STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145424	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	22660 South Cicero Avenue Richton Park, IL 60471

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45316 Based on observation, interview, and record review, the facility failed to follow their policy to ensure that a resident dignity is maintained for one of three (R90) observed for dignity in a sample of 20. Finding includes: On 4/30/2024 at 11:35 AM, R90 was observed with V2 (Director of Nursing) from the hall way. R90 was lying in his bed. R90 has an indwelling catheter and the drainage bag was half filled with urine. R90 drainage bag was not put in the dignity bag. On 4/30/2024 at 11:45 AM, this writer observed with V6 (Licensed Practical Nurse) from the hall way R90 drainage bag with urine. V6 said that the drainage bag should have been in the dignity bag. On 4/30/2024 at 11:35 AM, V2 said that the drainage bag should have been in the dignity bag. R90 is a [AGE] year-old male admitted on [DATE] with a diagnosis not limited to quadriplegia, tracheostomy, depression, and flaccid neuropathic bladder. Facility Policy: DIGNITY As an extension of appropriate interactions between staff and residents, the following will be practices of the facility: Note: Depending on scope and severity; what appears to be a dignity issue often can be interpreted and even meet the criteria for abuse. Misc. Dignity Concerns 9.) Urinary drainage bags will be covered unless residents are in their rooms, at which time the bag will be placed so as not be visible from the hall if at all possible.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based observation, interview and record review the facility failed to ensure clean resident room, bed, linens, and equipment are maintained. This deficiency affects one (R153) of three residents in the sample of 20 reviewed for providing Resident clean environment. Findings include: On 4/30/24 at 7:40AM, Observed R153 lying in bed with dirty bed sheet and pillows. The bed siderails, enteral feeding machine, IV pole and floor are dirty with stains of enteral feedings spillage. Called V8 Registered Nurse (RN) and showed observation. V8 said that house keeping is going to clean the room. On 4/30/24 at 9:43AM, V13 Housekeeping Aide (HA) said that he cleans the resident's room where R153 resides. Showed above observation made to V13 HA. V13 said that he already cleans the room, but he cannot remove the stains from the floor. V13 said that it has been like this since yesterday and he informed his supervisor. V13 said that the Certified Nurse Assistant (CNA) is responsible for cleaning the bed siderails and IV pole. On 4/30/24 at 9:46AM, Called V3 Infection Preventionist and showed observation made. V3 said that she will address the concerns presented. V3 said that they should provide clean environment to resident. On 4/30/24 at 10:19AM, Showed above observation made to V16 Housekeeping Director and requested for policy. R153 is admitted on [DATE] with diagnosis listed in part but not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Dysphagia, Gastrostomy status. Active physician order sheet indicates enteral feeding of Jevity 1.5 cal @ 65cc/hour x 24 hours until 1540 ml has infused via pump. Facility's policy on General cleaning policies and procedures Resident Room indicates: Procedure: 6. Clean and disinfect the room furnishings: a. Clean all furnishings in the resident's room including the bedrails, IV poles, doorknobs, wheelchair, walkers, and all other high contact surfaces. 14. Dust mop the resident room and bathroom floors 15. Wet mop the resident room and bathroom floors.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40001 Based on interview and record review the facility failed to ensure the resident is free from verbal and physical abuse from another resident. This deficiency affects one (R42) of three residents reviewed for resident-to-resident abuse in a sample of 20. Findings include: On 4/30/2024 at 8:00am, R42 said that on 4/1/2024 in the evening she was having a conversation with the nurse and walked out of the room yelling and slammed the door on her way out, R62 was walking past and started yelling and verbally abusing her, then pushed her to the floor calling her bad names. The nurse came out the room, helped R42 off the