STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146095	A. Building B. Wing	09/05/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Evenglow Lodge	215 East Washington Pontiac, IL 61764

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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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on interview and record review the facility failed to report a fall to the physician and resident representative for one (R12) of five residents reviewed for falls in the sample list of 24. Findings include: R12's Minimum Data Set, dated dated dated [DATE] documents R12 has moderate cognitive impairment. There is no documentation in R12's medical record that V21 (R12's Family) or V22 (R12's Physician) were notified on 5/5/24 that R12 was lowered to the floor during a staff assisted transfer. R12's Fall Report for fall on 5/5/24 documents R12's fall was not reported to V21 until 5/6/24 at 10:08 AM and V18 (Nurse Practitioner) until 5/6/24 at 8:08 AM. R12's Nursing Note dated 5/6/24 at 7:52 AM documents R12 complained of left toe discomfort and R12's left great toe and second toe were bruised/swollen. R12's Nursing Note dated 5/6/2024 at 3:47 PM documents V18 (Nurse Practitioner) evaluated R12 for toe bruising and pain and gave orders for Tylenol and foot x-ray. The Note documents R12's family was present and updated. The facility's Occurrence Report to the state surveying agency dated 5/10/24 documents the following: On 5/5/24 at 2:00 PM a Certified Nursing Assistant (identified as V17) transferred R12 from the recliner. R12 reported R12's knee gave out causing R12 to go down to the floor in a kneeling position, and R12's left foot slid underneath the recliner. R12's x-ray results received on 5/7/24 document an acute non-displaced fracture of the left great toe. On 9/03/24 at 1:05 PM V2 (Director of Nursing) stated R12's toe fracture was due to the fall on 5/5/24. At 3:21 PM V2 confirmed R12's fall on 5/5/24 should have been reported to R12's physician and family. V2 stated it wasn't reported until the following day when R12 reported the fall, since the agency nurse and CNA had not reported the fall. On 9/04/24 at 1:25 PM V18 (Nurse Practitioner) stated R12 told V18 on the morning of 5/6/24 that during a staff assisted transfer R12's foot bent underneath of R12, R12's knees buckled, and R12 was lowered to the floor. V18 stated V18 was not aware of this incident until she evaluated R12 on 5/6/24 for toe swelling and bruising. V18 stated V18 should have been notified of the incident and V18 is rarely notified by agency staff. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Procedure for Resident Falls & Incidents documents to report falls/incidents to the resident's physician and family.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40385 Based on observation, interview, and record review the facility failed to provide personal hygiene assistance for one (R3) of one resident reviewed for Activities of Daily Living in the sample list of 24. Findings include: On 9/03/24 at 9:28 AM R3 was sitting in the dining room and was finished with breakfast. R3's lower eyelids were very red and there was green discharge in the corner of R3's left eye. R3 stated R3's eyes have been bothering her today. R3 was asked what has been done to address R3's eye discomfort/redness/drainage. R3 stated R3 receives eye drops daily. On 9/4/24 at 9:06 AM R3 was present for the resident council meeting. R3's eyes remained red and there was white/yellow drainage on R3's eyelids. R3's Minimum Data Set, dated dated dated [DATE] documents R3 has moderate cognitive impairment and requires partial/moderate staff assistance for personal hygiene. R3's Nursing Note dated 9/3/2024 at 9:51 PM documents R3 complained of eye discomfort/pain and there was increased redness noted to R3's eyes and lower eyelids. R3's eyes had clear drainage and a warm compress was applied. On 9/04/24 at 12:41 PM V10 (Registered Nurse) stated it is not unusual for R3's eyes to have drainage in the morning. V10 stated R3 gets herself ready in the morning, but staff does provide assistance as well. V10 confirmed R3's eyelids should be washed with a warm washcloth as part of morning cares. V10 stated she will have to talk to the Certified Nursing Assistants about that. On 9/04/24 at 1:28 PM V18 (Nurse Practitioner) stated R3 has chronic dry eyes and it is not uncommon for R3 to have eye discharge related to allergies.