

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057950		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/29/2026	
NAME OF PROVIDER OR SUPPLIER BRIA OF ELMWOOD PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7733 WEST GRAND AVENUE , ELMWOOD PARK, Illinois, 60707			
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S0000	Initial Comments Annual Health Licensure Survey Complaint Investigation 2692766/2798484 Extended Survey		S0000			04/14/2026	
S9999	Final Observations Statement of Licensure Violations (1 of 7): 300.610a) 30.1210a) 300.1210b) 300.1210c) 30.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's		S9999			04/14/2026	

Office of Primary Care and Health Systems Management

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE
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S9999	Continued from page 1 comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act) b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents' respective resident care plan. Section 300.3240 Abuse and Neglect Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These requirements were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure one resident (R6) was free from unnecessary restraint use, failed to ensure restraints were applied in a manner that allowed for easy release, failed to obtain informed consent prior to restraint use, failed to release restraints in accordance with the facility's restraint program/policy and professional standards, failed to exhaust all required interventions prior to initiation of restraint use, failed to follow the facility's restraint protocol/policy. This failure affected one resident (R6) in a sample of 82 residents reviewed for restraints. Applying the reasonable person concept due to R6's inability to communicate and severe cognitive impairment, these failures would have subjected a reasonable person to avoidable psychosocial harm including but not limited to,	S9999				04/14/2026	

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S9999	Continued from page 2 agitation, anger, diminished sense of dignity, and feelings of dehumanization. Findings include: R6's face sheet documents in part the following diagnoses: nontraumatic intracerebral hemorrhage, morbid obesity, acute respiratory failure, cerebral palsy, dysphagia, stage 3 pressure ulcer of the sacrum/right ankle, unspecified convulsions, encounter for attention to tracheostomy/gastrostomy, dependence on ventilator status, osteoarthritis, depression, and hypertension. R6's physician orders document in part an active order for "May apply mittens to bilateral hands related to pulling at trach" (1/14/2026) and "Remove mittens and monitor bilateral hands for any skin issues Any skin issues-y/n" (1/14/2026). R6's medication administration record for 1/14/2026-3/2026 documents that mitt restraints were removed every shift. R6's Minimum Data Set (2/13/2026) documents in part that R6's is rarely/never understood and has a memory problem with short- and long-term memory. R6's Care Plan does not identify R6 uses restraints. On 3/23/2026 at 11:11 AM, observed R6 lying in bed resting. R6 appeared lethargic and was not responding to questioning. Bilateral mitt restraints were observed on R6's hands, with a brown substance on the outside of the left mitt restraint. V63 (Certified Nursing Assistant) confirmed the observation of the restraints. V63 stated, "I'm not really sure why (R6) has restraints, I think it's because (R6) scratches at (R6's) self". On 3/23/2026 at 11:14 AM, V49 (Agency Registered Nurse) confirmed observation that R6 had bilateral mitt restraints applied to R6's hands. V49 was unsure why R6's had the restraints and stated that it was R49's first time in the facility and first time assigned to R6. V49 denied ever receiving training on restraints from the facility prior to working in the facility. V49 stated the standard of care was to release restraints every two hours and that restraints required close monitoring. V49 was unsure when the restraints were last released. V49 released the right mitt restraint and could not untie the left mitt restraint. V49 stated, "This one is very tight, no I can't fit more than 2 fingers on this one." V49 was unable to get one finger in-between the restraint and	S9999				04/14/2026	

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S9999	Continued from page 3 R6's wrist. V49 stated, "The other one (mitt) I could. There are so many knots in this (restraint) ugh... who tied this?! I think this one must be malfunctioning. It shouldn't be like this; they should be tied in a manner that allows the restraint to come off easily. No, it is not coming off easily." It took approximately 2-3 minutes for V49 to untie the knots and release V49 from the restraints. V49 retied the restraint in a double knot. V49 observed the brown substance on the mitt and affirmed the mitts were not clean. V49 said to R6, "I'm going to go see if I can get you new ones" and pointed at the mitts. R6 did not attempt to pull at the trach for the entire observation with V49 or V63. On 3/24/2026 at 11:15 AM, observed R6 lying in bed resting with no mitt restraints on (R6's) hands. V36 (R6's Family Member) was observed at the bedside pacing while talking to V37 (R6's Family Member) on the phone. V36 was upset and stated, "This facility is (explicative). I have been complaining that (R6) has not been receiving proper treatment. I want her to have therapy or something to prevent her declining. They staff don't know what they are doing." V37 agreed via phone and added that there are a few CNAs (couldn't remember their names) that really don't know how to care for R6. V37 confirmed that V37 is the decision-making healthcare surrogate for R6. V36 continued, "... one day we came in one day and we saw her hands were covered in mitts. We had no idea". V36 and V37 affirmed there was no informed consent given by R6's family prior to the initiation of the restraint. V36 stated, "We come in and they are always on. They will never take them off; we have to take them off. There's no schedule for staff to take them off or to discontinue them. We have been asking for them (the restraints) to be stopped or decreased. I have removed them in the past and they were so tight there were blisters, that was like a few weeks ago. We are tired of telling them what to do, they should know how to care for (R6). These are people, yet this facility treats them so bad it's like they're just mannequins... Look at her restraints bro, they've got brown (feces) all over them." V36 flipped the inside of the restraint out and there was an approximately 3 inch x 2 inch patch of dried blood on the inside of the restraint located where the restraint is tied around R6's wrist. V36 stated, "That's from where it is tied, she had blisters, I'm telling you". V36 stated, "we have been trying to get her to another nursing home, (redacted), but we can't because of those mitts. They (the other nursing home) said they cannot meet resident needs if they require the mittens. We just want to get (R6) out of here, but we're stuck bro. We can't. (R6) deserves to live in a place that cares about her,	S9999				04/14/2026	

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S9999	Continued from page 4 please help us. Look, the whole time we have been here, (R6) hasn't grabbed at the trach. She's fine when someone is here, me and (V37) try to come as much as I can. I don't know of anything else they tried prior to the restraints to stop (R6) from pulling. (R6) can follow commands if you tell (R6)". R119's face sheet documents in part that R119 resides in the same room as R6 and has a history of the following diagnoses: type 2 diabetes with neuropathy, chronic obstructive pulmonary disease, chronic respiratory failure, anemia, obstructive sleep apnea, and schizophrenia. R119's minimum data set (1/5/2026) documents in part a brief interview of mental status summary score of 15, indicating that R119 is cognitively intact. On 3/24/2026 at 11:23 AM, R119 was observed lying in bed across from R6's in a shared room. R119 stated, "They don't help her (R6). They don't help any of us. I watch the staff take care of (R6) they never take those mitts off. They are on 24/7. No one checks on them or anything, like I said. They don't check on any of us. My care was much better when I was on the 4th floor." On 3/24/2026 at 11:25 AM, V23 (Registered Nurse) confirmed the observation inside of the restraint to be dried blood. V23 left the room and went to look for clean mittens. V36 stated, "They said they don't have any clean mittens". V37 added, "Yeah they said they had to order them. I don't know if they have come in yet". R6 was not observed pulling at the trach collar or any other dangerous behavior while the restraints were observed off from 11:15 until 11:40. On 3/24/2026 at 11:40, V23 (Registered Nurse) and V2 (Director of Nursing) applied the mitt restraints to R6's bilateral hands. Surveyor completed continuous observation of R6/surrounding area (including hallways, room, etc.) to monitor staff releasing R6's restraint. The continuous monitoring continued until 3:50 PM. During this observation, no staff member released R6's restraints (over 4 hours). On 3/24/2026 at 2:53 PM, observed V23 complete rounding on R6. V23 stated that V23 had been working at the facility for about 3 months but was agency staff prior for the facility. V23 did not recall if V23 received training on restraints, V23 stated, "I don't know. I know like restorative went over mechanical lifts; I think they might have talked about restraints then." V23 explained that to use restraints, you need a physician order, regular	S9999				04/14/2026	

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S9999	Continued from page 5 monitoring and they have to be applied to where 2 fingers can fit under the restraint. V23 said that it is important to monitor restraint use and that staff should be looking for things like impaired circulation or skin breakdown. V23 said that V23 thought the professional standard is to release the restraints every 2 hours. V23 (Registered Nurse) stated that V23 explained that V23 thought that restraints were supposed to be checked every 2 hours but there was an active order in R6's chart to check every shift. V23 was unsure if CNAs in the facility could remove the restraints. V23 stated, "I don't know, that (taking off the restraints/who takes off the restraints) would be something that is described in R6's care plan." V23 accessed R6's medical record and reviewed R6's plan of care. V23 stated the restraints were not care planned and that there should be a care plan in place to guide the staff's use of the restraint. When asked how often V23 had released the restraints during her shift or if V23 was aware of any other staff member releasing the restraints, V23 said, "To be honest, I hadn't released them since they were off with the family, so only like once today?". V23 confirmed that V36 is very adamant about the restraints not being on and stated that V37 has brought up concerns about the restraints. V23 confirmed that V37 is the healthcare decision maker. V23 recalled one time that V37 asked if they could get another squeeze stress ball to help keep R6's hands occupied-- it was a couple weeks ago. V23 stated, V23 thinks V67 (Nurse Practitioner) was going to talk to V37 about it. Cognitively V23 believed R6 is alert and oriented times 3 (person, place time) and can communicate by mouthing words and could follow basic directions. V23 was unsure if any other interventions were provided prior to the restraint use. V23 stated that V23 felt if R6 had more supervision or 1:1 with staff, the restraint wouldn't be needed. At 3:50 PM, the interview ended, and R6's restraints had not been released. During the observation, there were no observed behaviors that indicated R6 was attempting to pull at the trach or perform any other dangerous behaviors. On 3/24/2026 at 3:14 PM, V68 (Certified Nursing Assistant) was observed rounding on R6. V68 stated, "Yeah, I am familiar with (R6). She always has those (restraints) on. They are never taken off. The aides are not allowed to take off or touch the restraints." On 3/24/2026 at 3:35 PM, V69 (Registered Nurse) rounded on R6 and did not assess or release the restraint. V69 confirmed that V69 is assigned to care for R6 and is familiar with R6. V69 recalled that R6 has restraints on because R6 has a history of			S9999			04/14/2026

