STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145614	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Nrsg & Rehab Center	7050 Madison Street Willowbrook, IL 60521

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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 0572 Level of Harm - Potential for minimal harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on interview and record review the facility failed to provide residents residing in the facility both orally and in writing of their resident rights. This applies to 7 of 10 residents (R1, R17, R25, R34, R53, R75, R101) reviewed for resident rights in the sample of 25. The findings include: 1. R1's EMR (Electronic Medical Record) showed R1 was admitted to the facility on [DATE]. R1's MDS (Minimum Data Set) dated June 3, 2024, showed R1 was cognitively intact. 2. R17's EMR showed R17 was admitted to the facility on [DATE]. R17's MDS dated [DATE], showed R17 was cognitively intact. 3. R25's EMR showed R25 was admitted to the facility on [DATE]. R25's MDS dated [DATE], showed R25 was cognitively intact. 4. R34's EMR showed R34 was admitted to the facility on [DATE]. R34's MDS dated [DATE], showed R34 was cognitively intact. 5. R53's EMR showed R53 was admitted to the facility on [DATE]. R53's MDS dated [DATE], showed R53 was cognitively intact. 6. R75's EMR showed R75 was admitted to the facility on [DATE]. R75's MDS dated [DATE], showed R75 had moderately impaired cognition. 7. R101's EMR showed R101 was admitted to the facility on [DATE]. R101's MDS dated [DATE], showed R101 was cognitively intact. (continued on next page)

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

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F 0572 Level of Harm - Potential for minimal harm Residents Affected - Some	On August 6, 2024, at 1:10 PM during the Resident Council meeting, the residents indicated they were unaware of their resident rights, they did not know where they could find a list of their resident rights, and also could not recall anyone ever going over their rights. V30 (Ombudsman) said it is hanging on the wall in the dining room on the second floor. V30 pointed to the wall, R25 then stated oh, where on the wall, it is empty except for a red bordered frame with nothing in it. V30 shook her head yes. On August 7, 2024, at 1:37 PM, V18 (Activity Director) said she has not discussed resident rights with the residents during the resident council meetings. On August 6, 2024, at 3:21 PM, V1 (Administrator) said Resident Rights are part of the admission packet, and they are posted in dining rooms, hallways, and near the elevators. On August 6, 2024, at 3:45 PM, Resident Rights were not visible in the first floor dining room or near the first floor elevators. On August 6, 2024, V1 provided resident council meeting minutes from September 2023 to present for review. The minutes were reviewed and there was no documentation in any of the meeting minutes that residents' rights were discussed during the resident council meeting on September 20, 2023, October 25, 2023, November 29, 2023, December 27, 2023, January 24, 2024, February 28, 2024, March 27, 2024, April 24, 2024, May 31, 2024, June 27, 2024, and July 31, 2024.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 16746 Based on observation, interview, and record review, the facility failed to assist residents identified as needing assistance with personal hygiene. This applies to 4 of 5 residents (R20, R85, R100 and R108) reviewed for ADLs (activities of daily living) in the sample of 25. The findings include: 1. R108 had multiple diagnoses including, dementia with other behavioral disturbance and weakness, based on the face sheet. R108's quarterly MDS (minimum data set) dated July 23, 2024, showed that the resident was severely impaired with cognitive skills for daily decision making. The same MDS showed that R108 was totally dependent on the staff with her ADLs including upper body dressing and personal hygiene. On August 5, 2024, at 11:36 AM, R108 was sitting in her reclining wheelchair inside the unit dining/activity room. R108 was alert but confused. R108's fingernails were short with black substances underneath. R108 was observed sticking her fingers inside her mouth. V14 (CNA/Certified Nursing Assistant) was present during the observation and confirmed that R108's fingernails had black substances underneath. On August 6, 2024, at 10:51 AM, R108 was sitting in her specialized wheelchair inside the unit dining/activity room. R108 was alert and confused. R108's gray sweater had food debris on the chest area. V15 (CNA) was present during the observation and confirmed that there were food debris from breakfast on R108's sweater. R108's active care plan initiated on June 10, 2024, showed that the resident's ability to perform ADLs was impaired related to cognitive loss. The same care plan indicated that R108 needed maximum/total assistance with all her ADLs. 2. R20 had multiple diagnoses including hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, type 2 diabetes mellitus, cognitive communication deficit and generalized muscle weakness, based on the face sheet. R20's significant change in status MDS dated [DATE], showed that the resident was severely impaired with cognition. The same MDS showed that R20 required maximum assistance from the staff with personal hygiene and lower body dressing, and moderated assistance from the staff with upper body dressing. On August 5, 2024, at 12:13 PM, R20 was sitting in her reclining wheelchair inside the unit dining/activity room. R20 was alert, verbally responsive but confused. R20's fingernails were long, jagged with black substances underneath. V16 (Registered Nurse) was present during the observation and confirmed that R20's fingernails need trimming and cleaning because they were long, jagged and with black substances. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 6, 2024, at 10:54 AM, R20 was sitting in her reclining wheelchair chair inside the unit dining/activity room. R20's pants and long sleeve shirt had scattered food debris and her fingernails were long and jagged. V15 (CNA) was present during the observation and confirmed that R20 had food debris on her pants and shirt. V15 also confirmed that R20's fingernails were long and jagged. R20's active care plan initiated on June 10, 2024, showed that the resident had limitation in ADL functional status. The same care plan showed that R20 required extensive assistance for grooming and dressing. 3. R100 had multiple diagnoses including cerebrovascular disease, dementia and history of transient ischemic attack and cerebral infarction without residual deficits, based on the face sheet. R100's quarterly MDS dated [DATE], showed that the resident was severely impaired with cognition and required total assistance from the staff with personal hygiene. On August 5, 2024, at 11:47 AM, R100 was sitting in her reclining wheelchair inside the unit dining/activity room. R100 was alert and confused. R100 had accumulation of long facial hair above and directly below her lips, and on her chin. V12 (Registered Nurse) who was present during the observation confirmed that R100 had accumulation of long facial hair and that the resident needs assistance with shaving. On August 6, 2024, at 11:20 AM, R100 was sitting in her reclining wheelchair inside the unit dining/activity room. R100 was alert and confused. R100's fingernails were long with black substances underneath. V13 (Registered Nurse) was present during the observation and confirmed that R100's fingernails were long and needed to be cleaned due to black substances underneath. R100's active care plan initiated on February 14, 2024, showed that the resident's ability to perform ADLs was impaired related to cognitive loss. 4. R85 had multiple diagnoses including Parkinson's disease without dyskinesia, hemiplegia and hemiparesis following cerebral infarction affecting the right dominant side, weakness and vascular dementia with other behavioral disturbance, based on the face sheet. R85's quarterly MDS dated [DATE], showed that the resident was moderately impaired with cognition. The same MDS showed that R85 required maximum assistance from the staff with personal hygiene. On August 5, 2025, at 10:59 AM, R85 was in bed, alert and verbally responsive. R85 had accumulation of long facial hair and his fingernails were short, jagged with black substances underneath. R85 stated that he wanted the staff to shave him, and to file and clean his fingernails. V12 (Registered Nurse) was present during the observation and confirmed that R85 needed shaving and his fingernails needed to be filed and cleaned. R85's active care plan initiated on May 10, 2024, showed that the resident had limited ability to groom self, related to decrease mobility and endurance due to hemiplegia of the right dominant side. The same care plan showed an intervention to include, Provide assistance for grooming at level resident requires. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 7, 2024, at 12:25 PM, V2 (Director of Nursing) stated that it is expected and is part of the facility's nursing care/service to ensure that residents who are needing assistance with ADLs including removing/shaving unwanted facial hair, fingernails trimming and cleaning and dressing should be assisted by the staff to maintain resident's dignity, comfort and hygiene/grooming.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. 29562 Based on observation, interview, and record review, the facility failed to ensure that the indwelling urinary catheter was not positioned above the resident's bladder and failed to clean the catheter tube during incontinence care. This applies to 2 of 4 (R64 and R80) residents reviewed for peri-care and catheter care in the sample of 25. The findings include: 1. R80's face sheet shows that R80 has multiple medical diagnoses which includes Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms. On August 6, 2024, at 11:25 AM, R80 was resting in bed, he had an indwelling urinary catheter with the urinary bag hanging on the left side of the bed. V24 and V26 (Both Certified Nursing Assistants/CNA) rendered peri-care to R80. V24 cleaned R80's perineum from front to back. V24 cleaned the tip of R80's penis, however, she but did not clean the catheter tube. When V24 and V26 repositioned R80 on his right side, V24 lifted and handed the urinary bag to V26 to place it on the right side of the bed. The urinary bag was lifted high above the bladder which made the urine inside the urinary tube flow back towards R80's bladder. V24 also emptied the urinary bag by lifting the bag high above the bladder while emptying into to the urinal, it was observed that the urine in the tube continued to flow back towards the bladder. 