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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** 37813 Based on observation, interview, and record review the facility failed to implement fall prevention interventions, failed to obtain an ordered X-ray in a timely manner, and failed to document fall and post fall assessment for two residents (R13, R12) of five residents reviewed for falls in a sample list of 24 residents. Findings Include: 1. R13's Current Diagnoses list includes the following diagnoses: Fractured Right Hip, Alzheimer's Dementia, Unsteadiness on Feet, Difficulty Walking, and Instability of Left Hip. R13's Fall Risk assessment dated [DATE] documents R13 is at moderate risk for falls. R13's Progress note dated 7/30/24 at 6:25AM by V11 (Licensed Practical Nurse/LPN) documents (R13) slid off edge of bed and was sitting next to bed. Denies any injury but complained of usual arthritic pain. Ambulated to bathroom and then out to breakfast. Narcotic pain reliever given as ordered. R13's Progress note dated 7/30/24 at 10:33 AM documents Continues to complain of pain in hips especially right and then complains of back as usual. In bed and moving lower extremities but complaints of pain. Examined and no deformities noted. (V18) Advanced Practice Nurse made aware of slip to floor. Orders for bilateral hip X-rays. Power of Attorney notified (POA). (contracted X-ray company) notified of orders. R13's Progress note dated 7/30/24 at 12:37PM documents (R13) Continued to yell out periodically and especially pain more prominent of right hip. No deformity noted and demonstrating Active Range of Motion to both hips. In bed for comfort. POA and V18 (notified) new orders for x-rays of both hips. (contracted X-ray company) notified and orders sent. R13's Progress Note dated 7/30/24 at 7:21PM documents (Nurse) called (X-ray Company) again to check on Estimated Time of Arrival and spoke with (representative). Order was changed from routine to As Soon As Possible after (representative) suggested it due to ASAP orders and STAT orders having to be completed before routine orders. R13's Progress Note dated 7/30/24 at 7:51PM documents (contracted X-ray company) called back at and stated the technician would be here to x-ray (R13) within an hour and 30 minutes. R13's Progress Note dated 7/30/24 at 9:46PM documents (X-ray Company) arrived and completed imaging. Upon completion of Bilateral Lower Extremity x-ray (technician) saw some displacement of Right hip with possible suspicion of fracture. (Nurse) called ambulance to transport (R13) to hospital for further evaluation. (Nurse) informed POA. (nurse) also informed on call nurse. (Nurse) attempted to notify Primary Care Physician and received busy signal. Ambulance arrived. A copy of the images completed have been given to Emergency Medical Services (EMS) via disc. Paperwork printed (face sheet, order summary, transfer sheet, POLST (Physician Orders for Life Sustaining Treatment) form, administration record of MAR (Medication Administration Record) and Living will) have been given to EMS. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Subsequent Progress Notes document (R13) returned to the facility 8/9/24 after surgical repair of the fractured right hip. On 9/4/24 at 2:00PM V2 (Director of Nursing) stated We have trouble getting (contracted X-Ray provider) here to do X-Rays very quickly. On 9/4/24 at 1:17PM V18 (Nurse Practitioner) stated (R13) is very severely cognitively impaired. They did do surgery to repair (R13's) hip. That might have sped up (R13's) decline. 40385 2. On 9/03/24 at 11:38 AM R12 was sitting in a wheelchair in the dining room. On 9/03/24 at 12:06 PM R12 was sitting in a wheelchair in his room. R12 stated R12 had previously self-transferred out of the recliner, his foot got tangled up, and somehow, he broke his toe. On 9/03/24 at 2:51 PM R12 was sitting in the recliner in his room. There was a pressure relieving cushion in R12's wheelchair. The wheelchair did not contain a nonskid mat. R12's Minimum Data Set, dated dated dated [DATE] documents R12 has moderate cognitive impairment. R12's Fall Risk and Intervention Assessment/Observation dated 7/3/24 documents R12 is at high risk for falls. R12's Care Plan dated 1/11/24 documents R12 is at risk for falls related to impaired balance, weakness, and Congestive Heart Failure. This care plan includes an intervention dated 7/2/24 to use a nonskid