

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Dobson Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Dodge Avenue Evanston, IL 60202	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036</p> <p>Based on observation, interview, and record review, facility staff failed to report an allegation of abuse to the State Survey Agency within 24 hours of being made aware of a potential abuse allegation from a resident. This failure applied to one resident (R70) reviewed for abuse in a total sample of 35.</p> <p>Findings include:</p> <p>R70 is a [AGE] year-old resident admitted to facility on 02/29/2024 with medical diagnoses including but not limited to: legal blindness, muscle weakness, paroxysmal atrial fibrillation- on a blood thinner, polyneuropathy, essential hypertension, prediabetes, and moderate protein-calorie malnutrition.</p> <p>R70 has a Brief interview mental status (BIMS) score of 14/15 dated 06/04/2024 which means cognitively intact.</p> <p>R70 requires partial/moderate assistance for eating, oral hygiene, toileting hygiene, upper body dressing and personal hygiene according to minimum data set (MDS) section GG dated 6/4/2024.</p> <p>R70 requires substantial/maximal assistance for shower/bathe self, lower body dressing and putting on/taking off footwear according to MDS section GG dated 6/4/2024.</p> <p>R70 is on an anticoagulant medication.</p> <p>In physical therapy note written by V11 (physical therapy manager) dated 5/27/24 at 01:51 PM reads He (R70) reported that somebody tried to wrench his arm when he was attempting himself to get to the toilet.</p> <p>On 5/27/2024 at 01:56 PM x-ray was completed on R70 left shoulder, complete 2 views. Report documents slightly swollen and c/o (complaint of) pain. Impression: No acute skeletal injuries of the left shoulder.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/10/24 at 10:37 AM R70 was interviewed by surveyor in his room. He was alert and oriented to person and place. R70 stated I believe the guy's name is V12 first name. I woke up very early in morning and was very confused and V12 or whatever his name is got all excited because I was out of my bed and calling mommy or help to get help to go to the bathroom. He wrenched my arm. It didn't hurt that day, but it started hurting. I told V11 the next day and they took pictures. V11 is the head of Physical therapy. It happened in March or April. I don't know when the last time I seen him work. I have been putting heat compresses on it. I am on blood thinners. I think the staff rotate shifts. He speaks with an accent. I think he is Filipino. My biggest problem with him is his attitude like he is the boss and doesn't take your side of the story. You can't reason with V12. R70 left upper arm was noted to be purple and yellow almost full length of upper arm to elbow on front side and stated that it is spreading; it doesn't hurt now.</p> <p>On 06/10/24 at 11:46 AM Another surveyor observed bruise on R70 with this surveyor and resident changed story on when it happened. Large bruise ranging from about 1 inch below shoulder to 1 inch above elbow scattered purplish and yellow in color on anterior aspect of left arm. He now says it happened a week ago Sunday.</p> <p>On 06/11/24 at 10:47 AM Interview with V7 certified nursing assistant (CNA). I am a CNA. I saw the bruise on R70's arm yesterday and told V3 (regional director) about it. R70 is independent and I only help R70. R70 did not tell me how that happened, I just reported seeing it.</p> <p>On 06/11/24 at 10:56 AM Interview with V11 (physical therapy manager). V11 stated my therapist (V29) reported to me limitation of motion and a little swelling to left upper arm on 5/27/2024. I did not directly speak with R70 about it that day. I spoke to him the following day regarding this. R70 told me somebody wrenched my arm. R70 couldn't remember who. He told me it happened on the night shift. V29 told me she told the nurse of the arm limited motion and swelling. If someone tells me something that we suspect abuse, we are to report it right away. I told the floor nurse V12 that R70 said somebody wrenched his arm. It was reported already so I am assuming the nurses have it already. It would be considered abuse if somebody wrenches someone's arm in my book. That is exactly what is documented in my notes.</p> <p>On 06/11/24 at 10:58 AM Interview with V3 (regional director) stated investigation is ongoing. V3 provided us with copies of investigation what has been done so far. I am unaware of R70 stating someone wrenched his arm. He did not tell me that yesterday. I will take it one step further with my investigation.</p> <p>On 06/11/2024 V3 presented unusual occurrence report form dated 6/10/2024 documents V7 (CNA) reported discoloration to resident's R70 left upper arm - when asked resident what happened he stated that he got up at night, I was confused. He said that later his arm hurt, they did xray, they told me That it was old man stuff.