2. R64's face sheet shows that R64 has multiple medical diagnoses which include Benign Prostatic Hyperplasia (BPH) with lower urinary tract symptoms and urinary tract infection (UTI). On August 6, 2024, at 1:54 PM, R64 was resting in bed, he was awake, and was observed with a suprapubic urinary catheter. V24 and V25 (Both CNA) rendered incontinence to R64 who had a bowel movement. V25 cleaned R64's perineum from front to back. As V24 and V25 repositioned R64 on his right side, V24 handed the catheter bag to V25 to place the urinary bag on the right side of the bed. V24 lifted the urinary bag high above R64's bladder which made the urine inside the catheter tubing flow backwards towards R64's bladder. In addition, V25 did not clean the urinary catheter during the provision of care. On August 7, 2024, at 2:46 PM, V2 (Director of Nursing/DON) stated that when doing perineal care for a resident who has an indwelling urinary catheter, the staff must clean the catheter tube that is near the insertion site. When repositioning and transferring a urinary bag, the staff should not lift the urinary bag above the bladder, this is to prevent the urine from flowing backwards into the bladder and to prevent potential UTI. The Facility's Policy and Procedure for Urinary Catheter Care with revised date of September 2005 shows: Purpose: The purpose of this procedure is to prevent infection of the resident's urinary tract . General Guidelines: 4. The urinary bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder . Steps in the Procedure: 15. Use a clean washcloth with warm water and soap to cleanse and rinse the catheter from insertion site to approximately four inches outward.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. 29562 Based on observation, interview, and record review, the facility failed to check the placement of the gastrostomy tube (g-tube) prior to administration of medication. This applies to 1 of 2 residents (R80) reviewed for gastrostomy tube in the sample of 25. The findings include: On August 7, 2024, at 9:47 AM, V29 (Nurse) administered Hydrocodone-Acetaminophen 5-325 milligram tablet to R80 via g-tube. V29 flushed R80's g-tube with 60 milliliters (ml) of water and then administered Hydrocodone-Acetaminophen. Then V29 flushed the g-tube again with 60 ml of water. V29 did not check the placement of the g-tube prior to administering the medication. V29 stated that she forgot to do it. On August 7, 2024, at 10:51 AM, V28 (Assistant Director of Nursing/ADON) stated that when giving g-tube medication, the staff should check for the placement of the g-tube either by aspiration of residual or auscultation with stethoscope. This is to make sure that the medication is going into the right place. One of R80's g-tube care plan interventions dated July 15, 2024, shows Check placement and patency of feeding tube before each feeding or medication administration. R80's Medication Administration Record (MAR) dated August 2024 shows: Check for placement prior to medication, flush, or feeding administration. Aspirate residual feeding if more than 100 ml, hold feeding for 1 hour and recheck if still greater than 100 ml. Notify physician if no aspirate is obtained, check for placement using auscultation. If unable to aspirate or verify placement, hold administration of medication, flush or feeding and notify MD as needed.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. 16746 Based on observation, interview and record review, the facility failed to recognize, evaluate and manage a resident's pain during care. This applies to 1 of 1 resident (R24) reviewed for pain management in the sample of 25. The findings include: R24 had multiple diagnoses including, senile degeneration of the brain and dementia without behavioral disturbance, based on the face sheet. R24's quarterly MDS (minimum data set) dated May 9, 2024, showed that the resident was severely impaired with cognition and required total assistance from the staff with her ADLs (activities of daily living). On August 5, 2024, at 10:31 AM, R24's door was closed, and the resident could be heard from outside of the door, moaning. Upon entering R24's room, the resident was in bed and was moaning. R24 was confused and could not verbalize pain when asked. V15 (CNA/Certified Nursing Assistant) and V17 (CNA) stated that they just finished providing morning care to R24. According to V15, R24 would be moaning during provision of care. V15 was not aware if R24 had received any pain medication prior to them providing morning care. V15 was observed applying the bilateral hand splints to R24. V15 was asked to inform the nurse about R24's continued