| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146128 | A. Building<br>B. Wing | 01/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Plymouth Place | 315 North LA Grange Road<br>LA Grange Park, IL 60526 |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were assessed to self-administer medications and keep them at their bedsides.<br><br>This applies to 4 of 4 residents (R9, R34, R235, R237) reviewed for medication storage in a sample of 23.<br><br>The findings include:<br><br>1. On 01/21/25 at 11:15 AM a generic pain-relieving cream with unlabeled Lidocaine (Lidocaine Hydrochloride 4%) and unlabeled hemorrhoidal relief cream maximum strength bought from a local pharmacy was observed on R34's nightstand. R34 said family member bought medication for her. She said she rubs the pain-relieving ointment with Lidocaine on her thighs. She said she uses both creams as needed.<br><br>A review of R34's POS (Physician Order Sheet) showed an order for Preparation H External Cream 1% (Hydrocortisone Rectal), apply to hemorrhoids every six hours as needed after bowel movement. There was no order for pain-relieving cream with Lidocaine, no order for the medications to stay at bedside, and no order for self-administration of medications.<br><br>2. On 01/21/25 at 10:24 AM a tube of Ketoprofen 15% gel was observed on R237's bedside table. R237 said she uses the pain cream on her knees. She said it is a compound medication made by a local pharmacy for her knees. She said she knows she needs to apply it on both her knees three times a day but only uses it when she remembers to.<br><br>A review of R237's POS showed there is no order for Ketoprofen 15% gel, no order for the medication to stay at bedside and no order for self-administration of medication.<br><br>3. On 01/21/25 at 11:30 AM, a tube of Clobetasol Propionate tube was observed in R235's bathroom. R235 denied any swelling, redness, itching or rashes on skin. She said maybe the cream is just there for when she needs it. She said the medication has been in her bathroom for a long time.<br><br>A review of R235's POS showed there is no order for Clobetasol Propionate, and no order for the medication to stay at bedside, and no order for self-administration of medication.<br><br>4. On 01/21/25 at 11:31 AM, Mobisyl 10% pain-relieving cream was observed on R9's cube shelving in her room. R9 unable to say where it came from or what she uses it for. R9's MDS (Minimum Data Sheet) dated 1/2/25 documents a BIMS (Brief Interview for Mental Status) score of 4 which means she has severe cognitive impairment.<br><br>(continued on next page) |

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

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

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | A review of R9's POS (Physician Order Sheet) showed there is no order for Mobisyl 10% pain-relieving cream, no order for self-administration of medication, and no order for the medication to stay at bedside.<br><br>On 1/23/25 at 09:30 AM, V2 (DON- Director of Nursing) said if a resident requests for medication to be at bedside, nurses would ask for an order from resident's PCP (Primary Care Physician). She said the facility has no assessment tool to assess if it is appropriate for resident to have the medication at bedside. She said there is no assigned storage for medication that stays by bedside. She said unlabeled medications should be discarded or family should take it home.<br><br>Facility's Policy and Procedure titled Medication Storage in the Facility dated March 2021 documents the following: . ID3: Bedside Medication Storage . Policy- Bedside medication storage is permitted for residents who wish to self-administer medications, upon written order of the prescriber and once self-administration skills have been assessed and deemed appropriate in the judgement of the facility's interdisciplinary resident assessment team.Procedures: A. A written order for the bedside storage of medications is present in the resident's medical record. B. Bedside storage of medications is indicated on the resident medication administration record (MAR) and in the care plan for the appropriate medications. C. For residents who self-administer medications . 1) The manner of storage prevents access by other residents. |

