| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | 145479 | A. Building<br>B. Wing | 05/02/2025 |

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| Atrium Health Care Center | 1425 West Estes Avenue<br>Chicago, IL 60626 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>39779<br><br>Based on observation, interview, and record review the facility failed to maintain or enhance residents' dignity during dining when residents seated at the same table were served their meals at different times for two residents (R7, R41) reviewed for dignity in the total sample of 61.<br><br>Findings include:<br><br>On 04/29/25 at 11:28 AM during the dining observation in the third-floor dining room there were seven tables that seated two -four residents for dining. V19 (Certified Nurse Assistant) was observed passing out the meal trays to the residents at multiple tables without completing the service of the meals at one table before serving a meal tray to another table. R7 was served his (R7) meal tray at 11:42 AM. R7 waited 7 minutes to be served after the first residents meal tray was served at the same table that seated four residents. V19 served multiple meal trays at different tables and two resident rooms before serving R7.<br><br>R41 was seated across from R7. At 11:44 AM R41 asked about her meal tray.<br><br>On 04/29/25 at 12:02 PM When surveyor asked V19 (Certified Nurse Assistant) why the residents were served at multiple tables before completing the service to one table at a time. V19 responded, because sometimes the residents do not come at the same time. The meal trays are not aligned, and it is difficult. I was stretching my neck to see where the person is sitting. We would serve one table at a time, that's what we would do before. The residents will sit awkwardly and to keep the place calm we don't say anything.<br><br>On 04/30/25 at 11:37 AM V5 (Dietary Supervisor) stated all residents should be served table by table. All residents at one table should be served before going to another table. The residents normally sit at the same table. We try to keep the trays together table by table. It could be an issue of dignity.<br><br>Document Titled Residents' Rights for People in Long-Term Care Facilities undated document in part: Your facility must treat you with dignity and respect and must care for you in a manner that promotes your quality of life.<br><br>Policy:<br><br>(continued on next page) |

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

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Titled The Dining Experience dated 2017 document in part: Meals served will respect the clients' dignity as an individual. Procedure: Meals are served at approximately the same time to all the clients sitting at a table.<br><br>Titled The Dining Experience reviewed 11/24 document in part: Meals served will respect the residents' dignity as an individual. Procedure: Meals are served at approximately the same time to all the residents sitting at a table. |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate foot care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342<br><br>Based on observations, interviews, and record reviews the facility failed to provide podiatry services for one (R355) of six residents reviewed for foot care in a sample of 61.<br><br>Findings include:<br><br>On 04/29/25 at 10:57 AM, observed R335 lying in bed without socks on. R335's toenails were long, extending far past his toes and were jagged. R335 said, my toenails are really long and when I put on my socks my long toenails get snagged on them, so I have to be really careful when I put them on. R355 stated he's been living here since February 2025, and no one has cut his toenails since his been living at the facility. R355 stated the last time he remembers a podiatrist cutting his nails was in October 2024. R355 said, that is why they are so long! and no one has asked me if I'd like my toenails cut or offered to cut them for me since I've been here. I'd like for someone to cut them because they are too long and need to be cut.<br><br>On 04/29/25 at 12:06 PM, V13 (Licensed Practical Nurse) stated the CNAs only cut fingernails, not toenails and there is a podiatrist who comes to the facility to cut the residents toenails twice a month. V13 stated she does not know the last time the podiatrist was here but there is a binder kept at the nursing unit for the staff to write down the name of the resident(s) who need to have their toenails cut. Observed V13 searching the nursing unit but unable to locate the binder.