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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145259	A. Building B. Wing	04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Park Strathmoor	5668 Strathmoor Drive Rockford, IL 61107

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 36186 Based on observation, interview, and record review, the facility failed to treat a resident with dignity while in the dining room. This failure applies to one of one residents (R79) reviewed for dignity in the sample of 31. The findings include: The facility face sheet shows R79 was admitted to the facility with diagnoses to include hemiplegia (paralysis to one side), type 2 Diabetes, and depression. The facility assessment, dated 3/14/24, shows R79 to be cognitively intact and requires set up assistance with eating. The Physician orders, dated April 2024, for R79 shows an order for no concentrated sweets, mechanical soft texture and thin liquids. R79's care plan for activities of daily living shows an intervention to allow enough time for completion of tasks. On 4/2/24 between the hours of 12:15 PM and 1:15 PM, R79 was observed feeding himself lunch in the dining room with the others residents. As many of the residents were finished eating, they were asking the staff to take them back to their rooms. The staff could be heard telling the residents they had to wait until all the residents were done eating. At approximately 1:10 PM, V16, Certified Nursing Assistant, could be heard saying to the residents they had to wait until R79 and other residents were done eating before the residents could be taken to their rooms. At 1:13 PM, R79 was asked if he was finished. R79 said yes and he was taken back to his room. There was half of R79's meal left on his plate, and the only beverage he drank was his coffee. At 1:23 PM, R79 was asked by this surveyor if he had gotten enough to eat, and he said no. R79 said he overhears the staff telling the other residents they have to wait until he is done eating before they can be taken back to their rooms. R79 said, I didn't realize I was such a deterrent to the others. On 4/3/24 at 12:28 PM, V16 said a staff member has to stay in the dining room while the residents are eating, so the other residents have to wait until everyone is done eating. V16 said she would never mention another residents name as a reason why she could not help them. (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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 4/4/24 at 10:07 AM, V2, Director of Nursing, said the residents should be allowed the time they need to finish eating. V2 said there are plenty of staff available to help the residents get back to there rooms. V2 said the staff should not mention another residents name as a reason why they have to wait. The facility care plan, with a revision date of 6/2023, shows the facility will promote care for residents in a manner and in an environment that maintains or enhances each residents dignity and respect in full recognition of his or her individuality.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39537 Based on observation, interview, and record review, the facility failed to ensure pressure ulcer interventions were in place, residents were turned and repositioned, and residents at risk for pressure had prevention measures in place for 5 of 12 residents (R146, R2, R11, R36, R75) reviewed for pressure ulcers in the sample of 31. The findings include: 1.R146's Facesheet, dated 4/4/24, showed diagnoses to include, but not limited to: chronic respiratory failure, stroke with right sided weakness, disorder of the brain, acute necrotizing hemorrhagic encephalopathy, generalized edema, dysphagia, sacral pressure ulcer, neuromuscular dysfunction of the bladder, gastrostomy tube, and patent foramen ovale. R146's facility assessment, dated 1/20/24, showed he had severe cognitive impairment and was dependent on staff for all ADLs (Activities of Daily Living). R146's Care plan, iniated 3/14/24, showed, [R146] has an ADL functional performance deficit related to chronic respiratory failure, hemiplegia, HTN (hypertension), brain disorders, diabetes, dysphagia, edema, and muscle weakness . R146's Care Plan, initiated 3/14/24, showed, Actual alteration in skin integrity related to a stage 3 pressure injury on his sacrum, present on admission. Also has a healing tracheostomy . Pressure reduction foam mattress or pressure redistribution support (low air or alternation air) in bed. R146's Physician Order Sheet, dated 4/4/24, showed, low air loss mattress. R146's Weight on 4/1/24 showed 176.9 pounds. R146's Wound Assessment, dated 3/29/24, showed R146 had a sacral wound measuring 8 cm x 3 cm x 0.3 cm with 60% granulations; 20% necrotic/brown eschar; and 20% epithelialization. The note showed to continue offloading (proper use of the air mattress and turning/repositioning) and providing pericare. On 4/2/24 at 10:43 AM, R146 was lying on an air mattress, with the head of his bed elevated. The air mattress control panel was attached to the foot of the bed. The number on the weight display showed 270 pounds. R146's air mattress model had a digital display that showed the weight in numbers. At 1:29 PM, R146 was observed lying on the air mattress. The weight display showed 270. On 4/3/24 at 10:43 AM, R146 was lying in bed and the tube feeding pump was alarming. The air mattress weight display now showed 180. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 4/4/24 at 8:40 AM, V11 (Licensed Practical Nurse - LPN), V10 (Unit Manager), V3 (Wound Care Nurse), and V13 (Certified Nursing Assistant - CNA) entered R146's room to provide wound care. V13 (CNA) assisted R146 with turning to the left side. V11 (LPN) used hand on hand to assist R146 in turning further on his side. V11 removed an old foam dressing to R146's sacral wound. R146's entire sacral area had redness, and there were two open areas noted, one at the top of the gluteal cleft and one just to the right of this area. V3 (Wound Care Nurse) said she rounds with the Wound Care Nurse Practitioner, and she had assessed this area as one pressure wound. V11 completed the R146's dressing change. R146 remained on the air mattress with the weight display at 180. The surveyor asked V3 (Wound Care Nurse) what the settings on the air mattress display meant. V3 replied, I'm not an expert on the beds, but [V10] received the training and she knows how they work. V10 (Unit Manager) stepped up and said the 180 was the weight setting. V10 said the resident's weight is obtained and the bed is set with the correct information. V10 said she would have to check R146's weight and left the room. V10 returned and said R146's weigh was 176. The surveyor asked V10 if there was any reason R146's weight would have been set at 270. V10 stared blankly and replied, No, it should not have been set at that. I have no idea how it would have been. V10 said the display panel on R146's model did not lock, someone could have changed it. V3 (Wound Care Nurse) said the air distribution and firmness of the bed would be based on the resident's weight. V3 said the bed would be more firm with a higher weight setting. V3 said it's important to ensure the air beds are set properly for wound healing and prevention of pressure wounds. V3 stated, I don't know who is responsible for ensuring the beds are set properly, but someone should be rounding daily to check that. 2. R2's Facesheet, dated 4/4/24, showed diagnoses to include, but no limited to: chronic respiratory failure, diabetes, dependence on ventilator, osteoarthritis, hypertension, gastrostomy tube, congestive heart failure, unspecified convulsions, disorder of adrenal gland, aphasia, schizophrenia, hydrocephalus, and stroke. R2's Physician Order sheet, dated 4/4/24, showed low air loss mattress. R2's Weight on 4/1/24 was 161.8 pounds. R2's Care Plan, initatied 2/28/20, showed, [R2] has an ADL self care performance deficit related to limited mobility, CVA (stroke), chronic respiratory failure, HTN (hypertension), GERD, gastrostomy, type 2 diabetes, and osteoarthritis . R2's Care Plan, initated 2/10/20, showed, [R2] has the potential for alteration in skin integrity secondary to incontinence, assist required with bed mobility, and presence of medical equipment which may cause pressure. Has chronic moisture in skin folds causing rashes. MASD (Moisture Associated Skin Disorder) from loos stools related to antibiotic use . Pressure reduction foam mattress or pressure redistribution support (low air or alternating) in bed . (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 4/2/24 at 10:44 AM, V29 (Registered Nurse - RN) entered R2's room to administer medications. R2 was lying in an air bed. R2's elbows, wrists, knees, and hips were contracted. R2's arms were tucked tight against her chest, and her legs were pulled up toward her bottom. R2 was nonverbal and totally dependent on staff for care. R2 was receiving mechanical ventilation. V29 said R2 is contracted all over and is at risk for developing pressure ulcers. V29 said she is completely dependent on staff for all ADLs and doesn't communicate with the staff. R2's air mattress display had several green hash marks that displayed the weight setting. R2's showed that her bed was set at 340. At 1:19 PM, V30 (Respiratory Therapist - RT) entered R2's room to provide a nebulizer treatment. R2 was lying on her back, in the air bed. The weight setting remained at 340. On 4/4/24 at 8:32 AM, R2 was lying in her air bed. The setting had been changed to 180. On 4/4/24 at 8:16 AM, the surveyor took V10 into R2's room. V10 said R2's air mattress a different model than R146's. V10 said R2's model showed the green hashes lit up to the weight setting. V10 stated, Right now it's set at 180. The surveyor asked why it would be set at 340. V10 replied, It should not have been set at 340. I don't even know how that would happen. This display has a lock button on it. When the beds are delivered, I set them at the correct settings. I don't know how they would have been set incorrectly. This is ridiculous. On 4/4/24 at 8:28 AM, V3 (Wound Care Nurse) said she didn't know why R2 was on an air bed. At that time, V12 (CNA) walked by and replied, Because she's on a vent. All our vents are on an air mattress. V3 said she would review R2's care plan and past assessments because she wasn't familiar with R2. V3 said R2's care plan showed she is at risk for skin breakdown due to her diagnoses and dependence on staff for movement. 