floor, R42 called the police stating that R62 was yelling at every one all day and nothing was done about it. R42 said that she is afraid of R62 and does not want him around her. R42 said that R62 returned to her room twice yelling and using profanity, and that she went to her friends room and sat with him, because I did not want to be in my room alone with him walking around the floors. On 5/2/2024 at 11:00am V30 (Nurse Practitioner-NP) said that R62 is delusional, becomes aggressive and paces the floor constantly and will wonder into other resident's rooms and become aggressive. On 5/3/2024 at 9:45am V29 (Licensed Practical Nurse-LPN) said that R42 is alert and oriented times three and uses a rolling walker to ambulate. On 4/1/2024, R42 was upset that she had to move out of her room and began yelling, walking out of her room with her walker slamming the door. V29 said she then heard yelling from two people outside the room, she ran out of the room and observed R42 laying on her right side on the floor. R62 was observed standing over R42 yelling and using profanity, he was immediately sent to his room. R62 is alert times one with delusions and very easily agitated and paces the floor all the time and had been pacing all evening that day. R42 refused to be assessed and was assisted up to her walker. V29 said that R42 called the police because she wanted him sent out of the facility. The nurse for R62 was notified and R62 was given an as needed medication to calm him down and was monitored by staff the rest of the shift. On 5/3/2024 at 10:25am, V2 (Director of Nursing-DON) said that she was informed of the incident between the two residents and that, R62 is alert times one with delusions, agitation, aggressiveness, and he also paces the floor constantly and does get into altercations with other residents. The evening of the altercation R62 was placed in his room and given an as needed medication to calm him down and was not sent out for an evaluation. R42 is alert and oriented times three, uses a rolling walker to ambulate, R42 was moved to her new room the next morning instead of that night. I was not aware that R42 was afraid to stay in her room that night, I would have moved R42 that night. From my understanding R62 was monitored the remaining shift. On 5/3/2024 at 12:00pm, V1 (Administrator-Abuse Coordinator) stated, R42 is alert and oriented times three ambulates with a rolling walker. R62 is alert confused, delusional and paces constantly, V1 said I thought R62 was petitioned out to the hospital, or they gave him medication to calm him down and R42 was immediately the next day moved to another room not that night. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An admission record indicates that R42 is [AGE] years old and has a diagnosis of Chronic Obstructive Pulmonary Disease, an order summary report indicates that R42 is on Hospice since 10/14/2023. A care-plan dated 10/19/2023 focus of a history of suspected abuse and or neglect or factors that may increase susceptibility to abuse and neglect. Interventions to observe the resident for signs of fear and insecurity during delivery of care. Take steps to calm the resident and help the resident to feel safe. An admission record for R62 indicates a diagnosis of Unspecified psychosis not due to a substance or known physiological condition, unspecified dementia with behavioral disturbance, psychotic disturbance, mood disturbance and anxiety, psychoactive substance use, psychoactive substance induced persisting dementia, schizoaffective disorder, and cognitive communication. A care-plan not updated for incident of 4/1/2024, for displaying behavioral symptoms on 8/14/2022. R62 involved in altercation with a co-peer, on 3/7/2023 verbal aggression towards peer. Interventions for to staff intervene, place on 1:1 monitoring, social service to follow up, well being checks x 3, redirect. A care-plan dated 7/11/2019 and 10/23/2019 wandering into a resident's room and becomes aggressive. A facility incident report form indicates that R42 has a police report number completed on 4/1/2024. An incident on 4/18/2024 that indicates R62 had an altercation with a female peer where R62 and the peer was sent out for evaluation. Facility policy: Abuse Prevention Program, Revised 01/2019 Policy It is the policy if this facility to prohibit and prevent