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| F 0584<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.<br><br>Based on observation, interview, and record review, the facility failed to ensure residents were provided with a warm, comfortable room.<br><br>This applies to 2 out of 3 residents (R77 and R67) reviewed for homelike environment in a sample of 23.<br><br>The findings include:<br><br>On 1/21/2025 at 1:50 PM, R77 and R67 (roommates) were in their room. R77 said he gets extra cold because the room's heater unit has not been working for weeks.<br><br>On 1/21/2025 at 2:00 PM, V1 (Administrator) was asked to assess the room and said the heating unit in the room had been broken for more than a week and was still waiting to be repaired. V1 said urgent maintenance work orders should be addressed within 24 hours and non-urgent should be completed within 3-7 days.<br><br>On 1/23/2025 at 8:55 AM, V4 (Director of Facilities and Safety) said he received a Maintenance Work Order request for the room's heating unit on 1/5/2025. V4 said the temperature outside the room in the hallway was checked and noted at 72 F (Fahrenheit) degrees, but the temperature inside the room was not checked on 1/6/2025. V4 said resident rooms were equipped with individualized heating units to allow residents to adjust the temperature inside their rooms to their desired comfortable level. V4 said that on 1/6/2025, the maintenance department attempted to fix the heating unit but was unable to because R77 was in the room. V4 said the room's heating unit repair required for the room to be vacant for approximately 3 hours.<br><br>A facility Maintenance Work Order had been completed on 1/5/2025 for the affected heating unit temperature controls.<br><br>The facility's policy titled HVAC System Malfunction Reporting Process undated, said Objective: To ensure that HVAC system issues are promptly reported, addressed, and resolved to maintain a safe and comfortable environment for residents and staff .Resident-Centered Care: Always prioritize the comfort and safety of residents by taking immediate actions . |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 4. R12's MDS (Minimum Data Set) dated 12/16/24, shows she is cognitively intact and uses a walker and wheelchair for mobility. R12's current care plan includes at risk for falls related to weakness.<br><br>On 01/21/25 at 01:29 PM, R12 was in bed with her bed and overbed table in a high position. R12 stated she needed to raise her bed so she could comfortably reach the items on her overbed table. V13 (CNA) entered the room and demonstrated that both the bed and overbed table could be lowered to a safer height.<br><br>On 01/22/25 at 01:16 PM, R12's bed and overbed table were again elevated in a high position. At 01:18 PM, V14 CNA stated R12 raised the bed to eat her meal, but she should have let the over bed table down so R12 didn't have to raise the bed.<br><br>On 01/23/25 at 01:30 PM, V2 DON (Director of Nursing) stated staff should making sure the overbed table and bed are lowered to a safe height for the resident. If the overbed table was lowered, the resident shouldn't have to raise her bed. Staff are responsible for making sure the resident's environment is safe.<br><br>3. On 1/21/25 at 10:58 AM, yellow stars were observed on R49's door. R49 said she has fallen before but could not remember when.<br><br>On 1/23/25 at 10:30 AM, V11 (R49's caregiver) said she stays with R49 in the facility from 9 AM to 8 PM. She said R49 fell once in November 2024. She said when R49 was being transferred from wheelchair to bed using a mechanical lift, R49 started sliding from the wheelchair. She said R49 was in a squatting position with her buttocks on the floor. She said R49 complained of right hip pain right after the incident and left knee pain the day after the incident. She said only one staff was using the mechanical lift to transfer R49 when she fell.<br><br>On 1/23/25 at 09:30 AM, V2 (DON-Director of Nursing) said when using mechanical lift for transfers, she expects assist from two staff. She said one staff should be guiding and one staff maneuvering the mechanical lift machine.<br><br>On 1/23/25 at 09:45 AM, V10 (LPN- Licensed Practical Nurse) said he was R49's nurse when she fell on [DATE]. He said R49 was sliding while she was being transferred and was in a squatting position while in the mechanical lift. He said the transfer was done by an agency CNA and stated that the transfer was done improperly and caused R49's fall.<br><br>R49's Progress Notes 11/20/24 from 3:22 PM (written by V10) showed that V11 reported that staff dropped R49 on the floor while transferring R49 using the mechanical lift. It is documented that V11 claimed R49 fell to the floor. R49 complained of right hip pain after incident.