STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145511	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Lombard	2100 South Finley Road Lombard, IL 60148

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 45540 Based on interview and record review the facility failed to treat a resident in a dignified manner. This applies to 1 of 29 residents (R9) reviewed for dignity in the sample of 29. The findings include: On 6/24/2024 at 9:53AM, R9 said on Sunday (6/23/2024) in the morning he put his call light on. R9 said his call light was on from approximately 6:20AM until 8:20AM. R9 said he had soiled himself with stool and urine, requiring staff assistance. R9 said he didn't receive help until after 8:20AM from the nursing staff. On 6/25/2024 at 1:50PM, V9 Registered Nurse (RN) said R9 is very alert and oriented. V9 said R9 is aware of when he needs to be cleaned up and lets staff know. V9 said residents should be checked every 2 hours or as needed. V9 said residents should be cleaned up right away when they are soiled. R9's Minimum Data Set section C dated 5/30/2024 shows a BIMs score of 14, cognitively intact. R9's Task B&B - Bowel charting does not show any documentation on 6/23/2024. R9's Care Plan dated 6/7/2024 states, [R9] is always incontinent of bladder and bowel related to multiple sclerosis . interventions include . I would like staff to check me for inconvenience episode 2 hours. The facility's Privacy and Dignity policy dated 6/6/2024 states, . it is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times .

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. 34490 Based on observation, interview, and record review the facility failed to ensure a wound was assessed and the wound nurse practitioner notified of a new wound. The facility failed to ensure pressure relieving interventions were in place for residents who are at risk for pressure ulcer for 4 of 5 residents (R98, R105, R121 and R240) reviewed for pressure injuries in the sample of 29. The findings include: 1. On 6/25/24 at 10:59 AM, R98 was lying in bed. R98's left heel was laying directly on the bed. R98's heel protector boots were sitting in the wheelchair in her room. R98 was provided incontinence care. R98 had an open area on her sacrum that was approximately 3 centimeters (cm) x 3 cm x 0.2 cm. The wound was covered in white appearing cream. R98 had scar tissue present in the same area. On 6/25/24 at 11:27 AM, V6 (Wound Care Registered Nurse) said that R98 is at high risk for pressure ulcers. V6 said that R98 has a history of a very large unstageable pressure ulcer on her bottom and has had heel pressure ulcers in the past as well. V6 said that intervention put in place to prevent pressure ulcers for R98 include: an air mattress, frequent incontinence care, repositioning and offloading her heels when in bed. V6 said that the staff notified her of an area they were concerned about on her bottom. V6 said that she went and assessed the area and found that she had a skin tear in the same area as her previous pressure ulcer. V6 said that the flap of skin was still intact, so they kept the piece of skin there but eventually it came off and exposed pink tissue. V6 said that once the skin tear was found, an order to apply zinc cream was obtained and that is the treatment that has been in place daily since. On 6/26/24 at 10:30 AM, V13 (Wound Nurse Practitioner) said that she comes to the facility to see residents two times per week. V13 said that she sees all wound types. V13 said that if she is notified of a new wound, she would see the resident at her next visit to the facility. V13 said that she would do a wound assessment that included the type of wound, description of the wound and measurements of the wound. V13 said that she would ensure that the treatments in place were appropriate for the wound. V13 said that she would then see the resident weekly to do another assessment to ensure that the wound is healing and provide new treatment interventions if it is not healing. V13 said that she was not notified to see R98's wound. V13 said that the last time she saw R98 was in March, and she did not have any sacral wounds. V13 said that she has been to the facility multiple times since 6/7/24. On 6/26/24 at 10:40 AM, V14 (Registered Nurse) performed a wound assessment. The sacral wound measured 3.5 cm x 4 cm x 0.5 cm. The wound bed was pink with two areas in the middle of the wound that had whitish/yellow tissue present. V14 tried to clean the areas off to ensure that it was not cream present. The areas remained after cleaning. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/26/24 at 1:00 PM, V2 (Director of Nursing) said that she would expect her staff to report any new wounds to the physician or nurse practitioner to get orders for the wound and report the wound to the wound nurse. V2 said that the wound nurse would then do an assessment of the wound and document the assessment on the skin alteration form. V2 said that the wound nurse would then notify the wound Nurse Practitioner to see the resident on their next visit. V2 said that the wound should be assessed at least weekly or whenever the wound has a deterioration or change. V2 said that the assessments should be documented in the resident's medical record. On 6/26/24 at 1:24 PM, V7 (Nurse Practitioner) said that she went and saw R98's wound today and it looks like a stage 2 to 3 pressure ulcer now. V7 said that the wound bed was pink with a couple areas of yellowish fat tissue present (The National Pressure Injury Advisory Panel says stage 3 pressure injuries are full thickness loss of skin, in which adipose (fat) is visible in the ulcer). V7 said that to her it sounds like the wound started as a skin tear and then developed into a pressure ulcer. V7 said that the nurse should be monitoring and assessing any open area and if it gets worse, they should notify the physician or nurse practitioner. V7 said that R98 had zinc cream previously ordered but now that it is worse, she does not want zinc on it and put in a new order for collagen ointment and a dry dressing. V7 said that they do not do measurements for skin tears but once the wound changed to an open wound, an assessment should have been done at that time and the physician notified. R98's Nursing Notes dated 6/7/24 shows, Called to see pt (patient) due to the CNA (Certified Nursing Assistant) noted skin friction tear, upon assessment noted skin flap intact and pulled over, base of the wound pink and dry. Site is of healed wound area and over scar tissue. Pt already on air mattress, and seen by NP (Nurse Practitioner), treatment ordered. R98's Nurse Practitioner Note dated 6/07/24 shows, The pt was noted to have a new shearing/skin tear on her sacrum Skin: skin tear over sacrum, shearing-new .Plan: Wound care nurse to evaluate; zinc oxide added . No other assessment of R98's wound was documented in her clinical records from 6/7/24 to 6/25/24. There were no skin alteration forms completed in R98's clinical records between 6/7/24 and 6/25/24. There were no measurements or other descriptions of the wound documented until 6/26/24. R98's Quarterly Skin Evaluation Form dated 4/1/24 shows that she is at risk for pressure ulcer development. R98's Care Plan shows she has a history of a stage 4 sacral pressure ulcer and a stage 2 left heel pressure ulcer with intervention to include: off load heels as ordered. The facility's Wound Care Guidelines Policy revised on 1/24/24 shows, Elevate resident heels off the bed as indicated (place pillows under calf .or use heel protectors that offload the heel from the bed surface .The resident's skin alteration/breakdown (pressure ulcer, arterial, diabetic, venous ulcer and etc.) shall be documented in the resident's clinical records Pressure Injury treatment .Timely referral to the facility's Wound Care Specialist for all pressure injuries and/or wounds Wound assessment documentation shall include but are not limited to: type of wound and/or ulcer, etiology, location, date, stage (if applicable), length, width, and depth; wound description, wound edge description and if present, exudates, undermining, tunneling, and wound related pain. 35119 (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. On 06/24/24 at 10:25 AM, R240 was in bed with a pillow under her left side. R240's heels were flat on the bed. On 06/24/24 at 12:10 PM, R240 remained in the same position in bed with a pillow under her left side. R240's heels were flat on the bed. On 06/25/24 V6 Wound Registered Nurse said to reduce pressure on heels, interventions of heel boots or offloading the heels with pillows can be used. V6 said R240 does not like heel boots so pillows are used to float her heels off the bed. R240's Skin and Wound Note dated 6/21/24 shows R240 has an unstageable pressure injury to her right hip and shows float heels while in bed with use of foam boots. 3. On 06/24/24 at 12:20 PM, R105 was in bed on her back with her heels flat on the bed. On 06/25/24 at 9:43 AM, R105 was in bed on her back with her heels flat on the bed. R105's Skin and Wound Note dated 5/31/24 shows R105's pressure injury to her left heel is resolved and shows preventative measures: Float heels while in bed with use of heel boots. The facility's Wound Care Guidelines Policy dated 1/24/24 shows Elevate resident heels off the bed as indicated (e.g., place pillows under calf, not under ankles or use heel protector that offloads the heel from the bed surface) to raise heels off the bed. 37232 4. On 06/25/24 at 10:30 AM, 11:25 AM, 12:56 PM, and 2:37 PM, R121 was in bed with his heels resting directly on the mattress. R121's heel protector boots were in the corner of R121's room sitting next to the television. On 06/25/24 at 11:51 AM, V6 (Wound Care Nurse) said R121 had fragile skin and wearing heel protector boots was one of the pressure injury interventions in place for R121. R121's Order Summary Report showed to apply heel boots to bilateral lower extremities for skin protection. R121's care plan showed R121 was at risk for skin breakdown.

