STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145832	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze at the Ridge	6450 North Ridge Blvd Chicago, IL 60626

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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 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident when there is a significant change in condition 46342 Based on interview and record reviews, the facility failed to complete a significant change in status Minimum Data Set (MDS) assessments using the CMS-specified Resident Assessment Instrument (RAI) process within the regulatory timeframes for one (R30) of seven residents reviewed for resident assessment in a sample of 26. Findings include: On 8/20/24, per review of R30's electronic health record (EHR) R30 was admitted to hospice on 06/26/24. Review of R30's Minimum Data Set (MDS) schedule indicates R30's last MDS assessment was completed 06/14/24 as a quarterly assessment and R30's next quarterly assessment is scheduled for 09/16/24. On 08/21/24 at 1:44 PM, V23 (MDS Coordinator) stated residents are reassessed every 90 days and/or if there is a significant change. V23 stated significant change assessments must be done if there is a change in one or two areas relate to functional ability or Activities of Daily Living, if the resident is admitted to hospice, and/or if the resident has had a fall with injuries, and/or readmitted from the hospital with a new diagnosis. V23 stated a significant change assessment should be started within 14 days and completed by day 21. V23 stated V23 follows the Resident Assessment Instrument (RAI) Manual for MDS guidelines on completion and time frames. V23 stated R30 is on hospice. Looking at R30's electronic health record (EHR) V23 stated R30 was admitted to hospice 06/26/24 and R30's last MDS was completed on 06/14/24. V23 stated a significant change in status MDS should have been done according to the RAI Manual once R30 was admitted to hospice. V23 stated a significant change MDS should have been started no later than the 14th day which was 07/09/24 and completed by day 21. On 08/21/24 at 2:11 PM, V4 (Regional Director) stated when a resident gets put on hospice that is a significant change no matter what the reason they are put on hospice for. V4 stated this would mean a new MDS assessment should be completed. V4 stated R30 should have had a significant change in status MDS completed when R30 was admitted to hospice. (continued on next page)

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

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

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F 0637 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Chapter 2 of the RAI manual pages 22-23 titled RAI OBRA-required Assessment Summary documents in part, that a Significant Change in Status Assessment (SCSA) is required to be performed when a terminally ill resident enrolls in a hospice program, the ARD must be within 14 days from the effective date of the hospice election (which can be the same or later than the date of the hospice election statement, but not earlier than), a SCSA must be performed regardless of whether an assessment was recently conducted on the resident to ensure a coordinated plan of care between the hospice and nursing home is in place and for the nursing home to evaluate the MDS information to determine if it reflects the current condition of the resident, since the nursing home remains responsible for providing necessary care and service to assist the resident in achieving hi/her highest practicable well-being at whatever stage of the disease process the resident is experiencing.

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 46342 Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for a resident receiving hospice services for end-of-life support. This failure affects one resident (R30) out of one reviewed for hospice and comprehensive care plan in a sample of 26. Findings include: R30 has a diagnosis including but not limited to Chronic Respiratory Failure, Weakness, Unsteadiness On Feet, Dysphagia Following Cerebral Infarction, Lack of Coordination, Abnormal Posture, Chronic Obstructive Pulmonary Disease with (Acute) Exacerbation, Type 2 Diabetes Mellitus without Complications, Sequelae of Cerebral Infarction, Hydronephrosis, Shortness Of Breath, Long Term (Current) Use of Insulin, Cognitive Communication Deficit, Personal History of Traumatic Brain Injury, Hypertension, Personal History of Suicidal Behavior, Anemia, Gastro-Esophageal Reflux Disease without Esophagitis, Major Depressive Disorder, Schizophrenia, Hyperlipidemia, Bipolar Disorder, Current Episode Mixed, Severe, with Psychotic Features, Unspecified Dementia, Unspecified Severity, With Other Behavioral Disturbance, Hypothyroidism. On 08/20/24, per review of R30's electronic health record (EHR) R30 was admitted to hospice on 06/26/24 and does not have a care plan for hospice. On 08/21/24 at 1:40 PM, V23 (MDS Coordinator) stated a care plan should be generated if a resident is on hospice care. V23 stated the purpose of the hospice care plan is let everyone know that person is on hospice and receiving specialized care. V23 reviewed R30's EHR and stated R30 is on hospice. V23 stated R30 was admitted to hospice on 06/26/24. V23 stated a hospice care plan was added just today, 08/21/24 by V4 (Regional Director) for R30 being on hospice due to having a terminal condition. On 08/21/24 at 2:07 PM, V4 stated if a resident is on hospice this should also be care planned. V4 said, (R30) did not have a hospice care plan so I added one today. V2 stated it is important for a resident on hospice to have a hospice care plan to ensure the facility is meeting all of the resident's psychosocial needs. Facility policy titled; Comprehensive Care Plan dated 01/2023 documents in part: 1.) The facility must develop a comprehensive person-centered care plan for each resident. 2.) The care plan will include a focus, measurable goal, and interventions specific to the resident's medical, nursing, mental and psychosocial needs. 3.) The comprehensive care plan should drive the care and services provided for the resident and allow for the highest level of physical, mental, and psychosocial function based on the comprehensive MDS assessment. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	4.) The comprehensive care plan is reviewed quarterly, annually and with any significant change.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on observation, interview, and record review, the facility failed to ensure that residents who smoke are re-evaluated on a quarterly basis for their ability to smoke safely and smoking care plan was followed. These failures affect 4 (R1, R18, R41, R62) of 7 residents reviewed for smoking in the sample of 26. Findings include: Facility provided policy titled Smoking Policy dated January 2024 which documents in part, to establish guidelines to prohibit smoking by residents and visitors in the building except in designated areas. To establish guidelines for the specific circumstances in which residents may smoke in the designated areas and when increased supervision is required. Facility provided a document titled Smokers undated. R1, R18, R41, R62 are listed on this document. 