<br><br>Facility's Policy and Procedure titled Lifting Machine, Using Mechanical stated the following: . General Guidelines: 1. At least two (2) nursing assistants are needed to safely move a resident with a mechanical lift.3. Types of lifts. A. Floor based full body sling lifts; b. Sit-to-stand lifts.Based on observation, interview, and record review, the facility failed to safely transfer, position, and implement fall prevention interventions for residents at risk for falls.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | This applies to 4 out of 6 residents (R55, R285, R49, R12) reviewed for safety and accidents in a sample of 23.<br><br>The findings include:<br><br>1. On 1/22/2025 at 3:00 PM, V5 (Certified Nurse Assistant/CNA) and V10 (Licensed Practical Nurse/LPN) were assisting R55 in bed. R55 had a bruise on his right wrist and a skin tear on his right knee. V5 said R55 had recently fallen out of bed and possibly sustained those injuries then. The left side of R55's bed was parallel to the wall with approximately 12 inches of space in between. R55's boundary mattress was not secured to the bed's frame. V2 (DON/Director of Nursing) said R55 was dependent on his care and required 2-staff assistance with his bed mobility.<br><br>On 1/23/2025 at 1:00 PM, V7 (CNA) said that on 1/19/2025, she was providing incontinence care to R55 in bed when he fell out of bed. V7 said she knew R55 was at risk for falls because he was confused and at times resistant to his care. V7 said the left side of R55's bed was against the wall. V7 said she raised R55's bed and was unsure if the bed wheels were locked. V7 said she turned R55 onto his left side (away from her) and then she turned away from him (to the side) to get barrier cream from his nightstand table. V7 said she then noticed R55 started to slide and slip off the bed, with his mattress, and onto the floor. V7 said it did not appear that R55's mattress was safely secured to the bed frame. V7 said R55 fell on the floor in between his bed and the wall. V7 said she then called for help and two male CNAs came to assist R55 off the floor. V7 said they used R55's bed linen to lift him off the floor and place him back in bed.<br><br>R55's Progress Note dated 11/19/2025 said [Nurse on Duty] was called by CNA because the resident fell while she was doing his cares. He turned to his left side but the bed mattress flipped, hence the resident went down on the floor with legs stretched covered by sheets and holding a pillow with his hands that supported his head. Bed was low. Assessment revealed bruise in front of both knees, denies pain, no lumps and no open areas noted. He was put back to bed because he claimed he still wanted to sleep.<br><br>On 1/23/2025 at 10:45 AM, V2 (DON) said R55 was at risk for falls because he had a history of multiple falls and dementia-related behaviors. V2 said the facility staff implements standard fall interventions after fall incidents. V2 said R55 had fallen on 1/19/2025 from his bed. V2 said the facility was still investigating the incident and trying to re-interview V7 (CNA). V2 continued to say that the facility investigates falls to identify the root cause and implement appropriate fall interventions related to the root cause. V2 said the facility did not have a set time goal of when to complete root-cause fall investigations.<br><br>On 1/23/2025 at 11:00 AM, V2 was asked to assess R55's room and bed. V2 said they had just decided to move R55's bed away from the wall for his safety and would be providing him with double floor mats. V2 also said R55's bed frame was missing the mattress security latch to ensure the mattress was secured to the bed. V2 said she now sees how these environmental factors could have also contributed to R55's fall incident but they were still investigating the incident.<br><br>R55's MDS (Minimum Data Set) dated 12/30/2024 said R55 was severely cognitively impaired. The MDS also showed R55 was dependent on staff with bed mobility and ADL (Activities of Daily Living). R55's Fall Risk Evaluation dated 12/24/2024 said he was at At Risk for falls. R55's Care Plan had a at risk for falls focus problem initiated on 11/05/2023. R55's Care Plan had multiple fall interventions including, Ensure proper positioning while in bed .Staff to monitor resident for signs and symptoms<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | of agitation/impulsivity- if behavior noted a minimum of two staff members are recommended for care .Follow facility fall protocol.