</p> <p>On 06/11/24 at 12:17 PM V3 (Regional director) notified by surveyor that R70 accused V12 of wrenching his arm. Also asked for update of investigation once she finishes it.</p> <p>On afternoon of 6/11/2024 surveyor was provided with Facility reported incident report for this incident and was told that V12 was suspended pending ongoing investigation.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/11/24 at 03:15 PM Interview with V2 Abuse coordinator. When asked how you go about investigation V2 stated immediately report and look at the details of event. It is not reportable if it is witnessed. Avoid abuse, we work as a team we start an investigation immediately. We train staff on abuse and abuse reporting, Staff report to nurse on the floor and myself or director of nursing (DON). Staff must report immediately. When asked why the x-ray was ordered V2 stated we ordered x-ray because resident reported pain. Nurse called doctor and got the order. Morning nurse called doctor and did x-ray. I am not aware of communication between V11 and V12. When asked if therapy staff should have reported this right away V2 stated yes either to me or his supervisor. This resident uses a lot of interesting language to describe something, like yesterday he said I have old man bones. He describes he got up and was looking for something, he thinks it was his mother and got confused and he thinks it was V12 but not sure that V12 was who caught him. My DON is in Italy, and I am unsure if she started an investigation or not. She can start investigation without me .If R70 didn't use the word wrenched, then she may not have. R70 did not fall. I cannot reach DON. We don't see any communication between DON and staff of another investigation started by DON. When asked if this can be, she stated yes, she could have started an investigation on paper and not on the computer. There is a nurses note. I saw the 27th maybe he said something about his knees buckling and nurse got him back to bed. You know you don't lose your balance neatly. So, it is not necessarily graceful, and it prevented a fall. We investigate like crazy. Yesterday we started an investigation just because of the discoloration.</p> <p>Abuse & Neglect Policies/Procedures in Administrative Manual with a revised date of September 2016 received and reviewed on 6/11/2024 reads:</p> <p>V. Internal Reporting Requirements and Identification of Allegations:</p> <p>All employees are required to report any incident, allegation or suspicion or potential abuse or mistreatment they observe, hear about, or suspect.</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Respond appropriately to all alleged violations.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036</p> <p>Based on observation, interview, and record review, the facility failed to initiate an investigation in a timely manner for an allegation of abuse for one of one resident (R70) reviewed for abuse in a total sample of 35.</p> <p>Findings include:</p> <p>R70 is a [AGE] year-old resident admitted to facility on 02/29/2024 with medical diagnoses including but not limited to: legal blindness, muscle weakness, paroxysmal atrial fibrillation- on a blood thinner, polyneuropathy, essential hypertension, prediabetes, and moderate protein-calorie malnutrition.</p> <p>R70 has a Brief interview mental status (BIMS) score of 14/15 dated 06/04/2024 which means cognitively intact.</p> <p>R70 requires partial/moderate assistance for eating, oral hygiene, toileting hygiene, upper body dressing and personal hygiene according to MDS section GG dated 6/4/2024.</p> <p>R70 requires substantial/maximal assistance for shower/bathe self, lower body dressing and putting on/taking off footwear according to MDS section GG dated 6/4/2024.</p> <p>R70 is on an anticoagulant medication.</p> <p>In physical therapy note written by V11 (physical therapy manager) dated 5/27/24 at 01:51 PM reads He (R70) reported that somebody tried to wrench his arm when he was attempting himself to get to the toilet.</p> <p>On 5/27/2024 at 01:56 PM x-ray was completed on R70 left shoulder, complete 2 views. Report documents slightly swollen and c/o (complaint of) pain. Impression: No acute skeletal injuries of the left shoulder.</p> <p>On 06/10/24 at 10:37 AM R70 was interviewed by surveyor in his room. He was alert and oriented to person and place. R70 stated I believe the guy's name is V12 first name. I woke up very early in morning and was very confused and V12 or whatever his name is got all excited because I was out of my bed and calling mommy or help to get help to go to the bathroom. He wrenched my arm. It didn't hurt that day, but it started hurting. I told V11 the next day and they took pictures. V11 is the head of Physical therapy. It happened in March or April. I don't know when the last time I seen him work. I have been putting heat compresses on it. I am on blood thinners. I think the staff rotate shifts. He speaks with an accent. I think he is Filipino. My biggest problem with him is his attitude like he is the boss and doesn't take your side of the story. You can't reason with V12. R70 left upper arm purple and yellow almost full length of upper arm to elbow on front side. States it is spreading. It doesn't hurt now.</p> <p>(continued on next page)</p>		