resident abuse, neglect, exploitation, mistreatment and misappropriation of resident property and a crime against a resident in the facility. The facility will take steps to prevent mistreatment while the investigation is underway. Resident who allegedly mistreated another resident will be immediately removed from contact with that resident during course of the investigation. The accused resident's condition shall be immediately evaluated to determine the most suitable therapy, care approaches and placement, considering his of her safety, as well as the safety of the other resident and employees of the facility. Prevention: The facility desires to prevent abuse, neglect, exploitation, misappropriation, and a crime against a resident by establishing a resident -sensitive and resident -secure environment.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview and record review the facility failed to implement abuse prevention policy by failure to update Abuse assessment and formulate care plan after resident abuse incident occurred. This deficiency affects one (R81) of three residents in the sample of 20 reviewed for Abuse Prevention Program. Findings include: On 4/30/24 at 2:00PM, Observed R81 ambulatory, alert and oriented, and can verbalize needs to staff. R81 is admitted on [DATE] with diagnosis of Dementia, Opioid abuse, and weakness. Most recent Abuse/trauma screening done was on 4/28/23. No abuse care plan. R81's facility incident report dated 4/13/24 indicated: V6 Licensed Practical Nurse witnessed R81 and V21 Certified Nurse Assistant talking in the hallway. V21 CNA noted making inappropriate comment to R81. V6 LPN immediately separated the two and escorted V21 CNA out of the building. Social services will provide support follow up post incident. R81 was re-assessed and will continue to receive care in accordance with the individualized plan of care. V21 CNA was terminated due to nurse overhearing her comment. Social service following up with resident to ensure no negative outcome from this incident. On 5/1/24 at 12:30PM, V10 Assistant Social Service Director said that Abuse /Trauma assessment is done upon admission, quarterly and as needed when an abuse incident allegation occurred. V1 said that resident abuse care plan is formulated or updated when an allegation of abuse incident occurred. Informed V10 that R81 has recent employee to resident verbal abuse incident that occurred on 4/13/24. The Abuse/trauma assessment not updated, and no abuse care plan was formulated after the incident. V10 said that he is not aware of the abuse incident. Requested for Abuse/Trauma screening/assessment policy. On 5/2/24 at 10:14AM, V1 Administrator said that she is the abuse coordinator in the facility. She said that she discussed the abuse incident to the interdisciplinary team (IDT) to determine new intervention to prevent re-occurrence of abuse. V1 said that resident's abuse assessment and care plan will be updated. Informed V1 that R81 has recent employee to resident verbal abuse incident that occurred on 4/13/24. The Abuse/trauma assessment not updated, and no abuse care plan was formulated after the incident. On 5/2/24 at 10:53AM, V20 Social Service Director said that she just completed the abuse/trauma assessment and abuse care plan for R81 yesterday when she learned about the abuse incident. Facility's policy on Abuse Prevention Program Revised 1/2019 indicates: (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: to prohibit and prevent resident abuse, neglect, exploitation, mistreatment and misappropriation of resident property and a crime against a resident in the facility. The following procedures shall be implemented when an employee or agent becomes aware of abuse or neglect of a resident, or of an allegation of suspected abuse or neglect of a resident by a 3rd party. Procedure: VII Prevention *As part of the social history evaluation and MDS (Minimum Data Set) assessments, staff will identify residents with increased vulnerability for abuse, neglect, exploitation, mistreatment or who have needs and behaviors that might lead to conflict. Through the care planning process, staff will identify any problem, goals and approaches which would reduce the chances of mistreatment for these residents. Staff will continue to monitor the goals and approaches on a regular basis.

