STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145510	A. Building B. Wing	06/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Avantara Lincoln Park	1366 West Fullerton Avenue Chicago, IL 60614

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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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 49666 Based on observation, interview, and record review the facility failed to encourage and assist residents with cognitive impairments to dress in their own clothes, rather than hospital type gowns for 22 (R165, R184, R58, R86, R133, R46, R51, R59, R56, R63, R15, R98, R67, R124, R54, R158, R23, R99, R158, R13, R176, R16) residents, b.) Assist residents in maintaining and enhancing his or her quality of life, by providing equal access to quality care regardless of diagnosis and severity of condition for 3 (R58, R133,R165) residents reviewed for resident rights. Findings include: 6/4/2024 10:47 AM surveyor observed nine residents in the dining area/activity room, sitting in their wheelchair, wearing clothes, appear clean, hair combed, and music playing. 6/4/2024 10:53 AM R165 observed in bed, wearing gown, breakfast tray on bedside table. 6/4/2024 11:05 AM R184 in bed lying down, wearing gown. 06/4/24 11:12pm V20 (Activity Director) states that she has been working for the facility for about 5 and a half months. V20 states that the third floor has their own different calendar being it is a memory care floor. V20 states that she creates the monthly activities schedule for the third floor. V20 states that the type of activities for third floor include sensory, tennis, kickball, water painting, picture bingo, etc. V20 states it is important for residents with dementia to engage in activities because it keeps them uplifted and encouraged. V20 states that a lot of them when they are listening to music, they enjoy dancing to it, they also enjoy the music therapy. V20 states that activities are held in the third-floor dining room at 10am and V20 states it may run until 11:50AM and then prep for lunch and pick up again around 2:30 PM. 6/4/2024 11:14 AM R58 observed in bed lying down, wearing a gown. Surveyor observed V13 (Certified Nursing Assistant/CNA) bring water to R58, resident states the water was too cold. V13 states R58 is confused. 6/4/2024 11:30 AM- observed R86 lying on her bed, wearing a gown. 6/4/2024 11:31 AM - R133 lying on bed, wearing a gown. (continued on next page)

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 - Some	6/4/2024 11:37 AM R46 lying in bed, wearing gown, awake, looking at window. 6/4/2024 11:39 AM V13 states that she has been working for the facility for a month, she states that she has 12 residents assigned to her. She states that some residents are bedbound. She states that the residents who are fall risk are up in the wheelchair in the dining room. V13 states that the residents who are in bed don't get up. She states that for the residents who are nonverbal or confused, they cannot walk, but if they do have scheduled therapy, staff will get them up. 6/4/2024 12:04 PM R51 observed lying in bed wearing gown. On 6/4/2024 12:28 PM V36 (Certified Nursing Assistant) states that she is responsible to make sure the other CNAs are doing their job. V36 states that she completes the daily CNA assignment sheets for the 3rd floor, V36 states that 11:00pm-7:00am shift has a get up list. V36 states that on the daily CNA assignment sheet it includes what rooms are assigned to the CNAs, who the residents that require feeding assistance, scheduled showers, residents with indwelling urinary catheters, colostomy bags, and residents who have appointments for that day. V36 states that this floor is the memory unit. V36 states that the 11:00pm-7:00am shift getup list of residents are residents that staff know aren't going to stay in bed. V36 states that R133 would have a fit if staff attempt to get him up. 6/4/2024 12:47pm, R86 observed laying on her bed, wearing a gown, eating her lunch, head of bed elevated. 6/4/2024 12:50pm, R46 observed lying in bed, head of bed elevated, wearing a gown, tray with lunch food, asked for something to drink, no cup observed on tray, open door, R46 shouted out asking for something to drink. 6/4/2024 12:54 pm, no drink provided to R46 yet. Observed R46 shout out again can I have something to drink please. 6/4/2024 12:57pm, V20 observed telling R46 that she will get her some juice. 6/5/2024 11:54 AM surveyor observations in activity room/dining room, observed residents working on puzzles, sensory aprons on the tables. Surveyor observed 11 residents in the activity room. V53 (Activity Aide) states that she has been working for the facility for 3 years. V53 states that usually there is a couple more residents in the activity room, which usually is the residents who wander. V53 states it is maybe 4 more residents. 6/5/2024 11:58AM observed R58 in bed, wearing a gown. 6/5/2024 12:00 PM observed R59 lying in bed, wearing a gown. 6/5/2024 12:01 PM observed R184 lying in bed, wearing a gown. 6/5/2024 12:02 PM observed R56 in bed, wearing a gown. 6/5/2024 12:02 PM observed R63 in bed, lying down, wearing a gown. 6/5/2024 12:03 PM observed R46 in bed, lying down, wearing gown. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/5/2024 12:04 PM observed R86 in bed lying down, wearing a gown. 6/5/2024 12:04 PM observed R15 lying in bed, wearing a gown. 6/5/2024 12:06PM observed R133 in bed, wearing a gown. 6/5/2024 12:07 PM R98 observed in bed wearing a gown. R98 states that she is not aware of any activities. R98 states she didn't know there were any activities. R98 states that maybe she would give it a try. R98 states that she does not know if she has her clothes with me. R98 states she does not know where they are. V20 walked in room and surveyor asked if V20 can open R98's closest with R98's permission. R98 gave V20 permission to view R98's closet. Surveyor observed one pair of pants, 2 shirts, and a jacket in R98's closet. 6/5/2024 12:12 PM observed R165 lying in bed, wearing a gown. 6/5/2024 observed R67 lying down, wearing a gown. 6/5/2024 2:16 PM V36 (CNA) states that there is no get-up list for 7am-3pm shift. V36 states 11pm-7am does have a get up list. 6/5/2024 12:18 PM observed R124 in bed wearing a gown. 6/5/2024 12:21 PM observed R54 in bed wearing a gown. 6/5/2024 observed R158 in bed wearing a gown, sleeping. 6/5/2024 12:22pm observed R23 in bed awake, wearing a gown. 6/5/2024 12:31 PM observed R99 in bed, wearing gown. 6/5/2024 12:35 PM V54 (housekeeping) states that room of R158 and R23 was scheduled for deep cleaning today, and V54 states that she finished deep cleaning the room already. V54 states that sometimes if residents cannot stand, they stay in bed. V54 stated that R23 stayed in bed while she deep cleaned the room. V54 states that R158 can get up and she was out of the room. V54 states that most of the time when there are deep cleanings, if the residents can't walk, they remain in the room. V54 states that she does not use harsh cleaning products and are safe products. 06/05/2024 3:00 PM V3 (Director of Nursing) states that there are no residents who are bedbound on the 3rd floor. 6/6/24 9:28 AM V25 (Social Worker) states that he started working for the facility at the end of March. V25 states that he has not heard a family member express that explicitly that they would like residents to remain in bed. V25 states that the benefits of resident getting up exercises, socialization. 6/6/2024 12:40 PM dining area, observed 12 residents sitting on their wheelchairs, eating. 6/6/2024 12:41 PM R58 sleeping in bed, wearing a gown, covered halfway by a sheet. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	6/6/2024 12:43 PM V55(CNA) states that she normally works on the 6th floor, and she states that she received report from other CNAs. V55 states that she wasn't aware of any get ups for 7am-3pm shift. V55 states that she didn't ask R58 to get up because she didn't think to ask her because V55 states that she was changing R58, and R58 was complaining of discomfort. R58 states that sometimes it can or cannot be helpful for residents to be up because if they are not alert and oriented, they may just sit there and not participate in activities. V55 states that it may be helpful for residents to be up because it can help them with their emotional state. 