1. R41's diagnosis included but not limited to Chronic Obstructive Pulmonary Disease With (Acute) Exacerbation, Personal History Of Nicotine Dependence, Generalized Idiopathic Epilepsy And Epileptic Syndromes, Intractable, With Status Epilepticus, Suicidal Ideations, Schizoaffective Disorder, Bipolar Disorder, Paranoid Schizophrenia, Major Depressive Disorder, Extrapyramidal and Movement Disorder, Trigeminal Neuralgia, Fibromyalgia, Muscle Spasm Of Backpain Disorder Exclusively Related To Psychological Factors, Other Chronic Pain, Restlessness And Agitation, Generalized Anxiety Disorder. R41's MDS (Minimum Data Set) dated 08/01/24 indicates intact cognition with BIMS (Brief Interview for Mental Status) score 15/15 and R41 is a smoker. R41's document titled, Safe Smoking Evaluation last completed 04/16/24 documented in part, smoking determination (0-1) safe smoker: capable and safe, requires no assistance to smoke, develop care plan. R41's smoking care plan documents in part on R41 has a history of violating the facility smoke program, and a room search was conducted on 08/08/24 resident was caught in possession of contraband and was in violation of his smoking contract. R41's interventions in part include the resident requires a smoking apron while smoking and resident will participate in smoking assessments as needed. On 08/21/24 at 1:10 PM, observed V20 (Activity Aide) passing out cigarettes and lighting cigarettes for residents outside on the back patio. On 08/21/24 at 1:24 PM, observed R41 in wheelchair on front patio smoking. R41 was not wearing a smoking apron. On 08/21/24 at 1:28 PM, V16 (Certified Nursing Assistant) stated R41 does not use a smoking apron when smoking. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/24 at 4:08 PM, observed R41 smoking outside on back patio sitting in wheelchair. R41 was not wearing a smoking apron. R41 said, I used to have a winter coat with a lot of burn marks on it. I don't know how they got there. I don't know where that coat is. R41 stated R41 has never used an apron or covering of any type while smoking since R41 has been at the facility. On 08/21/24 at 9:30 AM, V2 (Social Service Director) stated the social service department is responsible for managing the smoking program which includes assessing the resident for safety, providing education, and smoking contracts signed. V2 stated smoking assessments are completed quarterly by the social service staff. V2 stated the purpose of the smoking assessment is to determine if it is still safe for the resident to smoke. Factors that go in to determining if residents are safe to smoke include if there has been a recent history of non-compliance with smoking in non-authorized areas, the resident's ability to hold their cigarette. V2 stated the other purpose of the smoking assessment is to provide ongoing education to the resident on the smoking rules which are part of the smoking contract. V2 stated any resident who smokes should have a smoking care plan and that the smoking care plan should list appropriate interventions specific to that resident. V2 stated smoking care plans are updated quarterly by the social service department. V2 reviewed R41's electronic health record (EHR) and stated R41's last smoking assessment was completed on 04/16/24 and another one should have been completed toward the end of July because the smoking assessment should be reassessed quarterly. V2 stated R41's Safe Smoking Evaluation form dated 04/16/24 determined R41 is a safe smoker and does not have a history of non-compliance with facility smoking policy or smoking in unauthorized areas. V2 was not aware of R41's recent non-compliance with the smoking contract and stated R41's Safe Smoking Evaluation needs to be reassessed. On 08/21/24 at 4:14 PM, V2 stated V2 has never seen any burn marks on R41's clothing or observed R41 falling asleep when smoking. V2 stated V2 was not aware of the intervention on R41's smoking care plan which says R41 should smoke wearing a smoking apron. V2 stated R41's care plan should reflect R41's current needs. V2 stated, I don't think she needs a smoking apron but based on R41's smoking care plan R41 should be wearing one. V2 stated R41 needs to be re-evaluated by social service using the Safe Smoking Evaluation which will reassess the need for a smoking apron and R41's care plan will need to be revised pending the outcome of the Safe Smoking Evaluation. On 08/21/24 at 2:07 PM, V4 (Regional Director) stated a smoking assessment should be done upon admission, readmission, quarterly and/or with a change in condition. V4 stated the purpose of the smoking assessment is to ensure that the resident can smoke safety. V4 stated if a resident's smoking assessment was completed 04/16/24 then a reassessment of the smoking assessment should have been completed in mid-July 2024. 2. R1's face sheet showed admitted on 4/8/2024 with diagnoses not limited to schizoaffective disorder bipolar type, Other asthma, Restlessness and agitation, Auditory hallucinations, Other schizophrenia, Essential (primary) hypertension, Syndrome of inappropriate secretion of antidiuretic hormone, Other iron deficiency anemias, Benign prostatic hyperplasia, Unspecified convulsions, Insomnia, Hyperlipidemia. MDS (minimum data set) dated 4/15/24 showed R1's cognition was intact and with current tobacco use. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's care plan dated 8/12/24 documented in part: SMOKING - R1 has a physical and psychological addiction to nicotine and smoking, has poor tolerance to disruptions that may occur to her daily smoking routine, and may act out by displaying physical, psychosocial, and/or behavioral disturbances when unable to smoke. R1's Social Service notes dated 8/18/2024 documented in part: R1 has been restricted from smoking for 7 days for breaking the solicitation contract. Resident was educated by social services on multiple different occasions on selling and buying products from other residents. R1's last smoking assessment was completed on 4/16/24 documented in part: Safe Smoker: Capable and safe, requires no assistance to smoke. On 08/21/24 at 9:30 AM, V2 (Social Service Director) stated the social service department is responsible for managing the smoking program which includes assessing the resident for safety, providing education, and smoking contracts signed. V2 stated smoking assessments are completed quarterly by the social service staff. V2 stated the purpose of the smoking assessment is to determine if it is still safe for the resident to smoke. Factors that go in to determining if residents are safe to smoke include if there has been a recent history of non-compliance with smoking in non-authorized areas, the resident's ability to hold their cigarette. V2 stated the other purpose of the smoking assessment is to provide ongoing education to the resident on the smoking rules which are part of the smoking contract. V2 stated any resident who smokes should have a smoking care plan and that the smoking care plan should list appropriate interventions specific to that resident. V2 stated smoking care plans are updated quarterly by the social service department. At 12:12 PM R1 Observed up and about, ambulatory with steady gait, alert, and oriented x 3, verbally responsive. Stated he is smoking. On 8/21/24 at 1:13 PM, V20 stated R1 is not outside smoking because R1 violated R1's smoking contract. On 08/21/24 at 2:07 PM, V4 (Regional Director) stated a smoking assessment should be done upon admission, readmission, quarterly and/or with a change in condition. V4 stated the purpose of the smoking assessment is to ensure that the resident can smoke safety. V4 stated if a resident's smoking assessment was completed 04/16/24 then a reassessment of the smoking assessment should have been completed in mid-July 2024. 