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<p>F 0610</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>On 06/11/24 at 03:15 PM Interview with V2 Abuse coordinator. When asked how you go about investigation V2 stated immediately report and look at the details of event. It is not reportable if it is witnessed. Avoid abuse, we work as a team we start an investigation immediately. We train staff on abuse and abuse reporting, Staff report to nurse on the floor and myself or director of nursing (DON). Staff must report immediately. When asked why the x-ray was ordered V2 stated we ordered x-ray because resident reported pain. Nurse called doctor and got the order. Morning nurse called doctor and did x-ray. I am not aware of communication between V11 and V12. When asked if therapy staff should have reported this right away V2 stated yes either to me or his supervisor. This resident uses a lot of interesting language to describe something, like yesterday he said I have old man bones. He describes he got up and was looking for something, he thinks it was his mother and got confused and he thinks it was V12 but not sure that V12 was who caught him. My DON is in Italy, and I am unsure if she started an investigation or not. She can start investigation without me . If R70 didn't use the word wrenched, then she may not have. R70 did not fall. I cannot reach DON. We don't see any communication between DON and staff of another investigation started by DON. When asked if this can be, she stated yes, she could have started an investigation on paper and not on the computer. There is a nurses note. I saw the 27th maybe he said something about his knees buckling and nurse got him back to bed. You know you don't lose your balance neatly. So, it is not necessarily graceful, and it prevented a fall. We investigate like crazy. Yesterday we started an investigation just because of the discoloration.</p> <p>Abuse & Neglect Policies/Procedures in Administrative Manual with a revised date of September 2016 received and reviewed on 6/11/2024 reads:</p> <p>V. Internal Reporting Requirements and Identification of Allegations:</p> <p>All employees are required to report any incident, allegation or suspicion or potential abuse or mistreatment they observe, hear about, or suspect.</p> <p>VII. Internal Investigation of Allegations and Response:</p> <p>Incident or allegation involving abuse or mistreatment will result in an investigation.</p>		

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036</p> <p>Based on interview and record review, the facility failed to develop and implement a comprehensive person-centered care plan for abuse for one (R70) of one resident reviewed for abuse in a total sample of 35.</p> <p>Findings include:</p> <p>R70 is a [AGE] year-old resident admitted to facility on 02/29/2024 with medical diagnoses including but not limited to: legal blindness, muscle weakness, paroxysmal atrial fibrillation - on a blood thinner, polyneuropathy, essential hypertension, prediabetes, and moderate protein-calorie malnutrition.</p> <p>R70 has a Brief interview mental status (BIMS) score of 14/15 dated 06/04/2024 which means cognitively intact.</p> <p>R70 requires partial/moderate assistance for eating, oral hygiene, toileting hygiene, upper body dressing and personal hygiene according to minimum data set (MDS) section GG dated 6/4/2024.</p> <p>R70 requires substantial/maximal assistance for shower/bathe self, lower body dressing and putting on/taking off footwear according to MDS section GG dated 6/4/2024.</p> <p>R70 is on an anticoagulant medication.</p> <p>In physical therapy note written by V11 (physical therapy manager) dated 5/27/24 at 01:51 PM reads He (R70) reported that somebody tried to wrench his arm when he was attempting himself to get to the toilet.</p> <p>On 06/12/24 at 02:37 PM During Interview with V3 and V21 RN. V3 Regional Director stated we do not do abuse risk assessments on residents when they are admitted . Residents have a care plan for behavior or history of abuse or behavior of a resident. We do not do a separate abuse risk assessment; it may be brought up in social history but not as a separate assessment. I will continue to look in the charts, but we do not do an abuse risk assessment on residents when they are admitted .</p> <p>On 06/13/2024 at 09:28 AM V13 (Clerical supervisor and schedule coordinator) stated Per V3, we checked the medical records and do not have abuse care plans or risk assessments at this time for R70.</p> <p>(continued on next page)</p>