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S9999	Continued from page 6 pulling out midlines and tries to pull off the collar/tubing. V69 explained, "Yes, we take off the restraints when the family (V36 and/or V37) are here, that way we know someone is watching her at all times. They have asked me before if they could take them off, but I don't think they meant like if we could stop it. The family would be able to let us know if she is pulling at anything there's alarms on the ventilator that go off too. We do try to take them off, and we would document that in R6's progress notes. Oh yeah, for sure if we had someone sitting with (R6), (R6) wouldn't need the restraints. Something like a sitter or something, she for sure wouldn't need it. We just don't have a lot of staff I don't know of any log or anything that we fill out for restraint monitoring. If we document in the progress notes, that's when it happened." V69 stated that restraint use can cause skin breakdown, agitation and worsening cognition. V69 stated restraints should be released every 2-4 hours and that V69 "tries her best" to release the restraints when she works. On 3/24/2026 at 3:50 PM, R6's mitt restraints had not been released. V2 (Director of Nursing) stated that restraints can have negative outcomes like agitation. V2 denied that V2 was ever trained on the facility's restraint policy. V2 stated that the facility should be following the restraint policy. The restraint policy/program was reviewed with V2 and V2 was unsure what interventions were tried prior to the restraint. V2 confirmed that physician orders and a care plan should be in place when a resident has restraints. V2 confirmed the restraints should be released every 2 hours per the policy. Surveyor requested documentation of the monitoring tools that are indicated in the facility's restraint program. V2 was unaware of the monitoring tools. V2 and V23 (Registered Nurse) checked the nurse's station and could not produce the documentation of the monitoring tools. V23 denied knowledge of monitoring tools and denied ever using monitoring tools for R6. V2 stated, "Maybe there is something in the restorative office, they should be tracking restraints". On 3/24/2026 at 4:11 PM, V2 checked the restorative office for any evidence of the monitoring tools or QAPI documentation. V2 and V62 (MDS Nurse) looked through the office and could not produce any documentation. V62 affirmed that V62 is an MDS nurse in the facility and is familiar with R6. V62 confirmed that R6 uses mitt restraints. V62 reviewed R6's MDS (2/13/2026) and confirmed that the MDS does not have mitt restraints coded. V62 reviewed R6's physician orders and medication administration			S9999			04/14/2026

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S9999	Continued from page 7 record and confirmed R6's MDS was miscoded. V62 affirmed that the mitt restraints should have been coded. V62 explained that it is important that MDS are coded accurately as MDS helps to guide the plan of care for the resident. V62 reviewed R6's care plan and affirmed that no care plan was developed to address R6's restraint use. V62 affirmed that restraint use requires a care plan to be developed. V62 was unaware of any prior alternatives used prior to restraining R6. No further monitoring or QAPI tools related to restraints were provided to the survey team that were completed prior to the start of the survey. On 3/25/2026 at 12:31 PM, V67 (Nurse Practitioner) affirmed that V67 is the provider that manages R6's care within the facility and ordered the restraints for R6. V67 explained that R6's baseline mental status can answer questions by mouthing words and can follow some commands. V67 stated, "Yeah, so I have talked to her multiple times about pulling at the trach tubing. I don't know what the issue is if she gets anxious or confused. The reason she has them is because she pulls at the ventilator tubing and has pulled out midlines. When I see her, I have taken off the restraints, and she goes pulling at the tubing. I don't know how much of it is agitation vs. forgetfulness". V67 confirmed that the mitts limit R6's purposeful movement. V67 stated that V67 had ordered hydroxyzine to help with anxiety but was not aware of other interventions that have been tried and failed. V67 stated, "I am not aware of any 1:1 intervention that were provided to (R6). I do agree with the others that if someone were to be with her all the time, (R6) wouldn't need the restraints, but I don't know if the facility can do that". V67 denied ever being educated on the facility's restraint policy. V67 explained that restraints should be closely monitored, released and checked for injury every 2 hours and be tied in manner that allows for easy release. V67 stated that restraints can cause wounds under the restraint, injury from the patient trying to take off the restraint. V67 confirmed V67 has talked to V36 and V37 about the restraints and that they verbalized understanding of the use and that V36 asked about things that could be provided like a PT evaluation, so V67 ordered that recently. V67 was aware that R6 was trying to be transferred to another facility and had talked to the other facility who told V67 they couldn't accept until the restraints were discontinued. V67 affirmed that V67 has assessed for other reasons why V67 might have agitation like pain, or toileting needs, infections prior to the restraint. When asked if R6 has ever had a psych consult to manage the behaviors or for medication management, V67 replied, "No, R6 isn't			S9999			04/14/2026

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S9999	Continued from page 8 seeing psych that I am aware of". R6's progress notes were reviewed. On 3/24/2026. the following timeline is documented within R6's progress notes from V67 (Nurse Practitioner): 12/12/2025: hydroxyzine increased dt agitation, patient attempting to pull at trach, will eval for mittens as needed. 01/01/2026: R6's readmit notes: Treated with Cefepime ongoing on discharge from hospital. nephrology was consulted for elevated BUN. Discharged with foley. No further paperwork of hospital course received. Patient decannulated self-due to anxiousness. RT able to reinsert without complication. R6's notes: 01/06/2026: Mittens ordered for patient safety due to decannulation risk. 01/12/2026: Received message from nurse that family is requesting that patient be sent to hospital for brain scan. family is concerned that patient is not mouthing words, and they want her to have a brain scan. Per hospital paperwork, patient has been nonverbal and does not answer questions. 01/14/2026: Readmitted with no new findings, treated for hypernatremia. Readmitted with no new orders from hospital. Report that labs have improved and does not need HD. 03/12/2026: Attempted to trial patient without mittens on while writer was in the room. When mitten was removed, patient attempted to pull at trach. SS aware. Family updated via phone in depth. 03/13/2026: Attempted without mittens, patient still attempting to pull at trach. 03/18/2026: Attempted again with no mittens with resulting pulling at tubing of trach/vent. 03/24/2026: Discussed with patient son at bedside. Explained the safety risk of removing mittens. Son verbalized understanding. requesting eval of PT-ordered. 03/26/2026: Removed mittens while this writer was at bedside. Skin and circulation assessed, no redness or pain reported by patient. Patient asked multiple times to have this writer put mittens back on. When asked why, patient pointed to her trach.			S9999			04/14/2026

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S9999	Continued from page 9 When asked why she pulls the trach tubing off, patient shrugged her shoulders and laughed, touched the trach tubing again. Attempted to educate patient on importance of keeping trach and tubing connected to breathing. Explained to patient the safety risk of disconnecting the tubing. Per staff report, patient had disconnected trach tubing this morning while mittens were off and again the night prior. Psych consulted to assess medication regimen for anxiety. Continue restraints with q2 hour skin/circulation checks, pain assessments and ADLS. No further interventions were documented within the progress notes or provided to the survey team prior to the exit of the survey. On 1/14/2026, V11 documented that V11 obtained informed consent for the restraints. On 3/25/2026 at 2:19 PM, V11 (Licensed Practical Nurse) affirmed that V11 was the original nurse that obtained consent from R6's family. When asked who V11 spoke to, V11 stated, "I spoke to the resident and (R6's) sister (NOT V37) to get consent. Yes, her sister, she is up here all the time". V11 recalled that the restraints were ordered because R6 was pulling at the tubing. V11 stated, "I have told her to stop, and sometimes she will look at me, and then grab the tubing again. I know she understands. I don't remember other interventions we have tried prior to the restraints. I don't think we have tried something like a 1:1 but she would definitely needs increased rounding. We try to remove the restraints whenever we (provide incontinence care). There is an order that reminds us to take them off, I don't know exactly how often. I think its twice per shift. If restraints aren't taken off regularly, it can cause skin breakdown. I don't know how I would feel if I wasn't released from the restraints, probably uncomfortable? I would want them released. I have met with (V36) and R6's sister, they didn't express issues with the restraint to me. I have overheard that (R6) can't be discharged to the other facility because of the restraints". On 3/25/2026 at 2:40 PM, V21 (Activity Director) affirmed that V21 is familiar with R6. V21 explained, "Okay so. (R6) can't leave the room, so we provide pop-in visits. (R6) is able to understand things, (R6) used to be able to use a communication board but now, not so much. I assess the residents for activity needs, and I know (R6) likes music. I have told (V37) to bring in a radio multiple times, but I don't think (V37) has. (R6) likes music, that would help (R6). V37 is very involved. When I visit with R6, I have seen R6 pull at the tubing. I just redirect (R6). It helps if you give (R6) things like hand massages with lotion. I usually take the mitts off when I visit and massage		S9999			04/14/2026	