3. R62's face sheet showed admitted on 1/17/2022 with diagnoses not limited to Chronic obstructive pulmonary disease, Ulcerative colitis, Anxiety disorder, Insomnia, Hyperlipidemia, Major depressive disorder, Other obesity due to excess calories, Essential (primary) hypertension, Bipolar disorder. MDS dated [DATE] showed R62's cognition was intact and with current tobacco use. R62's care plan dated 4/8/24 documented in part: SMOKING - has a physical and psychological addiction to nicotine and smoking, has poor tolerance to disruptions that may occur to his daily smoking routine, and may act out by displaying physical, psychosocial, and/or behavioral disturbances when unable to smoke. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/20/24 at 11:44 AM R62 observed sitting on the side of the bed, alert, oriented x 3 and verbally responsive. Stated he is smoking. On 08/21/24 at 9:30 AM, V2 (Social Service Director) stated the social service department is responsible for managing the smoking program which includes assessing the resident for safety, providing education, and smoking contracts signed. V2 stated smoking assessments are completed quarterly by the social service staff. V2 stated the purpose of the smoking assessment is to determine if it is still safe for the resident to smoke. Factors that go in to determining if residents are safe to smoke include if there has been a recent history of non-compliance with smoking in non-authorized areas, the resident's ability to hold their cigarette. V2 stated the other purpose of the smoking assessment is to provide ongoing education to the resident on the smoking rules which are part of the smoking contract. V2 stated any resident who smokes should have a smoking care plan and that the smoking care plan should list appropriate interventions specific to that resident. V2 stated smoking care plans are updated quarterly by the social service department. On 08/21/24 at 1:10 PM, observed V20 (Activity Aide) passing out cigarettes and lighting cigarettes for residents outside on the back patio. On 08/21/24 at 1:12 PM, observed R62 smoking outside on back patio. R62's Smoking assessment was last completed on 4/16/2024. On 08/21/24 at 2:07 PM, V4 (Regional Director) stated a smoking assessment should be done upon admission, readmission, quarterly and/or with a change in condition. V4 stated the purpose of the smoking assessment is to ensure that the resident can smoke safety. V4 stated if a resident's smoking assessment was completed 04/16/24 then a reassessment of the smoking assessment should have been completed in mid-July 2024. 4. R18's face sheet showed initial admitted on 9/24/2019 with diagnoses not limited to Chronic obstructive pulmonary disease, Hyperlipidemia, Other asthma, Insomnia, Low back pain, Schizoaffective disorder bipolar type, Major depressive disorder, Restlessness and agitation, Schizophreniform disorder, Other folate deficiency anemias, Bipolar disorder. R18's care plan dated 4/9/2024 documented in part: SMOKING PROGRAM - has a physical and psychological addiction to nicotine/smoking and smoking routine and significant extended disruptions in my smoking routine may result in physical and psychosocial/ behavioral disturbance. I have been provided education on the importance of engaging in safe smoking practices, on smoking cessation, and the negative health consequences of continuing to smoke. R18's Smoking assessment was last completed on 4/16/24. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/21/24 at 9:30 AM, V2 (Social Service Director) stated the social service department is responsible for managing the smoking program which includes assessing the resident for safety, providing education, and smoking contracts signed. V2 stated smoking assessments are completed quarterly by the social service staff. V2 stated the purpose of the smoking assessment is to determine if it is still safe for the resident to smoke. Factors that go in to determining if residents are safe to smoke include if there has been a recent history of non-compliance with smoking in non-authorized areas, the resident's ability to hold their cigarette. V2 stated the other purpose of the smoking assessment is to provide ongoing education to the resident on the smoking rules which are part of the smoking contract. V2 stated any resident who smokes should have a smoking care plan and that the smoking care plan should list appropriate interventions specific to that resident. V2 stated smoking care plans are updated quarterly by the social service department. MDS dated [DATE] showed R18's cognition was intact and with current tobacco use. At 3:38 PM Observed R18 alert and verbally responsive, ambulatory with steady gait, stated he is a smoker. On 08/21/24 at 1:10 PM, observed V20 (Activity Aide) passing out cigarettes and lighting cigarettes for residents outside on the back patio. On 08/21/24 at 1:12 PM, observed R18 smoking outside on back patio. On 08/21/24 at 2:07 PM, V4 (Regional Director) stated a smoking assessment should be done upon admission, readmission, quarterly and/or with a change in condition. V4 stated the purpose of the smoking assessment is to ensure that the resident can smoke safety. V4 stated if a resident's smoking assessment was completed 04/16/24 then a reassessment of the smoking assessment should have been completed in mid-July 2024. 47304

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observation, interview, and record review, the facility failed to follow their policies and procedures to appropriately store oxygen tubing when not in use for 1 (R70) resident in a sample of 26. Findings Include: R70's Minimum Data Set (MDS) dated [DATE] shows R70 is cognitively intact. R70's Physician Order Sheet (POS) shows active order as of 8/20/24, Oxygen at 2Liters per nasal cannula continuous every shift related to acute and chronic respiratory failure with hypoxia. On 08/20/24 at 11:14 AM, surveyor with V10 (Certified Nursing Assistant/CNA) observed R70's oxygen nasal cannula tubing on the floor when not in use. V10 picked R70's oxygen nasal cannula tubing from the floor and placed the nasal cannula tubing on the oxygen tank. On 08/20/24 at 11:20 AM, surveyor and V8 (Registered Nurse/RN)) both entered R70's room. Surveyor asked V8 where should R70's oxygen nasal cannula tubing be stored when not in use? V8 stated R70's oxygen tubing should have been stored inside a plastic bag when not in use to prevent infection. On 8/21/24 at 9:40 AM, V5 (Regional Nurse Consultant) stated, according to the policy of the facility, the oxygen tubing should be stored appropriately when not in use. V5 stated appropriately means, inside a plastic zip bag when not in use to prevent contamination. On 8/21/24 at 9:58 AM, V3 (Director of Nursing/DON) stated it is V3's expectation that nurses would keep oxygen nasal cannula tubing inside a plastic zip bag when not in use to prevent infection. V3 stated R70's oxygen nasal cannula tubing should not be on the floor. V3 stated R70's oxygen tubing should be replaced. On 08/21/24 at 12:55 PM, surveyor observed R70 with the same oxygen tubing. Surveyor asked V8 (RN) if R70 has the same oxygen tubing from 8/20/24? V8 stated yes, V8 did not change R70's oxygen nasal cannula tubing, because the tubing will be changed on Thursday (8/22/24). Facility Policy titled, Oxygen Safety/Use dated 01/2024 documents in part: Oxygen tubing will be changed weekly and appropriately stored to prevent contamination when not in use.