| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145632 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Warren Barr South Loop | 1725 South Wabash<br>Chicago, IL 60616 |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40061<br><br>Based on interviews and record reviews, the facility failed to identify a resident's (R113) code status for one out of 35 residents reviewed for advanced directives.<br><br>Findings include:<br><br>R113's Admission Record documents in part medical diagnoses of dementia and adult failure to thrive.<br><br>On [DATE] at 1:08 PM, R113's Care Plan Report documents in part that R113 received education on advanced directives and end of life care options. Pursuant to resident rights, the advanced directive status of Full Code has been selected (initiated [DATE]). The goal was as follows: [R113] wishes for Full Code status as specified in advance directive documents will be honored and delineated in the medical record in compliance with state law through next review (initiated [DATE]). Interventions initiated on [DATE] include: As indicated, my advanced directives code status will be documented on my physician order sheet in the electronic medical system and be clearly identified on my electronic chart page so that the facility personnel working with me will know my advanced directives code status. I will be provided with the option to document my advanced directives code status on a POLST form document and reminded that this matter is one of personal choice and that it is important to be comfortable with whatever advanced directives code status decision is selected. My physician and the personnel that is working with me will know that I have selected that my advanced directives status be a Full Code.<br><br>R113's physician orders at the time documented in part an active order of DNR (Do Not Resuscitate). V46 (former facility Nurse) entered the order on [DATE]. R113 had two conflicting code status.<br><br>R113's POLST (Physician Orders for Life-Sustaining Treatment) form was not uploaded to R113's electronic medical record.<br><br>On [DATE] at 2:07 PM, V19 (Nurse) stated [V19] did not know if the facility kept the residents' POLST forms on the floor. V19 stated the residents' code statuses are usually found on their computer profile under their picture in the electronic medical record where it says Code Status. R113's code status read DNR.<br><br>(continued on next page) |

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

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

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On [DATE] at 2:13 PM, V20 (Nurse) stated [V20] was the nurse for R113. V20 stated R113 was confused and unable to make treatment decisions. V20 stated a family member was the designated decision maker for R113. V20 looked at R113's computer profile and stated R113's code status was DNR. V20 could not locate R113's POLST in the electronic medical records. V20 did not know where the hard copy of R113's POLST form was located. V20 stated the other units in the facility usually had an Advanced Directive binder at the nurses' unit but V20 could not locate the one for the second floor.<br><br>Requested R113's POLST form from V1 (Administrator) and V2 (Director of Nursing). Facility failed to provide R113's POLST form.<br><br>On [DATE] at 9:32 AM, R113's Order Summary Report documented in part an active order for Full Code (active as of [DATE]). R113's Order Audit Report documents in part that V41 (Nurse Supervisor) struck out the previous DNR order on [DATE] at 3:07 PM.<br><br>On [DATE] at 12:17 PM, V2 stated [V2] did not know what was going on with R113's code status.<br><br>On [DATE] at 1:07 PM, V41 stated the facility ran an audit and did not find R113's POLST form. V41 stated R113 did not have a standing DNR so V41 changed R113's code status in the electronic medical records to Full Code. V41 stated [V41] was not sure who put the DNR order in or where they got it from.<br><br>Attempted telephone interview with V48 (listed responsible party on R113's Admission Record) on [DATE] at 1:05 PM and again on [DATE] at 1:58 PM and 5:06 PM. No answer.<br><br>Attempted telephone interview with V46 (Nurse that entered the DNR order on [DATE]) on [DATE] at 2:05 PM and 5:10 PM. No answer.<br><br>Facility's Advance Directives policy, last revised [DATE], document in part: An Advance Directive form (as provided by the healthcare facility) shall be completed with resident and/or legal representative to verify treatment options as well as code status. Appropriate information will be added to Physician Order Sheet (POS). The resident's Advance Directive choices/options shall be reviewed during the re-assessment and quarterly care planning process. If the resident is unable or chooses not to initiate any type of Advance Directive, it is the policy for this facility for the resident to be a Full code and to receive appropriate life sustaining treatment interventions such as CPR [Cardiopulmonary Resuscitation]. The facility shall maintain copies of all Advance Directives. |