31615 3. R11's admission record shows she was admitted to the facility on [DATE]. Her care plan for potential alteration in skin integrity documents a history of stage 3 pressure injuries to her sacrum. The interventions include a pressure reduction foam mattress or redistribution support (low air or alternating air)in bed. The facility resident matrix shows R11 currently has a Stage 3 pressure injury. On 4/2/24, the air mattress on R11's bed was a Proactive 4000/5000XD and was set at 210 pounds. On 4/3/24 the bed was set at 240 pounds. The weights and vitals summary sheet shows on 4/1/24, R11 weighed 186 pounds. 4. On 4/2/24, R36 was observed at frequent intervals between the hours of 10:00 AM and 2:30 PM, and during those observations, she was found to be lying on her back in bed. She had no pillows for repositioning or heels elevated during the observations. On 4/2/24, the air mattress was a Proactive Protekt 6000 and set to a weight of 280 pounds. On 4/3/24, the bed setting was 180 pounds. The weights and vitals summary sheet shows on 4/3/24, R36 weighed 157 pounds. On 4/4/24 at 9:50 AM, V27, CNA, said R36 has to be repositioned by staff at least every 2 hours as she is unable to move on her own. She said R36 has a pressure wound on her buttocks, and she needs to be moved so it can heal. 5. R75's 3/29/24 skin evaluation for R75 documents she has a stage 3 pressure ulcer to her sacrum. The same document shows a plan of care of off loading her torso, lower extremity, and general body. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	On 4/2/24, R75 was observed at frequent intervals between the hours of 10:00 AM and 2:30 PM, and during those observations R75 was sitting up in the same position in her bed. She was not out of bed for the noon meal or activities. R75 appeared to be a petite, frail woman. She had an air mattress Proactive 4000/5000XD on her bed set at 180 pounds. On 4/3/24 the bed setting was at 150 pounds. The weight and vitals summary shows on 4/1/24, R75 weighed 91 pounds. On 4/4/24 at 9:00 AM, V28 RN (Registered Nurse) said R75 has to be turned every 2 hours to relieve the pressure to the sacrum. She has a dressing change daily to her wound already on that area. The facility's Prevention and Treatment of Pressure Injury and Other Skin Alterations Policy, dated 3/2/21, showed, Policy: 1. Identify residents at risk for developing pressure injuries. 2. Identify the presence of pressure injuries and/or other skin alterations. 3. Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. The undated Air Mattress Operation Manual showed this mattress had individualized, customized settings. The manual showed, This product is designed to provide maximum comfort to patients. Make sure that you operate this product in a proper way optimizing its value . Weight/Pressure set up: Users can adjust air mattress to a desired firmness according to patient ' s weight or the suggestion from a health care professional .

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31615 Based on observation, interview, and record review, the facility failed to ensure a urinary catheter drainage bag remained below the level of the bladder during a transfer for 1 of 2 residents (R81) reviewed for urinary catheters in the sample of 31. The findings include: R81's admission record shows she was admitted to the facility on [DATE], with multiple diagnoses including retention of urine and chronic kidney disease. The facility quarterly assessment of 1/26/24 documents R81 to have an indwelling catheter. On 4/3/24 at 9:35 AM, V24 and V25, CNA's (Certified Nursing Assistants), said they were transferring R81 from her geriatric chair into bed. V25 widened the base of the mechanical lift while V24 was standing by R81, and removed the urinary drainage bag from the side of the chair. While removing the drainage bag, V24 raised the drainage bag over the level of the bladder and placed it on R81's lap in the mechanical lift sling. V26, LPN (Licensed Practical Nurse), was at the doorway supervising the transfer, and advised V24 to remove the drainage bag and put it below the bladder. V24 removed the drainage bag and placed it on the side of the bed. On 4/3/24 at 9:50 AM, V26 said V24 should not have raised the drainage bag above the level of bladder because it will cause the urine to flow back towards the bladder, and that could cause a urinary infection.