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<p>F 0656</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 06/13/24 at 11:00 AM, during phone interview with V4 (social service consultant), V4 said, I am an outside consultant with them; I have worked at the facility for about seven weeks now. I was hired to do MDS's and updating their care plans. I do not have anything to do with assessments when residents are admitted . I am not aware if there are any abuse risk assessments done on admission. I do not do any of the assessments. I do part of their care plans. When considering an abuse care plan, I ask residents if they have any history of drug abuse, suicidal issues, physical emotional or verbal abuse in the past. I would consider a dementia patient at risk for abuse. I would also consider a blind resident at risk for abuse. Both of those incidents would constitute an abuse care plan if they had definitive cognitive loss. But if resident is blind yes, an abuse care plan should be put in there. I also agree all dementia residents should have an abuse care plan as these residents are at risk for abuse. I just did R70's MDS, so the care plan is the next thing I am working on. I am unaware of any abuse care plan or abuse risk assessments for V70 as I am very part time and I have to go in and review it.</p> <p>Abuse & Neglect Policies/Procedures in Administrative Manual with a revised date of September 2016 received and reviewed on 6/11/2024 reads:</p> <p>Resident Assessment: As part of the resident social history assessment, and the MDS assessments, staff will identify residents with increased vulnerability for abuse, mistreatment or who have needs behaviors that might lead to conflict (i.e., combative behavior, verbal outbursts.) Through the care planning process, staff will identify any problems, goals and approaches, which would reduce the chances of abuse, mistreatment. Staff will continue to monitor the goals and approaches on a regular basis.</p> <p>Comprehensive care plan policy with a revised date of 11/17 reads:</p> <p>Policy Statement: An individualized comprehensive care plan that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychological needs is developed for each resident 7 days after the completion of the comprehensive assessment.</p> <p>2. The comprehensive care plan is based on a thorough assessment that includes but is not limited to the MDS.</p> <p>3. Each resident's comprehensive care plan is designed to:</p> <p>a. Incorporate identified problem areas.</p> <p>b. Incorporate risk factors associated with identified problems.</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on interviews and record reviews, the facility failed to follow careplan by not providing feeding supervision and assistance as required as documented in a resident's plan of care. This failure applies to one of three (R49) residents reviewed for falls and resulted in R49 sustaining a leg fracture during breakfast, while unsupervised.</p> <p>Findings include:</p> <p>R49's face sheet documents she is a [AGE] year-old female who was admitted to the facility 06/01/2021 with a diagnoses history of Mild Cognitive Impairment, Repeated Falls, and other Abnormalities of Gait and Mobility who was noted on 10/01/2022 with a diagnoses of Dementia with Other Behavioral Disturbance.</p> <p>R49's current physician orders document an active order effective 06/01/2021 for bed/chair alarm at all times and fall precautions; and an active order effective 04/18/2024 for an ortho consult scheduled on 04/19/2024 at 9:30 AM.</p> <p>R49's Quarterly Minimum Data Set assessment dated [DATE] documents she requires supervision or touching assistance with eating, and is totally dependent on staff for bed mobility, transfers, lower body activities, personal hygiene, and toileting activities.</p> <p>R49's current restorative and mobility care plan initiated 09/10/2023 documents she has decreased bed mobility due to decreased strength related to repeated falls and a history of a right arm fracture in addition to advancing age and dementia.</p> <p>R49's current care plan initiated 04/25/2024 documents she has a deficit in activities of daily living performance related to a diagnoses of mild cognitive impairment and dementia with behavioral disturbances and requires substantial assistance with eating.