6/6/2024 1:00PM observed R56 lying in bed, wearing a gown. 6/6/2024 1:01 PM observed R98 lying in bed, wearing a gown. 6/6/2024 1:02 PM observed R13 in bed lying down, wearing a gown. 6/6/2024 1:03 PM observed R133 in bed lying down, wearing a gown. 6/6/2024 1:03 PM observed R165 in bed lying down, wearing a gown. 6/6/2024 1:04 PM observed R67 in bed lying down, wearing a gown. 6/6/2024 1:04 PM observed R176 in bed wearing a gown. 6/6/2024 1:05 PM observed R23 in bed wearing a gown. 6/6/2024 1:05 PM observed R16 in bed wearing gown. Facility document, not dated, titled Contract Between Resident and Facility Attachment D: Statement of Resident Rights documents in part: No resident shall be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of the Community, nor shall a resident forfeit any of the following rights: The right to live in an environment that promotes and supports each resident's dignity, individuality, independence, self-determination, privacy, and choice and to be treated with consideration and respect .the right to retain and use or wear personal property in Resident's immediate living quarters, unless deemed medically inappropriate by a physician and so documented in the resident's clinical record .The right to exercise free choice in selecting activities, schedules and daily routines.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45001 Based on observation, interview and record review, the facility failed to ensure four (R43, R53, R131, R135) residents had access to the call light system in a total sample of 35 residents reviewed. Findings include: On 6/4/24 at 11:55 AM, surveyor observed R43 lying in bed watching television. Surveyor observed R43's call light clipped to the edge of the mattress on the left side dangling to the floor. Surveyor asked R43 to get the call light. R43 made slight movements attempting to find the call light and then stated I can't reach it. I don't see it. Surveyor asked R43 what the purpose of the call light is. R43 responded I use it to call if I need to be changed. On 6/4/24 at 12:05 PM, surveyor asked V38 (Certified Nursing Assistant) to come to R43's room to observe the call light placement. V38 stated R43 could not reach the call light because it was dangling to the floor. V38 stated I clipped it to the bed and put it on R43's stomach. R43 moves around a lot. R43 is not independent. R43 needs assistance. R43 can only use the right hand. R43 can't use R43's left hand that I have seen. The purpose of the call light is so they can call for help. According to R43's Restorative UDA, Call Light Evaluation, 3/13/2024, R43 is cognitively able to use the call light and R43 is able to call for assistance by pulling the call light string or pressing the call light button with the use of the right and left finger(s), hand or arm. On 6/4/24 at 1:05 PM, surveyor observed R131 lying in bed watching television. Surveyor observed R131's call light coiled around the left side bed rail dangling to the floor. Surveyor asked R131 to get the call light. R131 responded I can't reach the call light. Surveyor asked R131 what the purpose of the call light is. R131 responded Use it to call the nurse. I try not to call but if I'm feeling really bad, I do. On 6/4/24 at 1:15 PM, surveyor asked V39 (Licensed Practical Nurse) to R131's room to observe call light placement. V39 stated R131 could not reach the call light where it was placed. V39 stated R131 has trouble moving R131's arms. According to R131's Restorative UDA, Call Light Evaluation, 5/9/2024, R131 is alert, oriented x/times 3 and is able to move upper extremity and is able to pull the call light string or press the call light button. On 6/4/24 at 1:35 PM, Surveyor observed R53 lying in bed. R53 stated I'm legally blind. Surveyor observed the call light coiled around the left side bed rail dangling to the floor. Surveyor informed R53 where the call light was located and asked R53 to get the call light. R53 attempted to reach left arm/hand backward and responded Can you help me get it. I can't get it by myself. Surveyor asked R53 what the purpose of the call light is. R53 responded To get help. I can't get help now. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/4/24 at 1:40 PM, surveyor asked V40 (Certified Nursing Assistant) to R53's room to observe call light placement. V40 stated R53 is not able to reach the call light where it is placed. The light is not attached to R53. It has a clip on the light. We usually clip it to the gown after care. The purpose of the call light is for R53 to call in case R53 needs something. We have to keep the call light in reach for the residents. If not, they can't call, and we don't know if they need anything. According to R53's Restorative UDA, Call Light Evaluation, 6/6/2024, R53 is cognitively able to use the call light and R53 is able to call for assistance by pulling the call light string or pressing the call light button with the use of the right and left finger(s), hand or arm. On 6/6/24 at 3:30 PM, V3 (Director or Nursing) stated the call light should be within reach of the resident. The call light is to accommodate resident's needs. Facility policy Call Light Policy, 7/27/23, documents in part: Be sure call lights are placed within reach of residents who are able to use it at all times. 45000 On 06/04/2024 at 11:26AM, surveyor located inside of R135's room and R135 requests assistance from surveyor to be repositioned in bed. Surveyor inquiries about R135's call light and R135 states he is unable to reach his call light. Surveyor observes R135's call light hanging on the right side of his and not within R135's reach. On 06/04/2024 at 11:28AM, surveyor makes V9 (Licensed Practical Nurse/LPN) aware of R135's need for assistance and R135's call light not being within reach. On 06/04/2024 at 11:30AM, V10 (Certified Nursing Assistant/CNA) arrives to the fourth-floor unit and states she is responsible for caring for R135. Surveyor makes V10 aware of R135's need for assistance and R135's call light not being within reach. On 06/04/2024 at 11:32AM, V10 and surveyor located inside of R135's room and V10 states R135's call light device is not within R135's reach. V10 is then observed placing R135's call light device within R135's reach. V10 states R135 is able to use the call light and make his needs known. R135's Face sheet documents that R135 has diagnoses not limited to: Parkinson's disease, spinal stenosis, overactive bladder, and repeated falls. R135's Minimum Data Set/MDS dated [DATE] documents that R135 does not score on the BIMS/Brief Interview for Mental Status and is cognitively impaired. R135's MDS documents that R135 requires substantial/moderate assistance with ADL care. R135's care plan dated 04/17/2024 documents in part, Ensure call light button is within R135's easy reach at all times while in room. Re-educate R135 to use the call light for staff assistance if in need of anything, R135's call light evaluation dated 06/05/2024 documents that R135 is unable to use his call light. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 06/05/2024 at 3:02PM, V3 (Director of Nursing/DON) states the purpose of the call light is to attend to the residents' needs. V3 states if a resident is able to use their call light, then the call light should be kept within the reach of the resident. On 06/05/2024 at 3:41PM, surveyor located inside of R135's room with V3 (DON). R135 now observed with his call light within reach. Surveyor inquires to R135 the purpose of his call light device. R135 states his call light device is used to get the staff to come and R135 states he is aware of how to use his call light device. Surveyor asks R135 to perform a return demonstration of how to use his call light device. R135 then presses his call light button, and an audible sound is heard coming from R135's call light. V3 states that based on the observation of R135 using his call light device, R135's current call light evaluation is not correct and R135 would have to be re-evaluated for the use of his call light. Facility policy dated 07/27/2023 titled Call Light Policy documents in part, 5. Be sure call lights are placed within reach of residents who are able to use it at all times.