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. 34490 Based on observation, interview and record review the facility failed to ensure residents received their range of motion (ROM) exercises as ordered and failed to ensure splints were placed for a resident with contractures as ordered for 4 of 10 residents (R5, R14, R28 and R79) reviewed for restorative services in the sample of 29. The findings include: 1. On 6/24/24 at 10:10 AM, R28 was transferred from his bed to the wheelchair with two person assist. R28 was unable to stand up straight and required maximal assistance to pivot transfer to the wheelchair. R28 was not provided a walker to transfer. On 6/24/24 at 9:53 AM, R28 said that he used to be able to walk but can now barely get out of bed and it takes two people to get him up. On 6/25/24 at 1:38 PM, V3 (Restorative Nurse) said that all residents should receive their ordered restorative services. V3 said that it should be charted under that task section in the computer. V3 said that if the resident refuses, it should still be charted. V3 said that if it was not charted, then it was not done. On 6/25/24 at 2:00 PM, V10 (Restorative Certified Nursing Assistant) said that R28 is in the restorative program. V10 said that they stand him on the side of the bed with two persons daily to help with his leg strength and she either does arm exercises with him or has him use the arm bike for upper extremity strength daily. V10 said that when she performs the exercises, she documents it under the tasks in the computer program. V10 said that she would also document if he refuses. V10 said that she is not able to perform her restorative duties if she is pulled to work the floor but another restorative aide or the restorative nurse should be doing the residents who require restorative services. On 6/25/24 at 2:05 PM, R28 said that they do not have him stand on the side of the bed with his walker because he can't do it anymore. R28 said that he does not ever recall using an arm bike for exercise. R28's Physical Therapy Discharge Summary dated 4/12/24 shows that R28 requires moderate assistance for transfers and can currently ambulate 20-40 feet with his rolling walker. R28's Discharge Recommendations include: restorative range of motion, bed mobility and transfer program. R28's Physician's Order Sheet shows orders dated 5/2/24 for: upper extremity bike range of motion exercises daily for 15 minutes and sit to stand to rolling walker/grab bar as tolerated up to 7 days/week. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R28's Electronic Task History shows that R28 is to complete sit to stand with rolling walker or grab bar to strengthen bilateral lower extremities up to 7 days/week. The task history from 5/28/24 to 6/26/24 shows that this was performed 9 times and refused one time. R28's Electronic Task History shows that R28 is to complete upper extremity bike range of motion exercises to increase strength and endurance daily for 15 minutes. The task history from 5/28/24 to 6/26/24 shows that this was performed 7 times. 45540 2. On 6/25/2024 at 12:15PM, V3 Restorative Nurse said R14 has been receiving restorative services since 6/14/2024 since she finished physical therapy. V3 said we try to provide restorative services daily, but it hasn't been daily. V3 said sometimes restorative staff forget to chart when services are provided. V3 said R14 has not had a decline since beginning restorative services. R14's Task: Nursing Rehab: Active ROM and Active Assisted ROM lists recommendations for 15 min sets 2 times per day. R14's task documentation for the last 14 days does not show restorative services documentation for 6/15/2024, 6/18/2024, 6/19/2024, 6/20/2024, 6/21/2024, 6/22/2024, 6/23/2024, 6/24/2024. 37232 3. R79's Face Sheet showed R79 was diagnosed with hemiplegia of his left side. A facility assessment done 4/4/24 showed R79's mental status was intact. On 6/24/24 at 10:29 AM, R79 was in bed with a splint on his left hand. R79 said he had a stroke and could not move his left hand/arm. R79 attempted to move his left hand/arm but was unable to move it. R79 said the facility did not provide range of motion (ROM) everyday. R79 said he goes several days without getting ROM. R79 added that he has gone as long as a week without receiving ROM. R79's Order Summary Report showed R79 was to get passive ROM to his left upper and lower extremities with staff assistance daily as tolerated. R79's Care Plan showed he was on a passive ROM program and R79 was to receive ROM with his daily care. A review of R79's task passive ROM documentation for the last 30 days showed there was no documentation for 5/28/24, 5/30/24, 5/31/24, 6/1/24, 6/2/24, 6/3/24, 6/4/24, 6/5/24, 6/6/24, 6/7/24, 6/8/24 and 6/22/24 (missing 12 out of 30 days). 