<br><br>On 04/29/25 at 12:09 PM, V13 observed R355 toenails and said, those are too long and need to be cut. V13 stated the resident's nails should be kept trim and the problem with the toenails being too long is they can rip which would hurt the residents.<br><br>On 05/01/25 at 8:58 AM, V2 (Director of Nursing) stated the facility contracts out for podiatry services to come the facility to cut all the resident's toenails. V2 stated the podiatrist is on site twice a month and when they come into the building, they check the podiatry binder located on the nursing unit for any new residents they need to see. V2 stated whoever is listed on the podiatry log gets seen that day by the podiatrist. V2 stated at the end of the day when the podiatrist gives her a list of the residents who they have seen they email her their assessments. V2 stated maintaining toenails is part of grooming and should be checked by nursing staff daily when doing ADL (Activities of Daily Living) care. V2 stated even if a resident requires limited assistance or supervision with personal hygiene, it is still the nursing staff's responsibility to view resident's toenails and alert the nurse if their toenails need to be cut. V2 stated it is important for resident's toenails to be cut trim for infection control prevention because germs can be hiding under the nailbed and to prevent possible injury related to pulled nail. V2 stated R355 was admitted [DATE] and he is a diabetic. V2 stated she is not sure if podiatry has seen R355 yet and R355 should have been seen by now because it has been 2.5 months since he was admitted to the facility.<br><br>On 5/01/25 at 10:08 AM, V2 viewed R355's toenails. V2 stated R355's toenails are long, and they need to be cut. V2 stated she already has a call into the podiatrist to let them know R355 needs to be seen.<br><br>(continued on next page) |

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| F 0687<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 05/01/25 at 10:09 AM, R355 stated my toenails bite! and is someone going to be able to help me? I really need them cut.<br><br>R355 diagnosis not limited to Diabetes Mellitus, Cerebrovascular Disease, Hypertensive Heart Disease with Heart Failure, Heart Failure, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side.<br><br>R355's MDS (Minimum Data Set) from 02/24/25 BIMS (Brief Interview for Mental Status) score is 15/15 indicating intact cognition and R355 requires supervision or touching assistance with personal hygiene.<br><br>Facility policy titled Resident Fingernail/Toenail Care revised January 2025 which documented in part, activity of daily living is important for maintaining resident's cleanliness, proper hygiene and dignity and resident needing toenail care/trimming, will be performed by outside Podiatrist. Staff will identify resident that is need of toenail care service during daily ADL care.<br><br>Facility provided copy of Podiatry Services provided listing names of residents seen by podiatry up to 04/11/25 date. R355's name was not on this list. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>47304<br><br>Based on observation, interview and record review, the facility failed to follow their policy to ensure controlled medication that require refrigeration are stored within a locked box within the refrigerator to decrease the possibility of loss or diversion for 1 (R68) resident reviewed for medication storage and labeling in a sample of 61.<br><br>Findings include:<br><br>On 4/29/25 09:55 AM Surveyor inspected 2nd floor medication room with V7 (RN / Registered Nurse) and found R68's Lorazepam solution kept inside unlock refrigerator. Lorazepam was not kept / stored inside a lock box.<br><br>R68's face sheet showed last admitted on 7/26/2024 with diagnoses not limited to Cerebral infarction due to thrombus, Hypothyroidism, Seizure, Heart failure, Hypertensive heart disease with heart failure, Vascular dementia, Dysphagia. MDS (Minimum Data Set) dated 1/28/2025 showed R68's cognition was impaired.<br><br>R68's physician orders dated 4/29/25 showed order not limited to Lorazepam 2 mg/mL oral concentrate, give 0.25 milliliter (0.5 mg) by oral route every 2 hours for 14 days as needed.