</p> <p>R49's current fall risk care plan initiated 04/25/2024 documents she has potential for falls related to a diagnoses of mild cognitive impairment and dementia with behavioral disturbances and other diagnoses including a history of falls, abnormalities of gait and mobility, atrioventricular block, cardiac arrhythmias and a history of fracture; additional risks include repeated falls, possible side effects of medication, impaired sense of balance, generalized weakness, cognitive impairment and poor ability to learn safety measures; on 04/17/2024 upon hearing R49 the nurse on duty rushed to her room and observed her coming out of the bed and sliding to a sitting position before the nurse could reach her; R49 sustained discoloration on her right shin where it grazed the bedside table as she slid down; R49 was noted to be delusional and stated she was attempting to get to her daughter whom she thought she heard by the doorway; the physician ordered x-rays and R49 was found to have a fracture of her right shin bone.</p> <p>R49's current care plan initiated 04/25/2024 documents she sustained a right fracture after a recent fall.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>R49's incident progress note created by 4/17/2024 at 11:20 AM created by V8 (Registered Nurse) documents she heard R49's bed alarm ringing and rushed to room and noted resident exiting bed and sliding to a sitting position before this writer could reach her to assist her.</p> <p>On 06/12/24 at 11:30 AM V19 (Certified Nursing Assistant) stated she was assigned to work with R49 on 04/17/2024. V19 stated she begins her shift at 7:15 for breakfast. V19 stated R49 was served breakfast in her room on 04/17/2024 and is always in her room. V19 stated she served R49 breakfast in her bed. V19 stated there were two other residents also in the room who were served breakfast as well. V19 stated R49 was scheduled to get a shower that day and she was getting the bath chair to shower her in. V19 stated she was returning to R49's room with a shower chair and towels to transfer her to the shower and when she entered the room, she saw R49 sitting on the floor close to her bed with her back leaned on the bed. V19 stated she then immediately called the nurse. V19 stated R49 did not respond when asked what she was doing on the floor. V19 stated R49 had two bedrails at the time, and they were raised. V19 stated she was wondering how R49 got on the floor with the bedrails. V19 stated R49 also had a bedside table in front of her with her breakfast on it when she last saw her, so she was surprised that she was on the floor. V19 stated R49 did not have any floor mats and her bed was at normal height and not lowered all the way to the floor. Observed V19 raise her arm to the level of an arm rest on a chair she was sitting at least three feet above the floor to demonstrate that the height of R49's bed during the day of her fall. V19 stated no one had ever told her that R49 had a history of falls. V19 stated she doesn't know if R49 was considered a fall risk at the time. V19 stated she had worked with R49 once before the day of her fall. V19 stated she had not been educated or informed of any specific fall prevention interventions for R49.</p> <p>On 06/13/24 at 02:08 PM V21 (RN) stated that R49 requires substantial assistance with eating according to her care plan initiated 11/27/2023. V3 stated she would guess if R49 requires substantial assistance with eating and staff weren't there with her the day she fell while she was eating, they should have been.</p> <p>The facility's Fall Precaution/Safety Intervention Policy received/reviewed 06/13/2024 states:</p> <p>Safety intervention tools maybe implemented to provide safety to the residents and to prevent falls.</p> <p>Safety intervention tools include interventions such as low bed.</p> <p>The facility's Comprehensive Care Plan Policy received/reviewed 06/13/2024 states:</p> <p>Our facility's Care Planning/Interdisciplinary Team, in coordination with the resident, his/her family or representative (guardian), develops and maintains a comprehensive care plan for each resident that identifies a higher level of functioning the resident may be expected to attain.</p> <p>The comprehensive care plan is based on a thorough assessment that includes, but is not limited to, the MDS (Minimum Data Set).</p> <p>Each resident's comprehensive care plan is designed to: Aid in preventing or reducing declines in the resident's functional status and/or functional levels as is possible; Incorporate the resident's personal and cultural preferences.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145122	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/13/2024
NAME OF PROVIDER OR SUPPLIER Dobson Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Dodge Avenue Evanston, IL 60202	
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)		