moaning but V15 continued to apply the hand splints, even though the resident had increased moaning and appeared to be in pain when her hand was touched to apply the hand splints. Immediately after the bilateral hand splints were applied to R24, V16 (Registered Nurse) came in the room. V16 assessed R24, then stated that the resident is hospice care. According to V16, R24 appeared in pain, and she will administer pain medication. R24's active order summary report showed that the resident was admitted to hospice care on May 8, 2024. The order report showed multiple orders for pain medications dated January 31, 2024, for Acetaminophen 650 mg, insert one suppository rectally every four hours as needed and Acetaminophen 325 mg chewable, give two tablets orally every four hours as needed. The same order report showed an order dated May 8, 2024, to administer Morphine Sulfate (concentrate) oral solution 100 mg/5 ml, give 0.25 ml by mouth every two hours as needed for pain. R24's MAR (Medication Administration record) for the month of August 2024 showed that on August 5, 2024, at 11:03 AM, V16 (Registered Nurse) administered Morphine Sulfate 100 mg/5 ml, 0.25 ml by mouth due to pain. The MAR showed that on August 5, 2024, at 11:03 AM, R24's pain level was documented as 10. The same MAR showed that the Morphine Sulfate was effective. Further review of the same MAR showed no evidence that R24 had received any other pain medication on August 5, 2024, prior to the administration of the Morphine Sulfate at 11:03 AM, (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R24's active care plan initiated on June 13, 2024, showed that the resident was at risk for pain. The same care plan showed multiple interventions including, monitor and record any non-verbal signs of pain ([example] crying, guarding, moaning, restlessness, grimacing, diaphoresis, withdrawal, etc. (etcetera), monitor and record any complaints of pain: location, frequency, effect on function, intensity, alleviating factors, aggravating factors, and administer medications. Monitor and record effectiveness. Report adverse side effects. On August 7, 2024, at 1:35 PM, V2 (Director of Nursing) stated that when R24 was moaning and was visibly in pain when her bilateral hand splints were being applied, the CNA should stop the application and inform the nurse, to ensure that the resident was assessed for pain and appropriate pain medication was administered before continuing with the care/application. V2 stated that R24 is hospice care and the main goal for this resident is pain management and comfort. On August 7, 2024, at 2:26 PM, V22 (Nurse Practitioner) stated that it is appropriate for the staff to stop applying the hand splints if the resident was moaning during the application, have the nurse assess the resident and if after the assessment the resident was identified with pain, the appropriate pain medication should be administered. After the administration of the pain medication, the staff should wait to assess the effectiveness of the pain medication and if it was effective, the procedure or the application of the splints may proceed. The facility's policy regarding pain management program dated July 2019 showed in-part, It is the policy of the facility to facilitate resident safety, independence, promote resident comfort, preserve and enhance resident dignity and facilitate life involvement. The purpose of this policy is to accomplish the goals through pain management program. The same policy under definition showed, The facility will utilize a consistent pain assessment. The resident's descriptive words regarding the quality, duration, and location of pain will be used to evaluate the pain and to identify changes in pain. When the resident is unable to describe pain, physical signs such as grimacing, body posturing/protecting, vital sign changes and changes in behavior and mood will be used to determine the presence of pain.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 36567 Based on interview and record review, the facility failed to ensure that the dietary staff followed the approved recipe for chef salad. This applies to 8 of 8 (R25, R26, R27, R6, R84, R91, R101, R113) residents reviewed for dining in the sample of 25. The findings include: Facility Spring/Summer 2024 (Week 4) Menu on Thursday [August 1, 2024] showed Chef's salad, seasonal fruit, baked fresh roll, cinnamon apple sauce, margarine. On August 5, 2024, at 3:23 PM, R6 stated The whole place got a bowl container of some kind of lettuce with no meat or cheese. There was no bread roll served with it. I ate in the dining room, and everybody was startled. I did not ask for anything else as it was night-time, and the people (from kitchen) had cleaned up and left. On August 5, 2024, at 3:22 PM, R26 stated Last week some time at dinner I got a bowl of lettuce with ranch dressing and no meat. I ate in my room and did not say anything. On August 5, 2024, at 3:18 PM, R91 stated Sometime for dinner last week we got a bowl of shredded lettuce with no meat. I thought 'What is this?' I felt like a rabbit. It was weird. But I don't complain. On August 5, 2024, at 3:20 