Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006779	A. BUILDING: ______ B. WING ______	C 06/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK LAWN RESPIRATORY & REHAB	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments FRI of 3/28/2024/IL172092 & Complaint Survey: 2494799/IL1744534	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 2 300.610a) 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 nursing and personal care needs of the resident.	S9999		

Illinois Department of Public Health

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

Electronically Signed | | 07/18/24

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These Requirements were NOT MET as evidenced by:

Based on interview and record review, the facility failed to prevent or determine an injury of unknown origin for one resident. This affected one of three residents (R1) reviewed for injury of unknown origin. This failure resulted in R1 sustaining bruising to the left hip, left hand, amd left shin and superficial scratches to R1's back and treated at the local hospital.

Findings Include:

R1 is a 55 year old, female resident in the facility with diagnoses of but not limited to: Psychosis not due to substance or known physiological condition, anxiety disorder, acute stress reaction, and adult physical abuse.

R1 has a BIMS of 15 (Cognition Intact).

Facility Reported Incident with date of occurrence of 3/28/24, reads in part: R1 alleged rough treatment/abuse by agency staff nurse. Upon investigation, R1 has a history of non-receptive to touch and difficulty allowing anyone in her personal space related to history of adult physical abuse. However, body assessment did indicate bruises noted of unknown origin. R1 statement was inconsistent: Stating her clothing items "ripped off and cut up" (clothing was intact) Stating that 2 staff person in the room (camera indicates one person in the room). R1 stated "'a staff person standing outside guarding her door during alleged abuse (Camera indicated no one standing outside of room during time indicated). Unable to substantiate allegation of R1 was willfully physically abused by the staff person.

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R1's Facility Progress note dated 3/28/24, reads in part: skin assessment bruise to left lower leg bruise reddish in color, size of a yellow egg yolk. Noted bruise to upper left hip, grayish blue with size of a medium plum seed. Also, noted reddish bruise to both forearms. Lower right back noted two scratches, red, wound edges attached no drainage or bleeding noted. Unable to measure L (length) x W (Width) x D (Depth) of scratches due to resident DX of OCD.

Police Report dated 3/28/24, reads in part: Spoke with R1 in the presence of daugther. R1 said she was waiting in her room for her daugther to come to bring her clothes so that she could shower. R1 says that the nurse (V5) comes in and says that R1 has to take shower and got verbally aggressive towards R1. R1 says that they took her roommate out of the room. R1 says that she follows the nurse out of the room when the nurse then pushed her back in the room. R1 said she is pushed into shower. R1 says that the nurse said she was going to use scissors to cut her shirt off. R1 says that she takes her own shirt off but keep her pants on. R1 says the nurse grabs both of her hands and pushes her into the wall, while striking her on the head with the shower head. Writer observed no visible injuries to R1's head during interview. R1 says she got scratches on her wrist, which look like rash marks, scratched to her right shoulder. R1 says from getting pushed into the wall she got bruise to her lower left leg. R1 sad the nurse ripped her shirt off, where V1 (administrator) went and got the clothes from the shower and had no rip marks on them.

Hospital record dated 3/28/24, reads in part: R1 presents for evaluation after alleged assault at nursing facility. R1 and daugther at bedside report

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that there was an altercation approximately 1200 today wherein R1 did not want to shower and was injured by staff as they attempted to force her to shower. R1 reports being hit on Left temporal region of skull with shower head, as well as scratches on back and bruised on Left Hip, L shin during this altercation. Endorses L hand pain. Physical exam. Skin: Bruising left hip, left hand, and left shin present. Superficial nonbleeding scratches to back. Mental status: Alert, and oriented to person, time and place. Psychiatric: tearful and anxious. R1 to ED (Emergency Department) after daugther called 911 due to R1 states she was pushed, grabbed and bruised by nursing staff.