mat in R12's wheelchair. R12's Nursing Note dated 5/6/2024 at 3:47 PM documents V18 (Nurse Practitioner) evaluated R12 for toe bruising and pain and gave orders for Tylenol and foot x-ray. V21 (R12's Family) was present and updated. R12's Nursing Note dated 5/6/24 at 7:52 AM documents R12 complained of left toe discomfort and R12's left great toe and second toe were bruised/swollen. The Occurrence Report to the state surveying agency dated 5/10/24 documents the following: On 5/5/24 at 2:00 PM a Certified Nursing Assistant (identified as V17) transferred R12 from the recliner. R12 reported R12's knee gave out causing R12 to go down to the floor in a kneeling position, and R12's left foot slid under the recliner. R12's x-ray results received on 5/7/24 document an acute non-displaced fracture of the left great toe. R12's medical record does not contain documentation for the fall on 5/5/24 or that R12 was immediately assessed for injuries following the fall. R12's Fall Report dated 7/1/24 at 7:15 PM documents R12's alarm was sounding and R12 was found sitting on the floor in front of his wheelchair. R12 reported that he slipped out of his wheelchair. The facility's fall investigation dated 7/8/24 for R12's fall on 7/1/24 documents a nonskid mat was applied to R12's wheelchair as the post fall intervention. On 9/03/24 at 2:56 PM V16 (CNA) stated V16 has access to resident care plans and that is where she looks for fall interventions. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/03/24 at 3:00 PM V15 (Agency Licensed Practical Nurse) stated V15 has access to resident care plans and she looks there for fall interventions. At 3:15 PM V15 entered R12's room and verified R12's wheelchair seat did not contain a nonskid mat. V15 stated V15 will have to see if therapy staff is still in the building to obtain the nonskid mat. On 9/03/24 at 1:05 PM V2 (Director of Nursing) stated R12's toe fracture was due to the fall on 5/5/24. V2 confirmed R12's fall and post fall assessment should have been documented in R12's progress notes. V2 stated V17 (Agency CNA) transferred R12 from the recliner, R12's knee gave out and his foot bent underneath of him causing R12 to be lowered to the floor. On 9/03/24 at 3:21 PM V2 stated R12's fall was not reported until the following day when R12 reported the fall. V2 stated V2 completed the Fall Huddle form for R12's fall since it was not completed by the agency nurse working at the time.

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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. 32853 Based on observation, interview, and record review the facility failed to label and properly store nebulizer mask and tubing. The facility also failed label oxygen tubing when changed for two of two residents (R16, R3) reviewed for respiratory care in the sample list of 24. Findings include: The facility's Oxygen Policy and Procedure with a reviewed date of 12/13/23 documents, The nasal cannula or mask, the extension tubing, the pre-filled humidifier bottle and the baggie are to be changed weekly and as needed. The baggie and the pre-filled humidifier bottle are to be dated. 1.) R16's Order Summary Report dated 9/5/24 documents diagnoses including Dyspnea, Dependence of Supplemental Oxygen, Chronic Respiratory Failure with Hypoxia, Other Specified Interstitial Pulmonary Diseases, Chronic Obstructive Pulmonary Disease and Acute Upper Respiratory Infection. This Order Summary Report documents an order for Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) mg (milligrams)/3 ml (milliliters), 3 ml inhale orally every 6 hours as needed for wheezing/Shortness of Breath with a start date of 12/22/23. On 9/3/24 at 10:15 AM, R16's oxygen concentrator was running via a nasal cannula. R16's nebulizer mask was hanging on the drawer handle of the bedside stand and the medication cup portion of the mask was open to air and hanging on the side of the nebulizer machine. There was no date on the nebulizer mask or tubing to indicate when it was changed and was not stored in anything to protect from contamination. On 9/4/24 at 2:33 PM, R16 was in his room, in his recliner and the nebulizer mask and tubing were still hanging in the same place with no date and no covering. On 9/5/24 at 8:38 AM, R16 was in his room in his recliner and the nebulizer mask and tubing were still hanging in the same place with no date and no covering. On 9/5/24 at 9:34 AM, V2 (Director of Nursing) stated