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F 0640 Level of Harm - Potential for minimal harm Residents Affected - Some	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46560 Based on interview and record review, the facility failed to transmit assessments within 14 days of completion for three of three residents (R11, R43, R75) reviewed for resident assessment in a sample of 20. Findings include: On 05/02/2024 at 12:10PM, during record review with V26 (Minimum Data Set [MDS]/Care Plan Coordinator), R75's annual assessment dated [DATE] and R43's annual assessment dated [DATE] were not submitted yet. During this review with V26, R11's quarterly assessment dated [DATE] and completed on 04/05/2024 was submitted on 04/30/2024. On 05/02/2024 at 12:18PM, during interview with V26, V26 stated that the facility just completes all the assessments but V27 (MDS Consultant) reviews it and signs off on it to complete then she is the one that submits it. On 05/02/2024 at 2:08PM, during interview with V27, V27 stated that R75's annual assessment dated [DATE] with completion date of 04/16/2024 should have been submitted on 04/30/2024. V27 also stated that R43's assessment dated [DATE] with completion date of 04/08/2024 should have been submitted on 04/22/2024. V27 stated that R11's assessment date 03/22/2024 with completion date of 04/05/2024 should have been submitted on 04/18/2024 instead of 04/30/2024. Review of R75's MDS assessment dated [DATE] indicated 04/16/2024 as date assessment was signed by the person completing care plan decision. R75's MDS Final Validation Report indicated target date of 03/26/2024, message of record submitted late, and the submission date is more than 14 days after 04/16/2024. Review of R43's MDS assessment dated [DATE] indicated 04/15/2024 as date assessment was signed by the person completing care plan decision. R43's MDS Final Validation Report indicated target date of 03/25/2024, message of record submitted late, and the submission date is more than 14 days after 04/15/2024. Review of R11's MDS assessment dated [DATE] indicated 04/09/2024 as Date RN (Registered Nurse) Coordinator signed assessment as complete. R11's MDS Final Validation Report indicated target date of 03/22/2024, message of record submitted late, and the submission date is more than 14 days after 04/05/2024.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46560 Based on interview and record review, the facility failed to perform pacemaker check as ordered and obtain a copy of hospice plan of care for two of four residents (R63, R66) reviewed for quality of care in a sample of 20. Findings include: 1. On 04/30/2024 at 1:30PM, during record review, R63's electronic health records indicated presence of cardiac pacemaker and orders indicated pacemaker check every 3 months. There is no documentation of pacemaker check that can be located on R63's electronic health records. On 05/01/2024 at 1:19PM, during interview with V2 (Director of Nursing), V2 stated that she contacted the pacemaker company managing R63's pacemaker to ask for documentation of pacemaker check and she was informed that the last time R63's pacemaker was checked was in June of 2020. V2 stated that R63's pacemaker check should have been done every three months as ordered. Review of R63's face sheet indicated initial admitted [DATE]. Review of R63's Order Summary Report dated 05/01/2024 indicated order for pacemaker check every 3 months with order date of 03/13/2023. Review of R63's care plan revised on 10/02/2023 indicated R63 has a pacemaker and interventions include pacemaker checks every 3 months as ordered. Review of facility's policy entitled Pacemaker Management created on 12/2014 indicated the following: Policy: It is the policy of this facility that residents with a pacemaker be managed for safe operation and equipment functionality. Procedure 5. Conduct trans-telephonic pacemaker monitoring, according to manufacturer's instructions and as ordered. Document scheduled monitoring completion in the medical record and/or MAR (Medication Administration Record). 2. On 05/01/2024 at 11:25AM during record review with V10 (Assistant Social Service Director), V10 cannot locate R66's plan of care from hospice. On 05/01/2024 at 11:25AM during interview with V10, V10 stated that the facility should have a copy of R66's plan of care from hospice in the hospice binder that was provided by hospice. Review of R66's Order Summary Report dated 05/01/2024 indicated admitted [DATE], diagnoses including cerebral infarction, and order to admit to hospice with order date of 12/27/2023. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of facility and hospice company agreement indicated agreement was made on May 26, 2022, and under Section II: Services to be Furnished by the Hospice, it indicated that The Hospice shall furnish a copy of the Plan of Care for such resident to the Nursing Facility at the time of the resident's admission into the Hospice program. The Interdisciplinary Group will review the Plan of Care at regular intervals, and modify the Plan of Care as necessary. Review of facility's policy entitled Hospice Services Facility Agreement created 11/17 indicated the following: Policy: It is the policy of this facility to provide and/or arrange for hospice services in order to protect a resident's right to a dignified existence, self-determination, and communication with, and access to, persons and services inside and outside the facility. Policy Explanation and Compliance Guidelines: 11. The designated member if the facility working with hospice representative will be responsible for: d. Obtaining the following information from the hospice: i. The most recent hospice plan of care specific to each resident 12. The facility will under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the facility to attain or maintain the resident's highest practicable physical, mental, and psychological well-being.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview and record review the facility failed to prevent worsening of acquired moisture associated skin disorder to resident who is at high risk for developing skin impairment. The facility also failed to follow up wound care physician recommendation. This deficiency affects one (R16) of three residents in the sample of 20 reviewed for Pressure ulcer prevention and treatment management. Findings include: On 4/30/24 at 7:35AM, Observed R16 lying in bed with oxygen via nasal cannula. She is alert and oriented, can verbalized needs to staff. She said that she has bed sore, and her buttock hurts. She said that sometimes it takes time for them to answer her call light when she needs to be changed. R16 is admitted on [DATE] with admitting diagnosis listed in part but not limited to Morbid obesity, Type 2 Diabetes Mellitus, Spinal stenosis, Muscle wasting and atrophy. Braden scale for predicting pressure sore risk dated 3/4/24 indicated at moderate risk. Active physician orders indicate: Apply A&D ointment and Zinc oxide-based barrier cream as directed to the entire bilateral buttocks/diaper area every shift and as needed for irritant dermatitis. Weekly skin checks for wound prevention. Derma fungal external ointment 2% (Miconazole nitrate) topical apply to buttocks, perineal every shift and as needed for MASD (Moisture associated Skin disorder) /dermatitis. Care plan indicates R16 has an alteration in skin integrity as evidenced by irritant dermatitis. Interventions: Skin will be checked during routine care. CNA will report any new concerns to the charge nurse for further evaluation and or treatment changes or interventions. The charge nurse or treatment nurse will report any new skin integrity issues/concerns to the physician as needed. R16's wound assessment dated [DATE] indicated bilateral buttocks/diaper area, Skin irritant dermatitis/MASD date identified 4/9/24, multiple small skin openings, pink/red color, 100% dermis. No measurements of the affected area. Treatment: Vit A&D ointment and Zinc oxide-based barrier cream after each incontinent care. On 5/1/24 at 10:29AM, V12 Wound Care Physician (WCP) said that he has been treating R16 for the last 2 weeks. His last wound assessment was on 4/23/24. R16 has 1. left buttocks caused by Moisture Associated Skin Disorder (MASD), measures 0.5cm x 0.7cm x0.1cm, light serous exudate, open areas exposed dermis. 2. right buttock caused by MASD measures 1.0cm x 3.2cm x 0.1cm, light serous exudate, open areas with exposed dermis. Treatment: Zinc ointment every shift for both left and right buttocks. Recommendations: Off load wound, reposition per facility protocol On 5/1/24 at 10:38AM, Observed R16 lying in bariatric bed. Observed V14 Wound Care Nurse (WCN) providing wound treatment to R16. V14 said that R16 is not on low air loss (LAL) mattress because she has only MASD/dermatitis. V14 said LAL mattress is only given to resident with stage 3 or stage 4 pressure ulcer. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	V12 WCP did skin /wound assessment and measurement. V12 said that right buttocks MASD worsened. Measures 26cm x 9.2cm x 0.1cm, surface area 239.20cm, cluster wound-open ulceration area of 23.92cm, light serous exudate, dermis- open areas with exposed dermis, skin 90%, wound progress- exacerbated due to incontinence. V12 WCP said that contributory factor for complicating wound healing are incontinence and immobility/repositioning. V12 WCP said that he will recommend LAL mattress/Group-2 mattress. R16's wound care assessment completed by V12 WCP dated 4/30/24 indicated Right buttock MASD measures 26cm x 9.2cm x0.1cm, surface area 239.20 cm, cluster wound open ulceration area of 23.92cm, light serous exudate, open areas exposed dermis, 90% skin, exacerbated due to incontinence. Left buttocks MASD measures 0.5cm x 0.6cm x 0.1cm, surface area 