On 6/13/24 at 11:03AM, V1 (administrator) R1 reported that staff forced her to take a shower. Rambled on and backing up from me. V1 did not substantiate due to contradicting stories. R1 reported they ripped R1's clothes off, V1 asked and R1 said" the nurse". R1 showed me her clothes, and R1's clothes were not ripped. They made R1 take a shower and force R1 to take a shower. Hair was wet, evidence she had taken a shower. R1 reported that she was hit in the head with the shower, facility has detachable shower head. R1 kept saying "They" for what V1 can see was there was one person, the nurse. Ran back the video tape and observed the nurse was the only person went inside the room, and R1 stated there were several people, could not name them but keep on saying "them and nurse". Approximately for a brief time, the only and other person that came in the room before the nurse was the therapy person. Hospital would not give any more information when we tried to do follow up, because the daugther does not want the information to be given to us.
V1 also stated that V1 was unable to ascertain

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how and when R1 sustained the documented injury during complete body assessment. Staff knows to report to Director of Nursing (DON) and DON to report to V1 for any noted bruising in any residents. Nothing was reported to V1 by DON, regarding R1's bruising. V1 was only made aware of the injury after the wound nurse assessed R1. Asked R1 how R1 sustained the bruising, and R1 would not say anything. Police was also called, they have to wait for the daugther because R1 will not talk to the police unless her daugther is present. Daugther was also saying "You did this, the facility did this to Mom (R1)".
V1 stated "I do not know how R1 sustained those injuries. I did my due diligence with my investigation. Doing staff and residents interviews, review the recordings. No one reported to me any abuse for R1 or any residents in the facility.

On 6/13/24 V11 (R1's Daugther) stated that R1 had bruising on her body. R1 reported to V11 that a nurse hit R1 while taking a shower.

Abuse Prevention Program policy with a revised date of 1/2019, reads in part: All incidents, allegations or suspicion of abuse, neglect, exploitation, misappropriation of property, or crime against a resident should be documented. Any incident or allegation involving abuse, neglect, exploitation, misappropriation of resident property, or crime against resident will result in an abuse investigation.

For Resident injuries not involving allegation of abuse or neglect, the administrator will appoint a person to gather further facts to make a determination as to whether the injury should be classified as an "Injury of Unknown origin". An injury should be classified as an "injury of

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unknown origin" when both of the following condition are met:

The source of the injury was not observed by any person of the source pf the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (the injury is located in area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incident of injury overtime.

VII Prevention: The facility desires to prevent abuse, neglect, exploitation, misappropriation of proper and a crime against a resident by establishing a resident-sensitive and resident-secure environment. This will be accomplished by a comprehensive quality assurance performance improvement approach.

Policy: This facility will not tolerate resident abuse or mistreatment of crimes against a resident, including staff member other residents, consultant, volunteer and staff of other agency, family member, legal guardian, friend and other individual.

Procedure: Any alleged violation involving mistreatment, abuse, neglect, exploitation, and misappropriation of resident property and any injuries of unknown origin or reasonable suspicion of a crime against a resident must be reported to the Administrator or DON. The Administrator I am the abuse coordinator.

(B)

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300.610a)

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300.1210b)
300.2210b)2
300.2920g)1)A)B

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 nursing and personal care needs of the resident.

Section 300.2210 Maintenance

b) Each facility shall:

2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning

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condition. This shall include regular inspections of these systems.

Section 300.2920 Mechanical Systems

g) Heating, Ventilating, and Air Conditioning Systems

1) Areas of a nursing home used by residents of the nursing home shall be air conditioned and heated by means of operable air-conditioning and heating equipment. The areas subject to this air-conditioning and heating requirement include, without limitation, bedrooms or common areas such as sitting rooms, activity rooms, living rooms, community rooms, and dining rooms. (Section 3-202(8) of the Act)

A) The mechanical system shall be capable of maintaining a temperature of at least 75 degrees Fahrenheit, pursuant to the requirements of Section 300.670(j).

B) The air-conditioning system shall be capable of maintaining an ambient air temperature of between 75 degrees Fahrenheit and 80 degrees Fahrenheit, pursuant to the requirements of Section 300.670j)

These Requirements were NOT MET as evidenced by:

Based on observations, interviews, and record reviews, the facility failed to provide a safe environment and ensure comfortable room temperatures in resident rooms with temperatures above 80 degrees Fahrenheit and humidity above 60%. The facility failed to identify all residents at high-risk for heat stroke/heat exhaustion. The facility failed to follow their

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extreme weather conditions policy and implement an effective plan to monitor ambient temperatures in resident rooms. The facility failed to develop and implement an effective plan to monitor residents' physical condition and increasing residents' comfort. This failure has the potential to affect all 47 residents (R2-R48) residing in this facility.