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to provide assistance at meals or implement interventions for a resident with significant weight loss for 1 of 5 residents (R48) reviewed for nutrition in the sample of 31. This failure resulted in R48 having a 10.22% weight loss in one month. The findings include: R48's face sheet showed a [AGE] year old female with diagnosis of Alzheimer's Disease, cerebrovascular disease, dementia, osteoarthritis, and chronic kidney disease. A diagnosis of failure to thrive was added 3/14/24. R48's weights showed a 2/1/24 weight of 107.6 pounds, and a 3/4/24 weight of 96.6 pounds. R48's 3/16/24 nutrition note showed R48's weight of 96.6 pounds was a 5% weight change in one month. This note showed a failure to thrive diagnosis was added, and the weight loss was contributed to a recent illness. No new interventions were added or recommended. R48's care plan showed she was at risk for dehydration and weight loss due to variable intake, history of dementia, and history of dehydration. This plan of care showed to monitor and encourage fluid intake, offer substitutes as needed and provide assistance or cueing for meals as needed. R48's physician order sheet (POS) showed a a 5/20/20 order for fortified potatoes, a 5/21/20 order for fortified cereal, a 2/7/22 order for a nutritional supplement twice daily, and a 12/5/23 order for fortified pudding. R48's 2/16/24 Nutrition Quarterly Assessment showed she required supervision with meals. On 04/02/24 at 12:36 PM, R48 was in a wheelchair at a table in the dining room. R48's food was in front of her. Staff were present in the room assisting other residents. R48 was not assisted, cued to eat, or prompted by staff. At 12:45 PM, R48 repeatedly moved away from the dining table by self propelling and moving the wheelchair away from the table. Staff would push her wheelchair back into place at the table . No attempts to assist or encourage R48 to eat were done. At 12:56 PM, R18, who was seated to R48's right at the dining table, pulled R48's plate of food away from R48 and toward herself. R18 ate some of R48's food with her fingers. R48 showed indifference at her food being taken. At 12:58 PM, V4, Memory Care Director, moved R48 in her wheelchair back to the dining table without noticing there was no food plate in front of her. R48 continued to attempt to move away from the table. (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	At 1:01 PM, V4 pushed R48 in her wheelchair from the dining room and down the hall to her room. On 04/03/24 at 08:44 AM, R48 was in a wheelchair at the dining table. Minimal food was gone from her plate. There was no staff assisting R48. There was no cueing, supervision, or prompting her to eat. On 4/4/24 at 9:15 AM, V14, Dietician, said she was familiar with R48, and R48 is to be supervised during meals. I would expect the staff to be watching the residents, assisting them as needed, and to intervene if another resident is removing food from her tray. Due to her diagnosis of dementia, some days she eats well on her own, and other days she just stares off and needs staff assistance to eat. It's variable. I expect the staff to ensure they are meeting her needs each day. Cueing is an important aspect of meal supervision. Her PO (oral) intake is variable between 50-100%. On 4/4/24 at 10:42 AM, V2, Director of Nursing (DON), said R48 was diagnosed with shingles on 2/12/24, and was isolated in her room. V2 said, That's the reason for her weight loss.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35175 Based on observation, interview, and record review, the facility failed to to ensure a resident's breathing treatment equipment was stored in a manner to prevent cross contamination for 1 of 5 residents (R117) reviewed for respiratory in the sample of 31. The findings include: R117's face sheet showed a [AGE] year old male with diagnosis of acute and chronic respiratory failure, dependence on supplemental oxygen, dementia, heart failure, hypertension, diabetes, heart failure, and chronic kidney disease. R117's physician order sheet (POS), dated 10/24/23, showed to administer a medicated breathing treatment solution every six hours using the breathing treatment machine for respiratory symptoms related to acute and chronic respiratory failure with hypoxia. R117's Medication Administration Record (MAR) showed the breathing treatment was administered on 4/2/24 at 5:00 AM. On 04/02/24 at 09:52 AM, R117's breathing treatment (nebulizer) mask and tubing was inside the top drawer of his bedside table. The mask and tubing were not dated or covered. On 4/4/24 at 9:15 AM, V2, Director of Nursing (DON), said, Nebulizer and oxygen tubing and masks should be dated when first used and stored in a plastic bag when not in use for infection control and to prevent cross contamination. Used nebulizer masks should not be stored uncovered in a bedside table drawer. Oxygen and nebulizer treatment masks are changed weekly. After you left on 4/2/24 we did a sweep and switched out all the tubings, dated them, and made sure they were in plastic bags. A facility policy on storage of resident breathing treatment/oxygen equipment was requested and none was received.