<br><br>On 4/30/25 At 10:28am V2 (DON / Director of Nursing) stated she has been working in the facility for a year. She said Lorazepam is a controlled medication and should be kept / stored in lock box or locked refrigerator according to the regulations. V2 said it could be easily accessible to other staff if controlled medication was not stored / locked properly.<br><br>Facility's storage of medications policy dated 11/2020 showed in part: Controlled substances that require refrigeration are stored within a locked box within the refrigerator. This box must be attached to the inside of the refrigerator. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>47304<br><br>Based on observations, interviews and record reviews, the facility failed to ensure a medication error rate of less than 5% for 3 (R73, R125, R149) of 9 residents observed during medication administration. Surveyor observed 4 errors during 28 medication administration opportunities. This resulted in a medication error rate of 12.49%.<br><br>The findings include:<br><br>On 4/29/25 at 9:20AM Surveyor conducted medication administration observation with V8 (Licensed Practical Nurse / LPN) and she prepared the following medications for R73:<br><br>1. Celecoxib 200mg (milligram) 1 capsule.<br><br>2. Docusate sodium 100mg 1 capsule.<br><br>3. Vitamin C 500mg 1 tablet<br><br>4. Allopurinol 100mg 2 tablets<br><br>5. Acetaminophen 500mg 2 tablets<br><br>6. Folic Acid 100mg 1 tablet<br><br>7. Imbruvica 420mg 1 capsule<br><br>8. Vitamin D3 25mcg (micrograms) 1000iu (unit) 1 tablet<br><br>9. Iron tablet fe so4 (iron) 325mg 1 tablet<br><br>10. Miralax powder 17gm (gram) mixed with 1 cup water.<br><br>11. Fluticason Ellipta 100cmg/25mcg. R73 inhaled / puffed once.<br><br>12. Aspirin 81mg 1 tablet<br><br>On 4/29/25 09:28 AM V8 administered prepared meds to R73 and taken orally. V8 handed Fluticason Ellipta 100cmg/25mcg to R73 and inhaled / puffed once.<br><br>R73's MAR (medication administration record) and POS (Physician Order Sheet) reviewed and showed the following medication orders not limited to:<br><br>1. Celebrex 200mg give 1 capsule by oral route 2x per day.<br><br>2. Aspirin 81mg give 1 capsule by oral route 2x per day.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Risperidone 0.25mg tablet give 3 tablets (0.75mg) by oral route once daily at 9AM. Medication was not given during medication administration observation.<br><br>4. Docusate sodium 100mg give 1 capsule by oral route 2x per day.<br><br>5. Allopurinol 100mg give 2 tablets by oral route once daily.<br><br>6. Vitamin C 500mg give 1 tablet by oral route 3x per day.<br><br>7. Acetaminophen 500mg give 2 tablets by oral route 3x per day.<br><br>8. Folic acid 1mg give 1 tablet by oral route once daily.<br><br>9. Polyethylene glycol give 17grams by oral route 2x per day mixed with 8oz of water.<br><br>10. Imbruvica 420mg give 1 capsule by oral route once daily.<br><br>11. Breo Ellipta 100mcg-25mcg/dose powder inhale 1 puff by inhalation route once daily.<br><br>12. Vitamin D3 1000 unit give 1 tablet by oral route once daily.<br><br>13. Ferrous sulfate 325mg give 1 tablet by oral route once daily with breakfast at 9AM.<br><br>14. Oyster shell calcium 500mg 1250mg give 1 tablet by oral route 2x per day at 9am and 5pm. Medication was not given during medication administration observation.<br><br>On 4/30/25 at 8:55 AM Surveyor conducted medication administration observation with V29 (RN / Registered Nurse) and she prepared the following medications for R125:<br><br>1. Vitamin D 25mcg 1000iu 1 tablet<br><br>2. Famotidine 10mg 2 tablets<br><br>V29 administered medications to R125 and taken orally.<br><br>R125's MAR and POS reviewed and showed the following medication orders not limited to:<br><br>1. Vitamin D3 25mcg give 2 tablets by oral route once daily at 9am. V29 (RN) administered Vitamin D 25mcg 1 tablet to R125 during medication administration observation.<br><br>2. Famotidine 10mg give 2 tablets by oral route once daily.<br><br>On 4/30/25 at 9:13 AM V31 (LPN / Licensed Practical Nurse) checked R149's BP (Blood Pressure) = 132/73; HR (Heart Rate = 70/min) and prepared the following medications:<br><br>1. Amlodipine 10mg 1 tablet<br><br>2. Gabapentin 100mg 1 capsule<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 3. Fluticasone 50mcg nasal spray. V31 handed Fluticasone nasal spray to R149 and sprayed twice in each nostril during medication administration observation.<br><br>4. Carbamazepine 200mg 1 tablet<br><br>5. Folic Acid 400mcg 1 tablet<br><br>R149's MAR and POS reviewed and showed the following medication orders not limited to:<br><br>1. Folic acid 400mg give 1 tablet by oral route once daily.