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 49666 Based on observation, interview, and record reviews, the facility failed to accurately complete Minimum Data Set (MDS) assessments using the CMS-specified Resident Assessment Instrument (RAI) process for 2 (R59, R133) residents reviewed for resident assessment in a sample of 35. Findings include: 06/04/24 11:09 AM observed R59 lying in bed, wearing a gown, yellow non-skid socks, observed toothless. R59 states that she manages to eat without any teeth, R59 states that she eats really slow and R59 states that she must take her time because sometimes she struggles. R59's dental hygiene encounter form dated 5/8/2024, documents in part: complete oral cancer screening with normal findings, edentulous swab. R59's MDS (minimum Data set) Section L for annual comprehensive assessment (10/17/2023) no documentation of R59's accurate dental status. R133's physician order set documents in part: R133 admitted to hospice 02/03/2024. R133's MDS (minimum Data set) Section O for annual comprehensive assessment (05/13/2024) no documentation of R133's accurate hospice care status. 6/6/24 at 12:05 PM V45 (Clinical Care Coordinator) states is it important to accurately complete the MDS assessments so the facility can have the most reliable and exact assessment for all the residents in the facility and V45 states the staff can provide the needed services for the residents. V45 states the MDS assessments are the basis of the care plans, and the care plan should match with the assessment. V45 states that after the assessment is completed, the care plans are review, at least after a week.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45001 Based on interview and record review, the facility failed to refer three residents with newly evident or possible serious mental disorders to the appropriate state-designated authority for review. This failure affects three residents (R73, R125, R166) reviewed for PASSR (Preadmission Screen and Resident Review) in a total sample of 35 residents. Findings include: R73 face sheet printed 6/6/24, indicates R73 has diagnoses that include but are not limited to psychotic disorder with delusions due to known physiological condition, onset date 11/7/2023; depression, onset date 11/7/2023; anxiety disorder, onset date 11/7/2023. R73 Illinois PASRR Level I Form Preadmission Screening and Resident Review, 10/30/2023, documents in part: Level I Outcome: No Level II Required - No SMI/ID/RC. Rationale: The Level I screen indicates that a PASRR disability is not present because of the following reason: There is no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. R125 face sheet printed 6/6/24, indicates R125 has diagnoses that include but are not limited to major depressive disorder, onset date 4/4/2024; depression, onset date 2/25/2024. R125 Illinois PASRR Level I Form Preadmission Screening and Resident Review, 1/17/2024, documents in part: Level I Outcome: No Level II Required - No SMI/ID/RC. Rationale: The Level I screen indicates that a PASRR disability is not present because of the following reason: There is no evidence of a PASRR condition of an intellectual/developmental disability or a serious behavioral health condition. If changes occur or new information refutes these findings, a new screen must be submitted. On 6/6/24 at 11:20 AM, V18 (Admission Director) stated I have been her since November 30, 2023, as Admission Director. I have not had a Level II as an Admission Director in three years. If a level II is needed, I would report to the social services team, and they would follow through with the level II process. I Know if a level II is needed because it would say it on the level I. PASSAR is to determine if this level of care is appropriate for them. Before admittance I make sure the PASSAR/level I is completed from the hospital. If coming from the community I go into Maximus/Assessment Pro to create a profile and upload their clinicals and complete the questionnaire to admit them. CCU will then do a screening and get the DON (Determination of Need)/OBRA score and do the level I. Everything is uploaded to Maximus. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/6/24 at 11:56 AM, V14 (Social Service Director) stated I have been director here for five months. The purpose of PASSAR I/OBRA is to make sure they qualify to be in the nursing home. The purpose of PASSAR II is to make sure residents with psych diagnoses and mental disabilities get the resources they need in regard to their diagnoses. Every resident is admitted with a PASSAR I. Admissions will report to Social Service when a resident requires a PASSAR II and can also use the Maximus portal. The facility has not had a resident to require a PASSAR II since I've been here. If a resident has a change in status, new psych diagnosis, we will complete a new PASSAR II. We have a Psychiatric Nurse Practitioner that comes in twice a week and if there are new diagnoses, they will report to us (Social Service and Nursing). That's how we know of the change. R73 has a level I. There should have been a request for a new screening because of the new diagnoses. New diagnoses of SMI (Serious Mental Illness) should be reported to Maximus for a level II. R73 anxiety disorder is SMI that should be reported. R125 has a level I. The new diagnosis of SMI, major depressive disorder, should have been reported to Maximus. I'm not sure if it was reported. There should have been a request for a new screening. With a change in condition there should be a request for a new screening. Facility policy PASSAR Screening of Residents with Mental Disorder or Intellectual Disability, 7/24/23, documents in part: It is the facility's policy to ensure that residents with mental disorder and those with intellectual disorder will receive PASSAR screening within the timeframe allowed. 45111 R166 is a [AGE] year-old individual whose current face sheet documents R166's medical conditions to include but not limited to: cerebral infarction, unspecified, anxiety disorder, unspecified, heart failure, unspecified, type 2 diabetes mellitus without complications, and R166 MDS (Minimum Data Set) section C-Cognitive patterns dated [DATE], documents R166's Brief Interview for Mental Status (BIMS) as 8/15. Indicating R166 has moderate cognitive impairment. On 06/06/2024 at 12:20pm, V14 (Social Services Director) stated a PASRR 11 triggers when a resident has a severe mental illness, and after it triggers, we consult with the cooperate consultant, and he request for a screening through maximum. V14 stated Illness such as Schizophrenia, bipolar, major depressive, anxiety would trigger the need for PASARR 11 screening, and the importance of PASARR 11 is to make sure residents with serious mental health illness receive the services they need due to their diagnosis. V14 stated R166 needed to be screened since he has diagnosis that fall under the serious mental illnesses category. R166's PASARR 1 is dated 05/23/2024 and R166's Physician Order Sheet (POS) dated 5/31/2023 documents R1's medical diagnosis of anxiety disorder, unspecified.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35432 Based on observation, interview and record review, the facility failed to implement effective fall precautions for two of three residents (R37, R95) who were identified as fall risks. The facility also failed to provide effective interventions and monitoring to prevent falls, failed to provide access for ambulatory equipment per resident assessment and care plan to prevent fall. This failure includes 1 out of 1 resident (R95) who sustained multiple falls in a single month. R95 also sustained multiple knee abrasions. R37 and R95 were two of three residents identified in a total sample of 35 residents. 