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NAME OF PROVIDER OR SUPPLIER BRIA OF ELMWOOD PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7733 WEST GRAND AVENUE , ELMWOOD PARK, Illinois, 60707			
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S9999	Continued from page 10 her hands. Yes, (R6) was given a squish stress ball when (R6) was first here to occupy (R6's) hands, and R6 could kind of squeeze it. I haven't seen it in a while". When asked if providing more 1:1 care would allow R6 to be free from the restraints, V21 replied, "I don't know, I think it depends on the person and if (R6) likes you. Like (R6) listens to me, and she is able to be redirected". V21 denied witnessing staff remove the restraints. V21 stated, "When I go in there, I take them off, set an alarm for 15 minutes and give her a massage". Surveyor asked for documentation of activities provided for R6 (like the visits), V21 denied that the facility documents the visits. No further documentation was provided that indicates activities provided to R6. On 3/26/2026 at 10:37 AM, V47 (Medical Director) confirmed that V47 is a medical doctor (MD) and is the medical director for the facility. V47 affirmed that V47's job duties do not include supervising other physicians' medical practice in the facility, but is responsible for resident care-related things, including reviewing policies. When asked about restraint use in the facility, V47 replied, "It was my understanding that we (nursing homes) can't have restraints in the facility. I am not aware of any restraint use in the facility. If we did, I guess yeah, we should be following that protocol". V47 affirmed that residents have the right to be free from physical restraints and that other interventions should be exhausted like redirection prior to initiating a restraint. V47 stated that providers should be assessing for other causes of behaviors like infections and that restraints require informed consent. V47 explained that complications of restraint use include physical harm from the resident trying to get out of the restraint and psychosocial harm by feeling restricted or imprisoned, could make someone depressed. V47 affirmed that restraint use should be monitored for when the restraint could be released. On 3/26/2026 at 12:11 PM, V56 (Restorative Nurse, Licensed Practical Nurse) affirmed that V56 is responsible for monitoring for restraint use in the facility. Surveyor requested to see any QA documentation that indicated the monitoring of restraint use as indicated in the restraint protocol, V56 was unable to provide documentation. V56 stated, "It's in the computer I just can't get it open right now. There must be something wrong with the file. Besides we only have one resident on that has restraints, its (R95)". V56 did not identify that R6 uses restraints during interview. No further documentation was provided to the survey team that indicated the facility was monitoring restraint use			S9999			04/14/2026

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S9999	Continued from page 11 per the protocol. Record review of R6's restraint assessment completed by V56 (Restorative Nurse, Licensed Practical Nurse) documents that R6's restraint was not reviewed until 3/24/2026 after the survey had begun. Additionally, the assessment indicatest the order for restraints was given on 3/24/26 and consent was obtained from V37 on 3/24/2026, that the physician order was changed to remove every 2 hours, that R6's orientation was not assessed (blank). The following alternatives were not attempted prior to restraint use: reorientation/redirection, toileting, pain management, diversional activity, increased supervision, non-restrictive devices and repositioning. The order within the restraint assessment indicates that order was obtained on 3/25/2026 to apply bilateral mitt restraints daily, remove every 2 hours and check skin breakdown pain and ADLs. The duration of the restraint says, "Daily remove every 2 hours" and does not give a true duration for how long the restraint will be intended for use. No further documentation was provided to the survey team that indicated the restraint use was assessed prior to 3/24/2026. Record review of R6's care plan indicates that a care plan was initiated for restraint use on 3/24/2026. No care plan was developed of the restraint use occurred prior to 3/24/2026. Record review of R6's root cause analysis indicates that the root cause analysis was not completed until 3/24/2026. The root cause analysis indicates that R6 has anxiety/discomfort, and the only interventions tried prior to initiation was hydroxyzine and giving R6 stuffed animals to hold. No other root cause analysis was provided to the survey team that indicates root cause analysis was completed prior to 3/24/2026. Record review of an email chain (3/2/2026-3/25/2026) between the facility and the facility R6's family wished to be discharged to affirms that the next facility is unable to accept R6 while the restraints are in use. Facility Restraint Protocol (10/20/2025) documents in part, "1. Purpose To ensure the safety, rights, dignity, and well-being of residents by preventing unnecessary or inappropriate restraint use in accordance with: •Illinois Nursing Home Care Act (210 ILCS 45/),		S9999			04/14/2026	

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S9999	Continued from page 12 •Illinois Administrative Code (Title 77, Part 300), •CMS regulations (F604, F605), •IDPH survey expectations. The program ensures: •Restraints are not used for discipline, convenience, or staff shortage. •Restraints are used only to treat a medical symptom, with the least restrictive option. •Alternatives are attempted and documented. •Continuous monitoring and regular reassessment occur. 2. Illinois-Specific Legal Requirement A. Rights Under Nursing Home Care Act (210 ILCS 45/2-108) Residents have the right to: •Be free from physical and chemical restraints, unless necessary to treat a medical symptom. •Receive full explanation of the restraint, duration, alternatives attempted, and risks. •Provide informed consent (resident or surrogate). •Have restraint use reviewed every 30 days with documented justification. B. Requirements Under Title 77, Part 300 •Written physician order required. •Order must specify type, duration, clinical symptom, and monitoring frequency. •Documentation must include: - oAlternatives attempted - oOngoing clinical need - oResident/family education - oRelease schedule - oOutcomes of monitoring	S9999				04/14/2026	

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S9999	Continued from page 13 Definitions Physical Restraint Any device or method that restricts freedom of movement and is not easily removed by the resident. Examples :...Soft wrist restraints •Mitts...4. Assessment Requirements Before initiating a restraint: 1.RN assessment identifying medical symptom 2.Provider order (no PRN orders) 3.Review of untreated causes, such as: - oPain - oInfection - oUrinary retention - oHypoxia - oMedication side effects - oMental health symptoms 4.Behavioral triggers analysis 5.Functional evaluation by PT/OT if indicated 6.Documentation of ALL alternatives attempted 7.Informed consent documented and witnessed 5. Acceptable Medical Symptoms •Severe agitation placing resident/staff at risk •Self-extubation risk •Pulling essential medical devices (trach, feeding tube, central line) •Life-threatening line removal •Acute confusion with risk of injury •Severe fall risk unresponsive to alternatives Convenience or staffing limitations are NEVER acceptable.	S9999				04/14/2026	

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S9999	Continued from page 14 6. Required Alternatives Examples: •1:1 or increased supervision •Low bed, floor mats •Pain management •Reorientation •Toileting schedule •Medical review for infections, delirium, or dehydration •Activities or diversion •Environmental modification •Therapy evaluation •Medication review/adjustment •Bed alarms/chair alarms (not restraints) All alternatives must be documented with outcomes. 7. Procedure for Restraint Use A. Application •Two staff apply the device. •Use the least restrictive type. •Ensure correct fit and skin protection. •Explain procedure to the resident. B. Monitoring Schedule First hour: •Every 15 minutes Next two hours: •Every 30 minutes Ongoing: •Every 1 hour (minimum), unless order specifies more frequently	S9999				04/14/2026	

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S9999	Continued from page 15 Check and document: •Circulation •Skin •Respiratory status •Pain •Cognitive status C. Mandatory Release Schedule Every 2 hours minimum: •Range of motion •Mobility/ambulation •Repositioning •Toileting •Hydration/Nutrition •Skin check Document everything... 9. Documentation Requirements Nursing Documentation •Medical symptom requiring restraint •Full list of documented alternatives •Informed consent •Physician order •Monitoring checks •Release episodes •Behavioral outcomes •Skin integrity •Pain and comfort measures •Provider notifications •Family/resident education	S9999				04/14/2026	

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S9999	Continued from page 16 •Rationale for ongoing need Care Plan Requirements Care plan must include: •Restraint type •Reason/goal •Interventions •Monitoring •Discontinuation plan •Less restrictive alternatives •Resident rights protections Physician Documentation •Medical symptom •Expected outcome •Duration •30-day review note •Renewal or discontinuation 10. Monitoring Tools A. Illinois Restraint Monitoring Flow Sheet Time Circulation Skin Behavior Respiratory Distress (Y/N) Released? ROM/Toileting/Hydration Continued Need? Staff Initials	S9999				04/14/2026	

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S9999	Continued from page 17 B. Restraint Release Log (Every 2 Hours Time Released ROM Provided Mobility Toileting Hydration/Nutrition Reapplied? Notes Initials C. Weekly Restraint Review Tool (Completed by DON/ADON/IP) Resident Restraint Type Reason Hours/day Behavior Trends Alternatives Tried Injuries? DON Signature D. Monthly QAPI Audit Tool Standard Compliant (Y/N) Notes Physician order present & complete Consent present Resident informed of rights Alternatives documented Monitoring completed per schedule Release every 2 hours No injuries Care plan complete Monthly/30-day review Opportunity for reduction E. Restraint Root Cause Analysis (Required for: Injury, >72 hrs use, repeated restraint episodes) Questions: 1. Was the underlying cause identified and treated? 2. Were enough alternatives attempted? 3. Was staffing adequate at the time? 4. Did environment contribute? 5. Were medications contributing (delirium,			S9999			04/14/2026

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S9999	Continued from page 18 sedation)? 6. Were family/representatives involved? 7. Was the restraint clinically justified at each interval? 8. Is modification or discontinuation appropriate? 11. Staff Training Requirements Annual + upon hire: •Resident rights (Illinois Nursing Home Care Act) •Identifying and treating medical symptoms •Alternatives to restraints •De-escalation techniques •Safe application •Monitoring and circulation checks •Emergency removal •Documentation expectations •Abuse/neglect prevention •Recognizing adverse outcomes 12. Program Goals 1.Maintain a restraint-free environment. 2. Reduce restraint use to below state average. 3.Zero restraint-related injuries. 4.Ensure compliance with Illinois regulations and CMS F-tags. 5.Improve resident dignity, independence, and psychosocial well-being. Restraint Management Program specifically tailored for ILLINOIS Nursing Homes, aligned with: •Illinois Administrative Code Title 77, Part 300 (Nursing Homes Licensure) •Illinois Nursing Home Care Act (210 ILCS 45/) •CMS F604 & F605	S9999				04/14/2026	