<br><br>2. Gabapentin 100mg give 1 capsule by oral route 3 times per day.<br><br>3. Fluticasone propionate 50mcg/actuation 1 spray by intranasal route in both nostrils once daily at 9am. R149 sprayed twice in each nostril during medication administration observation.<br><br>4. Carbamazepine 200mg give 1 capsule by oral route 2 times per day.<br><br>5. Amlodipine 10mg give 1 tablet by oral route once daily.<br><br>On 04/30/25 03:24 PM V2 (DON / Director of Nursing) stated nurses are expected to follow 5 Rs (Right resident, medication, route, dose and time) in giving medication to make sure giving medication as ordered by physician. If medication is missed, depending on the types of medication could have an effect with resident. V2 said if the nurse missed Risperidone, potentially resident could have behavioral issues. V2 said if medication was missed or not given according to doctor's order could have a potential harm / effect with the resident, medication has purpose which was prescribed to the resident.<br><br>Facility's medication administration policy (undated) showed in part: Check all medications against the MAR prior to administration. Follow the medication specific instructions specifically. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304<br><br>Based on observation, interview and record review, the facility failed to properly date opened multi-dose inhaler for 1 (R27) resident, ensure that multi-dose insulins and antibiotic medication were stored properly at appropriate temperature for 4 (R12, R33, R57, R205) residents and discard expired multi-dose vial injection reviewed for medication storage and labeling.<br><br>The findings include:<br><br>On [DATE] at 9:34 AM Surveyor inspected 3B medication cart with V6 (Licensed Practical Nurse / LPN) and found the following medications inside the medication cart:<br><br>- R205's Penicillin G 4ml (milliliter) injection with Pharmacy label indicated keep in refrigerator do not freeze. Medication was found inside the medication cart and was not refrigerated.<br><br>- R27's opened multi-dose Ventolin HFA inhaler with no open date label.<br><br>V6 said once inhaler is opened it should be dated to know when to discard.<br><br>On [DATE] at 9:41am 3rd floor medication room inspected with V6 and found the following inside the refrigerator with temperature logged at 40F:<br><br>- R12's Lantus insulin vial kept in fridge with open date on [DATE]. Pharmacy label showed: Refrigerate until opened. Discard 28 days after opening at room temperature. R12's Fiasp flex (Aspart) insulin with open date on [DATE]. Pharmacy label showed: Refrigerate until opened. Discard 28 days after opening at room temperature.<br><br>- R33's Basaglar insulin with open date on [DATE]. Pharmacy label showed: Refrigerate until opened. Discard 28 days after opening at room temperature. R33's Humalog insulin with open date on [DATE]. Pharmacy label showed: Refrigerate until opened. Discard 28 days after opening at room temperature.<br><br>- R57's insulin aspart with open date on [DATE]. Discard date - [DATE]. Pharmacy label showed: Refrigerate until opened. Discard 28 days after opening at room temperature.<br><br>On [DATE] at 10:01am 2nd floor medication room inspected with V7 (RN / Registered Nurse) and found inside the refrigerator: Opened house stock multi-dose Tuberlicin PPD Mantoux injection (Tubersol) vial with date opened [DATE] expiry date [DATE]. V7 said expired medication should be discarded.<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On [DATE] At 10:28am V2 (DON / Director of Nursing) stated she has been working in the facility for a year. She said unopen Insulin are supposed to be stored in the fridge, should be labeled with open date and discard date. V2 said medications should be stored properly according to pharmacy recommendation so not to affect the potency of the medication. She said insulin should not be administered cold to resident. V2 said nurses are expected to date every time they open inhaler, to know when it was opened and when to discard it. She said multi-dose inhaler should be discarded after 30 days of opening. She said Tuberlicin / mantoux injection should be dated once opened and discarded after 30 days to make sure potency is not affected.<br><br>R12's physician orders dated [DATE] showed order not limited to:<br><br>- Lantus U-100 insulin 100unit/ml inject 60 units subcutaneous route once daily at bedtime.