg powder for injection D-Utility drawer 16." Record review of facility policy titled, "Change In Condition Physician Notification Overview Guidelines," dated 4/14, documents, in part, "These guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record. 2.Medical care non-emergency problems are communicated to the attending physician and family in a timely, concise, and thorough manner (generally with twenty-four (24) hours or sooner). 3. Medical care emergency problems are communicated to attending physician and family immediately. The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgment requires immediate medical intervention. Should the physician not be available, the alternate physician should be contacted. If neither of these physicians are available, the Medical Director should be notified. A. Any calls to or from physician	S9999		

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S9999	Continued from page 23 will be documented in the nurse's notes indicating information conveyed and received. B. All orders taken from the physician, the Physician's Assistant or Nurse Practitioner to be carried out. C. The nurse receiving telephone verbal orders should write it on the POS. Acute and subacute problems are to be communicated shift-to-shift by verbal report and highlighting or discussing the problems listed on the 24 Hour Shift Report to facilitate communication and Quality Assessment and Improvement follow-up. E. The nurse shall indicate in the nurses notes ongoing conversations with the physician regarding response to notification(s) (faxes, phone calls, and verbal conversations) of changes in condition, laboratory. F. Responsible Party is to be notified of change in condition. The attending physician is responsible for responding in a timely manner to nurses regarding prompt notification calls, or emergencies. In addition, the physician is responsible for communicating the results of assessments and medical plans to a licensed nurse when appropriate." Record review of pamphlet titled, "RESIDENTS' RIGHTS' For People In Long-Term Care facilities," revised date 11/18, documents, in part, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life… Your facility must provide equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care." Record review facility policy titled, "Urinary Catheter Care," undated, documents, in part, "Purpose: To establish guidelines to reduce the risk of, or prevent infections in resident with an indwelling catheter. 10. Urinary catheter and tubing will be removed and reinserted when any of the following are observed: a. Inability to observe urine contents in the urinary drainage bag or tubing. b. Observation of gross contamination. c. Obstruction of the catheter or tubing. d. Upon physician's orders. The date of the catheter insertion shall be documented in the nurses'	S9999		

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S9999	Continued from page 24 notes." (A) (6 of 6) 300.610a) 300.1210a) 300.1210b) 300.1210d)6) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) 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 plan. Adequate and properly	S9999		

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S9999	Continued from page 25 supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.These REQUIREMENTS were not met as evidenced by: Based on observation, interview, and record review the facility failed to follow policy and procedures, failed to implement fall prevention interventions, and failed to ensure the bed alarm was functioning for one of 25 residents (R12) in the sample. The facility further failed to provide adequate supervision one (R54) of 43 residents reviewed for hazards and supervision. Findings include: On 12/16/2025 at approximately11:07 AM, R54 observed in the room with air deodorizer aerosol can noted on the bed side table. R54 stated he used the product for his room. The air deodorizer can instruction on DANGER CAUTION read Inflammable. On 12/16/2025 at 11:08am, V32 stated, we (referring to facility housekeeping department) never stock or carry any aerosol because they are highly flammable. We don't use them. V32 stated possibly the family brought it for (R54). On 12/16/2025 at approximately 11:09am, V18, Licensed Practical Nurse (LPN) stated, R54 should not have this in his room because it is inflammable and can affect any of the resident with respiratory concerns. When asked how often rounds are made, V18 stated every two hours, and the rounds includes making sure nothing like this aerosol can is in the resident rooms. V18 stated, I am a floating nurse, and I could not tell you how R54 got it. I am not the regular nurse on this floor. On 12/17/2025 9:37 AM, V33, Assistant Director of Nurse's (ADON) stated, aerosols are not allowed because they are inflammable, highly toxic, can trigger respiratory problem with residents that have any respiratory problem like Asthma, Emphysema and bronchitis. V33 further stated, rounds are supposed to be made every two hours and it includes noticing and	S9999		