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36186 Based on observation, interview, and record review, the facility failed to safely administer medications as ordered by the physician for one of one residents (R74) reviewed for medication administration in the sample of 31. The findings include: The facility face sheet for R74 shows diagnoses to include hemiplegia (paralysis to one side of the body), hypertension, delusional disorders and anxiety. The facility assessment dated [DATE] shows R74 to be cognitively intact and is dependent on staff for activities of daily living. On 4/2/24 at 9:30 AM, R74 was in her room and a medication cup containing 5 pills was observed on her bedside table. R74 said, Oh I forgot, I need to take those. The nurse assigned to the unit was not observed near R74's room. On 4/4/24 at 9:10 AM, V15, Licensed Practical Nurse (LPN), said she delivered medications to R74 that morning, and said R74 refuses to take her medications when staff are in the room. V15 said she will take the prescribed narcotic while she is observed, but not the other medications. V15 said R74 will take the medications right after she leaves the room. On 4/4/24 at 10:07 AM, V2, Director of Nursing, said unless care planned, a resident is to be observed taking the medications, and the medications should not be left at the bedside. The Physician orders, dated 4/4/24, does not show any orders for self administration of medications. The current care plan for R74 does not show any interventions for self administration of medications. The medication administration record, dated April 2024, shows 5 medications were administered to R74 on 4/2/24 during the 8 AM medication administration. The facility policy, dated 3/2021, for medication administration shows to ensure that medications are administered safely as prescribed. 3. medications are prepared and administered by the same staff. Administrations should occur at the time of preparation.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34891 Based on observation, interview, and record review, the facility failed to ensure multi-dose vials were labeled when opened (R16, R13), failed to dispose of an expired medication (R56), and failed to double lock a controlled medication (R127) for four of four residents reviewed for medication storage in the sample of 31. The findings include: 1. R16's April 2024 order summary report showed an order start, dated 11/2/20, for fluphenazine decanoate (antipsychotic) to be administered intramuscularly at 37.5 milligrams every 21 days for schizophrenia. R13's April 2024 order summary report showed an order start, dated 6/7/17, for fluphenazine decanoate (antipsychotic) to be administered intramuscularly at 25 milligrams/milliliter every 28 days for schizophrenia and bipolar disorder. On 4/3/24 at 9:51 AM, R16 and R13's medications were in the B wing medication room. Both multi-dose vials were opened, and half of the medication had been dispensed. The vials were not dated with any open date or staff identification. 2. On 4/3/24 at 9:51 AM, the B wing medication room contained eight multi-dose vials of haloperidol (antipsychotic), which was labeled with R56's name. All eight vials were sealed and showed expiration dates of January 2024. R56's April 2024 order summary report was reviewed, and there was no order for the haloperidol. On 4/3/24 at 10:00 AM, V22 (Registered Nurse) stated she would guess the open multi-dose vials for R16 and R13 were only good for 30 days. V22 said after that it needs to be dumped. V22 said, The vials are undated and there is no way of knowing how long they are usable. They should have been dated so staff know when they are expired. V22 stated, The haloperidol is expired and needs to be discarded. It cannot be used after the expiration date. There is no need for it to be in the medication room. It should have been given to the Director of Nurses already. There is the potential to accidentally give it to the resident. It could cause a fatal mistake or not work as well. On 4/3/24 at 2:19 PM, V23 (Nurse Consultant Pharmacy) stated multi-dose vials need to be labeled with the open date, and are only good for so many days. V23 said the fluphenazine manufacturer determines how long the vials are usable after being open. V23 stated expired medication could become less potent and be less effective. V23 said there should not be expired medications in the medication room. There is the potential for nurses to give it to the resident by mistake, and it needs to be disposed of as soon as it is expired. At 3:05 PM, V23 verified the fluphenazine vials were usable for 28 days after being opened. V23 said there is no way of knowing when to disposed of the vials when the dates are missing. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Park Strathmoor	5668 Strathmoor Drive Rockford, IL 61107