<br><br>- Fiasp flexTouch U-100 insulin 100unit/ml inject 25 units subcutaneous route 3 times per day with each meals.<br><br>R27's physician orders dated [DATE] showed order not limited to Ventolin HFA inhaler 90mcg/actuation aerosol inhaler inhale 1 puff by inhalation route every 4 hours as needed.<br><br>R33's physician orders dated [DATE] showed order not limited to:<br><br>- Humalog U-100 insulin 100unit/ml inject 18 units subcutaneous route every day at 7am, 11am, 4pm.<br><br>- Basaglar insulin KwikPen U-100 insulin 100unit/ml inject 60 units subcutaneous route once daily at bedtime.<br><br>R57's physician orders dated [DATE] showed order not limited to Insulin aspart U-100 100unit/ml inject subcutaneous route insulin sliding scale.<br><br>Facility's storage of medications policy dated ,d+[DATE] showed in part: Outdated medication are immediately removed from inventory, disposed according to procedures for medication disposal. All medications are maintained within the temperature ranges. Room temperature 59F to 77F. Refrigerated 36F to 46F. Medications and biologicals are stored at their temperature and humidity according to the united states pharmacopeia guidelines for temperature ranges.<br><br>Facility's medication storage guide dated ,d+[DATE] showed in part: Fiasp, Lantus, Humalog U, Basaglar pen opened at room temperature (59F to 86F). Tuberlicin PPD, Mantoux injection (Tubersol) - keep refrigerated. Once vial is entered, the multi-dose vial should be discarded 30days after opening. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342<br><br>Based on observation, interview and record review, the facility failed to prepare pureed food in appropriate diet consistency form based on recipe and spreadsheet. This failure has the potential to affect four residents on pureed diets (R9, R15, R68, R75) prepared in the facility kitchen.<br><br>Findings Include:<br><br>On 04/30/25 at 11:06 PM, observed lunch tray line in progress. Desserts were already portioned out and on resident's meal trays. Observed regularly prepared gelatin without canned fruit on R9, R15, R68, R75's lunch trays. The regularly prepared gelatin without canned fruit was not pureed and the gelatin appeared firm and stiff, holding its shape in large, spooned portions in the bowl.<br><br>On 04/30/25 at 11:10 AM, V5 (Dietary Manager) stated the regular diets are receiving prepared gelatin mixed diced pears for dessert and the pureed diets are receiving regularly prepared gelatin but without the diced pears.<br><br>On 04/30/25 at 11:11 AM, V27 (Cook) stated he prepared regular gelatin with diced pears for the regular diets and the regular gelatin without dice pears for the pureed diets. V27 stated he did not puree the gelatin.<br><br>On 04/30/25 at 12:45 PM, V20 (Registered Dietitian) stated some of the reasons residents are on pureed diets is because they are missing teeth and cannot chew and/or they have swallowing issues. V20 stated those residents receiving pureed diets typically are at higher nutritional risk. V20 stated it is important for the cook to follow the recipes and the spreadsheets to make they are serving the food in the correct consistency. V20 stated if the spreadsheets list pureed gelatin to be served than it should have been prepared following the recipe for pureed gelatin and served in a pureed form. V20 stated the potential problem of a the resident on a pureed diet receiving regular gelatin is that the resident could choke or aspirate.<br><br>R9's diagnosis which includes but not limited to Dysphagia and has a physician order dated 01/04/25 for pureed diet with thin liquids. R9's MDS (Minimum Data Set) from 02/06/25 indicates resident is rarely/never understood. BIMS (Brief Interview for Mental Status) not able to be conducted. R9's meal ticket documents in part, R9 is on a pureed diet.<br><br>R15's diagnosis which includes but not limited to Dysphasia oral phase, Cerebrovascular Disease, Chronic Obstructive Pulmonary Disease, Unspecified Convulsions, Adult Failure to Thrive, Gastro-Esophageal Reflux Disease with Esophagitis and has a physician order dated 03/13/25 for pureed diet within thin liquids. R15's MDS dated [DATE] documents BIMS score 05/15 indicating severe cognitive impairment. R15's meal ticket documents in part, R15 is on a pureed diet.<br><br>(continued on next page) |