6/9/24 and 5/27/24 had Not Applicable documented for the ROM. The documentation did not indicate R79 had refused ROM. On 6/24/24 at 1:11 PM, V3 (Restorative Nurse) said he was familiar with R79 and R79 did not refuse ROM. V3 added that R79 was to get ROM to his left upper and lower extremities daily and once the ROM was provided it was to be documented in the task passive ROM. 4. R5's Face Sheet showed R5 was diagnosed with a stroke, hemiplegia, and contractures of the left and right hands. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/24/24 at 10:34 AM, R5 was in bed. R5 had a splint to his left hand and a carrot splint in his right hand. R5's right hand/fingers were closed around the carrot splint in a fist like shape. R5 was non-verbal and did not follow directions when asked. R5's Care Plan showed R5 had a self care deficit and impaired mobility related to contractures. Listed under interventions was for staff to provide gentle range of motion as tolerated with daily care and for splints to be applied daily. R5's Order Summary Report showed R5 was to get passive ROM to all extremities up to 7 days a week, a right hand splint, and a left carrot splint to manage contractures. A review of R5's task passive ROM documentation for the last 30 days showed there was no documentation for 5/28/24, 5/30/24, 5/31/24, 6/1/24, 6/2/24, 6/3/24, 6/4/24, 6/5/24, 6/6/24, 6/7/24, 6/8/24, and 6/22/24 (12 out of 30 days). For 5/27/24 and 6/9/24, Not Applicable was documented. On 06/24/24 at 01:11 PM, V3 said he was familiar with R5. V3 described R5 as pleasant, non-verbal and did not refuse ROM or his splint application. V3 added that R5 was to get ROM to all extremities daily and should have his splints placed daily. V3 said that once the ROM and splints were applied it was to be documented in the Tasks. V3 said the restorative aides were to provide the ROM and apply the splints. A review of R5's task splint application for 30 days showed No the splints were not applied on 5/28/24, 5/31/24, 6/1/24, 6/2/24, 6/5/24, 6/6/24, and 6/7/24. On 5/27/24, Not Applicable was documented for the splint application. On 6/25/24 at 1:45 PM, V3 said the floor certified nursing assistants (CNA) were documenting that the splints for R5 were not applied. On 6/25/24 at 11:50 AM, V4 (CNA) said she was familiar with R5 and normally takes care of R5. V4 said floor CNAs do not provide ROM, put on splints, or document about ROM/splints. V4 added that restorative will provide ROM and apply splints. On 6/25/24 at 11:59 AM, V5 (Restorative Aide) said she was the one that provides ROM and applies splints to R5 and R79. V5 confirmed R5 and R79 did not refuse ROM or their splints. V5 said there should be documentation that the ROM was done, and splints were applied. The facility's Restorative Nursing Program policy with a revised date of 6/6/24 showed appropriate nursing and restorative services consistent to the resident's functional needs must be provided. If the assessment showed the resident needs therapy, then therapy should be provided. Restorative programs shall be reflected and indicated in the resident's electronic restorative log in order to document the provision of services and the frequency by the nurses, CNAs and/or restorative aides.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 35119 Based on observation, interview, and record review the facility failed to ensure fall interventions were in place for residents with a history of falls for 2 of 29 residents (R108, R33) reviewed for safety in the sample of 29. The findings include: 1. On 6/24/24 at 9:56 AM, R108 was in bed with fall mats on each side of the bed. R108's bed was not in the lowest position. R108 said he fell and broke his hip and leg. On 6/25/24 at 9:46 AM, R108 was in bed (not in lowest position) with the call light on the floor near the head of the bed. On 6/25/24 at 1:55 PM, R108 was yelling out help me. R108's bed was not in the lowest position and his call light was wrapped around the bed rail and dangling down towards the ground, not within R108's reach. On 6/26/24 at 10:48 AM, V3 Restorative Nurse said after R108's fall he implemented the interventions of bed alarm, floor mats, and bed in lowest position. The facility's Post Fall Investigation dated 6/16/24 for R108 shows R108 got up from bed and fell . The same form shows interventions to address incident: Provided resident with bed alarm to alert staff when resident attempted to get up from bed unassisted and provided floor mats on both side of bed, position bed at lowest position. 37232 2. On 6/24/24 at 12:22 PM, R33 was in bed. Hanging on the bed frame was a bed alarm box. The sensor pad for the bed alarm was hanging behind the headboard of R33's bed. The sensor pad cord was unplugged from the bed alarm box. No staff were present in R33's room. On 6/24/24 at 12:32 PM, V4 (Certified Nursing Assistant) confirmed the bed alarm sensor pad was not under R33 and was unplugged from the bed alarm box. V4 said the pad should be under R33 and plugged into the alarm box. R33's Care Plan showed R33 was at risk for falls and requires a bed alarm to prevent falls. The facility's Fall Prevention Program Guidelines policy with a reviewed date of 12/5/23 showed safety interventions shall be initiated and implemented for each resident identified at risk for falls. Place call device within reach at all times and respond to call lights promptly. May utilize personal alarms when appropriate such as bed alarms.