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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Storage/Labeling/Packing of Medication policy, dated 1/2022, states: 4. Medication requiring refrigeration are stored in a refrigerator located in a locked room accessible only to licensed staff. 5. Individual resident's medications are stored and labeled according to legal requirements, including requirements of acceptable manufacturing practices. 10. Medication containers that are damaged, soiled, contaminated, or outdated are immediately removed and either returned or disposed of according to procedure. 35175 3 R127's face sheet showed a [AGE] year old female with diagnosis of dementia, severe protein calorie malnutrition, depression, Raynaud's syndrome, Systemic Lupus Erythematosus, functional quadriplegia, coronary artery dissection, heart failure and rheumatoid arthritis. On 04/03/24 at 08:51 AM, the medication storage task was done on the facility's memory care wing. This surveyor was assisted by V4, Memory Care Director. V4 was looking through keys to unlock the medication refrigerator in the medication room. This surveyor reached down and opened the unlocked door. Inside the refrigerator was an unopened bottle of lorazepam with R127's name on it. On 04/03/24 at 1:40 PM, V23, Nurse Consultant/ Pharmacy, said, Liquid lorazepam should be stored under 2 locks. It is considered controlled drug and has potential for abuse. V23 said she would check to see if there's a policy. The refrigerator should be locked for safety. That's not stored properly. A lorazepam controlled drug storage policy and recommendations was requested and not received. R127's physician order sheet (POS) showed a 3/27/24 order for lorazepam concentrate (liquid) to be given every four hours as needed. The National Institutes of Health (NIH) website showed lorazepam concentrate had a risk of abuse, misuse, and addiction. This drug was a Schedule IV medication with a potential for abuse and addiction and should be refrigerated. This site showed lorazepam was a federally controlled substance because it can be abused or lead to dependence.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/04/2024
NAME OF PROVIDER OR SUPPLIER Alden Park Strathmoor		STREET ADDRESS, CITY, STATE, ZIP CODE 5668 Strathmoor Drive Rockford, IL 61107	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34891 Based on observation, interview, and record review, the facility failed to maintain sanitization logs, and failed to ensure food was covered during transportation. This applies to all residents residing in the facility. The findings include: The CMS 671 form, dated 4/2/24, showed 155 residents residing in the facility. 1. On 4/2/24 at 9:53 AM, staff were observed using the facility dishwasher after the breakfast meal. V18 (Dietary Aide) stated, The dishwasher sanitizing temperature is tested with a heat strip before every use. It is tested before every meal to be sure it is running hot enough to clean the dishes correctly. The test results are documented on the log after each test. At 10:20 AM, V20 (Dietary Aide) tested random sanitizer buckets for the proper chemical levels. V20 said the buckets are tested three times each day, and the results are documented on the log. The March and April 2024 dishwasher and sanitation bucket logs were reviewed with V17 (Dietary Manager) present. The March dishwasher log was missing eight temperature test results. The March sanitation bucket log was missing 34 sanitation level test results. On 4/3/24 at 2:50 PM, V17 stated, It is important to test and document the results, so we know the dishes and surfaces are being sanitized correctly. Staff should be checking and documenting test results three times per day. Residents are at risk of food borne illness if dishes and surfaces are not clean. The facility's Mechanical Washing Sanitation Testing policy revision, dated 3/18, states: Before dishes are washed, the sanitation temperature or chemical sanitizer in the dish machine should be tested with the correct test strip . 2. On 4/2/24 at 11:31 AM, V19 (Dietary Aide) was observed transporting resident food carts from the basement kitchen to the first-floor kitchenette area. The carts came up from the basement via a common elevator used by staff and visitors. The dessert cakes on every cart were uncovered. On 4/3/24 at 11:39 AM, the resident lunch carts were observed in the first-floor kitchenette and C wing dining room. The chocolate puddings on every cart were uncovered. Dietary staff were observed exiting the elevator with additional lunch carts. All puddings were uncovered. At 2:48 PM, V17 (Dietary Manager) stated he was not sure why the desserts are not covered prior to leaving the kitchen. V17 said the foods are covered before being transported onto the resident units, but not on the way up to the kitchenette for plating. V17 said all food should be covered to prevent dust and other particles from falling on top of the food. V17 stated the desserts should have been covered prior to being transported upstairs. The facility's Transportation of Food policy revision dated 8/18 states: .Food will be transported in a covered container as quickly as possible.