<br><br>The facility's Falls Prevention and Management policy dated 12/8/2022, said Policy Statement- It is the policy of Plymouth Place to ensure a safe environment by preventing falls with the least restrictive measures, while promoting the highest possible level of independence and quality of life. All residents shall benefit from a safe environment and an individualized resident centered plan of care. Interventions will be implemented to prevent and reduce the risk of injury based on each individual's assessment of risk factors .Cause Identification 1. For an individual who has fallen, staff will attempt to define possible causes post fall. Causes refer to factors that are associated with or that directly result in a fall .<br><br>2. On 1/21/2025 at 10:25 AM, R285 was in bed. R285 had a thick black floor mat folded up and not in place on the floor. R285's call light was not in reach, and instead was on the floor between his bed and the wall. R285's room had multiple safety reminders posted to call for help to prevent him from falling. At 1:50 PM, R285 was still in bed with the floor mat not on the floor.<br><br>On 1/23/2025 at 11:00 AM, V2 (DON) said R285 was at risk for falls because he had fallen on 1/20/2025 after he attempted to self-transfer. V2 said R285 had multiple fall interventions, including the use of a fall floor mat when in bed. V2 said she expects nursing staff to ensure residents' fall interventions are implemented accordingly to ensure residents are provided with a safe environment.<br><br>R285's Care Plan had a an at risk for falls focus problem initiated on 1/14/2025. R285's Care Plan had multiple fall interventions, including, Ensure call light is available to Resident and If resident is a fall risk, initiate fall risk precautions. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review, the facility failed to maintain the kitchen in a manner to prevent foodborne illness.<br><br>This applies to 77 residents in the facility receiving dietary services.<br><br>Findings include:<br><br>On 01/21/25 at 03:53 PM, V1 (Administrator) confirmed 77 residents were being served from dietary services on entry to the facility 01/21/25.<br><br>On 01/21/25 at 09:57 AM, the kitchen tour began in the lower-level kitchen with V3 (Culinary Director) and V12 (Chef). V3 stated the kitchen serves the entire facility.<br><br>1. The dry storage contained:<br><br>A dented 4lb (pound) 4oz (ounce) can of mushrooms.<br><br>A dented 6lb 12 0z can of buttered beans.<br><br>Two dented 6lb 12oz cans of sweet potatoes.<br><br>A dented 6lb 9 oz can of sliced carrots.<br><br>The facility policy Receiving Goods and Storage of Goods dated 10/19 states if questionable cans are identified after receival, remove form their storage place and place in the Dented Cans area identified in the Dry Storage.<br><br>2. On 01/21/25 at 10:15 AM, the walk-in freezer contained:<br><br>Items identified by V12 as chicken tenders that had fallen out of the unsealed bag; green peas in a clear plastic bag that had been accessed that did not have a label or any dates; four brown chunks in an accessed clear plastic bag identified by V12 as pumpernickel bread that did not have any label or dates.<br><br>The facility policy Labeling and Dating dated 10/19 states all food products will be appropriately wrapped, dated with opened-date or labeled based on the guidelines posted outside each walk-in cooler, walk-in freezer, and inside dry storage.<br><br>3. On 01/21/25 at 10:19 AM, the dairy cooler contained a tray identified by V12 as whole turkey breast with a single date of 1/18/25; and a pan with three items identified by V12 as flank steak, which was stored over five 10lb boxes of tilapia and four 10lb boxes of white shrimp.<br><br>The facility provided food storage chart order in which food should be refrigerated: ready to eat food stored on the top shelf, followed by seafood on the second shelf, whole cuts meats on the third shelf, ground meat and fish on the fourth shelf, and whole and ground poultry on the fifth shelf.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 4. On 01/21/25 at 10:29 AM, the reach-in freezer contained a large clear plastic bag without a label or any dates which 5.contained a brown substance identified by V12 as French onion soup.<br><br>The cooks line cooler contained a small metal pan labeled tuna salad with single date of 1/20/25.<br><br>5. On 01/21/25 at 10:35 AM, a reach-in refrigerator contained:<br><br>An accessed one-gallon container of Asian sesame ginger dressing with a single date of 12/11/24; three small cups identified by V3 as sour cream with no labels or dates; an accessed one-gallon container of poppy seed dressing dated 8/16/24; a bottle of raspberry vinaigrette dated 11/4; a facility container of yellow peaches with a single date of 1/17; a facility container of apricots with a single date of 1/11; a facility container of mandarins with a single date of 1/10; a facility container of prunes with a single date of 1/9; a facility container of strawberry topping with a single date of 1/10; a facility container of prunes with a single date of 1/15.