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| | 145479 | A. Building<br>B. Wing | 05/02/2025 |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R68's diagnosis which includes but not limited to Dysphagia oral phase, Cerebral Infarction due to Thrombosis of Unspecified Precerebral Artery, Seizures, Cognitive Communication Deficit and has a physician order dated 01/04/25 for pureed diet on nectar thick liquid. R68's MDS dated [DATE] indicates resident is rarely/never understood. BIMS (Brief Interview for Mental Status) not able to be conducted. R68's meal ticket documents in part, R68 is on a pureed diet with nectar thick liquids.<br><br>R75's diagnosis which includes but not limited to Dysphagia, Oropharyngeal Phase, Unspecified Intellectual Disabilities, Convulsions, Dementia, Gastro-Esophageal Reflux Disease without Esophagitis and has a physician order dated 02/17/25 for level 1 puree with mildly thickened liquid nectar. R75's MDS dated [DATE] documents BIMS score 08/15 indicating moderately impaired cognition. R75's meal ticket documents in part, R75 is on a pureed diet with nectar thick liquids.<br><br>Facility provided document titled Daily Spreadsheet titled CCA Kosher Menu - Fall 2024/Winter 2024-2025 Week 4 Wednesday which indicates pureed diets to be served pureed fruited red Jello (#10 scoop) at lunch.<br><br>Facility provided recipe titled Pureed Fruited Jello (gelatin) dated 07/18 which documents in part, as part of preparation procedure to measure portion of regular fruited Jello (gelatin) and pureed fruited Jello (gelatin) in food processor or blender until blended smoothly. Add thickener in small amounts as needed to reach desired consistency.<br><br>Facility provide policy titled Pureed/Dysphagia Diet dated 2010 documents in part, food will be provided in a form designed to meet individual needs. The texture of the food may be altered to pureed consistency. Standardized recipes for pureed food will be followed.<br><br>Facility provided policy titled Standardized Recipes dated 2010 documents in part, standardized recipes will be available in the kitchen and will be used in food preparation. All foods will be prepared according to standardized recipes provide by the menu source and standardized recipes include number of servings, ingredients, preparation directions, and serving sizes. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342<br><br>Based on observations, interviews, and record reviews, the facility failed to a.) ensure food items were properly labeled and dated, b.) food items were stored according to manufacturer recommendations, c.) discard expired food based on use by date and guidelines, d.) sanitize kitchen equipment based on manufacturers' procedure directions. These failures have the potential to affect all 150 residents receiving food prepared in the facility's kitchen.<br><br>Findings include:<br><br>On [DATE] at 9:10 AM, during initial kitchen tour V5 (Dietary Supervisor) stated when items are delivered, they are labeled with a delivery date. When items are opened or prepared, they should be labeled with opened and/or preparation date and with a use by date. V5 stated all items should be used within seven days with day one being the preparation date, day seven being the use by date. At the end of day seven items should be discarded. V5 stated it is important for items to be labeled with a delivery date, opened date, and use by date so the kitchen staff knows when to discard items, so they are not served to the residents to prevent food borne illnesses. V5 stated manufacturer use by dates are followed and manufacturer storage guidelines are followed as listed on the product.<br><br>On [DATE] at 9:12 AM, observed the following items in walk-in refrigerator:<br><br>1. An unlabeled plastic container with boiled eggs inside. There was no prepared or use by date on the container. V5 stated there is no way of knowing when the boiled eggs were prepared because they were not dated, and they should have been labeled with a prepared and use by date.<br><br>2. Small prepared container of tuna fish salad made with what appeared to be mayonnaise covered in plastic wrap. Observed milky-colored liquid pooling around the edges of the tuna fish salad. The container was not labeled with a prepared date or use by date. V5 stated the tuna fish salad should have been labeled and dated with a prepared and use by date.