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| F 0604<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.<br><br>40061<br><br>Based on observation, interviews, and record reviews, the facility failed to follow their policy and assess a resident's (R99) need for restraints at least quarterly for one resident out of a total sample of 35 residents.<br><br>Findings include:<br><br>R99's Admission Record documents in part diagnoses of acute respiratory failure with hypoxia, stiffness of the right hand, anxiety disorder, conversion disorder with seizures or convulsions, and contracture of the left hand.<br><br>R99's Order Summary Report documents in part an active order to Apply Bilateral sheepskin restraint to avoid resident pulling trach (order date 1/28/2025). Prior to the sheepskin restraint, R99 also had an order to Apply Bilateral soft wrist restraint to avoid resident pulling trach (order date 8/19/2024).<br><br>R99's Care Plan Report contains an update from 1/28/2025 regarding application of sheepskin wrist restraint. The listed goal did not reflect the sheepskin wrist restraint. It read [R99] will not have injury or complications related to bilateral soft wrist restraint use thru next review (Target Date 5/05/2025).<br><br>On 2/18/2025 at 11:01 AM, R99 was lying in bed with sheepskin wrist restraints to bilateral wrists.<br><br>Facility dated the next quarterly MDS (Minimum Data Set) assessment for 2/04/2025. As of 2/19/2025 11:11 AM, it was still in progress.<br><br>On 2/19/2025 at 2:46 PM, surveyor requested R99's most recent restraint assessment from V28 (Restorative Nurse).<br><br>On 2/19/2025 at 2:55 PM, V2 (Director of Nursing) provided a Side Rail/Other Devices Evaluation UDA (User Defined Assessment) dated 8/19/2024 for R99's wrist restraint assessment. V2 did not provide a more recent restraint assessment for R99.<br><br>Surveyor asked for clarification and again requested R99's most recent restraint assessment from V1 (Administrator) and V2 on 2/20/2025 at 9:28 AM and 11:52 AM. Facility did not provide any other restraint assessment for R99 that was dated prior to the start of the survey.<br><br>On 2/20/2025 at 11:57 AM, V28 (Restorative Nurse) stated, the facility should conduct restraint assessments every quarter, during a significant change, and as needed. V28 stated R99 was due for a restraint assessment on 2/04/2025 but facility did not complete it.<br><br>Facility's Restraints policy, last revised 8/19/2024, documents in part: The use of the restraining device may be assessed and reduced at least quarterly. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103<br><br>Based on observation, interview and record review, the facility failed to ensure low air loss mattress devices were on the correct weights setting for a resident (R56) with current pressure ulcer and for a resident (R66) who is high risk in developing pressure ulcers. This failure has the potential to affect two (R56, R66) out of two residents reviewed for pressure ulcer care in a final sample of 35.<br><br>Findings Include:<br><br>On 2/18/25 at 12:16 PM and on 2/19/25 at 10:57 AM, R56 was noted lying in bed and noted on a low air loss mattress with the machine set to 120 pounds (lbs.).<br><br>On 2/18/25 at 12:14 PM, R66 was sleeping in bed and noted on a low air loss mattress with the weight dial on the machine set to 180 lbs.<br><br>On 2/19/25 at 10:49 AM, R66 was lying in bed alert and able to verbalize needs still noted on a low air loss mattress with the weight dial on the machine set to 180 lbs. R66 stated that [R66] feels like lying on a wood block because the mattress is too firm.<br><br>On 2/19/25 at 11:19 AM, interviewed V29 (Wound Care Coordinator/Licensed Practical Nurse) and stated that residents who are at risk for developing pressure ulcers are placed on a low air loss mattress as preventative measure. V29 stated that residents with current pressure ulcers are also placed on a low air loss mattress to help with wound healing to relieve pressure on the wound. V29 stated that the low air loss mattress should be set based on the current weight of the resident. V29 stated that if the low air loss mattress is not in the right setting and if it's too soft or too hard that would deplete the purpose of the low air loss mattress. If the setting is too low, it would be too soft and if the setting is too high it would be too firm. V29 stated that the facility uses a BRADEN score screening to assess a resident for risk of skin breakdown. V29 stated that R56 has stage 4 sacral wound present on admission and R56's current weight is 84 pounds dated 2/7/25. V29 stated that R56's low air loss mattress should be set between 80 to 90 pounds, 120 pounds is not the right setting. V29 stated R66 is high risk in developing skin breakdown due to history of having pressure injuries. V29 stated that R66's current weight is 136 pounds dated 2/18/25 and R66's low air loss mattress should be set to 135 pounds, 180 pounds is the incorrect setting.<br><br>R56's Minimum Data Set (MDS) dated [DATE] shows R56 requires staff assistance with positioning in bed. R56's skin progress notes dated 2/13/25 shows R56 has stage 4 sacral pressure ulcer. R56's physician orders show an order for pressure relieving mattress (order date 9/8/23). R56's weight records show R56 weighs 84 pounds dated 2/7/25.