<br><br>The facility-provided chart shows sour cream is good for five days after opening; canned fruits are good for five days after opening; and salad dressings are good for thirty days after opening.<br><br>6. On 01/21/25 at 12:51 PM, the third-floor kitchen was toured with V15 (Kitchen Special Projects). V15 tested the red sanitization bucket in use that tested at 0 ppm (parts per million). The reach in refrigerator contained 14 small factory sealed containers labeled pureed strawberry cheesecake with a manufactured dated of 4/12/23. The facility use by date of 1/20 was written on the facility container in which it was stored.<br><br>The facility Sink & Surface Cleaner Sanitizer test strips how to guide states the approved active range of sanitizer is 272 - 700 ppm.<br><br>The facility-provided Frozen Storage Life of Foods states to use the manufacture's expiration date for products, but do not exceed one year, if there is no expiration date on the package, add the date the food is received. If a case of food of partially used, and the remaining food is exposed to the air, re-label when the product is opened to use within 3 months.<br><br>On 01/22/25 at 02:06 PM, V3 (Culinary Director) stated there are no logs for the red sanitizing buckets because the sanitizer is taken from the same dispenser that fills the three-compartment sink. The three-compartment sink sanitizer level is tested, the red sanitizing buckets are not.<br><br>On 01/22/25 at 02:57 PM, V3 stated she would like to retract her earlier statement. The red sanitizing buckets sanitization level is tested but it is not logged. V3 stated she did not believe there is a requirement to log the sanitizer level for the red buckets, only the three-compartment sink, three times per day. V3 stated we are required to change the red sanitizing buckets and three-compartment sink before meals and if they become dirty.<br><br>On 01/23/25 at 01:11 PM, V3 stated items in storage areas should be properly sealed and labeled. Items in the freezer should be sealed to prevent freezer burn and labeled because foods can become unidentifiable when they are frozen. Items should be properly dated to assure they are not being served past the expiration date and so we know when to dispose of it. There are a few residents that have food allergies. If the food isn't labeled properly, it could inadvertently be served to someone with a food allergy. When storing food items, raw chicken and poultry should be on the lowest shelf, ground meat above that followed by red meat beef and pork and fish and seafood above that. The purpose<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | is to prevent cross contamination. Foods should not be utilized past the expiration date or use by date. The food quality diminishes, and the risks of contamination and bacterial growth puts the residents at risk for illness.<br><br>V3 stated there are no specific facility policies for the dry storage, coolers, or freezers, and only the storage chart that staff are to follow. V3 stated the facility policy does not have a specific direction for the sanitizer level since 2019 when the product they utilized changed. The policy states the sanitizer is to be checked before each meal service. The risk is staff may think the surface has been sanitized and it really hasn't which could cause the food to become contaminated. |

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
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| F 0909<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame.<br><br>Based on observation, interview, and record review, the facility failed to ensure resident beds were safely maintained.<br><br>This applies to 2 out of 3 residents (R55 and R14) reviewed for resident equipment in a sample of 23<br><br>1. R14 MDS (Minimum Data Set) dated 1/3/25, shows he is cognitively intact. R14 requires substantial staff assistance with repositioning in bed and is dependent on staff transfers between the bed and chair. R14's current care plan includes an ADL (Activities of Daily Living) self-care deficit related to mobility deficits and weakness.<br><br>On 01/21/25 at 11:33 AM, R14 was on an airloss mattress with approximately four inches of his bed frame exposed on each side of his bed.