<br><br>On [DATE] at 9:25 AM, observed in a reach-in refrigerator referred by V5 as the thaw-out reach in a container labeled as mechanical soft cold cut salad. The item was labeled with a preparation date of [DATE] and a use by date of [DATE]. V5 stated this was ground bologna mixed with mayonnaise and served to residents on mechanical soft diets. V5 stated it should have been thrown out on [DATE] and should not be served to residents because it could potentially make the residents sick if someone was to serve the item to them.<br><br>On [DATE] at 9:30 AM - observed the following items being stored on the spice rack next to the tray line:<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 1.) Opened 48-ounce bottle of lemon juice, 50% filled. The lemon juice manufacturer label printed on the side of the bottle listed refrigerate after opening for best results. The bottle was not labeled with an open or use by date. V5 stated the spice rack is where the lemon juice bottle is usually stored, and she was not aware that it needed to be refrigerated once it had been opened. V5 stated when the bottle was opened it should have been labeled with an opened date, so the staff knows when to throw it out and it should be stored in the refrigerator based on the manufacturer label.<br><br>2.) Opened 1-gallon container of soy sauce, 75% filled. The soy sauce manufacturer label printed on the side of the soy sauce container read refrigerate after opening for quality. The soy sauce bottle was labeled with a delivery date [DATE] but was not labeled with an opened or use by date. V5 stated the soy sauce should have been labeled with an opened date and use by date when the item was opened and based on the manufacturer's guidelines the soy sauce should be stored in the refrigerator.<br><br>On [DATE] at 10:18 AM, during pureed food preparation observations observed V27 (Cook) take the dirty blender parts to the three-compartment sink and wash, rinse and then quickly dip each blender piece into the sanitizing solution while still holding onto the item for the following time frame: blender lid (2 seconds), blade (3 seconds), blender container (2 seconds), 8-ounce spoodle (3 seconds). After quickly dipping each blender part into the sanitation solution V27 placed item on the side of the sink. Then, observed V27 retrieve a clean towel cloth and use the towel to hand dry each of the blender parts.<br><br>On [DATE] at 10:21 AM, observed V27 take the hand dried blender parts and put them back on the base on the blender and proceed to prepare the pureed diced potatoes to desired consistency.<br><br>On [DATE] at 10:25 AM, observed V27 take the dirty blender parts to the three-compartment sink and wash, rinse and then dip each piece into the sanitizing solution while still holding the item for the following time frame: blender lid (2 seconds), blade (2 seconds), blender container (2 seconds), measuring cup (2 seconds).<br><br>On [DATE] at 10:27 AM, observed V27 retrieve a clean towel cloth and use the towel to hand dry each of the blender parts and place the parts back on the base of the blender for use.<br><br>On [DATE] at 10:28 AM, V5 (Dietary Manager) stated items need to be fully submerged in the sanitizing solution in the third sink of the three-compartment sink for 60 seconds. V5 stated if the items are not fully sanitized for 60 seconds, then bacteria can grow, and this has the potential to cause food borne illness and could make the residents sick. V5 stated all items washed, rinsed, and sanitized in the three-compartment sink should be air dried. V5 stated a towel should not be used. V5 stated the poster attached to the wall over the three compartment is from the manufacturer of the sanitization solution the kitchen uses.<br><br>On [DATE] at 10:30 AM, V27 stated he did not know the items he was cleaning needed to be left in the sanitizing solution for a full minute. V27 stated he knew the cleaned items should be allowed to air dry before using but he did not have a choice because he was in a rush to prepare the pureed food before the tray line could start and the kitchen only has the one blender to use for pureed preparation.<br><br>On [DATE], facility provided list of diet orders for all residents in the facility. The diet order list indicates there is one resident receiving nothing by mouth (NPO).<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Facility provided copy of manufacturer's poster titled, Procedure for 3 Compartment Sink which documents in part, immerse utensils in SANITIZER SINK for a full minute and remove utensils from SANITIZER sink. Invert to drain. Let them air dry, do not wipe.