Findings include:

A review of the facility census on 06.18.2024 there are currently 47 residents residing in the facility.

On 6/18/24 at 11:30 AM, this surveyor observed V13 (director of maintenance) check temperature and humidity in each resident room. The resident room temperatures and humidity were checked with central air conditioner and portable fans running on high:

Room	Temperature w/AC	Humidity %
206	83.5	65.3
207	83.4	63.9
218	84.5	64.2
217	84.7	61.5
208	84.7	64.4
209	83.8	63.6
215	83.8	63.4
214	83.7	65.2
211	83.7	64.3
216	84.4	60.9
202	82.9	63
224	81.9	62.1
200	82.2	62.1
223	81.2	67.9
222	82.9	63.9
221	83	63.5
106	83.2	63.4
119	84.1	64.4

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121	83.2	64.2
104	83.1	58.6
117	84.4	65.4
120	83.7	59
113	83.4	65
108	83.4	65.9
105	83.7	59.8
122	81.4	63.8

Per www.timeanddate.com/weather, dated 6/18/24 at 10:53 AM, the outside temperature in Oak Lawn, IL was 84 degrees with 61% humidity. The highest temperate was 93 degrees with humidity of 41% at 2:53 PM.

On 6/18/24 at 11:35 AM, R2's family member was observed holding a portable fan on high blowing directly onto R2's upper torso and face. R2's family member was observed soaking a mouth swab in ice water and swabbing R2's mouth and lips.

On 6/18/24 at 11:36 AM, R8 states as long as she remains one foot away from fan on high she is okay.

On 6/18/24 at 11:38 AM, R9 and R10 state that there is no air movement even with AC and fans running.

On 6/18/24 at 11:40 AM, R11 states he checked his room temp yesterday and it was 84 degrees. R11 stated that the air conditioner is set on high but no air is blowing out.

On 6/18/24 at 11:42 AM, R13 stated that he is hot. R13 stated that staff told him the air conditioning unit in his room was broken. R13 stated that he has been without air conditioning in his room for one month. V13 was observed

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checking R13's air conditioning unit and informed R13 that there was nothing wrong with his unit, it was turned off and V13 turned it on.

Review of this facility's maintenance request log, dated 5/25/24, notes convector unit in R13's room not working. It also notes the control knob on convector unit in R13's room are missing; need to use pliers to turn knob. There is no documentation found noting these concerns were addressed by maintenance.

On 6/18/24 at 11:45 AM, R14 stated that the air conditioning unit in her room is on high but room does not feel cold at all.

On 6/18/24 at 11:46 AM, R6 stated that, It is not as hot in his room today, like it has been.

On 6/18/24 at 11:49 AM, R7 stated that it is too hot in her room.

On 6/18/24 at 11:53 AM, R12's family member stated it is too warm in room even with air conditioning on.

On 6/18/24 at 2:30 PM, R16 was observed to have a pitcher with clear liquid half full. No ice observed in pitcher. Condensation noted on pitcher and nightstand table. R16's pitcher was on nightstand next to head of bed and was not within reach.

On 6/18/24 at 2:30 PM, R17 stated that he has water in his pitcher. R17 stated that staff have not been offering him additional fluids today. R17's water pitcher was observed to be full of clear liquid, no ice.

On 6/18/24 at 2:30 PM, R7, R8, R9, R10, R14,

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and R22 were observed with water pitchers with water, no ice. All stated that their water is warm. All denied being offered cold drinks throughout the day. All denied being offered and assisted into dining area where it is cooler.

On 6/18/24 at 11:30 AM, V13 (director of maintenance) stated that he works at a sister facility and started coming to this facility yesterday (6/17/24). V13 stated that he came to facility today at 9:00 AM to fix air conditioner units in main lobby and conference room adjacent to it. V13 stated that he did not check facility temperatures yesterday or today prior to 11:30 AM.