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S9999	Continued from page 19 Record review of CMS Resident Assessment Instrument (RAI) (10/2025) documents in part, "Although the requirements describe the narrow instances when physical restraints may be used, growing evidence supports that physical restraints have a limited role in medical care. Physical restraints limit mobility and increase the risk for a number of adverse outcomes, such as functional decline, agitation, diminished sense of dignity, depression, and pressure ulcers. • Residents who are cognitively impaired are at a higher risk of entrapment and injury or death caused by physical restraints. It is vital that physical restraints used on this population be carefully considered and monitored. In many cases, the risk of using the physical restraint may be greater than the risk of it not being used. • The risk of restraint-related injury and death is significant when physical restraints are used. Planning for Care • When the use of physical restraints is considered, thorough assessment of problems to be addressed by restraint use is necessary to determine reversible causes and contributing factors and to identify alternative methods of treating non-reversible issues When the interdisciplinary team determines that the use of physical restraints is the appropriate course of action, and there is a signed physician order that gives the medical symptom supporting the use of the restraint, the least restrictive manual method or physical or mechanical device, material or equipment that will meet the resident's needs must be selected. • Care planning must focus on preventing the adverse effects of physical restraint use... 8. Physical Restraints A physical restraint is defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily and that restricts freedom of movement or normal access to one's body. The important consideration is the effect of the device on the resident, and not the purpose for which the device was placed on the resident. This category also includes the use of passive restraints such as chairs that prevent rising. Physical restraints are only rarely indicated, and at most should be used only as a short-term, temporary intervention to treat a resident's medical symptoms. They should not be used for purposes of discipline or convenience. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of the restraint and how the use of the restraint would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining their highest practicable level of physical and		S9999			04/14/2026	

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S9999	Continued from page 20 psychosocial well-being. Restraints are often associated with negative physical and psychosocial outcomes (e.g., loss of muscle mass, contractures, lessened mobility and stamina, impaired balance, skin breakdown, constipation, and incontinence). Adverse psychosocial effects of restraint use may include a feeling of shame, hopelessness, and stigmatization as well as agitation..." (B) (2 of 7) 300.610a) 300.1210b) 300.1210c) 300.1210d)1)2) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. c) Each direct care-giving staff shall review and be knowledgeable about his or her residents'	S9999				04/14/2026	

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S9999	Continued from page 21 respective resident care plan. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) Based on observation, interview and record review, the facility failed to provide R1 enteral nutrition as ordered by the physician/dietician, failed to follow the facility's tube feeding management policy, failed to provide nutrition and hydration to R11 as indicated in his Illinois Department of Public health Uniform Practitioner Order for Life-Sustaining Treatment (POLST) form, failed to notify the dietitian of changes in resident's diet order, and failed to document those changes in resident's medical record. Applying the reasonable person concept due to R1's severe cognitive impairment and inability to make needs known, a reasonable person would have suffered unnecessary psychosocial harm by the delay of feeding and not abiding by resident's last wishes by feelings of hunger, pain, and headaches. This failure affected two residents (R1, R11) in a sample of 82 residents reviewed for quality of care. Findings include: 1. R11 is 43 years old admitted to the facility on 3/21/2025. R11's face sheet listed the following medical history: Anoxic brain damage, unspecified severe protein- calorie malnutrition, acute and chronic respiratory failure, unspecified whether with hypoxia or hypercapnia, pressure ulcer of sacral region stage 4, tracheostomy status, gastrostomy status, personal history of sudden cardiac arrest, etc.		S9999			04/14/2026	

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S9999	Continued from page 22 Minimum data Set (MDS) assessment dated 1/26/2026 section C (cognitive patterns) indicated R11 has severely impaired memory, section GG (functional) of the same assessment indicated R11 is dependent on staff for all Activities of Daily Living (ADL) care needs. Care plan initiated 4/02/2025 documented R11 is on nothing by mouth (NPO) status and is receiving enteral feeding for all nutrition needs. Interventions include adjust tube feeding as needed, monitor tolerance of feeding, monitor weight, labs, skin and hydration, give additional fluids by feeding tube as ordered, refer to registered dietitian (RD) as needed, turn and reposition every two hours and as needed. Review of physician order summary for R11 showed the following: Consult with nutritionist to assess rate of feeding due to resident having an episode of emesis (order date 11/2/2025). Check residual. If greater than AND/OR equal 100 ml hold feeding. If feeding held: Check residual after 1 hour and if residual is still great than or equal to 100 ml notify MD (order date 3/21/2025). R11 did not have any active G-tube feeding order, only water flush and medications. On 03/23/2026 11:52AM, R11 observed in bed sleeping and unable to awake or respond to any questions. G-tube plunger at bedside, no feeding pump or feeding infusing. On 3/24/2026 at 9:50AM, R11 was observed in bed again, still not receiving any feeding. Surveyor inquired about resident's feeding orders from V24 (RN) who said she was not sure but could find out. On 3/23/2026 at 10:05AM, V24 said that she finally found information about resident's feeding, it was discontinued by hospice on 3/6/2026. On 3/25/2026 at 12:35PM, V44 (R11 family member/POA) said feeding was stopped because residents were throwing up, hospice came and decided to stop feeding. V44 had asked them if feeding could be restarted and they said no. V44 has no clinical experience and just went with what hospice told her, because resident is at the end of life, he does not need feeding. V44 added R11 does not get any water, just what they give him with medication. R11 is not being turned and repositioned every two hours, staff said he does not need it because he is on a special mattress. On 3/25/2026 at 1:00PM, V45 (RN/Hospice Nurse)		S9999			04/14/2026	

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S9999	Continued from page 23 said R11 was admitted to hospice on 1/17/2026, V44 (POA) wanted to do comfort measures, no intubation, no curative treatments, no full code. V45 said resident was able to open his eyes last year but currently not showing any progress, he has a new pain medication treatment that is helping now. G-tube feeding was stopped on 3/6/2026, because resident was showing a lot of respiratory distress. R11 was previously getting 2 calories feeding at 50ml/hour with a total volume of 425ml. Hospice discussed how feeding can cause resident respiratory distress with family. Surveyor asked V45 if any other interventions were attempted, like reducing the feeding rate or volume rather than stopping the feeding entirely and V45 said, "No, they thought resident was going to pass that week." V45 was asked if she told V44 (POA) R11 is at the end of life and does not need feeding and she said yes, V45 told V44 because it would cause R11 more respiratory distress. V45 was asked how she determined R11 was at the end of life. V45 said 'His blood pressure is low, today's reading was 110/50 and heart rate of 110'. Department of Public health Uniform Practitioner Order for Life-Sustaining Treatment (POLST) form dated 1/17/2026 documented in part, section D: Provide artificial nutrition and hydration by any means, including new or existing surgically placed tubes. On 3/26/2026 at 9:30AM V43 (Dietitian) said she was blindsided with this decision, no one notified her resident's feeding was stopped, most of the time she will make recommendations, but she is not aware of the decision. Surveyor asked V43 what effect not feeding can have on R11. V43 said because of resident's medical condition, it is hard to say, but without nutrition, resident can have weight loss and will not be getting nourishment. V43 said comfort measures do not include withholding feeding, not feeding the resident at all is 'extreme'. V43 added facility should be following resident's POLST form in determining resident's care. On 3/26/2026 at 10:29AM, V2 (DON) said V2 was not aware that R11's feeding was discontinued and said no one informed her. V2 added the facility should follow resident's POLST form in providing care. On 3/26/2026 at 10:52AM, V47 (MD) said he is familiar with R11, and she is aware R11's feeding was stopped by hospice. V47 was told it was because of risk for aspiration, the longer you feed the resident the longer he lives. Surveyor asked V47 if the feeding was stopped to hasten resident's			S9999			04/14/2026

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S9999	Continued from page 24 death and she said she did not give the that order, it was recommended by hospice and resident's wife was okay with it. V47 was informed R11 is 43 years old and his POLST form signed by the wife indicated nutrition should be provided by any means, and she said facility should follow what is in the resident's POLST form, if the g-tube feeding is discontinued, the facility needs to readdress the POLST form and get a new one. Advance directive and do not resuscitate (DNR) policy reviewed 9/2023, stated in part: General: When a resident is admitted to the facility, aa discussion of advance directives will take place between the resident and family if the resident is unable to make decisions. This enables the staff to readily and clearly ascertain how to treat the residents in advance of an emergency. Advance directives: 1. Under state and federal law, people have the right to make decisions regarding health care treatment. This includes their right to determine in advance what life sustaining treatment will be provided, if any, in the future if they are unable to communicate those desires themselves. However, a resident is not required to be a DNR upon admission. 2. Life-sustaining treatments are the measures we take to sustain an individual's life and health. For example, in the event someone suffers a heart attack, we will perform CPR. Further we will take any other measures ordered by the provider, including IV's, tubes and the administration of medications, antibiotics, artificial hydration and nutrition to maintain life unless there are specific directions from the residents and/or family not to. Guideline: #3 If changes are needed to the advanced directives, then write void across the old form and initiate a new form with the appropriate information. 2. R1's face sheet documents in part the following diagnoses: acute and chronic respiratory failure, type 2 diabetes, unspecified protein calorie malnutrition, dysphagia, pressure ulcer of right buttock stage 3, personal history of traumatic brain injury, epilepsy, encephalopathy, tracheostomy and gastrostomy status. R1's Minimum Data Set (1/14/2026) documents in	S9999				04/14/2026	