<br><br>Facility provided policy titled Manual Sanitizing in Three-Compartment Sink dated 2017 which documents in part, manufacturer's instructions on the wall poster above the three-compartment sink are followed and the length of the immersion time manufacturer's instructions are followed.<br><br>Facility provided policy titled, Labeling and Dating Food dated 2017 which documents in part, to decrease the risk of food borne illness and to provide the highest quality, foods is labeled with the date received, the date opened and the date by which the item should be discarded and refrigerated food prepared in the healthcare community is labeled with the date to discard or to use by and the discard/use by date will be a maximum of six days after preparation. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide and implement an infection prevention and control program.<br><br>47304<br><br>Based on observation, interview, and record review the facility failed to ensure staff wear proper PPE (Personal Protective Equipment) during high contact resident care activities for 1 (R1) resident on Enhanced Barrier Precautions (EBP) reviewed for infection control on the total sample of 61.<br><br>Findings include:<br><br>On 4/29/25 at 1:05 PM Surveyor conducted medication administration observation with V10 (LPN) and stated R1 is NPO (nothing by mouth) and has G-tube (Gastrostomy Tube). Observed R1 lying in bed, on moderate high back rest with G-tube feeding Nepro at 60ml (milliliter) flush 100ml every 8hrs (hours) infusing via pump. V10 prepared Valproic acid 250mg (milligrams) 5ml and administered medication via G-tube wearing gloves. Observed EBP (Enhanced Barrier Precautions) signage posted on the wall over R1's head part. V10 wore gloves during medication administration via G-tube but she did not wear gown.<br><br>On 4/30/25 At 10:28am V2 (DON / Director of Nursing) stated she has been working in the facility for a year. She said staff should observe EBP when resident has indwelling medical devices such as G-tube. V2 said if staff is performing high care resident activities such as G-tube medication administration, nurse should wear proper PPE such as gloves and gown to prevent cross contamination and prevent transmission of infection. She said if the nurse who administered medication via G-tube and not wearing proper PPE (Personal Protective Equipment) could potentially cross contaminate other residents she is taking care of or assigned to.<br><br>On 4/30/25 At 11:56am V4 (Infection Preventionist / IP NURSE) stated she has been working in the facility for 2 years. She said EBP are for residents with MDRO (Multidrug-resistant bacteria), with indwelling medical devices such as G-tube, indwelling urinary, dialysis catheter, open draining wounds. EBP signage is kept by door entrance or head of the bed to alert staff that resident is on EBP. V4 said when administering medication, feeding thru G-tube, staff must wear proper PPE such as gown and gloves to prevent cross contamination. Stated if staff is not wearing proper PPE it could cause potential cross contamination of other residents assigned to staff.<br><br>R1's face sheet showed last admitted on 2/20/2025 with diagnoses not limited to Encounter for attention to gastrostomy, Hyperlipidemia, Cerebral infarction, End stage renal disease, Dependence on renal dialysis, Hypertensive heart disease. MDS (Minimum Data Set) dated 2/27/2025 showed R1's cognition was severely impaired.<br><br>R1's physician orders dated 4/29/25 showed orders not limited to: Resident is placed on Enhanced Barrier Precautions due to Rt chest permcath for dialysis/Indwelling Foley Cath/ Wounds on the Sacrum/Peg-tube for feeding effective 2/20/25. Valproic acid 250mg/5ml give 5ml by G-tube route every 8 hours<br><br>Care plan dated 2/21/2025 showed in part: R1 is on Enhanced Barrier Precautions. Staff will wear PPE before entering resident's room.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Facility's EBP signage showed in part: Providers and staff must wear gloves and gown for the following high-contact resident care activities: Device care or use - feeding tube.<br><br>Facility's Enhanced Barrier Precautions policy dated 10/24 showed in part: EBP involve gown and glove use during high contact resident care activities. During care: Gown and gloves for these resident care activities: Feeding tubes. |