<br><br>R66's MDS dated [DATE] shows R66 requires staff assistance with positioning in bed. R66's BRADEN scale dated 2/11/25 shows R66 is high risk in developing skin breakdown. R66's physician orders show an order for pressure relieving mattress (order date 8/27/24). R66's weight records show R66 weighs 136 pounds dated 2/18/25.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's Specialized Mattress and Appropriate Layers of Padding policy dated 8/19/23 documents in part: Use specialized air mattresses like Low Air Loss Mattress on residents with stage 3 and 4 pressure sores to ensure moisture, heat, and friction control. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342<br><br>Based on observation, interview, and record review, the facility failed to follow the smoking policy and smoking assessment to ensure that smoking materials are not kept by the resident in their room. This failure has the potential to effect 2 (R110, R141) residents reviewed for smoking in a total sample of 35.<br><br>Findings include:<br><br>On 02/18/25 at 12:04 PM, observed red Oxygen in Use sign posted outside R110 and R141's room. R110 stated she smokes and is allowed to smoke independently meaning she can go outside to smoke whenever she wants unsupervised, and she is allowed to keep her cigarettes and lighter in her room. Observed R110 open her side table drawer, reach inside, and remove an opened pack of cigarettes and a lighter with fluid in it.<br><br>On 02/18/25 at 12:06 PM, observed an oxygen tank on R141's side of the room in the corner next to R141's bed. Also observed a nebulizer machine on R141's bedside table.<br><br>On 02/18/25 at 12:14 PM, V13 (Registered Nurse) looked in R141's electronic health record (EHR) orders and stated R141 has an order for PRN nebulizer treatments and oxygen as needed for shortness of breath. V13 did not know R141's roommate (R110) had a lighter in the room and stated she was going to remove the oxygen from the room immediately because that is a fire hazard; oxygen cannot be near a flame/fire because it could blow up.<br><br>On 02/18/25 at 12:24 PM, V14 (Psychiatric Rehabilitation Services) stated residents who smoke are screening quarterly for safety and are assessed to either be able to smoke independently or require supervision. V14 stated if a resident is determined to be safe to smoke independently then they may keep their cigarettes and lighter on them, in their room and are allowed to smoke independently outside in designated smoking areas. V14 stated even if a resident can smoke independently, they should not have a lighter in the room if there is also oxygen in the room because that is a fire risk. V14 was not sure of R110's smoking program status.<br><br>On 02/20/25 at 8:45 AM, V16 (Social Service Director) stated in September 2024, R110 was found to be smoking in undesignated area and as a result, her smoking program status was downgraded from independent to dependent with supervision. V16 stated as far as he knows R110 has been compliant with the smoking rules. V16 stated he was told about R110 keeping cigarettes and lighter in her room on 02/18/25 and stated, I don't know where she got her cigarettes/lighter, but she should not have had them on her. V16 stated oxygen and smoking are not a good combination for safety reasons due to flammability and R110 having a lighter in a room with oxygen is a fire risk. V16 stated R110's smoking material has already been removed from her room and the staff will be conducting random room checks.<br><br>On 02/20/25 at 1:30 PM, V2 (Director of Nursing) stated the resident(s) should not have any lighters in their room with oxygen because of the risk of combustion and explosion. V2 stated that puts both of those residents at risk. V2 stated R141 is on hospice care which is why she (R141) has oxygen in her room.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | R110's diagnosis included but not limited to Traumatic Subdural Hemorrhage with Loss of Consciousness of Unspecified Duration, COVID-19, Influenza, Major Depressive Disorder, Type 2 Diabetic Mellitus, Muscle Wasting and Atrophy, Abnormalities of Gait and Mobility, Lack of Coordination, Hemiplegia and Hemiparesis following Cerebral Infarction Affecting Right Dominant Side, Asthma, Dysphagia, Cocaine Use.<br><br>R110's MDS (Minimum Data Set) dated 01/01/25 indicates moderately impaired cognition with BIMS (Brief Interview for Mental Status) 12 out of 15.<br><br>R110's Order Summary Report dated 02/19/25 documents in part, Allowed to smoke cigarettes with order date 04/09/23.<br><br>R110's Smoking Contract signed on 09/18/24 documents in part, (R110) will not keep/hold my (R110) own lighter(s) and cigarettes/cigars due to safety reasons.