On 6/18/24 at 1:39 PM, V2 DON stated that the nurses are checking vital signs once a shift. Stated that the nurses work 12-hour shifts. V2 stated that the staff are monitoring residents' physical condition by checking vital signs twice a day. V2 stated that physician orders were received for residents receiving enteral feedings via gastrostomy tube to increase water flushes to maintain hydration.

Review of R15 and R20's POS (physician order sheet) notes orders were obtained to increase water flushes on 6/19/24 with this increase to start on 6/20/24 at 2:00 PM.

Review of R21's POS, notes an order was obtained to increase water flushes on 6/19/24 with this increase to start on 6/19 at 3:00 PM.

On 6/18/24 at 1:55 PM, V2 presented a computer generated list of all residents' temperature results from 6/15 through 6/18 at 1:50 PM. On 6/15/24, 16 residents had temperature checked only once; 18 residents had temperature checked twice; and

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13 residents did not have temperature checked at all. On 6/16, 18 residents had temperature checked only once; 16 residents had temperature checked twice; and 13 residents did not have temperature checked at all. On 6/17, 15 residents had temperature checked only once; 10 residents had temperature checked twice; and 22 residents did not have temperature checked at all. On 6/18, 1 resident had temperature checked and 46 residents did not have temperature checked at all.

On 6/18/24 at 1:45PM, V12 (administrator) stated that this is her second day at this facility. V12 stated that the previous maintenance person director walked out on 6/5/24. V12 stated that there has been no maintenance staff present in facility until 6/17/24. V12 stated that she does not know who has been checking facility ambient temperatures, if at all. V12 stated that this facility should be following its extreme weather condition policy at this time.

Review of this facility's temperature log book notes last time facility temperatures were checked was on 6/3/24 at unknown time.

On 6/18/24 at 2:04 PM, V19 (manager with outside heating and cooling company) stated that their employee came out to switch over system mid-May. V19 stated that the facility called to clean coils on air conditioning unit yesterday afternoon. V19 stated that the service technician has not come to facility yet to perform work order. V19 stated that no call was received regarding resident room temperatures being high. V19 stated that V19 considers temperatures 81-84.7 degrees Fahrenheit to be an emergency, facility did not notify him that this service call needs to be changed to an emergency.

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OAK LAWN RESPIRATORY & REHAB	**9525 SOUTH MAYFIELD OAK LAWN, IL 60453**

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On 6/18/24 at 3:05 PM, V12 (administrator) stated that the outside heating and cooling company came out this morning and cleaned the coils in the air conditioning unit. V12 denied notifying company of the high temperatures in facility.

On 6/18/24 at 3:20 PM, V14 CNA (certified nurse aide) stated that he worked on Sunday, denied residents complaining of indoor temperature then. V14 stated that he makes sure residents' rooms are cool, gives residents ice water, and checks on residents every two hours to see if they are okay. V14 stated that he refills residents' water pitchers when they are empty. V14 denied residents complaining of elevated room temperatures today.

On 6/18/24 at 3:24 PM, V15 CNA worked last night from 11:00 PM-7:00 AM. V15 stated that she is working 3:00 PM-11:00 PM today. V15 stated that during the night the resident room temperatures felt cooler than currently. V15 stated that at the start of her shift, she provides fresh ice water to her assigned residents.

On 6/18/24 at 3:31 PM, V16 LPN (licensed practical nurse) stated that she worked 7:00 AM-3:30 PM on first floor nursing unit. V16 stated that at the beginning of shift the resident room temperatures felt a little cooler, then the temperature quickly increased. V16 stated that she makes sure residents are checked frequently. V16 stated that she has been rounding constantly bringing residents with ice water, and taking ambulatory residents outside where it is cooler.

On 6/18/24 at 3:46 PM, V17 LPN stated that she

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is working 7:00 AM-7:00 PM on second floor nursing unit today. V17 stated that the residents' room temperatures were the same as today. V17 stated that she keeps residents hydrated, trying to keep windows and blinds closed, and ambulatory residents taken outside where it is cooler.

On 6/18/24 at 6:30 PM, R2's family member stated that a family member is present in this facility daily during the day and evening. R2's family member stated that R2 is not eating, and they use mouth swabs soaked in ice water to swab R2's mouth and lips. R2's family member stated that if they were not present in this facility, staff would not swab R2's mouth.