PM, R84 stated We only got a Styrofoam container of lettuce with couple tomatoes. We all talked about it and R101 was very upset as she was very hungry. It has happened a few months ago once too when we got no meat. On August 5, 2024, at 3:31 PM, R101 stated Last Thursday or Friday night we got a small Styrofoam container with some lettuce and a dressing on the side. They said it was a chef salad platter but there was no meat or cheese or croutons on it. Even the CNAs (Certified Nursing Assistant) said 'We can't feed this to these people.' We complained about it. On August 5, 2024, at 3:26 PM, R113 stated We got just lettuce for dinner last week and most of us went to bed hungry. We all raided our snack cabinets. One of the resident's son's thought we will all starve to death and went and bought 5 pizzas. R27's daughter (V8) stated that it is the last straw, and she took pictures of it and was going to go to the newspapers, but we thought she should take it to V1 (Administrator) first. Everybody told V1 about it including the residents. He said he will look into it. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On August 5, 2024, at 3:36 PM, V8 (R27's Power of Attorney) was visiting R27 in her room and stated that R27 is hard of hearing. V8 stated that she visits every day at dinner time and saw that R27 had received just a side order of lettuce and cucumber along with a hard cheese sandwich. V8 added that the cheese sandwich is just an addition to the meal that R27 is supposed to get with every lunch and dinner as written on her meal ticket. V8 stated that she took a picture of the meal with her cell phone. V8 had a picture on her cell phone that showed a Styrofoam container of lettuce with salad dressing on top, 3 small pieces of tomato in one of the compartments, served with a grilled cheese sandwich and a small bowl of a soupy mixture. The salad did not show cheese, or visible meat. Grievance report filed by V8 dated August 1, 2024, included that R27 verbalized displeasure with dinner served on that day. On August 5, 2024, at 4:20 PM, R25 stated that the facility provides small portions of food. R25 stated I think it was last Thursday (August 1, 2024) that everyone got just shredded lettuce and a cup of dressing on the side, and everyone went to bed hungry. I told V1 what we got. R25 stated that she filed a grievance report the next day. Grievance report dated August 2, 2024, included that R25 was displeased about the dinner served on August 1, 2024, dinner. On August 5, 2024, at 4:04 PM, V1 stated that there was a meal last week either on August 1, 2024, or August 2, 2024, that the residents did not like. V1 stated that it was chef salad that the residents were displeased about, and the facility notified the Dietitian to change the menu item. V1 stated that he spoke to V5 (evening Cook) who stated that he was preparing the meal according to the menus. On August 6, 2024, at 9:07 AM, V4 (Dietary Director) stated he was informed that the residents were not a fan of the chef salad. V4 stated It's a preference thing. I am looking into changing this menu item and a few other items that the residents don't care for. The chef salad should have had the turkey as that's the protein. On August 6, 2024, at 9:08 AM, V5 (Cook) stated that he followed the recipe for chef salad and added lettuce, turkey breast, cheese, and tomatoes. V5 added that he prepared a few with no tomatoes, no cheese respectively for those that are not able to have those items. V5 stated that the chef salad was served in a to go disposable container. On August 6, 2024, at 4:48 PM, V11 (Certified Nursing Assistant) stated that she recalls that the residents received a salad with less chicken in it. V11 did not recall seeing any egg or cheese in the salad. V11 stated that there was more salad than chicken and that the residents were not happy with the salad. V11 stated that even if one orders a salad meal from a restaurant there are certain expectations of how much meat you would expect to be put on the salad. Recipe for entree Chef Salad (Recipe #130) included the following ingredients and method of preparation: 1. Dice turkey and ham into 1/4 cubes. 2. Tear lettuce into bite-size pieces. (continued on next page)

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	145614	A. Building B. Wing	08/08/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Chateau Nrsg & Rehab Center	7050 Madison Street Willowbrook, IL 60521

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. Shred carrots and add to lettuce. Toss lightly. 4. Portion lettuce and carrot mixture into individual salad bowls: 4 1/2 oz/ounce (1 1/2 cup) per bowl. 5. Arrange 1-1/2 oz each of turkey, ham, and 1 oz of cheese on top of lettuce. 6. Slice green peppers into 10 rings. Place one green pepper ring on each salad. 7. Cut tomatoes into 8 wedges and place 2 tomato wedges on each salad. 8. Serve each salad with 2 tbsp (tablespoon) salad dressing. Facility diet order listing showed that R25, R26, R27, R6, R84, R91, R101, R113 were on Regular consistency diets. R27's diet order included Send soft grilled cheese sandwich with lunch and dinner tray.