that nebulizer mask, tubing and the oxygen tubing are to be labeled with the date they were changed. V2 stated they are supposed to be changed weekly and stored inside a plastic bag. 40385 2.) On 9/3/24 at 9:29 AM R3 was sitting in the dining room wearing Oxygen at 2 liters per minute per nasal cannula that was connected to a portable oxygen tank. This tubing was not labeled with a date. On 9/3/24 at 3:08 PM V15 (Licensed Practical Nurse) stated oxygen tubing is changed weekly on Sundays. V15 confirmed oxygen tubing should be labeled with a date. V15 entered R3's room and verified R3's portable oxygen tubing was not labeled with a date. V15 stated the tubing will need to be changed and dated. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R3's September 2024 Treatment Administration Record documents to change R3's oxygen tubing and humidifier weekly on Wednesdays and label with a date.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. 40385 Based on observation, interview, and record review the facility failed to post daily staffing and include total hours worked as part of the posted daily staffing. This failure affects all 30 residents who reside in the facility. Findings include: On 9/05/24 at 9:22 AM V2 (Director of Nursing) stated posted staffing is usually located on the bulletin board by the first-floor nurse's station. V2 confirmed the bulletin board did not contain the daily posted staffing. V2 stated V14 (Scheduler) usually posts the staffing and V2 keeps the forms. V2 provided a copy of the form, which does not include the total hours worked for licensed and unlicensed staff. V1 (Administrator) stated there should be another form that is posted for daily staffing which includes the hours worked. On 9/05/24 at 9:27 AM V14 (Scheduler) stated V14 has not posted daily staffing for September 2024. V14 was completing the form, which did not include the total number of hours worked. V14 stated V14 wasn't aware that the daily posted staffing must include the hours worked. The Report of (facility) Nursing Staff Directly Responsible for Resident Care dated September 2024, provided by V14, documents total licensed and unlicensed nursing staff full time employees for days, evening, and night shifts. This form does not document total number of hours worked. The facility's Resident List Report dated 9/3/24 documents 30 residents reside in the facility.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. 32853 Based on interview and record review the facility failed to complete an initial assessment prior to starting an antipsychotic medication for one of five residents (R28) reviewed for unnecessary medications in the sample list of 24. Findings include: The facility's Nursing Service Procedure for Psychoactive Medication use policy with a revised date of 12/15/23 documents, Before considering the use of an anti-psychotic medication, staff will first determine whether there is an underlying medical, physical, functional, psychosocial, emotional, psychiatric, or environmental cause of the behavior(s). The pre-psychoactive medication assessment form will be completed. R28's Order Summary Report dated 9/4/24 documents diagnoses including Major Depressive Disorder, Generalized Anxiety Disorder, Alzheimer's Disease with Late Onset, Dementia in Other Diseases Classified Elsewhere and Unspecified Psychosis not Due to a Substance or Known Physiological Condition. This Order Summary Report documents an order for Seroquel Oral Tablet 25 mg (milligrams) (antipsychotic) one tablet by mouth one time a day for Atypical Psychosis with a start date of 6/17/24. R28's Medication Administration Record dated 6/1/24 through 6/30/24 documents R28 received the first dose of Seroquel on 6/17/24. R28's Psychotropic Medication and Behavior Assessment/Observation dated 6/19/24, 6/26/24 and 7/3/24 do not include the Seroquel in the assessments. R28's first assessment for the Seroquel 25 mg is not until the 7/10/24 Psychotropic Medication and Behavior Assessment/Observation. R28's Care Plan updated on 8/16/24 documents R28 takes psychoactive medications including the Seroquel. R28's MDS (Minimum Data Set) dated 8/8/24 documents R28 takes an antipsychotic medication. On 9/5/24 at 9:34 AM, V2 (Director of Nursing) confirmed that there was not an initial psychotropic medication assessment completed for R28 prior to starting an antipsychotic medication (Seroquel) and there should have been one completed.