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S9999	Continued from page 25 part R1 is rarely/never understood and is severely impaired for cognitive decision making. Additionally, the minimum data set documents R1 receives 51% or more of R1's nutrition via enteral feeding. R1's care plan documents in part, R1 is at risk of hypoglycemia due to type 2 diabetes (1/19/2026). R1 is NPO due to dysphagia, tube feeding will provide approximately 100% of estimated needs, and staff should be monitoring R1's tube feeding tolerance (11/27/2023). Additionally, the care plan documents R1 may be at increased risk of abuse due to fragility/weakness, poor cognition, poor communication, and has a goal R1 will be free from mistreatment through the next review (1/6/2024). R1's physician orders document in part an active enteral feeding order (9/30/2025) for, "every shift 2 Cal HN @ 40 ml/hr. x 20 hrs. On at 2 pm Off 10 am via GT if not available, may substitute Jevity 1.5 @ 52 ml/hr. x21 hrs. On at 2 pm Off 11 am" R1's dietary evaluation completed by V43 (Registered Dietician) documents in part, "PMH includes Tracheostomy, Dysphagia, HTN, Protein-Calorie Malnutrition, Seizure disorder, DMT2, Anemia Diet: NPO GT 2 Cal HN 40 ml/hr. x 20 hrs. On at 2 pm Off 10 am Water flush 300 ml every 4 hrs. (1800 ml) TF volume: 800 ml 1600 kcal 67 gm pro 560 ml fw+1800 ml wf=2360 TF provides 100% of estimated nutritional needs. Ht. 64" 3/2/26 143.8 2/12/26 144.5 1/13/26 146.8 1/2/26 139 12/1/25 139.2 11/3/25 146 10/8/25 145.8 9/1/25 142.6 BMI=24.7 Normal range Est needs 65 kg: 1636-1964 kcal (25-30) 65-79 gm pro (1.0-1.2) 1964- 2291 ml (30-35 ml/kg) Weight fluctuates between 139-146\$ in 6 mos. BMI within normal range Per nurses note 3/6/26, feeding held due to vomiting. KUB was done due to abdominal distention (3/8/26) Feeding was resumed 3/9/26 started as 10 ml/hr. and increased by 10 ml/hr. q 4hrs until goal rate of 40 ml/hr. was reached. No reported/documentd feeding intolerance. Dependent on enteral feeding for nutrition support r/t dysphagia. 3/10/26 BUN 29 FBS 67 Cr 1.1 Na 138 L K 4.7 H/H 12.6/38.8 Skin intact, Hx of pressure ulcer Plan: Current order meets 100% of estimated nutritional needs..." On 3/23/2026 at 10:57 AM, R1 was observed lying in bed and was not able to be aroused for questioning. R1's enteral feeding pump was alarming with a "FEED ERROR". R1's carton of enteral feeding formula was desiccant and devoid of any liquid formula within the carton. A quarter sized amount of dried formula was observed on the inside of the bottle was dry and cracking. The written date			S9999			04/14/2026

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S9999	Continued from page 26 on the carton was 3/21/2026 (NO TIME), indicating the date the formula was last changed. A clear tube was observed connected to R1's gastrostomy tube. Within the tubing was dry residual formula occupied less than 10% of the overall length of tubing. V7 assessed the alarm from the pump, and said the alarm was from an issue like the tube feeding not administering. V7 stopped the tube feeding and disconnected the tubing from the R1's gastrostomy tubing. V7 observed the feeding carton and identified the carton contained 1 liter of 2 cal. HN. V7 confirmed the observation that the enteral feeding carton and tubing appeared dry. V7 read the date at the top of the carton and affirmed 3/21/2026 was the last date the enteral feeding was hung. V7 explained R7's tube feeding order is for 40 mL per hour, starting at 2pm and off at 10 AM. V7 stated, "No, this is not good. R1 definitely should have had another (carton) administered by now based on order. It should have been dated at least 3/22/2026 and changed yesterday, I don't know what happened here". On 3/23/2026 at 11:03 AM, a second surveyor confirmed the carton observation. V2 (Director of Nursing) observed the carton and confirmed the observations. V2 stated, "Yes, this carton was last hung on 3/21/2026 and it runs at 40 cc an hour". Surveyor calculated the amount of enteral feeding based on the physician's order and total volume of the carton to last R1 approximately 25 hours from 3/21/2025. This was confirmed with V2. V2 stated, "Yes, another carton should have been hung yesterday". V2 stated R1 is completely dependent on staff for enteral feeding/hydration. When asked what complications of the carton are not being changed/feeding not being administered, V2 stated, "someone could get an infection". Record review of R1's progress notes confirm no progress notes were written between 3/18/2026 and 3/23/2026. On 3/23/2026 at 3:10 PM, V6 documented, "Resident (R1) received in bed with HOB elevated, VSS, due meds given as ordered. GTF on going, on at 2pm off at 10am, trach/g-tube site intact, no s/s of infection. suprapubic cath draining amber yellow urine. Writer is notified of resident's secretion is greenish yellow. PA (Redacted) is made aware and reordered to do sputum cx and cbc bmp in am. Respiratory made aware to collect sputum. Resident repositioned q2h, kept clean and dry. call pad within reach." There is no documentation affirms any provider was made aware of the missing enteral feeding or a rationale as to why R1's feeding was not administered.			S9999			04/14/2026

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S9999	Continued from page 27 On 3/25/2026 at 10:38 AM, V1 (Administrator) confirmed V1 is the abuse prevention coordinator. V1 was asked what would happen to a reasonable person if they didn't get nourishment for a day. V1 replied, "If I didn't get nourishment for a day other than being hungry, I'd be upset." V1 confirmed providing enteral feeding is a service the facility is able to provide. On 3/24/2026 at 2:53 PM, V23 (Registered Nurse) affirmed V23 worked on 3/22/2026 but was not assigned to R1. V23 stated, "No I have never been assigned that set of patients. I don't even know who (R1) is". On 3/25/2026 at 11:21 AM, V43 (Registered Dietician) affirmed V43 is the dietician for the facility and is familiar with R1. V43 explained the purpose of enteral feeding is to ensure a resident's nutritional needs are met without oral intake. V43 confirmed R1's physician order is nothing by mouth (NPO) and 100% of R1's nutritional needs are delivered by the tube feeding. V43 affirmed R1 has a history of diabetes, protein calorie malnutrition, and dysphagia, and the tube feeding is in place because R1 cannot tolerate oral intake with dysphagia. V43 recalled R1 was admitted to the facility with the gastrostomy tube and has always been dependent on staff for nutrition. V43 affirmed staff should be following the physician orders and V43's dietary recommendations. V43 stated, "I spent time calculating all of (R1's) nutritional needs, they should be following". V43 explained if a reasonable person did not get enteral feeding for extended period of time, they obviously wouldn't get adequate nutrition and stated, "You know, it would be similar to a normal person and what they would experience if they didn't eat for an entire day. You would be very hungry, have headaches, feel irritable, have weakness. V43 affirmed the tube feeding should not have been last hung on 3/21/2026 and stated, "Wow 3/21 to 3/23...s almost like 2 days without feeding." On 3/25/2026 at 1:57 PM, V6 (Licensed Practical Nurse) affirmed V6 was assigned to care for R1 on 3/22/2026 from 7:00AM-3:00PM. V6 recalled the R1's enteral feeding was checked around 10:00AM when it was turned off. V6 denied V6 hung a new carton of formula during the shift and feeding was to resume at 2:00PM. When asked why the new formula was not hung, V6 stated, "I don't know I think I saw a little bit left in there. I don't recall (restarting it)." On 3/26/2026 at 10:37 AM, V47 (Medical Director)			S9999			04/14/2026

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S9999	Continued from page 28 affirmed V47 is a medical doctor (MD) and the medical director of the facility. V47 explained if a patient with a history of diabetes and does not receive enteral feeding as ordered, you would "expect the patient to have hypoglycemia (low blood sugar), dehydration, or electrolyte imbalances." On 3/26/2026 at 2:22 PM, V61 (Licensed Practical Nurse) affirmed V61 worked both the PM and NOC shift on 3/22/2026. V61 denied V61 was assigned to R1 and stated, "No, I had the other resident assignment". V61 said V61 recalled seeing R1 in bed while passing by R1's room at the start of the shift but did not enter the room, observe the tube feeding set, or hear any alarms coming from the room. On 3/27/2026 at 5:25 PM, V24 (Registered Nurse, Nurse Supervisor) affirmed V24 worked on 3/22/2026 on the PM shift. V24 did not recall who R1 was and stated, "Yeah I won't know who is unless I am standing in front of them or can see them. I am not at the facility-- I was just working my other job as a nursing instructor. I haven't been employed at the facility for very long. My assignment set was up to room (which includes R1's room). If (R1) was in my set, then yeah, I took care of (R1)". V24 denied ever changing any tube feeding cartons while working shift. V24 recalled doing rounds on all the patients and no one's tube feeding was alarming. V24 recalled 2 residents who received 2 cal, needed more tube feeding to be administered at the end of the shift. V24 could not recall which residents needed more tube feeding. V24 explained, "I did not change them, that is night shifts responsibility to change the tube feeding set at midnight and hand more tube feeding if needed. I told (V66) in report the two residents needed more feeding hung. (V66) asked me if she writes the date of the start of the shift or the date at midnight. I told her it should be dated for the date at midnight when the set is changed. That is our standard, we document the date the feeding is hung and night shift is responsible for changing out the sets. (V66) was aware of (expectation)". Record review of the facility staffing records documents in part on 3/22/2026, V6 (Licensed Practical Nurse), V23 (Registered Nurse) were assigned to R1's unit for AM (7AM-3PM) shift, V61 (Licensed Practical Nurse) and V24 (RN Floor Manager) for PM shift (3PM-11PM), and V61 and V66 (Agency Registered Nurse) for NOC shift (11PM-7AM). During this survey, surveyor attempted to contact V66 (Agency Registered Nurse) multiple times for		S9999			04/14/2026	

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S9999	Continued from page 29 interview and was unable to complete an interview prior to the exit of the survey. Facility policy titled "Tube Feeding Management" documents in part, "Nasogastric, gastrostomy, and jejunostomy tubes are used when an alternate method of nutrition is needed...1. Continuous tube feedings are based upon a 22-hour consumption period or other time frame based on individual resident need per Registered Dietician assessment and delivered over a 24-hour period...6. The Health Care Provider should be notified if tube-feeding amount is not infused as ordered...10. The tube feeding will be labeled with the resident's name, rate, total volume, date, and time hung... FEEDING PUMP:1. Use a feeding set for pump and assemble per manufacturer instructions. 2.Turn on pump, set prescribed rate and start feeding. 3. Flush the tube with water as ordered. 4.Pump should be cleared at the end of each shift. 5.Document tube feeding delivered. 6.Alert Health Care Provider of any issues or concerns." (A) (3 of 7) 300.610a) 300.1210b) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total			S9999			04/14/2026