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 35119 Based on observation, interview, and record review the facility failed to ensure resident nebulizer equipment was stored in a manner to prevent cross contamination for 3 of 6 residents (R3, R26, R69) reviewed for oxygen in the sample of 29. The findings include: 1. On 6/25/24 at 11:52 AM, R3's nebulizer mask/tubing was in an opened plastic bag on the nightstand next to the bed. The plastic bag was dated 4/22/24. R3's June 2024 Medication Administration Record (MAR) shows an order for Ipratropium-Albuterol Inhalation Solution nebulizer treatment was administered on 6/9/24. 2. On 6/24/24 at 10:08 AM, R26's nebulizer mask/tubing was in an open plastic bag on nightstand next to the bed. The plastic bag was dated 4/22/24. On 6/25/24 at 10:32 AM, R26's nebulizer mask/tubing was on the nightstand, still dated 4/22/24. R26 said she uses the nebulizer once in a while. R26's June 2024 MAR shows an order for Ipratropium-Albuterol Solution nebulizer treatment was administered on 6/9/24. 3. On 6/24/24 at 10:07 AM, R69 stated she was short of breath yesterday and received a nebulizer treatment. R69's nebulizer mask was sitting on the base of the nebulizer (not in a plastic bag) and the edges of the mask (which are secured around the resident's mouth and nose) were touching the privacy curtain. The mask/tubing was not dated. On 6/25/24 at 9:55 AM, R69's nebulizer mask remained in the same position, still touching the privacy curtain. On 6/25/24 at 1:00 PM, V16 Registered Nurse said nurses change nebulizer tubing and mask. V16 the tubing should be dated and stored in a plastic bag to prevent contamination and for infection control. V16 said usually there are orders to change the tubing weekly. V16 said if the nebulizer tubing is dated in April, it should be discarded and not used. R69's June 2024 MAR shows an order for Ipratropium-Albuterol Inhalation Solution every 6 hours as needed for shortness of breath/congestion. The facility's Oxygen Therapy and Administration Policy dated 6/6/24 shows Oxygen setups should be changed every seven days and as needed if heavy soiling is present.

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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. 45540 Based on observation, interview and record review the facility failed to reorder a resident's medication. This applies to 1 of 29 residents (R340) in the sample of 29 reviewed for pharmacy services. The findings include: On 6/24/2024 at 9:42AM, R340 was observed lying in bed in his room. R340 said he was waiting on the facility to reorder his morphine. On 6/24/2024 at 12:18PM, V8 Registered Nurse said the prescription from the hospital had a requested quantity of 60 but the pharmacy only sent 6 of the morphine tablets. On 6/26/2024 at 10:36AM, V2 Director of Nursing (DON) said the hospital prescription was electronically signed, but the pharmacy requires an actual signature for the medication. V2 said this is why the pharmacy sent only 6 pills and didn't fill the entire script. On 6/24/2024 at 1:39PM, V7 Nurse Practitioner (NP) said the prescription could have been filled over the weekend by the covering provider. V7 said [R340] had oxycodone ordered as well for pain control. V7 said she did refill his prescription for the morphine on 6/24/2024. R340's Medication Administration Record (MAR) dated 6/1/2024 shows an order for Morphine Sulfate ER 60 milligram (mg) give 1 tablet by mouth every 12 hours scheduled for pain. R340's MAR shows the medication was unavailable starting on 6/22/2024 at 9:00AM until 6/24/2024 at 9:00 AM. R340's MAR shows an order for oxycodone 30mg give every 6 hours as needed for pain. R340's MAR shows oxycodone given on 6/22/2024 at 8:31PM, 6/23/2023 8:17AM and 4:18PM for pain management. R340's Morphine prescription from the hospital had a quantity of 60. The facility's prescription quantity shows a quantity of 6 on the morphine label sent by the pharmacy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145511	A. Building B. Wing	06/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bella Terra Lombard	2100 South Finley Road Lombard, IL 60148