0.30cm, light serous exudate, open areas with exposed dermis. Recommendations: reposition per facility protocol, limit sitting to 60 minutes, Group 2 mattress (Low air loss mattress). On 5/1/124 at 1:02PM, Discussed with V14 WCN nurse's note dated 3/13/24 indicated that R16 requested for Low air loss (LAL) mattress. V14 said that R16 is not qualified for LAL mattress because she has only MASD, LAL mattress is indicated for stage 3 or 4 pressure ulcer. On 5/2/24 at 9:50AM, V2 Director of Nursing (DON) said that any changes /worsening of resident's skin condition should be reported to Wound care nurse to be referred to wound care physician. V2 said that wound care physician 's recommendation should be carried out. On 5/2/24 at 10:31AM, V8 Registered Nurse (RN) said that wound treatment of R16 is provided by floor nurse and wound care nurse. V8 said that any changes /worsening of resident's skin impairment should be reported to V14 WCN. On 5/2/24 at 10:54AM, V14 WCN said that he only sees R16 every Tuesday when he makes round with the wound care physician. The floor nurses are the one providing treatment to R16. V14 said that the CNAs and Nurses should notified him if they observed resident's worsening of wound or skin impairment. Review R16's medical records with V14 WCN. Informed V14 WCN that V12 WCP ordered zinc oxide for both right and left MASD, but the facility was applying multiple treatments such as Vit and D ointment and derma fungal ointment to the same site. The nurses nor CNAs did not notify him of R16's worsening MASD right buttocks. V12 WCP recommended LAL in is wound care assessment yesterday but not carried out. Informed him of the facility's failure to ensure on going assessment to monitor, implement and evaluate intervention in place. Facility's policy on Prevention/Treatment of Pressure ulcer injuries indicates: Purpose: It is the intent of the facility to recognize the following information and to act on it such a way to practice evidenced based recommendations for the prevention/treatment of pressure injuries to the residents who reside in the facility. Objectives: In accordance with federal regulations and based on the resident assessment, the facility will ensure: 1. A resident receives care, consistent with professional standards of practice; to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrate that they were unavoidable and (continued on next page)

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	145424	A. Building B. Wing	05/03/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Landmark of Richton Park Rehab & Nsg Ctr	22660 South Cicero Avenue Richton Park, IL 60471

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. A resident with pressure ulcer receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview and record review the facility failed to implement catheter care to resident with suprapubic catheter. This deficiency affects one (R153) of three residents reviewed for Catheter care management. Findings include: On 4/30/24 at 7:40AM, Observed R153 lying in bed. Observed brownish sediments attached inside the entire catheter tubing draining dark yellow orange urine. Called V8 Registered Nurse and showed observation made. V8 said that R153 has suprapubic catheter. V8 said that they monitor the catheter every shift for sediments and change catheter tubing/bag as needed. On 4/30/24 at 8:59AM, Informed V2 Director of Nursing (DON) of above observation. V2 said that they should monitor catheter every shift, catheter flush as needed and change catheter tubing and bag as needed. On 4/30/24 at 9:51AM, Observed V14 Wound Care Nurse (WCN) providing wound care to R153. Observed plastic wrapped around the urinary tubing approximately 10 inches from the catheter site. R153 said he did not know where the plastic came from. V14 WCN removed the plastic wrapped around the catheter tubing. V14 said it was probably from the food wrapper. V14 said that R153 is on pleasure feeding. Showed to V14 brownish sediments attached inside the catheter tubing. V14 said that the floor nurse is responsible for resident's catheter care. R153 is admitted on [DATE] with diagnosis listed in part but not limited to Hemiplegia and hemiparesis following cerebral infarction affecting left nondominant side, Urinary tract infection. Active physician order indicates Diagnosis for Suprapubic urinary catheter, flaccid neurogenic bladder. Suprapubic catheter 16 FR and 10cc balloon. Suprapubic catheter bag changes every night shift starting on the 1st and ending on the 1st every month for maintenance. Monitor and record amount and color of urine with supplemental documentation for yellow, amber, dark, bloody and monitor and record clarity, clear, cloudy, sediment, pus every shift. Care plan indicates that he is at risk for complications related to catheter use related to neurogenic bladder. Interventions: Monitor indwelling catheter and change catheter bag as needed. Monitor urine for increase sediment, cloudy urine, odor, blood, and output- alert nurse with concerns- call MD with concern. R153 has history of UTI (Urinary tract infection). Urine culture reported date 2/16/24 indicated Morganella morganii bacteria, he was treated with antibiotics. Most recent urinalysis reported 3/22/24 indicated protein trace in urine. Facility's policy on Suprapubic catheter care indicates: Procedure purpose: To maintain catheter patency. To facilitate frequent bladder irrigations. To facilitate instillation of drugs as ordered. To evacuate blood clots and as hemostatic agent. To keep area clean and prevent infection.