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S9999	Continued from page 30 nursing and personal care needs of the resident. These REQUIREMENTS were not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one resident's (R183) call light was readily accessible and within reach to call for staff assistance and failed to ensure one resident (R183) was able to effectively utilize the call system. These failures affect 1 resident (R183) in a sample of 82 residents reviewed for accommodation of needs. Findings include: On 3/23/26 at 10:20am, R183 was observed lying in bed, with the pressure-sensitive call light positioned at the upper right corner of the bed, out of R183's immediate reach. R183 said, "I'd like a call light that I can use more than a cover for my bag (urinary privacy bag). I can't reach it (pressure-sensitive call light). They (facility staff) expect me to use my chin to press it (pressure-sensitive call light). I have been here since Thursday (3/19/26) and told them (facility staff) that I can't use this (pressure-sensitive call light). Yes, I need a way of getting the staff to help me. I'm paralyzed. I've just been yelling for staff when I need help since I can't use this light (pressure-sensitive call light). I try not to call out often, so I don't disturb everyone." R183's face sheet documents an admission date of 3/19/26 and diagnoses that include but are not limited to quadriplegia, chronic pain, muscle spasm, neuromuscular dysfunction of the bladder, and Type 2 Diabetes Mellitus. R183's BIMS (brief interview for mental status), dated 3/25/26, is 14 which indicates R183 is cognitively intact. R183's care plan, dated 3/23/2026, documents, in part, "(R183) has potential for an alteration in musculoskeletal status r/t (related to) muscle spasms," with interventions that document, is part, "Anticipate and meet needs. Be sure call light is within reach and respond promptly to all requests for assistance." R183's care plan, dated 3/23/2026, documents, in part, "(R183) has Quadriplegia r/t (related to) Trauma from a fall and requires the use of a blow call light," with interventions that document, in part, "Provide blow call light and confirm proper function and placement during rounds and care."		S9999			04/14/2026	

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S9999	Continued from page 31 R183's care plan, dated 3/23/2026, documents, in part, "FALL: (R183) is at risk for falls due to Dx (diagnosis) of Anemia, T2DM, Hypertension and Hypotension, muscle spasms, Quadriplegia, dysphagia, polyneuropathy, neurogenic bowel, and neuromuscular dysfunction of bladder, protein-calorie malnutrition, Advanced Disease process, Chronic physical, circulatory, Musculoskeletal, neurological, and other clinical complexities," with interventions that document, in part, "Promote placement of call light within reach and assess residents' ability to use." On 3/23/26 at 10:23am, V40 (R183's family member) said, "Day 2 (3/20/26) of R183 being here I told them (staff) that she (R183) couldn't use that light (pressure-sensitive call light). They (staff) said they (staff) would get her (R183) one (call light) that she can blow into with her mouth to call for help." On 3/23/26 at 10:27am, V4 (Licensed Practical Nurse/LPN) said, "They (maintenance) are getting her (R183) the call light that she (R183) can blow into. Yes, I talked to maintenance today. They (maintenance) are going to set it up today. I don't know why she (R183) didn't get it (breath-activated call device) sooner. I just had her (R183) today and like I said I called maintenance, and maintenance is bringing one (breath-activated call device) today." On 3/25/26 at 2:34pm, V2 (Director of Nursing/DON) said that "Call lights should be answered in an appropriate amount of time and placed within reach of the resident. Yes, the resident should have a call light that the resident has the ability to use." Record review of facility policy titled, "Call Light Response," dated 9/2025, documents, in part, "Ensure call light is within resident's reach at all times. When the patient or resident is in bed or confined to bed or chair, provide the call light within easy reach of the patient or resident." Record review of facility policy titled, "Resident Rights," dated 9/2024, documents, in part, "The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preference. It is the facility's policy to identify and provide reasonable accommodation for resident needs and preferences except when it would endanger the health or safety of the resident or other residents. The facility will	S9999				04/14/2026	

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S9999	Continued from page 32 provide a safe, clean, comfortable, and homelike environment. Call light in reach for room and bathroom and the correct type for resident use. The residents' environment will be maintained in a homelike manner." (B) (4 of 7) 300.696b)3) 300.696d)1)5)7) 300.696g) Section 300.696 Infection Prevention and Control b) Written policies and procedures for surveillance, investigation, prevention, and control of infectious agents and healthcare-associated infections in the facility shall be established and followed, including for the appropriate use of personal protective equipment as provided in the Centers for Disease Control and Prevention's Guideline for Isolation Precautions, Hospital Respiratory Protection Program Toolkit, and the Occupational Safety and Health Administration's Respiratory Protection Guidance. The policies and procedures must be consistent with and include the requirements of the Control of Communicable Diseases Code, and the Control of Sexually Transmissible Infections Code. 3) Facility activities shall be monitored on an ongoing basis by the Infection Preventionist to ensure adherence to all infection prevention and control policies and procedures. d) Each facility shall adhere to the following guidelines and toolkits of the Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, Agency for Healthcare Research and Quality, and Occupational Safety and Health Administration (see Section 300.340): 1) Guideline for Prevention of Catheter-Associated Urinary Tract Infections 5) Guidelines for Preventing Healthcare-Associated Pneumonia 7) Infection Control in Healthcare Personnel: Infrastructure and Routine Practices for Occupational Infection Prevention and Control Services	S9999				04/14/2026	

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S9999	Continued from page 33 g) Certified facilities shall comply with 42 CFR 483.80(h). These REQUIREMENTS were not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the respiratory equipment was contained for two residents (R8, R68); failed to ensure the respiratory equipment was changed for two residents (R5, R68); and failed to ensure the respiratory equipment was dated for two residents (R68, R184). These failures have the potential to affect four residents (R5, R8, R68, R184) reviewed for respiratory care in a total sample of 84 residents. Findings include: On 03/23/2026 at 11:06 am, there was a sign 'Oxygen in use' posted by R68's door frame. With V16 (Certified Nursing Assistant) inside R68's room. R68 was seated on a chair not using a nasal cannula. V16 checked R68's nasal cannula and stated it was not labeled and it was not contained; V16 also checked R68's nebulizer mask and stated it was labeled with a date 12/22/25 and it was not contained. V16 stated she was not responsible for changing and labeling of nasal cannula and nebulizer mask. R68's (01/30/2026) Minimum Data Set documented, in part "Section C. Cognitive Patterns. C0500. BIMS (Brief Interview for Mental Status) Summary Score: 15." Indicating R68's mental status as cognitively intact. R68's (Active Order as of: 03/24/2026) Order Summary Report documented, in part "Diagnoses: (include but are not limited to) pleural effusion, obstructive sleep apnea, and iron deficiency anemia. Order summary: Change nebulizer tubing weekly one time a day every Sun for infection control. Active. Order Date: 10/31/2025. Start Date: 11/02/2025. Change oxygen tubing and humidifier bottle weekly one time a day every Sun for infection control. Active. Order Date: 10/31/2025. Start Date: 11/02/2025. Oxygen at 4 LPM per nasal cannula as needed for Shortness of Breath. Active. Order Date: 10/31/2025. Start Date: 10/31/2025. Ipratropium-Albuterol Solution 0.5-2.5 (3) MG/3ML 3 ml inhale orally every 6 hours as needed for SOB/Wheezing. Active. Order Date: 01/29/2026. Start Date: 01/29/2026."		S9999			04/14/2026	

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S9999	Continued from page 34 R68's (02/02/2026) care plan documented, in part "Focus: has potential for difficulty in breathing related to pleural effusion, shortness of breath, active tobacco use. Goal: Respiratory symptoms will be managed. Interventions: administer medication/treatments as ordered." On 3/23/26 at 10:58am, R8's BiPAP (bilevel positive airway pressure) mask was observed lying on the bedside dresser, not contained. R8 stated, "I don't know anything about putting my mask in a bag. I can't do it myself. The nurses help me." R8's face sheet documents an admission date of 5/13/25 and diagnoses that include but are not limited to chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypercapnia, urinary tract infection, urogenital implants, neuromuscular dysfunction of the bladder, and quadriplegia. R8's BIMS (brief interview for mental status), dated 3/25/26, is 14 which indicates R8 is cognitively intact. R8's care plan, dated 5/15/25, documents, in part, "(R8) has potential for difficulty in breathing r/t (related to) COPD (chronic obstructive pulmonary disease), OSA (obstructive sleep apnea), dependence on O2 (oxygen), and Chronic Respiratory Failure." R8's physician order, order date 12/30/25, documents, in part, "BiPAP- IPAP SETTING: 16; EPAP SETTING: 5; RR.12; 40% oxygen; at bedtime related to obstructive sleep apnea." On 3/23/26 at 10:57am, R5 was observed lying in bed, on R5's back, with an oxygen trach collar attached and in use. R5's humidifier was observed with a date of 2/19 and R5's suction canister was observed on R5's bed side dresser with a date 2/25. When R5 was asked about R5's respiratory equipment, R5 shook R5's head "no" and R5 shrugged R5's shoulders indicating R5 was not sure of the changing of the respiratory equipment. R5's face sheet documents an admission date of 1/26/24 and diagnoses that include but are not limited to chronic respiratory failure, tracheostomy, dependence on respirator, obstructive sleep apnea, and morbid obesity. R5's BIMS (brief interview for mental status), dated 3/13/26, is 15 which indicates R5 is cognitively intact.			S9999			04/14/2026