<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p> <p>Note: The nursing home is disputing this citation.</p>	<p>Care plan interventions are designed after careful consideration of the relationship between the resident's problem areas and their causes. When possible, interventions address the underlying source(s) of the problem area(s), rather than addressing only symptoms or triggers. It is recognized that care planning individual symptoms or care area triggers in isolation may have limited, benefit for the resident.</p> <p>Identifying problem areas and their causes and developing interventions that are targeted and meaningful to the resident are interdisciplinary processes that require careful data gathering, proper sequencing of events and complex clinical decision making.</p> <p>Assessments of residents are ongoing and care plans are revised as information about the resident and the residents condition change.</p>		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40718</p> <p>Based on observations, interviews, and record reviews, the facility failed to follow their policy and procedures by not properly labeling and storing food. This failure applies to all 77 residents in the facility who receive meals from the kitchen.</p> <p>Findings include:</p> <p>On [DATE] from 09:43 AM - 10:20 AM during kitchen observations observed an unlabeled partially closed bag of green beans stored in a freezer; Observed freezer number 5 outside thermometer temperature fluctuating from ,d+[DATE] degrees; Observed a large tub of ice-cream in freezer number 5 was soft; Observed 9 unlabeled packs of English muffins, and 9 unlabeled packs of plain bagels stored in the freezer; Observed one pack of raisin bagels with a sell by date of [DATE] stored in the freezer; Observed a large, opened pack of chocolate chip muffins with a use by date of [DATE] stored in the freezer; Observed 3 unlabeled large boxes of muffins stored in the freezer; Observed 2 packs of soft tortillas with a use by date of [DATE] stored in the freezer. Observed a 1.57-pound pack of hamburger buns with a use by date of [DATE] stored in the freezer. Observed five 6lb cans of canned foods stored with undented canned foods in the dry storage area; Observed a separate area for storing dented cans. Observed 2 unlabeled large 20ML bins containing oatmeal stored in the dry storage area. Observed 2 unlabeled 20ML bins containing dry milk powder stored in the dry storage area. Observed refrigerator number 7 with 8 heads of wilted lettuce stored inside. Observed a cart with a cup of coffee, a cup of juice, a bowl of cornflakes, and a partially eaten pastry sitting on the elevator with no staff around.</p> <p>On [DATE] at 10:35 AM V17 (Dietary Manager) stated when items are taken out of their original package the printed used by date is placed on the item before placing in the freezer for storage. V17 stated items should have use by dates to ensure consumption before expiring. V17 stated if the use by date of tortillas is February 2024 they are expired and should be discarded. V17 stated if the package date of hamburger buns is [DATE], they are no longer good to consume. V17 stated dented cans should be placed by the door or sent back right away. V17 stated we wouldn't want the dietary staff to use dented cans because they are not safe. V17 stated freezer temperatures should be below zero. V17 stated if ice cream is soft and the freezer temperatures showing higher than below zero this may mean the freezer isn't cold enough which could cause issues with proper storage and contamination. V17 stated the milk powder and oatmeal were delivered last week but they should have a visible date labeled on them. V17 stated if a food cart with a cup of juice, cup of coffee, bowl of cornflakes, and partially eaten pastry is left on the elevator unattended the residents could consume them and there is a risk of contamination, allergy, or possibly swallowing issues.</p> <p>The facility's Food Return/Rejection Policy received/reviewed [DATE] states:</p> <p>Any item which is past the use by date should be rejected.</p> <p>Storage of dry items including all shelf-stable dried foods includes visible labeling.</p> <p>Any canned item without a label should be rejected.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Dobson Plaza		STREET ADDRESS, CITY, STATE, ZIP CODE 120 Dodge Avenue Evanston, IL 60202	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Storage of Fresh Fruits and Vegetables including all fresh produce that is either whole or cut should have no wilting.</p> <p>The facility's Policy for Receiving and Storage of Food Items Policy received/reviewed [DATE] states:</p> <p>Upon delivery, food items are to be kept in their original packaging for storage. Once a food item (without a printed expiration date) is removed from the original box or packaging, the item is then to be labeled with the date of delivery.</p>		