41356 1. On 06/05/2024 10:08 AM, R95 was seen alert but with confusion hard to maintain conversation. R95 was seen with cast on his left arm and abrasion on both knees. R95 [AGE] years old, initially admitted on [DATE]. R95 medical diagnosis includes schizophrenia, bipolar disorder, and dementia. R95 cognition impaired with brief interview of mental status (BIMS) score of 4 dated 3/16/2024. Per residents' record, R95 had 4 falls for the month in May 2024. R95 fell on the following dates: 5/1/2024, 5/15/2024, 5/24/2024, and 5/29/2024. On 06/05/2024 at 11:50 AM, V12 (Fall Coordinator / Registered Nurse) stated that R95 had six (6) falls for this year from January to May 2024. And in one of the falls R95 sustained abrasion on his bilateral knees. On the fall dated 5/1/2024, V12 stated that intervention was to place R95 in the center of the bed to prevent from rolling out of the bed. V12 stated, Yes, R95 fell because he rolled out of the bed. On the fall dated 5/15/2024, V12 stated that the cause was that R95 slip from the edge of the bed. V12 stated that it happened around 1:15 AM. V12 was asked since the fall that happened on 5/1/2024 happened because R95 rolled out of the bed. How did R95 slip at the edge of the bed? Was there monitoring done? V12 did not answer. V12 then stated, We did educate staff to adjust height of the bed to resident sitting level when he transferred back to bed. On the fall dated 5/24/2024, V12 stated that it happened around 2:00 PM, R95 claims he wanted to sit in the chair. R95 sat on his roommate wheelchair. R95 abruptly transferred back to bed. R95 forgot to lock brakes lost balance end up on the floor. On the fall dated 5/29/2024 stated that R95 attempted to get out of the bed without a walker and fall. The walker was at the foot of the bed. R95 cannot reach the walker easily. R95 landed on the floor through his knees then causing abrasions on both knees. V12 stated that falls of R95 was related to his behavior. V12 was asked if fall care plan includes R95 behavior to prevent R95 to fall. V12 reviewed the care plan and said, I don't see care plan for behavior to prevent R95 from falling. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/05/2024 at 01:09 PM, V23 (Restorative Director / Licensed Practical Nurse) stated that based on the last quarterly MDS (Minimum Data Set) R95 needs supervision during all transfers. R95 needs rolling walker or walker with the wheels. R95 needs a walker when ambulating because without the walker R95 is at high risk for fall. Resident goes to the bathroom or toilet at times by himself because of his cognition he does not ask for help. Ideally walker needs to be placed next to resident. R95 is at high risk of falling when ambulating without a walker. Per MDS assessment dated [DATE], R95 needs walker for mobility device. Per R95 fall care plan dated 4/4/2024 intervention includes have commonly used items, especially walker, within reach at all times. Post Fall Investigation for R95 are as follows: Dated 5/1/2024, time of the incident 5:37 PM. Documents that R95 has poor safety awareness and slid off the bed. Dated 5/15/2024, time of the incident 1:15 AM. R95 fell at the edge of the bed when trying to sit. R95 miscalculated how low the bed was and slipped fell on the floor. Dated 5/24/2024, time of the incident 2:00 PM. R95 fell after sitting on roommate's wheelchair and abruptly transferred back to bed. Dated 5/29/2024, time of the incident 2:47 PM. Abrasion of bilateral knees due to fall. R95's walker was at the foot of the bed not within reach. R95 attempted to go out of the bed without using his walker and landed on the floor resulting with abrasion on both knees. 45000 2. On 06/06/2024 at 11:41AM, surveyor located inside of R37's room and observes R37's bed in a high position, R37's bed observed to not be in the lowest position. R37 observed in a supine position with head of bed at 45 degrees. R37's bed observed in a high position that reaches surveyor's mid upper thigh measuring approximately 2 feet, 8 inches in height. R37 states she is not sure why her bed is positioned so high. R37 states she doesn't want to fall again because she fell in the facility sometime last year and broke her knee cap. R37 states she is still healing from her injuries. On 06/04/2024 at 11:45AM, surveyor makes V9 (Licensed Practical Nurse/LPN) aware of R37's bed being in a high position. V9 located inside of R37's room and observes R37's bed position and states R37's bed should not be this high. V9 observed operating R37's bed and lowering R37's bed to the lowest position. R37's bed is now in a position that reaches the bottom of surveyor's kneecap measuring approximately 1 feet, 6 inches in height. V9 states with R37's bed being in a high position, R37 could have reached for something, fallen, and sustained an injury. V9 states one of R37's fall precaution interventions is to have R37's bed in the lowest position when R37 is in bed. On 06/04/2024 at 11:54AM, V11 (CNA) states she is responsible for caring for R37. V11 states she recently was inside of R37's room changing R37's incontinence briefs. V11 states she forgot to lower R37's bed to the lowest position. V11 states she handed R37 the remote to lower the bed herself because that's what R37 likes to do. V11 states it is still V11's responsibility to make sure R37's bed is in the lowest position. V11 states R37 could have fallen and sustained an injury from R37's bed being in a high position. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 06/04/2024 at 1:52PM, V12 (Fall Coordinator/RN) states he has been the fall coordinator at the facility since January 2024. V12 states when a resident is admitted , they are assessed for their risk for falls by completing a fall risk assessment. V12 states a fall risk assessment should be completed upon admission and each time a resident fall. V12 states fall risk interventions are documented in the resident's care plans and updated with each fall incident. V12 states he checks the facility's electronic health record/EHR system to check for resident's fall information in risk management. V12 states he also leaves his telephone number on the home page pf the facility's EHR home page and tell staff to call or text him to notify him of any resident fall. V12 states the staff also knows to call and inform the nurse practitioner/NP or the medical doctor/MD and wait for their orders. V12 states the protocol to follow when a resident fall is to: Not move the resident off of the floor, perform an assessment, if the resident hit their head or are on blood thinners, then the resident is sent to the ER for evaluation automatically, and document in risk management. V12 states after each fall he gathers information to perform a root cause analysis of why a fall may have occurred. V12 states he and the IDT/interdisciplinary team meet every Thursday to discuss the falls of the week and any interventions to implement. Surveyor and V12 has R37's fall risk assessment dated [DATE] deployed on the computer. V12 and surveyor observes that R37's fall risk assessment documents that R37 scores a 7, indicating that R37 is at low risk for falls. V12 states R37's fall risk assessment section F. Mobility f1 is documented incorrectly. V12 states section f1 should be checked no instead of yes because R37 does not ambulate via walking. V12 states this is not an inaccurate assessment but V12 is not sure if correcting section f1 would change R37's fall risk score. V12 states if R37's bed is positioned in a high position, then R37 could potentially fall and sustain a great injury. R37's Fall risk assessment dated [DATE] documents that R37's fall risk score is a 7, indicating that R37 is at low risk for falls. R37's Face sheet documents that R37 has diagnoses not limited to: History of falling, personal history of (healed) traumatic fracture, cardiac pacemaker, unspecified dementia, and atrial fibrillation. R37's MDS dated [DATE] documents that R37 ambulates via wheelchair and no other assistive devices. R37 requires substantial/maximal assistance with ADL/Activities of Daily Living care. R37's MDS documents in part Sit to stand: The ability to come to a standing position from sitting in a chair, wheelchair, or on the side of the bed- Not attempted due to medical condition or safety concerns. Walk 10 feet: Once standing, the ability to walk at least 10 feet in a room, corridor, or similar space- Not attempted due to medical condition or safety concerns. R37's care plan dated 10/05/2023 documents a fall precaution intervention for R37's bed to be in the lowest position, R37's care plan documents in part, Bed in low position with wheels locked. Facility policy dated 07/17/2023 titled Fall Occurrence documents in part, It is the policy of the facility to ensure that residents are assessed for risk for falls, that interventions are put in place, and interventions are reevaluated and revised as necessary. Procedure- 2. Those identified as high risk for falls will be provided fall interventions. 3. If a resident had fallen, the resident is automatically considered as high risk for falls. 6. The nurse may immediately start interventions to address falls in the unit .8. The Fall Coordinator will add the interventions in the resident's care plan.