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S9999	Continued from page 26 removing any hazardous products immediately. R12's (11/22/25) fall risk assessment states reason for assessment: recent falls. Based on the Fall Risk Review, the resident has been determined to be high risk for falls. R12's (7/14/21) risk for falls care plan includes the following intervention: resident needs a safe environment with a reachable call light. On 12/15/25 at 11:09am, surveyor inquired about R12. V6 (Licensed Practical Nurse) stated, "She (R12) was hospitalized (11/19/25) for AMS (Altered Mental Status). She's on hospice because she started to degress (deteriorate). She was having frequent falls." On 12/15/25 at 11:14am, R12 was lying in bed, and 3 side rails were up. A bed alarm was underneath R12's fitted sheet however it was not underneath the resident. Surveyor inquired about R12's fall prevention interventions. V8 (Certified Nursing Assistant) stated, "We (staff) put the rails up, she (R12) pretty much stays in this bed." Surveyor inquired if both of R12's lower side rails were up. V8 responded, "No, I (V8) just changed her not too long ago and I forgot to let it up." Surveyor inquired about R12's bed alarm. V8 replied, "It's for when she moves." V8 subsequently removed R12's bed alarm from underneath the fitted sheet (as requested) however the device did not sound. Surveyor inquired if R12's bed alarm was working. V8 stated, "No because I don't think it's hooked up. I think the batteries run out of it. No, there's no batteries." R12's call light was also noted to be dangling from a pole (behind the headboard) and out of reach. The (2/28/14) fall prevention program states call lights are kept within reach and answered properly. Safety interventions will be implemented for each resident identified at risk using a standard protocol. At the time of the initial assessment, a determination will be made to determine if the resident needs or desires side rails as a safety measure. The (6/14) fall prevention alarm devices and systems policy states it is the policy of the facility to use a variety of devices and systems to promote the safety of all residents and to help prevent/reduce falls and injuries. Safety/movement devices will be used as an integral tool to prevent unassisted ambulation and to prevent/reduce resident falls. Record review of facility policy titled, "Supervision	S9999		

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S9999	Continued from page 27 and Safety," dated 3/15, documents, in part, "Policy: Our policy strives to make the environment as free from hazards as possible. Resident safety and supervision are facility-wide priorities. Safety risks and environmental hazards are identified on an ongoing basis through employee training conducted upon hire, annually and as needed. Staff will use various sources to identify resident risk factors. Resident supervision is a core component to resident safety. The type and frequency of supervision is determined by the individual resident assessment needs. Staff to decrease safety risk factors as much as possible. Staff to make visual rounds on residents minimally every two hours and more often if necessary based on resident's assessment needs." Record review of facility policy titled, "Care Plan," dated 3/15/22, documents, in part, "All residents will have comprehensive assessments, and an individualized plan of care developed to assist them in achieving and maintaining their optimal status. 5. Care plans are reviewed and discussed individually. a. Concerns, problems, needs, and/or strengths are listed based on resident's individual needs. Physicians' orders and personal care and nursing needs are also listed based upon comprehensive assessments. b. Approaches are written clearly to be understood by all. Approaches include specific departments and staff member(s) responsible. Approaches must reflect Interdisciplinary Team involvement. c. All concerns, problems, needs and/or strengths have a corresponding goal. The format for a goal is who, what, how, and when. Goals are resident oriented, specific problem-oriented goals relative to medical and nursing diagnosis, realistic, measurable, and directed towards increased functional levels. e. Notation is made on the care plan when a goal is resolved and changed. f. Notation is made on the care plan when a goal is changed. The goals may be changed for many reasons. A Few examples are: resolved, unrealistic, deterioration in condition. 8. Care conferences for review and revision of resident's care plan are scheduled at a conducive time for residents and their families. a. Skilled and intermediate residents every 90 days and PRN b. When a change occurs in a resident's condition the Care Plan Coordinator is notified by a member of the Interdisciplinary Team. The care plan is then reviewed and updated. c. The Care Plan Coordinator reads report books and makes rounds daily and updates care plans as needed. 9. The Care Plan Coordinator has responsibility for each resident's care plan. a. The Care Plan Coordinator is responsible for coordinating each resident's care plan and for ensuring that the appropriate information is available to all staff and is transmitted at time of discharge or	S9999		