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S9999	Continued from page 35 R5's physician orders, order date 7/20/23, documents, in part, "Change all aerosol tubing change on 1st and 15th when using trach collar for weaning and prn. Change nebulizer tubing weekly and as needed weekly every wed (Wednesday). Change suction canister and tubing weekly and prn (as needed). On 3/23/26 at 12:32pm, R184's oxygen humidifier was observed, in use, undated, and connected to the oxygen concentrator. R184's face sheet documents an admission date of 3/16/26 and diagnoses that include but are not limited to dementia, acute embolism and thrombosis of unspecified deep veins of unspecified lower extremity, and dysphagia. R184's BIMS (brief interview for mental status), dated 3/24/26, is 2 which indicates R184's cognition is severely impaired. R184 is unable to be interviewed due to altered mental status. R184's physician order, dated 3/16/26, documents, in part, "2 lpm VNC check O2 (oxygen) sat (saturation) q (every) shift." On 3/23/26 at 11:02am, V7 (Licensed Practical Nurse/LPN) said that the respiratory therapists "handle all the respiratory equipment." V7 said, "I know all the respiratory equipment has to be dated when changed, but I'll have to check how often it (respiratory) needs to be changed." On 3/25/26 at 2:34pm, V2 (Director of Nursing/DON) said that the Respiratory Department is responsible for managing the respiratory equipment and ensuring it is properly dated. The "respiratory equipment is too dated" for "equipment changes." The BiPAP mask and respiratory equipment not in use should be "stored in a protective plastic bag for bacterial reasons." Record review of facility policy titled, "Care and Cleaning of respiratory Equipment," dated 12/01/24, documents, in part, "To maintain equipment in proper /working order and to reduce the risk of nosocomial infection. It is the policy of this facility that disposable respiratory equipment will be replaced on a scheduled basis in order to minimize the risk of nosocomial infection. These guidelines are based upon recommendations from various sources including the manufacturer, the Centers for Disease Control and Prevention, and practice			S9999			04/14/2026

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S9999	Continued from page 36 standards. Labeling: A. All disposable respiratory equipment is labeled with date when placed in use. B. Name is also placed on water bottles and other such equipment/supplies. Corrugated tubing is changed weekly and as needed. Humidifier bottle is changed weekly and as needed. Hand held nebulizer is changed weekly and as needed. Suction tubing (short/long) is changed weekly and as needed. Suction canisters are changed weekly and as needed. Nasal cannulas are changed weekly and as needed. Masks (simple, non-rebreather, venturi) are changed weekly and as needed." Record review of facility policy titled, "Resident Rights," dated 9/2024, documents, in part, "The objective of the accommodation of resident needs and preferences is to create an individualized, home-like environment to maintain and/or achieve independent functioning, dignity, and well-being to the extent possible in accordance with the resident's own needs and preference. It is the facility's policy to identify and provide reasonable accommodation for resident needs and preferences. The facility will provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. The residents' environment will be maintained in a homelike manner." (B) (5 of 7) 300.1210d)1)2)5) Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered. 2) All treatments and procedures shall be administered as ordered by the physician. 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition	S9999				04/14/2026	

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S9999	Continued from page 37 demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. These REQUIREMENTS were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that five residents (R1, R11, R12, R39, and R172) reviewed for medication administration, remained free from significant medication errors in a sample of 82 residents. Findings include: Record review of facility schedule, 3/24/26, documents V23 (Registered Nurse/RN) and V25 (Registered Nurse/RN/Agency) were assigned to provide care to the residents on the third floor. On 3/24/2026 at 9:58 am, V23 (Registered Nurse/RN) said, "I still have a few residents to pass medications on. They (medications) are going to be given late. There definitely needs to be a third nurse for this floor (third floor). My medications are late every day on this floor (third floor). It's not possible to pass all the residents I'm assigned to medications on time. There are a lot of residents that have gastrostomy tubes, and it's time consuming cause you have to check placement, residual, crush meds, flush. There's a lot. And then if a resident has to be sent out to the hospital or is experiencing issues, the whole day is over. I'm grateful we have respiratory staff, but we (third floor) still need a third nurse." On 3/24/26 at 10:07am, V24 (Registered Nurse/RN/Floor Manager) said, "They (facility) asked me to come in and help until the agency nurse got here. I passed 2 residents' medications because of behaviors. Yes, the rest of the residents' medications were due by 10:00am. The medications are scheduled for 9:00am. I was assessing and checking on residents, and then I started to pass the medications. I am going to stay and help the agency nurse pass the residents' medications." On 3/24/26 at 10:08am, V25 (Registered Nurse/RN/Agency) said, "I just got here. I'm getting report on the residents. I have 19 residents for my assignment. There are 17 residents left that still need their morning medications. Yes, the medications are scheduled for 9:00am so the medications are due by 10:00am. Yes, it's passed 10:00am so the residents			S9999			04/14/2026

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S9999	Continued from page 38 will be receiving their medications late." R1's "Medication Admin Audit Report," dated 3/25/26, documents that on 3/24/26, R1's medications that were due for 9:00am: Levetiracetam was given at 11:03am (one hour and 3 minutes late); Losartan Potassium was given at 10:59am (59 minutes lates); and Carvedilol given at 11:12am (one hour and 12 minutes late). R1's physician order, ordered date 10/01/25, documents, in part, Levetiracetam Oral Solution Give 10 ml via G-Tube every 12 hours related to Epilepsy. R1's physician order, start date 3/11/2026, documents, in part, Carvedilol 6.25mg Give 1 tablet two times day for hypertension. R1's physician order, start date 2/26/25, documents, in part, Losartan Potassium Give 50mg via g-tube one time a day for elevated blood pressure. R1's face Sheet documents diagnoses that include but are not limited to respiratory failure, type 2 diabetes mellitus, dysphagia, pressure ulcer of right buttocks, traumatic brain injury, epilepsy, gastrostomy, and tracheostomy. R11's "Medication Admin Audit Report," dated 3/25/26, documents that on 3/24/26, R11's medication that was due for 9:00am: Keppra were given at 1:21pm (3 hours and 21 minutes late). R11's physician order, order date 3/21/25, documents, in part, Keppra Solution 100 mg/ml Give 10 ml via G-Tube every 12 hours for seizures. R11's face Sheet documents diagnoses that include but are not limited to respiratory failure, anoxic brain damage, pressure ulcer, gastrostomy, and tracheostomy. R12's "Medication Admin Audit Report," dated 3/25/26, documents that on 3/24/26, R12's medication that was due for 9:00am: Valproic Acid was given at 12:36pm (2 hours and 36 minutes late). R12's physician order, ordered date 12/30/25, documents, in part, Valproic Acid Oral Solution 250 MG/5ML (Valproate Sodium) Give 15 ml enterally two times a day for seizure. R12's face Sheet documents diagnoses that include but are not limited to respiratory failure, epilepsy, pressure ulcer, gastrostomy, and tracheostomy.			S9999			04/14/2026

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S9999	Continued from page 39 R39's "Medication Admin Audit Report," dated 3/25/26, documents that on 3/24/26, R39's medication that was due for 8:00am: Metoprolol Tartrate was given at 10:41am (one hour and 41 minutes late); and R39's medication that was due for 9:00am: Keppra as given at 10:41am (41 minutes late). R39's physician order, start date 7/14/25, documents, in part, Metoprolol Tartrate 25mg Give 1 tablet two times a day for hypertension. R39's physician order, ordered date 12/30/25, documents, in part, Keppra Oral Solution 100 MG/ML (Levetiracetam). Give 5 ml via G-Tube two times a day for seizures. R39's face Sheet documents diagnoses that include but are not limited to respiratory failure, chronic obstructive pulmonary disease, epilepsy, gastrostomy, and tracheostomy. R172's "Medication Admin Audit Report," dated 3/25/26, documents that on 3/24/26, R172's medication that were due for 9:00am: Metoprolol Succinate ER was given at 12:28pm (2 hours and 28 minutes late and Amiodarone was given at 12:29pm (2 hours and 29 minutes late). R172's physician order, ordered date 8/31/25, documents, in part, Amiodarone HCl Oral Tablet 200 MG (Amiodarone HCl) Give 0.5 tablet by mouth one time a day related to atrial fibrillation. R172's physician order, ordered date 8/16/25, documents, in part, Metoprolol Succinate ER Tablet Extended Release 24 Hour 25 MG Give 1 tablet by mouth one time a day for hypertension. R172's face Sheet documents diagnoses that include but are not limited to chronic obstructive pulmonary disease, respiratory failure, type 2 diabetes, quadriplegia, and end stage renal disease. On 3/25/26 at 2:34pm, V2 (Director of Nursing/DON) said, "Medications are due one before or one hour after the scheduled time. I do expect medications to be given on time." V2 affirmed that giving a medication more than one hour passed the schedule time is "technically a timing medication error" and the "physician should be notified. V2 affirmed that medications such as Coreg, Losartan Potassium, Metoprolol Tartrate, Metoprolol Succinate ER, Amiodarone, Levetiracetam (Keppra) and Valproic Acid that are administered late "can possibly" be a significant medication error "depending on the			S9999			04/14/2026

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S9999	Continued from page 40 resident, resident's condition, and how late the medication was given." V2 said, "Heart and seizure medications should be given on time for absorption reasons and so the medications can do what they need to do. It depends, if those medications (Coreg, Losartan Potassium, Metoprolol Tartrate, Metoprolol Succinate ER, Amiodarone, Levetiracetam (Keppra) and Valproic Acid) are administered late, based on a couple minutes late may not really have an impact, but several hours can have some type of bad impact." Record review of facility's policy titled, "Medication Administration," dated 9/2025, documents, 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. Verify that the medication is being administered at the proper time, in the prescribed dose, and by the correct route. If the medication is given at a time different from the scheduled time, document the reason why. If the physician's order cannot be followed for any reason, the physician should be notified in a timely manner (depending on the situation), and a note should reflect the situation in the resident's medical record." Record review of facility policy titled, "Resident Rights," dated 9/2024, documents, in part, "It is the facility's policy to identify and provide reasonable accommodation for resident needs and preferences except when it would endanger the health or safety of the resident or other residents. The facility will provide a safe, clean, comfortable, and homelike environment." (B) (6 of 7) Section 300.1220 a)1)3)4)5)6)7) Supervision of Nursing Services a) Each facility shall have a director of nursing services (DON) who shall be a registered nurse. 1) This person shall have knowledge and training in nursing service administration and restorative/rehabilitative nursing. This person shall also have some knowledge and training in the care of the type of residents the facility cares for (e.g., geriatric or psychiatric residents). This does not mean that the director of nursing must have			S9999			04/14/2026