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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** 41356 A. Based on observations, interviews, and review of records the facility failed to follow policy to accurately account residents' narcotic medication for 2 out of 6 medication carts for a total of 11 medication carts reviewed for controlled substance or narcotic storage accuracy. These failures have the potential to affect R12 and R95 narcotic medication improperly accounted. B. Based on observations, interviews, and review of records the facility failed to follow policy on labeling and dating insulin vials opened for residents use. Failed to ensure tuberculin vials stored in the refrigeration are not expired. Failed to maintain medication cart free from expired house stock medication. And failed to ensure medication for topical use are in proximity to supplement taken by residents orally. Failure applies to 2 out of 3 medication rooms for a total of 5 medication room. And 2 out of 6 medication carts for a total of 11 medication cart reviewed for medication storage and labelling. These failures have the potential to affect R66 and R50 in receiving insulin as ordered by physician within recommended use after opening. Recently admitted residents that may use tuberculin testing that are out of recommended dates after opening. Residents that have order to receive house stock medicine that is expired. Finding includes: A. On [DATE] at 11:40 AM with V30 (Registered Nurse) medication cart R12's bottle of Lorazepam 2 milligram (MG) per milliliter (ML) with instruction to give 0.25 milliliter every 4 hours as needed. Per Individual Controlled Substance Record document, it was recorded that it was given three (3) times with each dose of 0.25 milliliter (ML). Each calculation was incorrect, dose given on [DATE] 30 milliliters (ML) subtracted by 0.25 milliliter (ML) should be 29.75 milliliter (ML) but it was recorder 29.5 milliliter (ML). Dose given on [DATE] of 0.25 milliliter (ML) should be 29.50 (correct calculation) or 29.25 milliliter (ML) (if based on the prior error calculation) but it was recorded as 29.00 milliliter (ML). Dose given on [DATE] of 0.25 milliliter (ML) should be recorded as 29.25 milliliter (ML) (correct calculation) or 28.75 milliliter (ML) (if based on the prior error calculation) but it was recorded as 29.00 milliliter (ML). Actual bottle of Lorazepam 2 milligram (MG) per milliliter (ML) seen inside the medication cart was a little over 22.00 milliliter (ML). V30 stated that it was around 25 milliliter (ML) and that the count was off because it was far from 29.00 milliliter (ML). V12 (Registered Nurse) took the bottle and stated that the amount left was 24 milliliters (ML). Then V12 tried to calculate the three (3) doses given on the Individual Controlled Substance Record with off numbers. Took his cellphone after using calculator on his cellphone said, the remaining amount should have been 29.25 milliliter (ML). Both V30 and V12 was unable to account what happened to discrepancies of the amount actually left in the bottle and the record which four (4) to five (5) milliliters (ML) of controlled medication / narcotic Lorazepam 2 milligram (MG) per milliliter (ML). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 09:43 AM, V32 (Licensed Practical Nurse) medication cart R95 narcotic medication Clonazepam 0.5 milligram (MG) has discrepancy between the actual tablet in the bingo card which has nine (9) tablets to the controlled drug administration record that document ten (10) tablets. V32 stated We might have missed it. Narcotic medication Clonazepam 0.5 milligram (MG) was not able to be accounted. On the shift change accountability record for controlled substances document that needs to be signed by incoming and outgoing nurses the narcotics record, and actual narcotic medications are accurate was not signed on a shift dated [DATE]. On [DATE] at 2:15 PM, V2 (Director of Nursing) made aware. V2 stated that nurses need to know how to properly document narcotic medication and make sure narcotic count is accurate at the beginning and end of the shift. Controlled Medication Count Policy dated [DATE], reads: It is the policy of the facility to maintain an accurate count of Scheduled II controlled medications. Under procedure, after removing the controlled medication from the bingo card or individual packet, the nurse will sign off the accompanying controlled medication sheet indicating the medication is taken. B. On [DATE] at 10:35 AM with V29 (Registered Nurse) medication cart R66 Humalog Kwikpen insulin was found inside a transparent bag labelled as Lantus Solostar Pen. Humalog Kwikpen has around 20 percent left seen in a transparent area of the pen. Humalog Kwikpen has no label, V29 stated that there should be a date when it was opened and when will it expire. At the bottom drawer of the medication cart, nutritional supplement of Boost was seen near topical medications antifungal powder, nystatin power and other supplies use for skin treatment such as gloves. V29 stated that it may contaminate supplement taken by resident orally when it is stored near topical medication. At the medication room tuberculin vial was seen inside the refrigerator labelled as follows: Date opened [DATE] and date expired [DATE]. V29 stated that tuberculin vial is used by residents that are newly admitted . And that the vial has already expired because today is already June. V29 said, It should have been taken out of the fridge. On [DATE] at 11:40 AM with V30 (Registered Nurse) at the medication room inside the refrigerator Tuberculin or PPD testing vial has a date written with marker that reads, opened [DATE]. V30 said that generally vials expires 28 days after opening. Then said, What date is it now? Oh, its June. This already expired. On [DATE] at 1:11 PM with V31 (Licensed Practical Nurse) medication cart house stock Probiotic in a plastic bottle labelled ,d+[DATE] expired. V31 took the bottle and set it aside stated she need to discard the bottle because it was expired. R50 Humalog Kwikpen insulin was seen without label date. V31 took the insulin and wrote todays date [DATE] as the date when insulin was first opened. V31 was asked if she personally knew it was opened today. V31 stated that she did not actually saw when the insulin was opened but was assuming that the night nurse may have opened it the shift before. V31 was asked if her assumption turned out to be false. Then the recommended days to use the insulin will be off. V31 stated that she cannot be certain when insulin was opened and erased the date she wrote. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:15 PM, V2 (Director of Nursing) made aware, stated medication needs to be within the recommended date use. And will review all insulins, vials (Tuberculin), and house stock that it is within recommended use date. Medication Pass policy dated [DATE], reads: Under Medication Labeling: 1. All opened medication vials in the refrigerator should be labeled with the date when it was opened and discarded within 28 days of opening except for Levemir insulin which can be discarded 42 days after opening and Xalatan eye drops which can be discarded 6 weeks after opening. 2. Follow pharmacy recommendation as to when the medication should be discarded after opening. 3. Insulin vials are to be discarded within 28 days after opening, except for Levemir insulin which are to be discarded 42 days after opening. Medication Storage, Labeling, and Disposal Policy dated [DATE], reads: It is the facility's policy to comply with federal regulations in storage, labelling, and disposal of medications. Under procedures, house stocks designed for multiple administration will be labelled with the name of the medication, the strength, instruction, and expiration. The information from the manufacturer is enough to meet this requirement. The facility does not date this medication when opened. And the medication automatically expires based on the expiration date based on the manufacture's guidelines.