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview and record review the facility failed to follow up with pharmacy recommendation for physician response. This deficiency affects two (R16 and R63) of three residents in the sample for 20 reviewed for Pharmacy medication review. Findings include: 1. On 4/30/24 at 7:35AM, Observed R16 lying in bed with oxygen via nasal cannula. She is alert and oriented, can verbalized needs to staff. R16 is admitted on [DATE] with diagnosis listed in part but not limited to Major depression, Anxiety disorder, Opioid dependence. Active physician order sheet indicates Trazadone HCl oral tablet 50mg give 1 tablet by mouth at bedtime for prophylaxis; Atorvastatin calcium oral tablet 20mg give 1 tablet by mouth at bedtime for prophylaxis; Cyclobenzaprine HCl oral tablet 5mg give 1 tablet by mouth at bedtime for prophylaxis; Duloxetine HCl oral capsule delayed released particles 60mg give 1 capsule by mouth one time a day for prophylaxis; Latanoprost ophthalmic solution 0.005% instill 1 drop in both eyes at bedtime for prophylaxis; Moisture barrier ointment apply to affected area topically every 6 hours as needed for prophylaxis; and Pregabalin oral capsule 25mg give 1 capsule by mouth two times a day for prophylaxis. Pharmacy recommendation dated 3/4/24 indicated newly admitted resident has several medication orders with no appropriate indication for use. Please review chart and update prophylaxis is not an acceptable indication. On 5/2/24 at 9:50AM, V2 Director of Nursing (DON) said that pharmacist comes to the facility monthly to review resident's medications. List of pharmacy recommendations were given to DON. V2 said that she reviews and address the recommendation, call the physician, or make any changes based on recommendations. V2 said that they will follow up with the pharmacist recommendation as soon as possible. Informed V2 of pharmacy recommendations dated 3/4/24 that was not followed up. Requested for policy. Facility's policy on Medication regimen review indicates: Policy: The consultant pharmacist will provide pharmaceutical care consultation including a medication regimen review on a monthly basis for each resident residing in a certified area of a long-term care facility. For residents residing in the long-term care facilities licensed for the developmentally disabled, pharmaceutical care consultation including regimen review will be conducted as required by federal/state laws. Procedure: 1. The consultant pharmacist will review the medication regimen of each resident in sufficient detail to determine if any apparent irregularities exist. Federally mandated standards of care as well as other applicable standards serve as the basis for the review. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. If the consultant pharmacist identifies a concern or irregularity in the resident's medication regimen that requires urgent action, the consultant pharmacist will immediately notify the Director of Nursing of the potential for negative outcome. 4. In addition to the written communication to the attending physician, the director of nursing and medical director on a consultant pharmacist progress report form, a medication regimen review log will be maintained in the resident's clinical record. The log will include whether any apparent irregularities were found. Pharmacist's signature and date the review was performed. 6. The consultant pharmacist is available to consult with the prescribing physicians or the nursing staff regarding recommendations resulting from medication regimen reviews. It is the responsibility of the facility to assure that each recommendation results in a written response by either the physician or nurse as appropriate. 