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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. 36567 Based on observation, interview and record review, the facility failed to store, prepare, and serve food in a sanitary manner. This has the potential to affect all 116 residents that receive food prepared in the facility kitchen. The findings include: Facility provided information that the census on August 5, 2024, was 117 residents with one resident on NPO (nothing by mouth) status. On August 5, 2024, at 9:17 AM, during initial tour of the kitchen the following observations were made: At the 3-compartment sink, used for wash, rinse and sanitizing dishes, dirty dishes were seen in the sanitizing sink. V6 (Dietary Aide) was seen washing the dishes in the middle sink, which should be used for rinsing dishes. V6 stated that she is going to fill the sanitizing sink with sanitizer. V6 then removed the dirty pans from the sanitizing sink and filled it with water mixed with sanitizer. It was noted that the sanitizing well still had food debris from the dirty pans and also had dirty rags in it. When notified that the sanitizer was contaminated, V6 cleaned and refilled the sanitizing sink with water mixed with sanitizer. When asked if she uses test strips to check the strength of the sanitizer, V6 was not sure of which test strips to use. V6 then used test strips for chlorine sanitizer which tested and remained white color. V6 stated that it should have tested 200 (ppm/parts per million) and pointed to the darkest color scale on the test strip container. V7 (Dietary Aide), who was washing dishes in the high temperature dish machine volunteered to test the sanitizer with the same test strip she uses for the high temperature dish machine. On prompting by State Agency personnel, V6 used the test strip for QUATS (quaternary ammonium compounds) sanitizer that was placed directly in front of the 3-compartment sink with directions for use of the same. The same test strip was unopened and after eventually breaking the seal with some difficulty with her long artificial nails, V6 was able to test the sanitizer but was not sure of what range it should test to and remarked I am guessing that it should test 200. Both V6 and V7 were noted to have long artificial nails and when questioned about it, V6 and V7 stated that they are used to working with the same. V7 was working at the high temperature dish machine. The dish machine wash area had grayish fuzzy patches on the conveyor belt and wall area. The plastic curtains at entrance (dirty side) and exit (clean side) of the dish machine were also noted to have excessive food debris and grayish patches on. A free-standing cart near the dish machine held washed bowls, most of which were not stored inverted. Multiple bowls had food debris and spills still in them. V6 stated that these dishes are used to serve dessert and that they were washed and stored by the dietary staff that worked the night before. V9 (Cook) was seen in the kitchen preparing the lunch meal and was noted to also have long artificial nails. V6, V7 and V9 were noted to wear gloves and remove them in between tasks during meal preparation and service. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The walk-in Cooler had several bowls of pudding stored on a free-standing cart open to air. The walk-in Freezer had extensive ice built up under the shelving at the back of the freezer with other miscellaneous debris. There were multiple cardboard boxes containing food products stacked on the floor which appeared dirty and strewed with debris. On the back shelving, there were several cardboard boxes containing frozen meat products of chicken cordon blue, pork crumble, beef, pork and other meat products that were not in cardboard boxes and were completely covered with ice that seemed to have formed from drippings from condensation from above. Multiple unidentifiable boxes of food products including dough rolls were open to air and appeared freezer burnt. V1 (Administrator) who had come to the area stated that V4 (Dietary Director) was on vacation. V1 stated that he is aware of the ice build-up and a company from outside is scheduled to fix the leak that is causing the ice build-up. V1 was notified that the frozen meats and other items with extensive ice build-up will not be at a quality to serve the residents. On August 6, 2024, at 10:30 AM, during pureed meal preparation of vegetable soup, V4 stirred the soup mixture in the blender with a spatula, and then placed the spatula in a sink that had running water and food debris and used utensils. In between