<br><br>On 01/23/25 at 11:59 AM, R14 was still on an air mattress with approximately four inches of his bed frame exposed on each side of his bed.<br><br>On 01/23/25 at 01:30 PM, V2 DON (Director of Nursing) stated staff that provide direct care are responsible for making sure the bed is safe for the resident. If there is any issue the direct care staff should place a work order to maintenance to have the equipment changed out immediately. The mattress should fit the frame. There is a potential for entrapment or potential for injury to the resident and staff.<br><br>2. On 1/22/2025 at 3:00 PM, V5 (Certified Nurse Assistant/CNA) and V10 (Licensed Practical Nurse/LPN) were assisting R55 in bed. V5 said R55 had recently fallen out of bed. R55's boundary mattress was not secured to the bed frame.<br><br>On 1/23/2025 at 1:00 PM, V7 (CNA) said that on 1/19/2025 she was providing care to R55 in bed when he fell out of bed. V7 said she noticed R55's mattress was not secured properly because it shifted and slid off the bed frame when he fell.<br><br>On 1/23/2025 at 11:00 AM, V2 (Director of Nursing/DON) was asked to assess R55's bed. V2 said R55's bed frame was missing the mattress security latch to ensure the mattress was secured to the bed.<br><br>On 1/23/2025 at 2:40 PM, V1 (Administrator) said maintenance performs weekly environmental rounds and an outside vendor also performs monthly resident equipment safety checks, including beds. V1 said he expects environmental and nursing staff to inspect residents' beds daily and report broken or unsafe beds immediately to ensure resident safety.<br><br>The facility's policy titled Bed Safety and Bed Rails dated 8/2022, said Policy Statement Resident beds meet the safety specifications established by the Hospital Bed Safety Workgroup .6. Maintenance staff routinely inspects all beds and related equipment to identify risks .8. Any worn or malfunctioning bed system components are repaired and replaced using components that meet manufacturer specifications .10. Additional safety measures are implemented for residents who have been identified as having a higher than usual risk for injury . |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 146128 | A. Building<br>B. Wing | 01/24/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Plymouth Place | 315 North LA Grange Road<br>LA Grange Park, IL 60526 |

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

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
|---|---|
| F 0921<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.<br><br>Based on observation, interview, and record review, the facility failed to ensure residents' rooms with sharps disposal containers were safely maintained.<br><br>This applies to 5 residents (R3, R73, R287, R79, and R39) reviewed for facility environment in a sample of 23.<br><br>The findings include:<br><br>On 1/21/2025 at 10:15 AM during the initial tour of the facility, five residents' rooms (R3, R73, R287, R79, and R39) were observed with overflowing sharps disposal containers:<br><br>1. R3's sharps disposal container located in her room was overfilled above the indicated full line and contained sharp items on top of the security flip lid.<br><br>2. R73's sharps disposal container located in her room was overfilled above the indicated full line and contained sharp items on top of the security flip lid.<br><br>3. R287's sharps disposal container located in her room was overfilled above the indicated full line and contained sharp items on top of the security flip lid.<br><br>4. R79's sharps disposal container located in her room was overfilled above the indicated full line and contained sharp items on top of the security flip lid.<br><br>5. R39's sharps disposal container located in her room was overfilled above the indicated full line and contained sharp items on top of the security flip lid.<br><br>On 1/22/2025 at 12:35 PM, V2 (Director of Nursing/DON) said nurses were expected to check and dispose of sharps disposal containers once filled to the indicated full line. V2 continued to say that staff should not continue to dispose of sharp items once containers are filled to ensure safe handling and disposal of sharp items, including needles and syringes.<br><br>The facility's policy titled Sharps Disposal dated 01/2012, said Policy Interpretation and Implementation .3. During use, containers for contaminated sharps will be handled as follows: c. Designated individuals will be responsible for sealing and replacing containers when they are 75% to 80% full to protect employees from punctures and/or needlesticks when attempting to push sharps into the container. |