46560 2. On 05/02/2024 at 11:30AM, during record review with V2 (Director of Nursing), a pharmacy recommendation was made for R63 on 03/04/2024. On 05/02/2024 at 11:30AM during interview with V2, V2 stated that the pharmacy comes in the facility monthly to check on all medications of all the residents and makes recommendations if she finds any irregularities. V2 also stated that all pharmacy recommendations are left for the physician on their mailboxes for them to review the next time they come in the facility. V2 stated that she has not received any response from the physician or psych nurse practitioner for R63's pharmacy recommendation regarding gradual dose reduction. V2 also stated that pharmacy recommendations should be followed up as soon as possible but stated that she was not able to follow up on R63's. Review of R63's pharmacy recommendation dated 03/04/2024 indicated recommendation for gradual dose reduction of a psychotropic medication. Review of R63's order summary report dated 05/01/2024 indicated order for Quetiapine fumarate 200mg 2 tablets by mouth at bedtime with order date of 03/03/2023. Review of R63's psychiatric progress notes from February 2024 to April 2024 did not indicate any attempt of gradual dose reduction or documentation of why gradual dose reduction attempt is clinically contraindicated.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 46560 Based on observation, interview and record review, the facility failed to discard potentially hazardous food (PHF) items by the use-by date. This failure has the potential to affect 15 residents who would receive the sandwiches from the kitchen. Findings include: On 04/30/2024 at 7:21AM, during observation with V25 (Dietary Aide), the cooler was observed with 15 prepared cold cut sandwiches placed in a pan with use by date of 4/24/2024. On 04/30/2024 at 7:21AM, during interview with V25, V25 stated that the 15 prepared cold cut sandwiches should have been discarded on 04/24/2024. On 05/01/2024 at 10:27AM, during interview with V28 (Food Service Director), V28 stated that the any prepared cold cut sandwiches should have been discarded on the date indicated on the label. Review of facility policy with section entitled Food Safety and Sanitation, policy on Dating and Labeling developed on 04/2017 indicated the following: Policy: The facility will follow safe handling and storage of PHF (potentially hazardous foods)/TCS (Time-Temperature Control for Safety) foods Procedure: - PHF/TCS foods will be stored, dated and labeled in the refrigerator held at 41F for a maximum of 7 days. The count begins on the day that the food was prepared or a commercial container was opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39781 Based on observation, interview and record review the facility failed to clean and cover a nebulizer mask after each use. This deficiency affects one (R16) of three residents in the sample of 20 reviewed for Infection control protocol. Findings include: On 4/30/24 at 7:30AM, Observed R16 lying in bed with oxygen via nasal cannula at 2.5LPM. Observed nebulizer mask dirty and exposed, connected to machine placed on bedside table next to opened container of zinc oxide cream, 2 opened tubes of vit A and D ointments, empty pudding container and used spoon. R16 said that the nurse provides her nebulizer treatment when she has problem with breathing. On 4/30/24 at 8:43AM, Observed R16 lying in bed with oxygen via nasal cannula at 2.5LPM. She just finished eating breakfast. The dirty and uncovered nebulizer mask connected to machine still placed on bedside table, next to breakfast tray with the opened container of zinc oxide cream, 2 opened tubes of vit A and D ointments, empty pudding container and used spoon. Called V8 Registered Nurse and showed observation. V8 said that the nebulizer mask should be clean and placed in the plastic bag and kept in the bedside drawer after use. V8 said that she did not give the nebulizer treatment, the night shift nurse did. V8 said the barrier cream and ointment should be closed and kept inside the bedside drawer after each use. These items should not be next to the meal tray of the resident for infection control. On 4/30/24 at 8:59AM, Informed V2 Director of Nursing (DON) of above observation. V2 said that the nebulizer mask should be cleaned and covered after each use. The barrier ointments and cream should be kept in treatment cart after using not at bedside. On 4/30/24 at 9:46AM, Informed V3 Infection Preventionist of above observation and requested for policy. R16 is admitted on [DATE] with diagnosis listed in part but not limited to Chronic obstructive pulmonary disease, Pneumonia, Pulmonary hypertension, Obstructive sleep apnea. Active physician order sheet indicates Ipratropium-albuterol solution 0.5-2.5 (3)mg/3ml inhale every 6 hours as needed for shortness of breathing or wheezing via nebulizer. Facility's policy on administering nebulizer therapy indicates: Purpose: to provide accurate and safe administration of medications requiring nebulization to residents. Medications requiring nebulization for inhalation therapy will be administered via individual nebulizer machines by licensed nurses. Procedure: 2. Each resident requiring nebulized medication will have a nebulizer machine at the bedside with individual connecting tubing with mask or mouthpiece. The connecting tubing will be changed on a weekly basis and will be cleaned and covered after each use.