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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. 32853 Based on observation, interview, and record review the facility failed to store resident's medications separately from food, failed to maintain a pharmacy label on medications and failed to discard/return medication for someone who was not a resident in the facility. This failure affects four residents (R11, R6, R8, R18) with medication in the medication room refrigerator in the sample list of 24. Findings include: The facility's Medication Storage Policy updated 11/1/16 documents, Medications and biologicals that are dispensed by a licensed nurse are stored in a locked cabinet/cart or locked in the medication room. On 9/3/24 at 2:38 PM, V3 (Registered Nurse) opened the medication storage room refrigerator and confirmed there is food stored in the refrigerator with resident's medications. At this time the medication storage room refrigerator contained: 1. R11's Lantus (insulin), 2. R6's Bisacodyl suppositories, 3. Two vials of Tuberculin solution, 4. Emergency stock supply of insulin and Lorazepam, 5. R8's Bisacodyl suppositories, 6. R18's Dorzolamide drops, 7. A clear plastic bag full of Acetaminophen suppositories with no label, name or identification on the bag, 8. R6's Acetaminophen suppositories, 9. Four pudding cups, several cups of applesauce, three bottles of nutritional drink, three boxes of fortified nutritional liquid supplement and 10. A locked controlled medication box. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The medication storage room refrigerator also contained a Lantus pen for an unidentified name - not a resident of the facility and never has been a resident of the facility. This Lantus pen had this person's name on the pharmacy label with a dispensed date of 7/14/24. V3 stated she did not know who the resident was and stated that maybe they passed away. At this time, V4 (Registered Nurse) stated that she thinks this was a pharmacy delivery error, that it was not supposed to be delivered to this facility. V3 confirmed that the dispensed date was back in July 2024 and has been stored in the medication storage room refrigerator. R11's Order Summary Report dated 9/4/24 documents an order for Lantus Subcutaneous Solution 100 unit/ml (milliliters) inject 20 units subcutaneously one time a day related to Type 2 Diabetes Mellitus with a start date of 4/4/24. R6's Order Summary Report dated 9/4/24 documents an order for Bisacodyl Rectal Suppository, insert one suppository rectally every 24 hours as needed for Constipation with a start date of 4/24/24 and an order for Acetaminophen Rectal Suppository 650 mg (milligrams), insert one suppository rectally every four hours as needed for Mild Pain; Elevated Temperature with a start date of 4/24/24. R8's Order Summary Report dated 9/4/24 documents an order for Bisacodyl Suppository 10 mg, insert one suppository rectally every 24 hours as needed for Constipation or if no bowel movement after three days. R18's Order Summary Report dated 9/4/24 does not document any orders for Dorzolamide ophthalmic drops. On 9/4/24 at 12:07 PM, V2 (Director of Nursing) stated that the (unidentified resident's) Lantus pen belongs to a resident at one of the other facility's in town and she stated that she was surprised no one had sent it back to the pharmacy. On 9/5/24 at 9:34 AM, V2 confirmed that there should not be food stored in the refrigerator with medications.

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40385 Based on observation, interview, and record review the facility failed to ensure food is handled in a sanitary manner for one (R12) of 16 residents reviewed for dining in the sample of 24. The facility's undated policy titled Handwashing, Glove Use, and Personal Standards for (facility) Foodservice, documents wear gloves when handling ready-to-eat foods. On 09/03/24 at 11:39 AM The noon meal was distributed on the second floor. V12 (Volunteer/R22's Family) was assisting staff in serving resident meal trays. R12 requested ketchup for his turkey burger. V12 touched R12's turkey burger bun with V12's bare hands and applied ketchup. On 9/03/24 at 12:00 PM V12 confirmed he volunteers at the facility and assists in serving meal trays. V12 stated V12 only wears gloves when prepping chicken on the bone. V12 confirmed V12 did not wear gloves when he touched R12's turkey burger. On 9/04/24 at 1:18 PM V6 (Dietary Manager) stated gloves should be worn when handling ready to eat foods.