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 41356 Based on observation, interview and record review, the facility failed to administer the right medication as ordered and failed to administer intended medication dose as ordered per policy. There were 28 (twenty-eight) opportunities with 3 errors resulting in 10.71% (percent) error rate. This applies to 2 (two) residents (R118 and R68) of 8 (eight) residents observed for medication administration. These failures have the potential to affect 2 residents (R118 and R68) in receiving the right medicine and the right dose as ordered by physician. Findings include: On 6/4/2024 at 1:58 PM, during medication administration observation with V9 (Licensed Practical Nurse). Medication of R118 Deep Sea Nostril Spray administered 1 spray to left nostril and Artificial Tears eye drop administered 1 drop to the left eye. Review on R118's physician order, documents that Sodium Chloride Nasal Spray instructed to be administered one (1) application in both nostrils and Artificial Tears eye drop instructed to be administered two (2) drops in both eyes. On 6/4/2024 at 2:05 PM, during medication administration observation with V9 (Licensed Practical Nurse). R68 verbalized she needs her eye drop because of dry eyes. V9 stated that R68 does not have any eye drops inside the medication cart. V9 stated she needs to get the eye drops from another floor. V9 went to another floor, and upon returning administered Artificial Tears 1 drop to each eye of R68. Review on R68's physician order, documents that the order for R68 as needed eye drop is Tetrahydrozoline HCl Ophthalmic Solution 0.05 % not Artificial Tears. On 6/4/2024 at 2:15 PM, V2 (Director of Nursing) made aware, stated during medication administration nurse's need to follow the five rights of every resident that includes right medication, right dose, and right route. V2 stated that she will inform the physician for changes of medication order if needed to accommodate the needs of residents. Facility Policy Title: Administration Procedures for All Medications not dated, reads: To administer medications in a safe and effective manner. Under procedure, Review 5 Rights (3) times. CMS Guidelines dated 6/6/2014, reads: Under basic safe practices for medication administration, includes the following: Right medication: the correct medication, to ensure that the medication being given to the patient matches that prescribed for the patient and that the patient does not have a documented allergy to it. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Right dose: the correct dose, to ensure that the dosage of the medication matches the prescribed dose, and that the prescription itself does not reflect an unsafe dosage level (i.e., a dose that is too high or too low).

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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** 41356 A. Based on observations, interviews, and review of records the facility failed to follow policy to accurately account residents' narcotic medication for 2 out of 6 medication carts for a total of 11 medication carts reviewed for controlled substance or narcotic storage accuracy. These failures have the potential to affect R12 and R95 narcotic medication improperly accounted. B. Based on observations, interviews, and review of records the facility failed to follow policy on labeling and dating insulin vials opened for residents use. Failed to ensure tuberculin vials stored in the refrigeration are not expired. Failed to maintain medication cart free from expired house stock medication. And failed to ensure medication for topical use are in proximity to supplement taken by residents orally. Failure applies to 2 out of 3 medication rooms for a total of 5 medication room. And 2 out of 6 medication carts for a total of 11 medication cart reviewed for medication storage and labelling. These failures have the potential to affect R66 and R50 in receiving insulin as ordered by physician within recommended use after opening. Recently admitted residents that may use tuberculin testing that are out of recommended dates after opening. Residents that have order to receive house stock medicine that is expired. Finding includes: A. On [DATE] at 11:40 AM with V30 (Registered Nurse) medication cart R12's bottle of Lorazepam 2 milligram (MG) per milliliter (ML) with instruction to give 0.25 milliliter every 4 hours as needed. Per Individual Controlled Substance Record document, it was recorded that it was given three (3) times with each dose of 0.25 milliliter (ML). Each calculation was incorrect, dose given on [DATE] 30 milliliters (ML) subtracted by 0.25 milliliter (ML) should be 29.75 milliliter (ML) but it was recorder 29.5 milliliter (ML). Dose given on [DATE] of 0.25 milliliter (ML) should be 29.50 (correct calculation) or 29.25 milliliter (ML) (if based on the prior error calculation) but it was recorded as 29.00 milliliter (ML). Dose given on [DATE] of 0.25 milliliter (ML) should be recorded as 29.25 milliliter (ML) (correct calculation) or 28.75 milliliter (ML) (if based on the prior error calculation) but it was recorded as 29.00 milliliter (ML). Actual bottle of Lorazepam 2 milligram (MG) per milliliter (ML) seen inside the medication cart was a little over 22.00 milliliter (ML). V30 stated that it was around 25 milliliter (ML) and that the count was off because it was far from 29.00 milliliter (ML). V12 (Registered Nurse) took the bottle and stated that the amount left was 24 milliliters (ML). Then V12 tried to calculate the three (3) doses given on the Individual Controlled Substance Record with off numbers. Took his cellphone after using calculator on his cellphone said, the remaining amount should have been 29.25 milliliter (ML). Both V30 and V12 was unable to account what happened to discrepancies of the amount actually left in the bottle and the record which four (4) to five (5) milliliters (ML) of controlled medication / narcotic Lorazepam 2 milligram (MG) per milliliter (ML). (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 09:43 AM, V32 (Licensed Practical Nurse) medication cart R95 narcotic medication Clonazepam 0.5 milligram (MG) has discrepancy between the actual tablet in the bingo card which has nine (9) tablets to the controlled drug administration record that document ten (10) tablets. V32 stated We might have missed it. Narcotic medication Clonazepam 0.5 milligram (MG) was not able to be accounted. On the shift change accountability record for controlled substances document that needs to be signed by incoming and outgoing nurses the narcotics record, and actual narcotic medications are accurate was not signed on a shift dated [DATE]. On [DATE] at 2:15 PM, V2 (Director of Nursing) made aware. V2 stated that nurses need to know how to properly document narcotic medication and make sure narcotic count is accurate at the beginning and end of the shift. Controlled Medication Count Policy dated [DATE], reads: It is the policy of the facility to maintain an accurate count of Scheduled II controlled medications. Under procedure, after removing the controlled medication from the bingo card or individual packet, the nurse will sign off the accompanying controlled medication sheet indicating the medication is taken. B. On [DATE] at 10:35 AM with V29 (Registered Nurse) medication cart R66 Humalog Kwikpen insulin was found inside a transparent bag labelled as Lantus Solostar Pen. Humalog Kwikpen has around 20 percent left seen in a transparent area of the pen. Humalog Kwikpen has no label, V29 stated that there should be a date when it was opened and when will it expire. At the bottom drawer of the medication cart, nutritional supplement of Boost was seen near topical medications antifungal powder, nystatin power and other supplies use for skin treatment such as gloves. V29 stated that it may contaminate supplement taken by resident orally when it is stored near topical medication. At the medication room tuberculin vial was seen inside the refrigerator