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 47304 Based on observation, interview, and record review, the facility failed to ensure a medication error rate of less than 5% for 2 (R27, R103) of 11 residents in the sample reviewed for medication administration. There were 31 opportunities and 4 errors resulting to 12.9% medication error rate. Findings include: R27's face sheet documented admitted on 8/25/2021 with diagnoses not limited to Type 2 diabetes mellitus, Chronic obstructive pulmonary disease, Personal history of covid-19, Schizoaffective disorder, Bipolar disorder, Major depressive disorder, Anxiety disorder, Gastro-esophageal reflux disease without esophagitis, Fibromyalgia. R103's face sheet documented admitted on 4/12/2023 with diagnoses not limited to Schizophrenia, Major depressive disorder. On 8/20/24 at 9:33AM Medication administration observation conducted with V6 (Registered Nurse / RN), checked R27's BP (blood pressure) =125/78 and PR (Pulse Rate) =101/min. V6 prepared and administered the following medications to R27: Saccharomyces Boulardi Probiotic 1 capsule, Omeprazole (Anti-reflux) 20mg (milligrams) 1 capsule, Aspirin (non-steroidal antiinflammatory) 81mg 1 tablet, Lisinopril (Antihypertensive) 2.5mg 1 tablet, Divalproex (Anit-seizure) 500mg 1 tablet, Metformin (antidiabetic) 1000mg 1 tablet. R27 took medications by mouth. V6 instilled 1 drop Cromolyn sodium 4% ophthalmic solution to each eye. V6 administered 2 sprays of Fluticasone (steroid) nasal spray to each nostril for about 3-5 seconds between sprays. She administered 2 puffs Albuterol (corticosteroid) inhaler for about 3-5 seconds between puffs. V6 said saline nasal spray was not available. R27 stated has only been getting 1 kind of nasal spray, did not receive saline nasal spray for a long time. R27's POS (Physician Order Sheet) and MAR (Medication Administration Record) reviewed with orders not limited to: Aspirin EC Tablet Delayed Release 81 MG, Lisinopril Tablet 2.5 MG, Probiotic Oral Capsule 250 MG (Saccharomyces boulardii) Give 1 capsule, Cromolyn Sodium Ophthalmic Solution 4 % Instill 1 drop in both eyes, Divalproex Sodium Tablet Delayed Release 500 MG, metformin HCl Tablet 1000 MG, Fluticasone Furoate Nasal Suspension 2 puff in each nostril, Omeprazole Capsule Delayed Release 20 MG Give 1 capsule, Ventolin HFA Aerosol Solution 2 inhalation inhale orally every 6 hours as needed, Saline Nasal Spray Solution 1 spray in each nostril four times a day (ordered time at 8am, 12noon, 4pm and 8pm). R27's MAR showed saline nasal spray was not given at 8am and 12noon dose on 8/20/24. R27's record did not show that V6 informed the doctor that Saline nasal spray was not available and R27 missed doses of medication. At 9:47 AM V6 prepared and administered Sertraline 100mg 1 tablet to R103 and taken by mouth. V6 administered earwax softener drops to R103's left ear, she instilled 4 drops for about 1-2 seconds between drops. V6 was not observed cleansing the external auditory canal with a cotton applicator and did not straighten auditory canal by pulling up and back. V6 did not insert a small cotton ball in external auditory canal. (continued on next page)

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Ryze at the Ridge	6450 North Ridge Blvd Chicago, IL 60626

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R103's POS AND MAR reviewed with order not limited to: Sertraline HCl Tablet 100 MG Give 1 tablet by mouth one time a day, Debrox Otic Solution (Carbamide Peroxide (Otic)) Instill 4 drop in left ear two times a day. On 8/21/24 at 9:24am V3 (Director of Nursing / DON) stated nurses are expected to follow the 5R's (right resident, right medication, right route, right time, right dose) in giving medications. She said if medication is not available, nurses are expected to call the doctor or follow up with pharmacy. If resident missed nasal spray as scheduled could possibly cause respiratory issues. V3 said nurses are expected to wait at least 2 minutes between puffs of nasal spray, so it doesn't force medication to go down, don't want to rush to administer another puff. She said same thing with Inhaler, wait for at least 1-2 minutes between puff to give the lungs time to expand and absorb the puff and have full effect of the medication. She said for ear drop administration, nurse is expected pull up the earlobe and wait for at least 1-2 minutes in between drops for full medication absorption. Facility's policy for medication administration dated 1/2024 documented in part: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. Check medication administration record prior to administering medication for the right medication, dose, route, patient / resident and time. If medication is not given as ordered, document the reason on the MAR and notify the health care provider if required. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner. Facility's oral inhalation administration policy dated 8/2020 documented in part: If another puff of the same or different medication is required, wait at least 1-2 minutes between. Facility's ear drops policy dated 1/2024 documented in part: Ear drops are placed in the auditory canal for purposes of softening cerumen, removing debris and reducing inflammation. Cleanse the external auditory canal with a cotton applicator and wipe away discharge. Straighten auditory canal by pulling up and back. Insert a small cotton ball in external auditory canal.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview, and record review, the facility failed to: (a) properly date opened multi-dose medication solution, eye drops and inhalers; (b) properly store unopened multi-dose insulin vial and (c) properly discard expired house stock medication from 3 of 5 medication carts and 2 of 3 medication storage rooms inspected for medication storage and labeling. These failures affect 7 residents (R4, R16, R29, R34, R70, R75, R127) reviewed during medication storage observation. Findings include: On [DATE] at 10:23am Medication cart on 3rd floor inspected with V7 (Licensed Practical Nurse / LPN), stated has been working in the facility for [AGE] years. Observed the following inside the medication cart: 1. R16's Risperidone solution opened with no open date labelled. R16's POS (Physician Order Sheet) with order not limited to: risperidone Oral Solution 1 MG/ML (Risperidone) Give 2 ml by mouth two times a day. 2. R127's multi-dose Brimodine 0.2% solution with no open date. R127's POS showed order not limited to: Brimonidine Tartrate Ophthalmic Solution 0.2% Instill 1 drop in both eyes every 12 hours for Glaucoma. 