<br><br>R110's Smoking Program (Evaluation for Risk) dated 09/18/24 documents in part, staff witness resident smoking in room, Resident will be placed on dependent smoking program until next review. R119's Smoking Program Evaluation dated 01/02/25 documents in part, (R110) smokes in unauthorized areas, inappropriately extinguishes cigarettes or matches, poor judgement or decision-making skills and resident is not considered a safe smoker and requires smoking management and supervision consistency with facility policy and may not have access to smoking materials outside of supervised smoking.<br><br>R141's diagnosis included but not limited to Senile Degeneration of the Brain, Cerebral Infarction, Major Depressive Disorder, Type 2 Diabetes Mellitus with Hyperglycemia, Hypertension, Muscle Wasting and Atrophy, Difficulty in Walking, Lack of Coordination, History of Falls.<br><br>R141's MDS dated [DATE] indicates resident was not able to complete BIMS.<br><br>R141's Order Summary Report documents in part, Admit to Amenity Hospice order date 03/28/24 and Albuterol Sulfate Inhalation Nebulization Solution 3 ml inhale orally via nebulizer every 6 hours as needed for SOB order date 09/03/24.<br><br>Facility provided policy titled, Smoking Policy undated which document in part, all smoking material: cigarettes, lighters, rolling materials etc. will kept with facility staff. Residents are not permitted to keep such materials in their rooms and residents may never smoke near and/or while carrying any oxygen tanks/machines/etc. This policy was signed and dated by R110 on 09/18/24. |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103<br><br>Based on observation, interview and record review, the facility failed to ensure the appropriate side rails were used for three residents (R16, R28, R144), and failed to follow their policy and evaluate the use of side rails at least quarterly for two (R132, R99) residents out of a total sample of 35 residents.<br><br>Findings Include:<br><br>1. On 2/18/25 at 11:54 AM, R16 was lying in bed alert with some forgetfulness and noted with three half side rails up; 2 half upper rails and 1 half lower rail.<br><br>Reviewed R16's side rail assessment dated [DATE] revealed R16 was assessed to only use 2 half-length rails for assistive device to turn and reposition and/or transfer. R16's Minimum Data Set (MDS) dated [DATE] shows R16 is cognitively impaired and needs staff assistance with activities of daily living (ADLs).<br><br>2. On 2/18/25 at 12:52 PM, R144 was sitting on the side of the bed trying to eat lunch with R144's both legs squeezed in between the two half side rails that were up on the right side of R144's bed. The other two half side rails were also up on the left side of R144's bed.<br><br>Reviewed R144's side rail assessment dated [DATE] revealed R144 was assessed to only use 2 half-length rails for assistive device to turn and reposition and/or transfer. R144's side rail consent dated 8/16/24 also shows 2 half-length side rails to be used for R144. R144's care plan (date initiated 8/26/24) revealed bilateral upper half side rails. R144's MDS dated [DATE] shows R144 is cognitively impaired and needs staff assistance with ADLs.<br><br>3. On 2/19/25 at 11:02 AM, R28 was observed sleeping in bed and noted with all 4 half side rails were up.<br><br>Reviewed R28's side rail assessment dated [DATE] revealed R28 was assessed to only use 2 half-length rails for assistive device to turn and reposition and/or transfer. R28's side rail consent dated 10/8/23 also shows 2 half-length side rails to be used for R28. R28's care plan (date initiated 10/18/23) revealed bilateral upper half side rails. R28's MDS dated [DATE] shows R28 is severely impaired with cognition and needs staff assistance with ADLs.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/19/25 at 12:38 PM, interviewed V28 (Restorative Nurse) and V28 stated that there should be a side rail assessment and consent from the family or resident prior to using the side rail. Side rail assessments are done for all residents. It would indicate there how many side rails the staff are supposed to be using for the residents. V28 stated the main purpose of the side rail assessment is to prevent any entrapment for the residents and to determine the proper use of the side rails. If there is no assessment or consent the side rails should not be used. V28 stated the facility uses side rails for the residents for bed mobility and transfer assistance. V28 stated side rail assessment is completed within 24 hours of admission and needs to be re-evaluated quarterly, annually, with significant change and acute change. V28 stated that the use of the side rail is important to address in the care plan for the resident's safety and for the staff to know what the interventions for the resident. V28 stated R144's recent side rail assessment was done 2/10/25 and is supposed to be using 2 half-length rails. V28 stated R28's recent side rail assessment was completed on 12/19/24 and indicates 2 half-length rails when in bed. R28's care plan also shows 2 half-length side rails. V28 stated that staff should not be using 4 side rails for the residents because it could increase the risk of entrapment. V28 stated, We do in-service with the frontline staff regarding use of side rails monthly. We don't have any resident in the facility that uses more than 2 half-length side rails.