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 47552 Based on observation, interview, and record review the facility failed to ensure food preparation equipment was sanitized prior to preparing food. This has the potential to affect all 138 residents receiving food from the kitchen. The findings include: The CMS 671 dated 6/24/24 shows there are 139 residents residing in the facility. Facility provided Diet Type Report shows that there is only one resident with an order of NPO (nothing by mouth) and does not receive food from the kitchen. On 6/24/24 at 10:37 AM, V18 (Chef) said that he had just finished pureeing the chicken for lunch and had to finish pureeing the noodles and broccoli. On 6/24/24 at 10:42 AM, V18 went to the prep sink where water was running onto a soiled food processor container, food processor lid, food processor blade, and spatula. V18 grabbed a rag from a green bucket next to the sink and proceeded to use it to wash the items in the prep sink. When finished, V18 returned the rag to the green bucket, removed the items from the sink, and brought all the items to the prep table to begin his puree process. V18 placed the spatula on the prep table and assembled all the food processor components before placing them onto the food processor base. The items were still wet from being washed and were not sanitized. On 6/24/24 at 10:46 AM, V18 returned to the prep table where he began to puree the broccoli. At 10:52 AM, V18 picked up the un-sanitized spatula that was on the prep table and used it to scoop the pureed broccoli out of the food processor pitcher and into a serving pan. At 10:55 PM, V18 brought the food processor components and the spatula back to the prep sink where he continued the same process as before, washing all the items in the prep sink and returning them to the prep table without sanitizing and air drying. On 6/24/24 at 10:55 AM, V17 (Food Service Director) confirmed that the contents of the green bucket were only water with soap. On 6/24/24 at 10:59 AM, V18 began to puree the pasta. At 11:03 AM, V18 finished with the pureed pasta and used the un-sanitized spatula to scoop the pureed pasta into a serving pan. On 6/24/24 at 12:10 PM, V17 said that no additional purees were made for lunch and the ones used for service were the ones made by V18. On 6/25/24 at 1:24 PM, V17 said that V18 should have brought the food processor pitcher, lid, blade, and the spatula to the dish room to wash, rinse, and sanitize the parts. He (V18) . needs to wash, rinse, sanitize, and air dry before starting the next puree. V17 said in a perfect world, the facility would have two or more complete food processor pitchers for the puree process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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. 34490 Based on observation, interview and record review the facility failed to ensure staff wore personal protective equipment (PPE) when providing direct resident care for residents on enhanced barrier precautions (EBP) for 2 of 29 residents (R28 and R97) reviewed for infection control in the sample of 29. The findings include: 1. R97's current Care Plan shows that R97 is on EBP related to having a gastrostomy tube. The Care Plan shows interventions of: Ensure that gown and gloves are used during high-contact resident care activities (like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting). On 6/24/24 at 11:14 AM, V15 (CNA) went into R97's room to provide incontinence care and reposition R97. V15 put gloves on but did not don a gown. V15 performed incontinence care and repositioned R97. R97 was observed to have a gastrostomy tube. 2. R28's current Care Plan shows that R28 is on EBP related to an indwelling foley catheter and a surgical wound. The Care Plan shows interventions of: Ensure that gown and gloves are used during high-contact resident care activities (like dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting). On 6/24/24 at 10:05 AM, R28 was observed to have an indwelling urinary catheter. At 10:10 AM, V15 (Certified Nursing Assistant/CNA) went into R28's room and applied gloves. V15 did not don a gown. V15 assisted R28 to sit on the side of the bed. V15 applied a gait belt to R28 and assisted him to his wheelchair. V15 then removed the gait belt and put it around her waist. On 6/26/24 at 9:06 AM, V20 (Infection Preventionist) said that any resident that has a gastrostomy tube, indwelling urinary catheter or wound need to be on EBP. V20 said that the staff need to don gloves and a gown if they are going to have any type of contact with the resident if they are on EBP. The facility's EBP Policy revised on 6/6/24 shows, EBP involves the use of gowns and gloves to reduce transmission of resistant organisms during high-contact resident care activities for residents know to be colonized or infected with MDROs as well as residents with wounds and/or indwelling medical devices .EBP will be used for any resident in the facility: With open wounds .urinary catheter, feeding tube .Examples of high-contact resident care activities requiring gown and glove use among residents that trigger EBP use include: .Transferring, providing hygiene .,Changing briefs