pureeing, V4 used the same spatula from the sink to stir the vegetable soup mixture to check the consistency of the soup. V4 was notified that the pureed product was contaminated and was not safe to serve. V4 also had a beard with a beard cover that was under his chin. During further observations on the same day, V5 (Cook) and V10 (Dietary Aide) were also seen in the facility kitchen assisting with food stocking in cooler and freezers and were noted to have long dreadlocks that were partially tucked into a hair net and/or chef cap. V5 was also seen at tray line for lunch service with his dreadlocks partially covered in the hairnet. V4 was notified of the observations. On August 6, 2024, at 4:00 PM, V21 (R61's Power of Attorney) stated Once they were served a thin patty on a dry bun with some mayo on the side. They said it was chicken. The patty was so hard, and one of the ladies hit it on the table and it broke in two. The meat was hard, and freezer burned. None of the residents were able to eat it. On August 7, 2024 at 9:39 AM, V4 stated that the items in the freezer were used to prepare meals. V4 stated that he was aware of the freezer condition prior to going on vacation. V4 added that he threw away the food items that were earlier identified during initial tour covered in ice and freezer burnt. Service Order for Freezer dated July 26, 2024, included the following: Multiple issues appear to be causing ice buildup. There is an active condensate leak above the walk-in freezer coming from poorly insulated suction line drip water onto freezer ceiling then leaking into freezer. The suction line inside of freezer is bad. Water can be seen leaking of drain line when defrost comes on Drain line is partially broken or cracked and hidden under insulation heat tape needs to be replaced. Sections of curtains are missing. Suction lines on both outside unit needs to insulate. Suction line inside of the walk-in cooler also needs new insulation and evaporation coil needs to be cleaned. Outside electrical disconnect for freezer condensing unit is bad electrician work. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Policy titled Food Storage (revised June 2023) included as follows: Policy: It is the policy of [Facility] that all food products will be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, and security. Process: 1. Food storage area shall be clean at all times . 13. No meat or vegetable is refrozen . 17. All stored food will be at least 18 inches from the ceiling or pipes, and at least 6 inches off the floor. 18. All exposed foods shall be tightly covered. Facility Policy titled Dishwashing and Sanitation (revised June 2023) included as follows: Policy: It is the Policy of [Facility] to store, prepare, distribute and serve food under sanitary conditions. Purpose: To properly wash and sanitize is necessary to prevent food-borne diseases. Dishware, pots pans or utensils should be thoroughly cleaned and sanitized before use in food preparation or food serving to prevent the spread of food-borne diseases. Process: 2. Culinary Host will be trained in the proper use of the dish machine and three- compartment sink. 4. Food Service personnel will follow cleaning schedules and procedures in all areas for which they are responsible. Mechanical Dishwashing: 3. Dishwashing interior, exterior, jets, filters and rinse areas should be kept clean and free from food build-up. Manual Dishwashing: 1. Pot washing areas and sinks should be cleaned prior to use and have three compartment sinks for washing, rinsing and sanitizing. 3. Items should be pre-soaked (if necessary) and then scraped free of food debris before placing in the wash sink. 5. Items should be washed thoroughly in clean water with detergent solution. Dirty water should be changed frequently. 6. Items should be rinsed thoroughly in clean water to remove any remaining food particles or detergent. 7. If chemical sanitation is used, sanitize for 60 seconds. Solution should be mixed twice the recommended amount of solution to keep the strength because rinse water is carried over to the sanitizing sink. 8. Items should be allowed to air dry. Pots and pans should be inverted to speed drying process and allow excess water to drain away . Facility undated Policy titled Personnel and Sanitation (Policy #121-1) included as follows: 8) An employee who handles exposed food and food-contact surfaces: a) Keeps fingernails clean and neatly trimmed. b) Unless wearing gloves that are in good repair, does not wear fingernail polish or artificial fingernails: e) Uses hairnets, caps, or other effective hair restraints in order to keep hair from contacting food and food -contact surfaces.