3. R75's multi-dose Albuterol Sulfate inhaler was open, pharmacy sticker indicated date opened and there was no open date found. R75's POS showed order not limited to: Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT 1 puff inhale orally every 4 hours as needed for sob. 4. R4's multi-dose Albuterol inhaler opened with no open date. R4's POS showed order not limited to: Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG/ACT 1 puff inhale orally every 4 hours as needed for sob. At 10:36am 2nd floor medication cart 2 inspected with V8 (Registered Nurse/RN), stated has been working in the facility for 5 years. Observed the following inside the medication cart: 1. R70's multi-dose Trelegy ellipta (Bronchodilator) inhaler opened with no open date. Pharmacy label indicated: Discard 6 weeks after opening. R70's POS showed order not limited to: Trelegy Ellipta Inhalation Aerosol Powder Breath Activated , d+[DATE]XXX,d+[DATE] MCG/ACT (Fluticasone-Umeclidinium-Vilanterol) 1 puff inhale orally in the morning. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R34's multi-dose Albuterol inhaler with no open date. R34's POS showed order not limited to: Albuterol Sulfate HFA Inhalation Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate)2 puff inhale orally every 4 hours as needed for SOB/Wheezing. 3. R29's unopened Insulin Lispro vial was kept inside the medication cart. Pharmacy label: Refrigerate. V8 said insulin is refrigerated if not opened. R29's POS showed order not limited to: Insulin Lispro Injection Solution 100 UNIT/ML (Insulin Lispro) Inject as per sliding scale: if 61 - 174 = 0 units; 175 - 200 = 1 unit; 201 - 250 = 3 units; 251 - 300 = 5 units; 301 - 350 = 7 units; 351 - 400 = 9 units, subcutaneously two times a day. At 10:56am 2nd floor medication room inspected with V9 (LPN) and found 1 bottle of house stock medication - Vitamin B6 tablets with expiration date ,d+[DATE] was kept inside the medication cabinet in the medication storage room. V9 said expired medication should be disposed or discarded. On [DATE] at 9:24am V3 (Director of Nursing / DON) said nurses need to label the date when the medication was opened to know when to discard the medication. Inhalers need to be discarded in 6 weeks after opening. If there is no open date, we will not know when the next 6 weeks is, not able to know when to discard the medication. She said the medication will not have a full effect if given after the discard date, it's like the resident is not getting medication. Stated eye drops could store at least 30days once opened, then should be discarded. V3 said insulin vial if not open should be refrigerated for temperature control and maintain potency of the medication. V3 said nurses should check expiration date of every medication including house stock and if expired should be discarded right away. If not discarded, could potentially give expired medication to the resident, and potentially cause some reactions to resident. Facility's policy for medication labels dated ,d+[DATE] documented in part: Medications are labeled in accordance with facility requirements and state and federal laws. Each prescription medication label includes: Beyond use or expiration date of medication. Facility's policy for medication storage dated ,d+[DATE] documented in part: Medications requiring refrigeration are kept in the refrigerator. Outdated drugs will be immediately withdrawn from stock by the facility. They will be disposed of according to drug disposal procedures.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 46342 Based on observation, interview and record review, the facility failed to ensure the cook has appropriate competencies and skills resulting in recipes during food preparation not being followed. This failure has the potential to affect all 128 residents receiving food prepared in the facility's kitchen. Findings include: On 08/21/24 at 10:30 AM, V21 (Cook) stated V21 is the cook that will be preparing the pureed foods for lunch. V21 stated there are four residents on a pureed diet and V21 follows the recipe for five serving portions. V21 said, I follow that pointing to the recipe binder which was opened to recipe for pureed pork fritter. On 08/21/24 at 10:38 AM, observed V21 review the recipe for pureed pork fritter and then grab a regular soup spoon, not a standard measuring Tablespoon. The recipe for pureed pork fritter on bun listed 1 Tablespoon of chicken base to be added for 5 servings. Observe V21 then opened a large bin container of powdered chicken base and reached in using the regular soup spoon to scoop out two heaping scoops of the chicken base. V21 placed the chicken base in a Styrofoam cup which was approximately 1/3rd full of the chicken base. On 08/21/24 at 10:41 AM, observed V21 add 5 pork breaded fritters and 5 hamburger buns into the blender. Then, observed V21 sprinkle the unmeasured amount of chicken base on top of the hamburger buns and added 1/2 of the water before turning on the blender to pureed the pork fritter. V21 continued to stop and start the blender while added more of the water until 2 1/2 cups were used and the desired pureed consistency was obtained. On 08/21/24 at 10:53 AM, observed V21 add 5-4-ounce portions of tater tots to 2nd blender container with blade. V21 stated the 1st blender lid used to prepare the pureed pork needed to be washed because the kitchen does not have a 2nd blender lid. On 08/21/24 at 10:54 AM, observed V21 take the blender lid to the 3-compartment sink and put the blender lid in the sink containing soap, then rinsed the blender lid in the 2nd sink and then quickly dipped the blender lid into the 3rd sink containing sanitizing liquid while still holding the blender lid the entire time and then placed the blender lid to the side of the 3rd compartment sink to dry. The blender lid was dipped into the sanitizing liquid for 1-2 seconds, not 60 seconds. V19 (Dietary Manager) observed this process and told V22 (Dietary Aide) to clean the blender lid. On 8/21/24 at 10:58 AM, V19 read from the manufacturer's poster on the wall above the 3-compartment sink which stated in part items need to be submerged for a full minute. V19 stated the item needs to be left in the sanitizing solution for a full minute in order to kill bacteria and to disinfect. V19 stated this potential cross contamination could lead to a foodborne illness outbreak. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/21/24 at 10:59 AM, observed V21 using a regular soup spoon add 2 large scoops of chicken base into a Styrofoam cup and measure out 1 1/2 cup of water. V21 then sprinkled the unmeasured amount of chicken base on top of the tater tots and add water in 1/2 cup increments until desired consistency was obtained. On 08/21/24 at 11:08 AM, surveyor tasted the pureed tater tots. The taste was so salty it was not edible or palatable. On 08/21/24 at 11:11 AM, V19 tasted the pureed tater tots and V19 stated it tasted too salty. V21 reviewed with V19 how V21 prepared the pureed tater tots including using a soup spoon to scoop out the chicken base. V19 stated that is a soup spoon, not a measured Tablespoon and using the soup spoon would give more product that is needed because it is not a standard measurement. V19 stated the recipe called for 1/2 Tablespoon and V21 should have used standard measuring spoons to measure out the chicken base. V19 stated because V21 did not use the correct measurement of chicken base the product came out too salty. On 08/21/24 at 11:20 AM, V21 stated V21 remade the pureed tater tots to serve to the residents for lunch and asked surveyor to taste them. Surveyor tasted the remade pureed tater tots which was palatable, and not salty. On 08/21/24 at 3:51 PM, V19 stated the cooks should follow the recipe. V19 stated it is important for the cooks to follow the recipes to make sure they are