<br><br>The facility's Side Rail policy dated 8/19/24 documents in part: Prior to the use of side rails, alternative devices like pillows, wedges, foams, and other repositioning devices will be utilized first for residents in need of repositioning. If the alternative devices failed to assist the resident in repositioning, the resident will be assessed for the use of side rails, to determine risk for entrapment and other potential danger to the resident. If side rails are appropriate for the resident, a verbal or written consent will be obtained by the facility prior to the use of side rails. The use of side rails will be evaluated at least on a quarterly basis.<br><br>40061<br><br>4. R99's Admission Record documents in part diagnoses of acute respiratory failure with hypoxia, stiffness of right hand, and contracture of the left hand.<br><br>R99's Order Summary Report documents in part an active order for Bilateral upper half siderails for turning, reposition, and safety (order date 8/07/2024).<br><br>R99's Care Plan Report documents in part that R99 uses two half side rails for bed mobility.<br><br>On 2/18/2025 at 11:01 AM, R99 was lying in bed with bilateral upper half side rails up.<br><br>Requested R99's most recent side rail assessment from V2 (Director of Nursing) on 2/19/2025 at 11:14 AM.<br><br>Requested R99's most recent side rail assessment from V1 (Administrator) on 2/19/2025 at 1:59 PM.<br><br>Requested R99's most recent side rail assessment from V28 (Restorative Nurse) on 2/19/2025 at 2:46 PM.<br><br>On 2/19/2025 at 2:55 PM, V2 provided a Side Rail/Other Devices Evaluation UDA (User Defined Assessment) dated 8/19/2024. The assessment did not include an evaluation for side rails. Facility did not provide any other side rail assessment for R99.<br><br>(continued on next page) |

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| F 0700<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 2/20/2025 at 11:57 AM, V28 (Restorative nurse) stated V28 provided R99's side rail assessment to V1 prior to leaving work yesterday. V28 stated it was the one from 8/19/2024. V28 stated R99 was due for a side rail assessment on 2/04/2025 but they did not complete it.<br><br>5. R132's Admission Record documents in part diagnoses of anoxic brain damage, weakness, muscle wasting, lack of coordination, abnormal posture, and reduced mobility.<br><br>On 2/18/2025 at 10:44 AM, R132 was lying in bed with both upper side rails up.<br><br>On 2/19/2025 at 10:50 AM, R132 was lying in bed and holding onto the right-side rail with the right hand.<br><br>R132's Care Plan Report documents in part that R132 uses two upper half side rails for bed mobility (date initiated 8/10/2023).<br><br>The Restorative UDAs (User Defined Assessments) for 1/07/2025 and 3/12/2024 were not complete.<br><br>On 2/19/2025, surveyor requested R132's side rail assessments since the last standard survey from V1 (Administrator), V2 (Director of Nursing), and V28 (Restorative Nurse) (refer to time stamps listed above when surveyor requested R99's most recent side rail assessment).<br><br>On 2/19/2025 at 2:55 PM, V2 provided R132's side rail assessments from 2023 with the most recent one from 12/19/2023. Facility did not provide any of R132's side rail assessments from 2024 or from 2025 that were dated prior to the start of the survey.<br><br>On 2/20/2025 at 12:00 PM, V28 stated facility missed R132's side rail assessments. V28 stated the last one was from 12/19/2023. V28 stated it somehow fell through the crack. V28 stated the facility started the Restorative UDAs but did not complete them.<br><br>Facility's Side Rail policy, last revised 8/19/2024, documents in part: The use of side rails will be evaluated at least on a quarterly basis. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103<br><br>Based on observation, interview and record review, the facility failed to follow their policies and procedures to ensure a resident received medications according to the physician's order for 1 (R441) out of 8 residents reviewed for pharmaceutical services. The facility also failed to follow their policies and procedures to properly dispose of controlled substances dispensed to its residents due to discontinuance of the medication, and failed to account for and dispose of controlled medications in a manner that would decrease the possibility of loss or diversion. These failures were found for two residents (R35, R162) during narcotic reconciliation from two out of five inspected medication carts.<br><br>Findings include:<br><br>On 2/18/25 at 10:46 AM, surveyor reviewed the first-floor team two medication cart with V6 (Agency Registered Nurse). In the narcotics bin, there was a blister packet for R162's Oxycodone 5 mg capsule. There were thirteen capsules in the blister packet. The number six and number two slots were compromised and had a piece of transparent tape over the back. V6 was not sure if the yellow and brown capsules in the number six and two slots were Oxycodone. V6 stated the nurse who broke the seal should have thrown out the tablet in the sharps and had it witnessed by another nurse.