On 6/18/24 at 1:34 PM, V12 (administrator) presented a list of high-risk residents for heat stroke/heat exhaustion. This list contained residents with respiratory diseases. This list did not identify bed bound residents, residents with total dependence on staff for fluid intake, or residents with gastrostomy tubes receiving enteral feedings.

On 6/19/24 at 8:30 AM, R18 and R8 stated that room is still hot. Both stated that they must request fluids and ice. Both denied staff offering cold drinks to them.

On 6/19/24 at 8:35 AM, R10 stated that yesterday he felt dizzy, weak, and had a headache when the room temperature got high. R10 stated that he does not have any symptoms at this time. R10 stated that his room is still warm and there is no air circulating. R10's water pitcher was observed to be full of clear liquid. R10's cup was on nightstand behind him and not within reach.

On 6/19/24 at 8:35 AM, R19 was observed to

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have a cup half filled with thickened water on R10's bedside table, not within reach.

On 6/19/24 at 8:39 AM, this surveyor observed a cooler filled with ice and pitcher of water at the second floor nurses' station.

On the second floor nursing unit continuous observation from 8:39 AM until 11:20 AM:
On 6/19/24 at 9:00 AM, this surveyor did not observe any staff passing ice water to residents or checking on all the residents' physical condition. R44 stated that her room remains hot.
On 6/19/24 at 9:15 AM, this surveyor did not observe any staff passing ice water to residents or checking on all the residents' physical condition.
On 6/19/24 at 9:30 AM, this surveyor did not observe any staff passing ice water to residents or checking on all the residents' physical condition.
On 6/19/24 at 9:45 AM, this surveyor did not observe any staff passing ice water to residents or checking on all the residents' physical condition.
On 6/19/24 at 10:00 AM, this surveyor did not observe any staff passing ice water to residents or checking on all the residents' physical condition.
On 6/19/24 at 10:15 AM, this surveyor did not observe any staff passing ice water to residents or checking on all the residents' physical condition.
On 6/19/24 at 10:30 AM, this surveyor did not observe any staff passing ice water to residents or checking on all the residents' physical condition.
On 6/19/24 at 10:35 AM, R23 was observed exiting room and walking to the nurses' station for a cup of water.

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On 6/19/24 at 10:45 AM, this surveyor did not observe any staff passing ice water to residents or checking on all the residents' physical condition.
On 6/19/24 at 10:50 AM, staff were observed passing out popsicles to residents. R20 nor R22 received a popsicle.

On 6/19/24 at 8:40 AM, R18's was observed to have window air conditioning unit sitting on R18's nightstand, not installed. R18 stated that her room is hot.

On 6/19/24 at 8:41 AM, signage posted on the wall next to R20, R21, and R22's room notes please pass ice water to residents each shift per diet order.

On 6/19/24 at 8:42 AM R20 was observed to have a water pitcher full of clear liquid no ice with a straw piercing the lid. Liquid did not appear to be nectar thickened. Pitcher was not within R20's reach. R20 was observed to have enteral feedings tubing attached to gastrostomy tube, not infusing.

R20's POS (physician order sheet) notes R20's diet order is pureed diet with nectar thickened liquids.

On 6/19/24 at 8:42 AM, R21 was observed to have a water pitcher full of clear liquid no ice with a straw piercing the lid. Pitcher was not within R21's reach. R21 was observed to have enteral feedings tubing attached to gastrostomy tube, not infusing.

R21's POS notes R20's diet is nothing by mouth.

On 6/19/24 at 8:42 AM, R22 was observed to

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have a water pitcher full of clear liquid no ice with a straw piercing the lid. Pitcher was not within R22's reach.

R22's POS notes R22's diet order is general diet with thin liquids.

On 6/19/24 at 8:50 AM, R23 did not have a pitcher or cup in R23's room.

R23's POS notes R23's diet order is general diet with thin liquids.