labelled as follows: Date opened [DATE] and date expired [DATE]. V29 stated that tuberculin vial is used by residents that are newly admitted . And that the vial has already expired because today is already June. V29 said, It should have been taken out of the fridge. On [DATE] at 11:40 AM with V30 (Registered Nurse) at the medication room inside the refrigerator Tuberculin or PPD testing vial has a date written with marker that reads, opened [DATE]. V30 said that generally vials expires 28 days after opening. Then said, What date is it now? Oh, its June. This already expired. On [DATE] at 1:11 PM with V31 (Licensed Practical Nurse) medication cart house stock Probiotic in a plastic bottle labelled ,d+[DATE] expired. V31 took the bottle and set it aside stated she need to discard the bottle because it was expired. R50 Humalog Kwikpen insulin was seen without label date. V31 took the insulin and wrote todays date [DATE] as the date when insulin was first opened. V31 was asked if she personally knew it was opened today. V31 stated that she did not actually saw when the insulin was opened but was assuming that the night nurse may have opened it the shift before. V31 was asked if her assumption turned out to be false. Then the recommended days to use the insulin will be off. V31 stated that she cannot be certain when insulin was opened and erased the date she wrote. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 2:15 PM, V2 (Director of Nursing) made aware, stated medication needs to be within the recommended date use. And will review all insulins, vials (Tuberculin), and house stock that it is within recommended use date. Medication Pass policy dated [DATE], reads: Under Medication Labeling: 1. All opened medication vials in the refrigerator should be labeled with the date when it was opened and discarded within 28 days of opening except for Levemir insulin which can be discarded 42 days after opening and Xalatan eye drops which can be discarded 6 weeks after opening. 2. Follow pharmacy recommendation as to when the medication should be discarded after opening. 3. Insulin vials are to be discarded within 28 days after opening, except for Levemir insulin which are to be discarded 42 days after opening. Medication Storage, Labeling, and Disposal Policy dated [DATE], reads: It is the facility's policy to comply with federal regulations in storage, labelling, and disposal of medications. Under procedures, house stocks designed for multiple administration will be labelled with the name of the medication, the strength, instruction, and expiration. The information from the manufacturer is enough to meet this requirement. The facility does not date this medication when opened. And the medication automatically expires based on the expiration date based on the manufacture's guidelines.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45111 Based on observations, interviews, and record review, the facility failed to follow their policy on Sanitation & Safety Operations by (a) failing to maintain proper food temperatures, (b) failing to date opened food items with open and use by date, (c) failing to store kitchen cleaning supplies/chemicals away from food items and silverware, (d) falling to monitor and make sure dishwasher temperatures reached at least 160 degrees F during the wash/rinse cycle of the dish washer These deficiencies have the potential to affect 204 residents who are on an oral diet and receiving meals from the kitchen. Findings include: On [DATE] at 9:25am during tour of the kitchen with V35 (Food Service Director), observed stored in the walk-in fridge in a clear plastic bag were uncooked open waffles patties with no open date/use by date on them. V35 stated all open food should be dated with a date showing when they were open and use by date to let kitchen staff know if the waffles are still good to be cooked for resident consumption to. V35 stated the open/use by dates lets staff know when to discard stale/expired foods to prevent residents from getting sick. During tour of the dry food pantry with V35, surveyor and V35 observed kitchen cleaning chemicals such as: 24 one-gallon full bottles of floor cleaner in liquid form were observed in an open shelf in the food pantry, and 15 bags of waters softener. The 24 one gallon of floor cleaner and other chemicals were placed on the first and second shelf in the food pantry and above the open shelves where the chemicals were stored on the third shelve, plastic cups and food service containers used for residents were observed stored there. On the side of that food pantry were observed other food items placed on the shelves. V35 stated the kitchen cleaning chemicals used to be stored in a room (caged) next to the food pantry separate from the foods. V35 stated that room was emptied of the chemicals to store emergency foods and the chemicals were moved to the food pantry. V35 stated he had asked for a cabinet that can be locked to store the kitchen cleaning supplies in, but he was told that there was no other space, and he was instructed to put the kitchen cleaning chemicals in the bottom two sections of the shelf in the food pantry. V35 stated he discussed this with V48 (Dietitian), and she (V48) said that it was fine that the kitchen cleaning chemicals were in the food pantry, if they were on the bottom shelf despite being close to food supplies. V35 stated cleaning chemicals should not be near food stuff because the chemicals can leak and contaminate the food stuff in that food pantry which can lead to residents getting ill from eating contaminated foods. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On ,d+[DATE] /2024 at 9:57 during tour of the dish washing area with V35, three dietary aides were observed operating the dishwasher. Surveyor requested V35 to test the temperature of the cleaning cycle. V35 put a thermometer which he stated was to test dish washer temperature in the dish washer and placed a testing strip on plate and put it inside the dishwasher and run the cycle. The dishwasher cycle completed and the temperature on the thermometer gauge was 143 degrees F, and the testing strip did not turn black. V35 stated if the dishwasher reaches the right temperature, the testing strip turns black in the middle. V35 stated that the final temperature should reach at least 160 degrees F indicating the correct temperature for dish washing and sanitizing has been reached. With surveyor watching V35 tested the dishwasher three more times, and the testing strip did not turn black indicating the right dishwasher temperatures were not reached. V35 stated it was important that the right temperature be reached while washing dishes to kill all germs and to prevent foodborne illness to residents. On [DATE] at 10:12am V50 (Assistant Dietary Manager) stated testing strips for the dishwasher are supposed to turn black when the correct temperature for the dishwasher is reached, and further stated if the testing strip does no turn black, then the machine is not reaching the correct sanitizing temperature, which can cause residents to suffer from foodborne illness. V50, V35 and surveyor reviewed the dish washer dishwasher temperature log for [DATE]. V35and V50 stated they could not find the temperature logs for the other months. The June log only documented the temperature with no testing strips attached to indicate if the testing strips turned black during testing. V50 stated the new dishwasher servicing company, who also supply the testing strips told the staff to no longer place the testing strips on the log as it was no longer important, and just to write the temperature on the log. Surveyor asked V50 how V50 would verify if the machine was reaching the correct temperature if the testing strips were not attached to the log. V50 stated that she trusts what the kitchen staff writes, and there is no need of confirming with the testing strip. On ,d+[DATE] at 10:55 am V51 (Cook) was observed preparing lunch, which pierogi casserole, cabbage, and carrot. O[DATE] at 12:13pm, V51 was observed serving food to the warming carts to transport to the units. The Pierogi tested at 200 degrees F, and the cabbage and carrot 167 degrees F, hamburger meat at 146 degrees F, and the pureed mashed potatoes tested at 167 degrees F. [DATE] at 12:20pm V49 (Dietary Aide) was observed without wearing gloves while helping serve residents plates on the tray line. V4 observed touching each plate as it moved along the serving line. V49 observed putting deserts on trays, such as Yogurt, Ice Cream rice crispy treats on each tray. V49 stated that he is supposed to wear glove to prevent cross contamination of foods which can make residents sick. [DATE] at 1:00am The last food cart reached the fourth floor, and the last tray was tested by V35 at 1:14 with surveyor observing. The carrots and cabbage tested at 112 degrees F. The Pierogi was 136 degrees F. V35 stated all the hot food should be at least 135 degrees when it reaches the units so the residents can enjoy warm food and to prevent food borne illness. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:53pm, V48-dietitian) stated the chemicals for kitchen use should be stored away from the food where it cannot come into close contact with the food products to limit the possibility of the chemicals coming into contact with foods and other kitchen supplies to prevent potential contamination which can cause residents to become ill and it also prevents anyone from using the wrong products. V48 further stated the Dish washer machine should be 160 degrees on a test strip and 180 degrees in the machine [NAME] during the rinse cycle to make sure the dishes are sanitized property, to prevent contamination which can lead to food borne illness. Facility policy titled Food Temperature Maintenance dated[DATE] documents: -Hot foods items should leave the kitchen or steam table and served to the residents at a temperature at a temperature above 135 degrees Fahrenheit. -Dish washer testing strips document if center is black, the correct temperature has been reached. The testing strip documents 160 degrees F a s the correct temperature. Food Handling Policy dated [DATE] documents: - Food will be stored, prepared, handled and served so that the risk of foodborne illness is minimized. All employees who handle, prepare or serve food will be trained in the practices of safe food handling and preventing foodborne illness. Employees will demonstrate knowledge and competency in these practices prior to working with food or serving food to residents. Policy Titled Kitchen, dated [DATE] documents: - Refrigerated food should be covered, dated, labeled, and shelved to allow air circulation. - Food Temperature a. Hot food temperature should be 135 degrees F and above. - Dishwasher a. Hot temperature dishwasher should turn the strips black or orange depending on the type of strips when the hot water temperature sanitizes the dishes, utensils, and blenders.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49783 Based on observation, interview, and record review the facility failed to ensure staff and family follow recommended isolation guidelines consistent with current standard of practices to prevent cross contamination for 3 of 4 residents (R499, R500, R168,) observed for infection control in the sample of 35. Findings include: On 06/04/2024 at 10:59AM surveyor observed R500 room with enhanced barrier sign on door and precaution set-up outside of room. On 06/04/2024 at 11:30AM surveyor observed V5 and V6 without PPE.V6 observed applying specialized device to R500 left foot. On 06/04/2024 at 11:48AM surveyor observed R499 room with contact isolation sign on door and precaution set-up outside of room. On 06/04/2024 at 11:50AM surveyor observed R499 family member enter R499 room with PPE/personal protective equipment on and exited room with same PPE. Family member walked down the hall to talk to staff with gown on. Family member stopped to talk to surveyor with PPE gown on. Family member observed touching linen cart next to R499 room. On 06/04/2024 at 11:51AM V4, V7 and surveyor observed V46 exit R499 room and walked down the hall with PPE on. On 06/04/2024 at 11:54AM surveyor observed R168 room with enhanced barrier sign on door and precaution set-up outside of room. On 06/04/2024 at 11:55AM surveyor observed V8 assisting R168 to bed without PPE on. On 06/04/2024 at 11:57 V8 stated, I was assisting R168 back to bed he is a fall risk. I don't put PPE if I'm not doing any patient care. 06/04/2024 at 11:31AM V5 stated, I'm a therapist working with R500. V5 stated enhance barrier is if you are given care to patient. R500 is a functional transfer. If staff encounter resident or touch them, we should wear PPE. On 06/04/2024 at 11:32AM V6 stated, no instructions of were provided regarding enhanced barrier. I only applied boot to R500 left foot he has a wound and wound vac attached. On 06/04/2024 at 11:56AM V7 stated, R500 has a left foot wound with wound vac. R500 is on enhanced barrier precaution. If staff touch residents, they should wear required PPE. All staff should follow protocol including physical therapist. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/04/2024 at 11:52AM V46 states, I'm aware R499 is on contact isolation for C-Diff she came here from the hospital with it. No one educated me on the isolation protocol, I didn't know I should've taken the gown and gloves off in the room before leaving out. On 06/04/2024 at 11:58AM V4 stated, any contact or enhanced barrier, staff should wear PPE. On 06/05/2024 at 10:46AM V17 stated, enhanced barrier precaution are for those patients with history MDRO, with indwelling medical devices (urine catheters, g-tube,central lines) and residents with wound. When staff is given high contact or touch residents they should put on gown and gloves. This should be all staff. Staff is educated once a week to keep them familiar with the policy. They also must wear gown if resident has a G-tube. All departments are educated once a week. Physical therapy education just started yesterday. Family is called once resident are placed on contact or enhance barrier isolation. Nursing staff and I educate the family on infection control. When they get here, we should inform them of PPE rules and hand hygiene. Reviewed R500's physician orders, care plan and progress notes. R500's progress notes documents, have PMHx as below who was admitted to hospital for left foot wound dehiscence. Patient had initial surgery on left foot [NAME]/fracture and dislocation on 3/18/24. This hospitalization patient underwent surgical I&D with placement of wound VAC. Once stabilized, patient was transferred to facility for further rehabilitation and management. R499 Physician orders dated 6/4/2024 document in part, Strict Contact Isolation (C.Diff): Monitor loose consistency. Indicate whether F (Formed), SF (Semi-Formed), W (Watery) and indicate frequency. Maintain at all times: Strict contact isolation precautions due to an active infection. Single room, resident alone and not cohorted with a roommate. Resident remains in the room at all times. All services done inside the room. Records show R499 with diagnosis of CLOSTRIDIUM DIFFICILE (C-DIFF) Reviewed R168's physician orders, care plan and progress notes. R168 record documents resident has a chronic foley catheter and peg-tube. Skin and wound note dated 6/3/2024 documents, full thickness wound to right toes, sacral areas. Record shows R168 with peg-tube, wounds an indwelling foley catheter. Facility policy dated 10/23/2023 titled Infection Prevention and Control documents in part,7. A transmission-based precaution set up will be provided outside the resident's room to provide Personal Protective Equipment (PPE) like a gown and gloves to staff and visitors entering the resident's room. Contact Precaution b. Use of gown and gloves is necessary prior to room entry. Enhanced barrier Precaution a. Involves the use of gloves and gowns during high contact resident care activities infected with MDROs as well as with wounds and/or indwelling medical devices.