<br><br>On 2/18/25 at 12:32 PM, surveyor reviewed the fourth-floor team one medication cart with V50 (Licensed Practical Nurse). In the narcotics bin, there was a blister packet for R35's Clonazepam 0.5 mg tablet. There were twenty-five tablets in the blister packet. The number five, six, seven, and eight slots were compromised. The number six and seven slots had a piece of transparent tape over the back.<br><br>During an interview with V2 (Director of Nursing/DON) on 2/19/25 at 1:08 PM, V2 stated if a resident refuses a controlled substance, the nurse should properly discard the medication with two nurses present. Nurses should recount the controlled substances and make sure the drug records are correct. V2 stated nurses should not attempt to return controlled medications once their original seal or packaging is broken. V2 stated that discontinued controlled medications should not be stored in the medication carts and should be properly disposed.<br><br>R162's face sheet shows R162's included diagnosis but not limited to encounter for other orthopedic aftercare. R162's narcotic count sheet documents in part: Oxycodone 5 mg take one capsule by mouth every 8 hours as needed for severe pain. R162's Order Summary Report printed on 2/19/25 does not show an order for Oxycodone medication.<br><br>R35's face sheet shows R35's included diagnosis but not limited to generalized anxiety disorder. R35's narcotic count sheet documents in part: Clonazepam 0.5 mg take 1 tablet by mouth every twelve hours as needed. R35's Order Summary Report printed on 2/19/25 does not show an order for Clonazepam medication.<br><br>(continued on next page) |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility's policies and procedures for Medication Storage, Labeling, and Disposal dated 8/16/24 documents in part: Controlled meds should be disposed properly to prevent accidental exposure and diversion using Drug Buster or Rx Destroyer.<br><br>The facility's policies and procedures for Controlled Substance Disposal dated 3/1/24 documents in part: The facility adheres on guidelines for proper destruction/disposition of Controlled substances dispensed to its residents due to discontinuance of the medication, death of the resident or other reasons necessitating destruction. Discontinued Controlled medications will be endorsed to the DON/ or designee for proper destruction/disposition. The DON or designated licensed nurse authorized for destroying or otherwise disposing in witness of another healthcare professional maintains a Controlled Substance Record indicating amount of medications disposed, date of destruction/disposition and method.<br><br>49486<br><br>R441's Electronic Medical Record (EMR) revealed R441 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: malignant neoplasm of pancreas, gastro-esophageal reflux disease without esophagitis, acute and chronic respiratory failure with hypoxia, encounter for attention to tracheostomy, encounter for attention to gastrostomy, other encephalopathy, essential hypertension, immunodeficiency due to drugs, diverticulosis of intestine, and insomnia.<br><br>On 2/18/25 at 12:45 PM, surveyor and V4 (Licensed Practical Nurse/LPN) entered R441's room and observed prepared crushed medications in a medicine cup at R441's bed side dresser. R441 stated that R441 could not remember if R441 has received medication today. V4 acknowledged the medications as Famotidine tablet 0.5 mg and Senna-plus tablet 8.6-50mg. V4 stated that the medications should have been given at nighttime because V4 has given medication to R441. V4 stated that medication should not be left at bed side to prevent medication error, and to prevent other resident from taking wrong medication. V4 stated leaving prepared medication at bed side means the medication was not administered as ordered and could potentially prevent the resident from receiving the benefit of taking the medicine as ordered.<br><br>On 2/19/25 at 1:08 PM, V2 (Director of Nursing/DON) stated that it is V2's expectation that nurses should be observing the Five Rights of medication administration, and no medication should be left at bed side. V2 agreed that other resident could have access to medication kept at bed side, causing medication error.<br><br>R441's Minimum Data Set (MDS) dated [DATE] shows R441 is moderately cognitively impaired. R441's Physician Order Sheet (POS) with active orders as of 02/18/25 shows an order for senna-plus tablet 8.6-50 MG, give 2 tablets via Gastrostomy tube/ G-Tube 2 times a day for constipation, and Famotidine 20mg, give 0.5 mg via G-Tube at bedtime for indigestion.<br><br>The facility's policy titled Medication Pass dated 8/16/24 documents in part: It is the policy of the facility to adhere to all federal and state regulations with medication pass procedures. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103<br><br>Based on observation, interview and record review, the facility failed to safely secure medication in a locked storage area to limit access to unauthorized personnel for 1 (R442) resident. The facility also failed to properly date opened multi-dose inhalers for 1 resident (R46), failed to properly date opened multi-dose insulin pens for 3 residents (R16, R51, R129), and failed to ensure opened multi-dose insulin pens were stored to prevent the potential for cross contamination for 2 residents (R51, R129) from one of five medication carts and one of three medication rooms inspected for medication storage and labeling.<br><br>Findings Include:<br><br>On 2/18/25 at 10:46 AM, inspected first floor medication cart 2 with V6 (Agency Registered Nurse) and noted R46's Arnuity Ellipta inhaler without the date opened written on the label. R46's Arnuity inhaler shows on the label to discard 6 weeks after opening.<br><br>On 2/18/25 at 12:42 PM, inspected fourth floor medication room with V47 (Licensed Practical Nurse) and noted the following: R16's Insulin Aspart pen with date 3/11/25 written as opened date on the label. R51's Novolog insulin pen and insulin glargine pen without the date opened written on the labels. R51's insulin glargine pen was not inside an individual clear bag. R129's Toujeo insulin pen was not inside an individual clear bag and without the date opened written on the label.<br><br>On 2/19/25 at 1:08 PM, interviewed V2 (Director of Nursing) and V2 stated that inhalers and all insulin pens and vials should be labeled when they were opened and labeled with the expiration date because we should not use expired medications. V2 stated that insulins are discarded 28 days after opening except Levemir is 42 days. V2 stated opened insulin pens and vials should be stored inside a clear bag individually for each resident to prevent cross-contamination and for infection control purposes.<br><br>R46's physician order sheet (POS) reads in part: Arnuity Ellipta Inhalation 1 spray inhale orally two times a day (ordered 1/2/25).<br><br>R16's POS reads in part: Insulin Aspart Pen inject per sliding scale (ordered 1/27/25).<br><br>R51's POS reads in part: Insulin Glargine Solution Pen-Injector inject 13 units subcutaneously at bedtime (ordered 2/4/25) and Novolog FlexPen inject 6 units subcutaneously before meals (ordered 2/4/25).<br><br>R129's POS reads in part: Toujeo Solution Pen-injector inject 25 units subcutaneously at bedtime (ordered 2/11/25).<br><br>(continued on next page) |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility's Medication Storage, Labeling, and Disposal policy dated 8/16/24 documents in part: It is the facility's policy to comply with federal regulations in storage, labelling, and disposal of medications. Medications will be stored safely under appropriate environmental controls. Medications will be secured in locked storage area.<br><br>The facility's guide titled; Insulin Reference Guide dated 2/24 documents in part: Novolog Aspart Pen refrigerate or room temperature for up to 28 days when in-use. Insulin glargine to be stored in room temperature for up to 28 days when in use. Toujeo Solostar Pen is to be stored in room temperature for up to 56 days and do no refrigerate.<br><br>The manufacturer's guidelines for Arnuity inhaler dated 8/14 documents in part: Write the Tray opened and Discard dates on the inhaler label. The Discard date is 6 weeks from the date you open the tray.<br><br>49486<br><br>R442's Electronic Medical Record (EMR) revealed R442 was admitted to the facility on [DATE] and is [AGE] years of age with diagnoses that included but were not limited to: acute and chronic respiratory failure with hypoxia, simple chronic bronchitis, other heart failure, pneumonia due to Escherichia coli, other encephalopathy, and other specified chronic obstructive pulmonary disease.<br><br>On 2/19/25 at 10:24 PM, surveyor and V26 (Respiratory Manager) entered R442's room and observed an unopened 10 ml vial of acetylcysteine solution at R442's bed side. V26 stated that the medication should not be left at bed side but should have been locked up in the medication room to prevent other resident from taking wrong medication. V26 picked up the medication for proper storage.<br><br>On 2/19/25 at 1:08 PM, V2 (Director of Nursing/DON) stated that it is V2's expectation that nurses should be observing the Five Rights of medication administration, and no medication should be left at bed side. V2 stated that medication should be stored securely in the medication room, and V2 agreed that other resident could have access to medication kept at bed side, causing medication error.<br><br>R442's Minimum Data Set (MDS) dated [DATE] shows R442 is cognitively impaired. R442's Physician Order Sheet (POS) with active orders as of 02/19/25 shows an order for acetylcysteine inhalation solution 10%, 2ml via trach three times a day for thick secretion. |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342<br><br>Based on observation, interview and record review, the facility failed to prepare pureed food in appropriate diet consistency form. This failure has the potential to affect 19 residents (R3, R11, R16, R17, R20, R28, R43, R55, R59, R65, R85, R88, R95, R130, R138, R144, R148, R175, R184) receiving pureed diets prepared in the facility kitchen based on list of residents receiving pureed diets dated 02/18/25.