On 6/19/24 at 11:20 AM, this surveyor observed V13 (director of maintenance) check temperature and humidity in each resident room. The resident room temperatures and humidity were checked with central air conditioner and portable fans running on high:

Second floor nursing unit:

Room	Temperature w/AC	Humidity %
206	80.6	52
207	80.2	52.1
218	80.6	52.2
217	81	55.4
208	80.9	57.1
209	81	57.7
215	80.8	59.7
214	80.5	59.3
211	80.5	54.6
216	80.9	57
202	79.5	51.7
224	78.4	53
200	78.3	50.8
223	79.1	55.6
222	80.2	50.9
221-A	80.4	53

First floor nursing unit at 11:30 AM:

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106	80.4	59.1
119	81	62.2
121	78.7	60.3
104	78.2	60.1
117	81.9	60.3
120	79.6	57.7
113	81.1	59.2
108	81.9	57
105	79.3	62.1
122	77.7	61.5
100	78.1	60.5
102	77.7	61.4
123	77.9	60.3
101	77.9	61.4
103	77.7	59.4

Per www.timeanddate.com/weather, dated 6/19/24 at 7:53 AM, the outside temperature in Oak Lawn, IL was 82 degrees with 65% humidity. The highest temperate was 94 degrees with humidity of 38% at 1:53 PM.

On 6/19/24 at 11:30 AM, V13 (director of maintenance) stated that he is putting in window air conditioning units in the resident rooms on the second floor today. V13 stated that he does not have enough window air conditioners to place one in each resident room on the second floor.

On 6/19/24 at 1:45 PM, there are 16 rooms with residents on the second floor. Four of these rooms, room 214, room 215, room 208, and room 217, do not have window air conditioning units installed as of yet.

On 6/20/24 at 12:30 PM, V19 (outside heating and cooling company) stated that the rooftop has two compressors and one is totally nonfunctional. V19 stated that he gave V12 (administrator) an estimate to replace the rooftop unit and is waiting

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for decision. V19 stated that this unit cannot be repaired. V19 stated that yesterday the technician came out to check the outside chiller pumps and these are pumping cold water to the convectors in the resident rooms. V19 stated that these units in the residents' rooms needed extensive cleaning due to not blowing air. V19 stated that he does not know when the facility last performed preventive maintenance on the units in the residents' rooms. V19 stated that once these units were cleaned, cold air was blowing into the residents' rooms. V19 stated that there are three units on the second floor (rooms 222 has two units and room 211) that need new motors which V19 did order today. V19 stated that the technician cleaned a total of 15 rooms yesterday and has 4 rooms that still need to be done; V19 is unsure which rooms still need to be done. V19 stated that the technician will be at this facility tomorrow to finish cleaning the units on the second floor.

On 6/20/24 at 3:00pm, V25 (technician with outside heating and cooling company) stated that he spoke with V12 (administrator) and V13 (director of maintenance) yesterday regarding what needs to be done in this facility and estimate of cost. V25 stated that he has been coming to this facility for the past 10 years and management has not wanted to do the necessary repairs and now the unit needs to be replaced. V25 stated that the convectors in the residents' rooms are supposed to be cleaned with a brush monthly as preventive maintenance. V25 stated that the company had two technicians at facility yesterday and the convectors were so clogged that they had to use their hands to pull the junk out of it. V25 stated that by what they saw yesterday, the convectors have not been properly maintained for a long time. V25 stated that the filters hadn't

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been changed for long time.

During this survey, this facility was unable to provide intake and output documentation for all residents residing in this facility.

The facility's loss of utilities action plan, undated, notes the air-conditioning system shall be capable of maintaining an ambient temperature of between 75-80 degrees F. If temperatures are not maintained between 75-80 degrees F, maintenance director may obtain alternate source of cooling until repairs are complete. If temperatures reach 81 degrees F or higher, the following precautions will be put in place: provide ample fluids to all residents; assess residents for signs and symptoms of heat exhaustion/heat stroke such as headache, weakness, dizziness, nausea, and vomiting.

The facility's extreme weather conditions policy, undated, notes during extreme weather periods, ambient air temperature will be monitored and documented for various locations throughout the building such as dining areas, lounges, and a sampling of resident rooms. All high-risk residents will be identified and carefully monitored by nursing personnel for appropriate clothing, over-exertion, body temperature changes, hydration, and other signs and symptoms of hyperthermia.

(B)