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S9999	Continued from page 28 transfer. b. The Interdisciplinary Team is responsible for the implementation of resident care management. 10. All interdisciplinary Team departments are responsible for charting that reflects the care plan concerns, problems, needs and/or strengths, approaches, progress or lack of progress with possible reasons for and any new problems. 11. The Care Plan Coordinator is responsible for in-service training for all departments and shifts to assure understanding of the care plan process and each person's responsibility and participation in the care plan. 12. All Interdisciplinary Team members are expected to participate in the care conference and to have input into each resident's care plan. a. Communication of goals and approaches developed are communicated to all care givers b. Certified Nurse Assistants are responsible for reporting to the charge nurse at the end of the shift any progress or lack of progress seen in their assigned residents. 13. After care conference, all Interdisciplinary Team members are responsible for communication of the care conference information to staff, resident, and family when appropriate. 14. If resident is found to need services not provided by facility, the Social Service Director, Director of Nursing and Care Plan Coordinator will work together by: a. Obtaining service, if feasible. b. Recommending to resident/family appropriate facility. c. Arranging for transfer. 15. When appropriate, resident teaching is planned and coordinated with interdisciplinary team members. The care plan reflects the problem, need or concern, approach (es) to be taken, Interdisciplinary Team members responsible, and goals. 16. If there has not been a significant change in resident condition upon readmission, the care plan can be used from previous admission. 17. Care plans must be person-centered inclusive of skilled therapy needs." Record review of pamphlet titled, "RESIDENTS' RIGHTS' For People In Long-Term Care facilities," revised date 11/18, documents, in part, "Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life… Your facility must provide equal access to quality care regardless of diagnosis. You must not be abused, neglected, or exploited by anyone - financially, physically, verbally, mentally, or sexually. Your facility must provide services to keep your physical and mental health, at their highest practical levels. Your facility must be safe, clean, comfortable, and homelike. You may participate in developing a person-centered care plan which states all the services your facility will provide to you and everything you are expected to do. This plan must include your personal and cultural choices. Your facility must make	S9999		

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S9999	Continued from page 29 reasonable arrangements to meet your needs and choices. You should receive the services and/or items included in the plan of care." Record review of facility policy titled, "Change In Condition Physician Notification Overview Guidelines," dated 4/14, documents, in part, "These guidelines were developed to ensure that: 1. All significant changes in resident status are thoroughly assessed and physician notification is based on assessment findings and is to be documented in the medical record. 2.Medical care non-emergency problems are communicated to the attending physician and family in a timely, concise, and thorough manner (generally with twenty-four (24) hours or sooner). 3. Medical care emergency problems are communicated to attending physician and family immediately. The nurse should not hesitate to contact the attending physician at any time for a problem which in his or her judgment requires immediate medical intervention. Should the physician not be available, the alternate physician should be contacted. If neither of these physicians are available, the Medical Director should be notified. A. Any calls to or from physician will be documented in the nurse's notes indicating information conveyed and received. B. All orders taken from the physician, the Physician's Assistant or Nurse Practitioner to be carried out. C. The nurse receiving telephone verbal orders should write it on the POS. Acute and subacute problems are to be communicated shift-to-shift by verbal report and highlighting or discussing the problems listed on the 24 Hour Shift Report to facilitate communication and Quality Assessment and Improvement follow-up. E. The nurse shall indicate in the nurses notes ongoing conversations with the physician regarding response to notification(s) (faxes, phone calls, and verbal conversations) of changes in condition, laboratory. F. Responsible Party is to be notified of change in condition. The attending physician is responsible for responding in a timely manner to nurses regarding prompt notification calls, or emergencies. In addition, the physician is responsible for communicating the results of assessments and medical plans to a licensed nurse when appropriate." The facility policy on Supervision and Safety dated 3/15 documents that the policy arrives to make environment as free from hazards as possible. Residents' safety and supervision are facility-wide priorities. (B)	S9999		