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S9999	Continued from page 41 completed a specific course or a specific number of hours of training in restorative/rehabilitative nursing unless this person is in charge of the restorative/rehabilitative nursing program. (See Section 300.1210(a).) 3) In skilled nursing facilities of 100 or more occupied beds, there shall be an assistant director of nursing (ADON) who is a registered nurse. This person shall also meet the qualifications specified in subsection (a)(1) of this Section for the director of nursing service. 4) In intermediate care facilities of 150 or more occupied beds, a licensed nurse shall be designated as the ADON. The assistant may provide direct patient care and be included in staff-to-resident ratio calculations. 5) The assistant shall be a full-time employee who is on duty a minimum of 36 hours, four days per week. The assistant may be assigned to work hours any time of the day or night. 6) The assistant shall assist the DON in carrying out his/her responsibilities. 7) If other duties interfere with the proper performance of the DON's or ADON's duties, another nurse shall be assigned to perform the duties of the DON or assistant for that period of time. These requirements are NOT met as evidenced by: Based on interview and record review, the facility failed to employ a registered nurse to serve as the facility's assistant director of nursing (ADON). This failure has the potential to affect all 170 residents that reside within the facility. Findings include: Facility census (3/23/2026) documents 170 residents reside within the facility. Facility CASPER 0003D Report (3/19/2026) documents that the facility has been licensed/certified for 245 beds. On 3/23/2026 at 9:40 AM an entrance conference was held with V2 (Director of Nursing). V2 explained that the facility does not have an ADON and that the prior ADON (V53) left approximately a month prior to the survey. V2 affirmed that the facility has pulled V11 (Licensed Practical Nurse) from the floor and V11	S9999				04/14/2026	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0057950		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 03/29/2026	
NAME OF PROVIDER OR SUPPLIER BRIA OF ELMWOOD PARK				STREET ADDRESS, CITY, STATE, ZIP CODE 7733 WEST GRAND AVENUE , ELMWOOD PARK, Illinois, 60707			
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S9999	Continued from page 42 is covering the job responsibilities of the ADON. On 3/25/2026 at 10:30 AM, V1 (Administrator) confirmed that the facility does not have an ADON on staff. V1 stated that V11 (Licensed Practical Nurse) has been pulled from providing direct care responsibilities and is assuming the responsibilities of the ADON while the facility does not have an ADON. V1 affirmed that that based on the number of licensed beds and the state regulations, the facility requires an ADON that is an RN. V1 explained that the prior ADON (V53) resigned and then took vacation through the duration of the resignation notice. V1 affirmed that V53 (Former Assistant Director of Nursing) has not been employed for approximately a month. Record review of V53's time keeping records indicate that V53's final day of work was 2/24/2026. On 3/25/2026 at 2:19 PM, V11 (Licensed Practical Nurse) confirmed that V11 is a licensed practical nurse and not a registered nurse. V11 affirmed that V11 assumed the job duties of V53 "a few weeks ago". V11 explained that V11's new job duties include, but are not limited to, supervision of nurses (including licensed practical nurses and registered nurses), supervising the residents' care, to ensure staff are reporting lab values to providers, ensuring staff are processing physician orders, managing/monitoring psychotropic medication use within the facility, and helping V2 (Director of Nursing) or other nursing staff with any needed tasks. V11 affirmed V11 no longer has a direct care assignment unless a nurse calls in. V11 stated V11 has been working 4-5 days a week performing the newly assigned duties. On 3/26/2026 at 10:33 AM, V54 (Scheduler) confirmed that V54 is responsible for scheduling staff within the facility. V54 confirmed that the facility does not have an ADON and that V11 is covering the role of ADON. On 3/26 2026 at 1:14 PM, V39 (HR Director) confirmed that V53's final day of work was 2/20/2026. Record review of Illinois Department of Financial and Professional Regulation Professional License Lookup Database documents that V11 is a Licensed Practical Nurse. Illinois Administrative Code titled, "TITLE 77: PUBLIC HEALTH CHAPTER I: DEPARTMENT OF PUBLIC HEALTH SUBCHAPTER d: LONG-TERM		S9999			04/14/2026	

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S9999	Continued from page 43 CARE FACILITIES PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE SECTION 300.1220 SUPERVISION OF NURSING SERVICES" documents in part, " a) Each facility shall have a director of nursing services (DON) who shall be a registered nurse. 1) This person shall have knowledge and training in nursing service administration and restorative/rehabilitative nursing. This person shall also have some knowledge and training in the care of the type of residents the facility cares for (e.g., geriatric or psychiatric residents). This does not mean that the director of nursing must have completed a specific course or a specific number of hours of training in restorative/rehabilitative nursing unless this person is in charge of the restorative/rehabilitative nursing program... 3) In skilled nursing facilities of 100 or more occupied beds, there shall be an assistant director of nursing (ADON) who is a registered nurse. This person shall also meet the qualifications specified in subsection (a)(1) of this Section for the director of nursing service... 5) The assistant shall be a full-time employee who is on duty a minimum of 36 hours, four days per week. The assistant may be assigned to work hours any time of the day or night. 6) The assistant shall assist the DON in carrying out his/her responsibilities...b) The DON shall supervise and oversee the nursing services of the facility, including: 1) Assigning and directing the activities of nursing service personnel. 2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation potential, cognitive status, and drug therapy... 7) Coordinating the care and services provided to residents in the nursing facility..." Facility job description for the assistant director of nursing (undated) identifies the following job duties are the responsibility of the ADON: "Will act as DON in absence of DON. Assist the DON in planning, developing, organizing, implementing the day to day functions of the nursing department in accordance with all governing rules...Chart Audits a) Admission audit within 72-hours- follow 72 hour protocol b. Audit of all charts on each respective floor Quarterly 2. Lab reports; analyze for your floor all labs for Physician notification nurse noted lab and new orders New orders are followed through 3. PT/INR- in absence of evening supervisor, log all daily reports from lab and ensure that proper action is being taken...Assist in determining and maintaining staffing needs in the nursing department. Monitor			S9999			04/14/2026

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S9999	Continued from page 44 nursing personnel to ensure that they are following established safety regulations in use of equipment and supplies..." The facility assessment documents in part, "Part 3. Facility Resources Needed to Provide Competent Support and Care for our Resident Population Every Day and During Emergencies 3.1 Staff- Please refer (3.1 A, 3.1 B)... Nursing Services (e.g. DON, ADON, RN, LPN, CNA, MDS Nurse)". The staffing plan identifies that "the facility has a labor budget the it follows which meets the minimum staffing requirements according to regulations". The ADON is not identified in the staffing plan. (C) (7 of 7) 300.2210b)6)7)8) Section 300.2210 Maintenance b) Each facility shall: 6) Maintain the grounds and other buildings on the grounds in a safe, sanitary, and presentable condition. 7) Maintain the grounds free from refuse, litter, insect, and rodent breeding areas. 8) The building and grounds shall be kept free of any possible infestations of insects and rodents by eliminating sites of breeding and harborage inside and outside the building; eliminating sites of entry into the building with screens of not less than 16 mesh screen to the inch and repair of any breaks in construction. These Requirements were NOT MET as evidenced by: Based on observation, interview and record review, the facility failed to ensure that the outside dumpsters were closed and failed to maintain the facility premises free of waste and garbage, creating potential conditions for insect and rodent infestations. These failures affect all 170 residents residing at the facility. Findings include: Facility census, dated 3/23/2026, documents 170 residents residing at the facility.		S9999			04/14/2026	

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S9999	Continued from page 45 On 3/23/2026 at 9:43am, during observation of the external facility dumpster area, accompanied by V3 (Dietary Director), both dumpsters were observed with their lids left open, containing a combination of bagged garbage filled beyond the point of proper closure and loose debris, along with an additional bag of trash outside the dumpsters. V3 said, "I've been telling them (garbage company) that we (facility) need a steady flow of garbage pickup. They (garbage company) should have been and come already. They (garbage company) come around 7:30am, every day, even on weekends. Yes, the dumpsters lids should be closed so garbage doesn't fall out, raccoons don't get into it (dumpsters), and so the garbage don't attract critters." On 3/23/26 at 9:52am, with V3 (Dietary Director), the exit door leading to the dumpster area was observed being held open with a dustpan. V3 said, "What's going on here." V3 then preceded to remove the dustpan that was propping the door open and closed the exit door leading to the dumpster area. V3 said, "Um, that's a critter issue too." Record review of facility policy titled, "Disposal of Garbage and Refuse," dated 10/2025, documents, in part, "Record review of facility policy titled, "Disposal of Garbage and Refuse," dated 10/2025, documents, in part, "The facility will dispose of garbage and refuse properly and in a timely manner. The facility will assure all garbage and refuse containers are in good condition (no leaks) and waste is properly contained in dumpsters or compactors with lids and covered. Garbage storage areas are maintained in a sanitary condition to prevent the harborage and feeding of pests and rodents." Record review of facility policy titled, "Resident Rights," dated 9/2024, documents, in part, "The facility will provide a safe, clean, comfortable, and homelike environment. The residents' environment will be maintained in a homelike manner." (C)		S9999			04/14/2026	