preparing the food in the right way. V19 stated the recipes provide consistency so the food should taste the same no matter who is preparing it. V19 stated V22 did not follow the recipe so the food was too salty, which made the food not good to eat. V19 stated if the food is not good to eat and it is served like that the resident may not want to eat it which could potentially affect their meal intake and nutrition. V19 stated this could also be a problem for any of the residents on a low salt diet which potentially might not be good for their health. Recipe titled, Pureed Pork Fritter on Bun dated 2024 lists ingredients for 5 servings as follows: 5 each pork fritter on bun, 2 1/2 cups water, 1 Tablespoon chicken base and documents in part, combine chicken base and water to make chicken broth. Recipe titled Pureed Tater Tots dated 2024 lists ingredients for 5 servings as follows: 2 1/2 cups tater tots, 1 1/2 cups water, 1/2 Tablespoon chicken base and documents in part, dissolve chicken broth in water to make broth. Facility provided policy titled, Standardization Recipes undated which documents in part, standardized recipes should be followed to produce high quality, flavorful, and consistent products, the Dietary Manager should provide and implement the use of standardized recipes to provide a consistency quality product while maintaining food cost. Facility provide job description for the cook titled Position Description [NAME] undated which documents in part, the cook prepares quality meals for residents in accordance with all laws, regulations, and standards, must have the ability to implement and interpret the programs, goals, objectives, policies and procedures of the dietary department and must be able to read, write, speak and understand the English language. (continued on next page)

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility provide policy titled Three and Two Compartment Sinks documents in part, three and two compartment sinks should be maintained, washed, and sanitized properly, purpose to ensure food safety, submerge pots and pans for a minimum of 60 seconds or per the manufacturer's guidelines. Facility provided copy of manufacturer's signage posted above the three compartments sink titled Procedure For 3 Compartment Sinks which documents in part, immerse utensils in SANITIZER SINK for a full minute. On 08/21/24, facility provided list of diet orders for all residents in the facility as of 08/20/24 from the facility electronic health system. The diet order list indicates there are no residents receiving nothing by mouth (NPO).

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on observation, interview, and record review, the facility failed to ensure food items were labeled and dated with an opened and use by date, failed to discard expired food based on use by guidelines and labeled use by date. The facility also failed to sanitize cooking equipment based on manufacturers' guidelines. These failures have the potential to affect all 128 residents receiving food prepared in the facility's kitchen. Findings include: On [DATE] at 9:22 AM, V19 (Dietary Manager) stated all items in the refrigerators should be labeled with an open and use by date. V19 stated if the item was first delivered as a dry storage item, then there should also be a delivery date on that item in addition to the open and use by date. V19 stated items should be used within six days unless manufacturer label says otherwise. V19 stated it is everyone's responsibility to label and date items. It is important for all items to be labeled and dated to make sure the kitchen does not use expired products because this could potentially lead to food borne illness. On [DATE] at 9:30 AM, observed the following items in the reach in cooler: 1.) Opened 5-pound bag of shredded mozzarella cheese filled 50% labeled with delivery date [DATE]. There was no opened or use by date documented on the opened product. 2.) Opened 46-ounce carton labeled Thickened Honey Orange Juice From Concentrate approximately 60% full labeled with opened date [DATE], and use by date [DATE]. Manufacturer's label printed on container documented in part, After opening may keep up to 7 days under refrigeration. 3.) 2nd Opened 46-ounce carton labeled Thickened Honey Orange Juice From Concentrate approximately 25% labeled with opened date [DATE], and use by date [DATE]. Manufacturer's label printed on container documented in part, After opening may keep up to 7 days under refrigeration. V19 stated the honey thickened juice is used because the facility has two residents requiring honey thickened liquids. V19 stated V19 thought since the use by date printed on the carton was [DATE] that was what the use by date was. V19 stated V19 did not realize that once the product was opened it should be discarded after 7 days and stored in the refrigerator. V19 stated these will be thrown out right away. 4.) Opened one gallon container labeled Red Cooking Wine labeled with opened date [DATE] and use by date [DATE]. Manufacturer's label printed on container documented best if used by [DATE]. On [DATE] at 9:41 AM, observed 16-ounce opened container of cornstarch in the spice storage area with no opened or use by date. V19 stated the cornstarch should be labeled with an open date and use by date. On [DATE] at 9:46 AM, observed in walk-in cooler large plastic bag containing individual slices of garlic bread labeled with preparation date [DATE] and use by [DATE]. V19 stated since the use by date is [DATE] the garlic bread should have been discarded by [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 10:54 AM, during pureed food preparation observations observed V21 (Cook) take blender lid to the 3-compartment sink and put the blender lid in the sink containing soap, then rinsed the blender lid in the 2nd sink and then quickly dipped the blender lid into the 3rd sink containing sanitizing liquid and then placed the blender lid to the side of the 3rd compartment sink to dry. V21 did not leave the blender lid in the sanitizing liquid for more than ,d+[DATE] seconds. V19 (Dietary Manager) observed this and told V22 (Dietary Aide) to clean the blender lid. On [DATE] at 10:55 AM, observed (Dietary Aide) take the blender lid and re-dipped it into the 3rd sink containing sanitizing solution and pulled it out of the sanitizing solution after ,d+[DATE] seconds. V19 observed this and told V22 to put it back in the solution. Surveyor asked V22 how long items need to stay in the 3rd sink to sanitize and V22 stated, four seconds. V19 quickly said, no, it needs to be in the solution for 60 seconds. V22 quickly put the blender lid back into the sanitizing solution and V19 told V22 when to remove it after 60 seconds had lapsed. V19 read from the manufacturer's poster on the wall above the 3-compartment sink which stated in part items need to be submerged for a full minute. V19 stated the item needs to be left in the sanitizing solution for a full minute in order to kill bacteria and to disinfect the item. V19 stated if the cooking equipment is not kept in the sanitizing solution for the full minute this could lead to cross contamination and potentially lead to a foodborne illness outbreak. On [DATE], facility provided list of diet orders for all residents in the facility as of [DATE] from the facility electronic health system. The diet order list indicates there are no residents receiving