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 29562 Based on observation, interview, and record review, the facility failed to follow standard infection control practices with regards to hand hygiene and gloving during provisions of incontinence care. This applies to 5 of 25 (R20, R62, R64, R80, R85) residents reviewed for infection control in the sample of 25. The findings include: 1. On August 6, 2024, at 11:25 AM, V24 and V26 (Both Certified Nursing Assistants/CNAs) rendered peri-care to R80. V24 cleaned R80's perineum from front to back, then she placed a clean incontinence brief underneath R80 while wearing same gloves. V24 then, changed her gloves without performing hand hygiene and continued to reposition R80. V24 then handled the indwelling urinary catheter bag and straightened clean bed linens without performing hand hygiene in between tasks. 2. On August 6, 2024, at 1:39 PM, V25 (CNA) assisted R62 to the toilet where R62 voided and had a bowel movement. After R62 used the toilet, she wiped her frontal perineum, then V25 assisted R62 to stand up and cleaned R62's back perineum. V25 wiped R62's rectum multiple times, pulled R62's incontinence brief and pants back in place and assisted R62 to transfer back to the wheelchair while wearing the same soiled gloves. 3. On August 6, 2024, at 1:54 PM, V24 and V25 (CNAs) rendered incontinence care to R64 who had a large bowel movement. V25 cleaned R64's perineum from front to back, changed the incontinence brief, changed bed linen, applied barrier cream to R64, handled indwelling urinary catheter bag, while wearing the same gloves. 4. On August 7, 2024, at 9:11 AM, V20 (Nurse) administered medications to R85 via gastrostomy tube (g-tube). Prior to administration of medications, V20 donned a pair of gloves, gown, and mask. When V20 entered R85's bedroom, she touched and folded the bedside floor mattress, drew the privacy curtain around R85, filled the plastic container with water to flush the g-tube, check placement of g-tube, and administered medications via g-tube while wearing the same gloves. On August 7, 2024, at 2:32 PM, V2 (Director of Nursing/DON) stated that when staff provides care to the resident, the staff should perform hand hygiene before donning gloves and after contact with residents. They should change gloves and perform hand hygiene in between tasks, they should also change gloves and do hand hygiene when touching different surfaces and equipment. This is to prevent infection and/or spread of infection. 16746 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	5. On August 6, 2024, at 12:45 PM, with the assistance of V27 (CNA/Certified Nursing Assistant), V15 (CNA) provided bowel and bladder incontinence care R20. With her gloved hands V15 used disposable wet wipes to clean R20's buttocks and perineal area. R20 had wet stool. After cleaning R20, V15 removed her soiled gloves and put on a new pair of gloves without performing hand hygiene (either hand washing or use of alcohol/hand sanitizer), then proceeded to wipe R20's buttocks with a wet washcloth. V15 then again, removed her used gloves, put on a new pair of gloves without hand hygiene (hand washing or use of sanitizer/alcohol), and proceeded to put on R20's clean socks, pants and disposable brief. On August 7, 2024, at 12:31 PM, V2 (Director of Nursing) stated that the staff should wash their hands or sanitize after removing the used or soiled gloves after provision of incontinence care to prevent cross contamination and to ensure infection control is maintained. The facility's handwashing/hand hygiene policy dated March 2020 showed, It is the policy of the facility to assure staff practice recognized handwashing/hand hygiene procedures as a primary means to prevent the spread of infection among residents, personnel, and visitors. Alcohol based hand rubs (ABHR) can be used for hand hygiene when hands are not visibly soiled or contaminated with blood or bodily fluids. The same policy under specifications showed in-part, 4. When hands are not visibly soiled, employees may use an alcohol-based hand rub (foam, gel, liquid) containing at least 60% alcohol in all of the following situations: .g. before moving from a contaminated body site to a clean body site during resident care; h. before and after putting on and upon removal of PPE (personal protective equipment), including gloves; . k. after contact with objects such as medical devices or equipment in the immediate vicinity of a resident that may be potentially contaminated; . m. after removing gloves.