nothing by mouth (NPO). Facility provided policy titled OnTray Dietary Policies and Procedures undated documents in part foods with a use-by guidelines for opened thickened liquids 7 days. Facility provided policy titled Food Safety undated which documents in part, food should be labeled and dated to monitor food safety, food or beverage items that have exceeded the manufacturer's expiration date should be discarded, food items that do not have a manufacturer's expiration date should be labeled with contents and dated with a received and use-by date, and all food items should be consumed or discarded after standard expiration date of food category. Facility provided policy titled, Infection Control undated which documents in part, the Dietary Department should have established effective infection control guidelines in place, purpose to prevent cross-contamination and the spread of infection and open foods are labeled and dated with content, opened on date, and use by date according to guidelines. Facility provide policy titled Three and Two Compartment Sinks documents in part, three and two compartment sinks should be maintained, washed, and sanitized properly, purpose to ensure food safety, submerge pots and pans for a minimum of 60 seconds or per the manufacturer's guidelines. Facility provided copy of manufacturer's signage posted above the three compartment sink titled Procedure For 3 Compartment Sinks which documents in part, immerse utensils in SANITIZER SINK for a full minute.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on interview and record review, the facility failed to assess eligibility and offer pneumococcal vaccinations, and failed to provide eligible residents and/or resident representatives education regarding the benefits and potential side effects of all available pneumococcal vaccinations to 4 (R1, R11, R128, R102) out of 6 residents reviewed for pneumococcal vaccinations in the sample of 26. Findings Include: On 8/20/24 at 10:54 AM, interviewed V14 (Infection Control Nurse) and stated that the facility sets up vaccination clinics for residents who need to receive the vaccines. V14 stated that the residents are educated about the vaccines. V14 stated that after the education is provided, consents are obtained from the resident or their representative. V14 stated that consents are uploaded right away in the resident's electronic health records (EHR) under the miscellaneous tab. V14 stated that V14 has no educational material that V14 provides to the residents about the vaccines. V14 stated V14 does it verbally. V14 stated that all education is documented electronically in the residents' chart, and it should show under the immunizations tab. V14 stated that V14 does not keep an immunization tracker because everything should be recorded in the resident's electronic records. V14 stated that the residents' immunization report is pulled from the EHR. On 8/20/24 at 11:37 AM, the following residents' EHR were reviewed for their information regarding pneumococcal vaccinations. R128's EHR shows R128 is [AGE] years of age and was admitted on [DATE] with diagnoses that included, but were not limited to type 2 diabetes mellitus, essential hypertension, alcoholic liver disease, and congestive heart failure. R128's Minimum Data Set (MDS) dated [DATE] shows R128's Brief Interview for Mental Status (BIMS) is 6 which means R128 is cognitively impaired. R128's EHR revealed no information of R128's pneumococcal vaccination status. R128's EHR revealed no documentation indicating the facility assessed R128's eligibility to receive the pneumococcal vaccination and/or that R128 or R128's representative was provided education related to the pneumococcal vaccination. R102's EHR shows R102 is [AGE] years of age and was admitted on [DATE] with diagnoses that included, but were not limited to anemia, essential hypertension, acute kidney failure, and bipolar disorder. R102's MDS dated [DATE] shows R102's BIMS is 14 which means R102 is cognitively intact. R102's EHR revealed no information of R102's pneumococcal vaccination status. R102's EHR revealed no documentation indicating the facility assessed R102's eligibility to receive the pneumococcal vaccination and/or that R102 was provided education related to the pneumococcal vaccination. R11's EHR shows R11 is [AGE] years of age, a smoker, and was admitted on [DATE] with diagnoses that included, but were not limited to alcohol use, essential hypertension, and schizophrenia. R11's Minimum Data Set (MDS) dated [DATE] shows R11's Brief Interview for Mental Status (BIMS) is 15 which means R11 is cognitively intact. R11's EHR revealed no information of R11's pneumococcal vaccination status. R11's EHR revealed no documentation indicating the facility assessed R11's eligibility to receive the pneumococcal vaccination and/or that R11 was provided education related to the pneumococcal vaccination. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145832	A. Building B. Wing	08/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Ryze at the Ridge	6450 North Ridge Blvd Chicago, IL 60626

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's EHR shows R1 is [AGE] years of age, a smoker, and was admitted on [DATE] with diagnoses that included, but were not limited to asthma, essential hypertension, hyperlipidemia, and convulsions. R1's MDS dated [DATE] shows R1's BIMS is 15 which means R1 is cognitively intact. R1's EHR revealed no information of R1's pneumococcal vaccination status. R1's EHR revealed no documentation indicating the facility assessed R1's eligibility to receive the pneumococcal vaccination and/or that R1 was provided education related to the pneumococcal vaccination. R1, R11, R128, and R102 are not listed in the facility's pneumococcal immunization report provided on 8/20/24 at approximately 2:00 PM. On 8/20/24 at 12:14 PM, interviewed R128 and was unable to recall if R128 received the pneumococcal vaccine. R128 stated that R128 has not received any education about the pneumococcal vaccination. On 8/21/24 at 10:43 AM, interviewed R11 and stated that R11 has been in the facility for four months. R11 stated that R11 did not receive the pneumococcal vaccine. R11 stated that R11 does not think the facility provided education on any immunizations. On 8/21/24 at 10:46 AM, interviewed R102 and stated that R102 does not need to receive any vaccines. R102 stated that R102 was vaccinated years ago but was unable to recall which type of vaccines. R102 stated that the facility did not provide education on the immunizations. R102 stated, That would be good to get some education on those vaccines. They have not done it yet. I would like to know about those unnecessary vaccines. On 8/21/24 at 9:20 AM, interviewed V3 (Director of Nursing) and stated that documentation should be completed after an education to the resident is provided. V3 stated, They have to document under the resident's chart. Everything is electronic. They have to document to show that the resident is educated. If it's not documented that means, it's not done. The facility's policy titled; Pneumococcal Vaccinations reads 1/24 reads in part: All current residents or the resident's responsible party will be screened and offered the pneumonia vaccine within the 1st week of admission and annually if eligible per Centers for Disease Control (CDC) guidelines. A consent will be obtained and serves as the education tool for the vaccine. If the Resident has previously received any of the pneumonia vaccines, the date and location will be entered into the Immunization Tab of EHR.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on interview and record review, the facility failed to assess eligibility and offer COVID-19 vaccination for 4 residents (R11, R110, R231, R128), failed to ensure the residents medical records includes documentation if COVID-19 vaccinations were received or did not receive for 5 residents (R1, R11, R110, R231, R128), and failed to ensure the residents medical records includes documentation that education was provided to residents and/or resident representatives regarding the benefits and potential side effects of COVID-19 vaccination for 6 residents (R1, R11, R110, R231, R128, R102) out of 6 residents reviewed for COVID-19 vaccination in the sample of 26. Findings Include: On 8/20/24 at 10:54 AM, interviewed V14 (Infection Control Nurse) and stated that the facility sets up vaccination clinics for residents who need to receive the vaccines. V14 stated that the residents are educated about the vaccines. V14 stated that after the education is provided, consents are obtained from the resident or their representative. V14 stated that consents are uploaded right away in the resident's electronic health records (EHR) under the miscellaneous tab. V14 stated that V14 has no educational material that V14 provides to the residents about the vaccines. V14 stated V14 does it verbally. V14 stated that all education is documented electronically in the residents' chart, and it should show under the immunizations tab. V14 stated that V14 does not keep an immunization tracker because everything should be recorded in the resident's electronic records. V14 stated that the residents' immunization report is pulled from the EHR. On 8/20/24 at 11:37 AM, the following residents' EHR were reviewed for their information regarding COVID-19 vaccinations. R11's EHR shows R11 was admitted on [DATE] with diagnoses that included, but were not limited to essential hypertension and schizophrenia. R11's Minimum Data Set (MDS) dated [DATE] shows R11's Brief Interview for Mental Status (BIMS) is 15 which means R11 is cognitively intact. R11's EHR revealed no information of R11's COVID-19 vaccination status. R11's EHR revealed no documentation indicating the facility assessed R11's eligibility to receive the COVID-19 vaccination and/or that R11 was provided education related to the COVID-19 vaccination. R110's EHR shows R110 was admitted on [DATE] with diagnoses that included, but were not limited to type 2 diabetes mellitus, essential hypertension, and schizophrenia. R110's MDS dated [DATE] shows R110's BIMS is 15 which means R110 is cognitively intact. R110's EHR revealed no information of R110's COVID-19 vaccination status. R110's EHR revealed no documentation indicating the facility assessed R110's eligibility to receive the COVID-19 vaccination and/or that R110 was provided education related to the COVID-19 vaccination. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R231's EHR shows R231 was admitted on [DATE] with diagnoses that included, but were not limited to schizoaffective disorder and bipolar disorder. R231's MDS dated [DATE] shows R231's BIMS is 15 which means R231 is cognitively intact. R231's EHR revealed no information of R231's COVID-19 vaccination status. R231's EHR revealed no documentation indicating the facility assessed R231's eligibility to receive the COVID-19 vaccination and/or that R231 was provided education related to the COVID-19 vaccination. R128's EHR shows R128 was admitted on [DATE] with diagnoses that included, but were not limited to type 2 diabetes mellitus, essential hypertension, alcoholic liver disease, and congestive heart failure. R128's MDS dated [DATE] shows R128's BIMS is 6 which means R128 is cognitively impaired. R128's EHR revealed no information of R128's COVID-19 vaccination status. R128's EHR revealed no documentation indicating the facility assessed R128's eligibility to receive the COVID-19 vaccination and/or that R128 or R128's representative was provided education related to the COVID-19 vaccination. R102's EHR shows R102 was admitted on [DATE] with diagnoses that included, but were not limited to anemia, essential hypertension, acute kidney failure, and bipolar disorder. R102's MDS dated [DATE] shows R102's BIMS is 14 which means R102 is cognitively intact. R102's EHR revealed R102 refused the COVID-19 vaccination. R102's EHR revealed no documentation indicating that R102 was provided education related to the COVID-19 vaccination. R1's EHR shows R1 was admitted on [DATE] with diagnoses that included, but were not limited to asthma, essential hypertension, hyperlipidemia, and convulsions. R1's MDS dated [DATE] shows R1's BIMS is 15 which means R1 is cognitively intact. R1's care plan shows R1 is a smoker. R1's EHR revealed no information of R1's COVID-19 vaccination status. R1's EHR revealed no documentation indicating the facility assessed R1's eligibility to receive the COVID-19 vaccination and/or that R1 was provided education related to the COVID-19 vaccination. R1, R11, R128, R231, R110, and R102 are not listed in the facility's COVID-19 immunization report provided on 8/20/24 at approximately 2:00 PM. On 8/20/24 at 12:11 PM, interviewed R231 and stated that R231 did not receive the COVID-19 vaccine. R231 stated R231 has been in the facility for a month and has not received any education about the COVID-19 vaccination. On 8/20/24 at 12:14 PM, interviewed R128 and was unable to recall if R128 received the COVID-19 vaccine. R128 stated that R128 has not received any education about the COVID-19 vaccination. On 8/21/24 at 10:41 AM, interviewed R110 and stated that R110 has been in the facility for a year. R110 stated that R110 is vaccinated with COVID-19. R110 does not remember if facility provided education on COVID-19 vaccination. On 8/21/24 at 10:43 AM, interviewed R11 and stated that R11 has been in the facility for four months. R11 stated that R11 did not receive the COVID-19 vaccine. R11 stated that R11 does not think the facility provided education on any immunizations. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/21/24 at 10:46 AM, interviewed R102 and stated that R102 does not need to receive any vaccines. R102 stated that R102 was vaccinated years ago but was unable to recall which type of vaccines. R102 stated that the facility did not provide education on any vaccinations. R102 stated, That would be good to get some education on those vaccines. They have not done it yet. I would like to know about those unnecessary vaccines. On 8/21/24 at 9:20 AM, interviewed V3 (Director of Nursing) and stated that documentation should be completed after an education to the resident is provided. V3 stated, They have to document under the resident's chart. Everything is electronic. They have to document to show that the resident is educated. If it's not documented that means, it's not done. The facility's policy titled; COVID-19 VACCINATION - Resident dated 5/31/23 reads in part: All residents will be offered the COVID-19 vaccine. Vaccine clinics will be held within the facility on a regular basis. Unvaccinated residents will be offered the COVID-19 vaccine prior to each clinic date. Facilities will report vaccination data as required into the NHSN database weekly.