<br><br>Findings Include:<br><br>On 02/18/25 at 12:40 PM, observed R138 sitting in room eating lunch. Observed a pile of food particles on the side of R138's plate. R138's meal ticket list Cardiac-Pureed. Observed R138 put a spoon full of pureed ham into mouth and then take her fingers to pull out particles of food from her mouth and place them into the pile on the side of the plate. R138 stated there is skin and [NAME] in the ham which she cannot chew so that is why she has to remove them from her mouth.<br><br>On 02/18/25 at 12:56 PM, V11 (Food Service Director) observed R138 still eating her lunch with pile of food particles on the side of her plate. R138 told V11 I cannot eat this! It's too hard for me to chew! V11 stated the pureed food should be a smooth consistency with no lumps and R138 should not be able to feel any particles or [NAME] because that is a potential choking hazard.<br><br>R138 diagnosis includes but not limited to Chronic Kidney Disease, Dementia, Severe Protein-Calorie Malnutrition, Muscle Wasting and Atrophy, Unsteadiness on Feet, Lack of Coordination, Abnormal Posture, Reduced Mobility, Visual Loss, Dysphagia, Adult Failure to Thrive. R138's Order Summary Report dated 02/19/25 lists diet order as Cardiac Diet - 2 gm Na (Sodium), Low Fat, Low Cholesterol, Pureed texture, thin liquids. R138's MDS dated [DATE] documents intact cognition based on BIMS (Brief Interview for Mental Status).<br><br>On 02/19/25 at 10:19 AM, V33 (Training Chef) stated pureed food should be applesauce consistency, smooth with no lumps or pieces. V33 stated if pureed items are pureed correctly there should not be any particles or small pieces of food. V33 stated the pureed food should be smooth on the tongue.<br><br>On 02/19/25 at 11:13 AM, V34 (Traveling Culinary Manager) stated she was working with a new cook yesterday preparing food for the lunch meal. V34 stated V34 observed the new cook prepare the first patch of pureed but did not see the rest of the prepared pureed food or check the consistency it.<br><br>On 02/19/25 at 11:17 AM, V12 (Regional Director of Operations) stated the problem with pureed ham having pieces in it yesterday was because of the skin on the ham. V12 stated when V12 heard there was an issue with the pureed ham yesterday she tasted the pureed ham and could feel particles in it. V12 stated they should have cut off the skin on the ham before they pureed the ham and next time the skin will be removed before pureeing.<br><br>On 02/19/25 at 3:50 PM, V31 (Registered Dietitian) stated pureed diets are used for residents with swallowing or chewing issues.<br><br>(continued on next page) |

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| F 0805<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/19/25 at 4:20 PM, V32 (Speech Language Pathologist) stated pureed consistency should be like a mashed potatoes consistency, with a smooth and uniformed texture and should be a cohesive mass. V32 stated you should not be able to detect or spit particles of food in the pureed consistency.<br><br>Facility provided document titled Diet Type Report dated 02/18/25 listing all of the residents receiving pureed diets.<br><br>Facility provided recipe used on 02/18/25 titled Honey Glazed Ham which documents in part, for pureed measure desired number of servings into food processor and blend until smooth.<br><br>Facility provided policy titled Quality and Palatability dated October 2019 which documents in part, food and liquids are prepared and served in a manner, form, and texture to meet resident's needs, the Dining Services Director and Cook(s) are responsible for food preparation. Menu items are prepared according to the menu, production guidelines and standardized recipes. The Cook(s) prepare food and liquids/beverages in a manner, form and texture that meets each resident's needs. |

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| F 0806<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options.<br><br>44103<br><br>Based on observation, interview and record review, the facility failed to ensure a resident's food preference was followed for one (R81) out of 3 residents reviewed during dining observation in a final sample of 35.<br><br>Findings Include:<br><br>On 2/18/25 at 1:00 PM, Surveyor entered R81's room and observed R81's eating lunch in bed alert and able to verbalize needs. R81 stated, What is this on my plate? I don't see it listed on this menu (R81 pointed at her meal ticket). I don't want to eat it. I don't know what it is. I don't eat pork or beef. Do you know what type of meat this is? Surveyor observed R81's lunch tray with diced carrots, pudding, cornbread, diced sweet potato, and ham with gravy. R81 stated that [R81] cannot eat beef of pork because R81 gets indigestion. R81 stated that the kitchen staff knows that R81 does not eat beef or pork.<br><br>On 2/19/25 at 2:46 PM, interviewed V31 (Registered Dietitian) and V31 stated that V31's progress notes on 9/26/24 for R81 indicate that R81 does not eat pork or beef. V31 stated, The meal tracker says [R81] dislikes pork or beef and [R81] should not be getting pork or beef. V31 stated that it is very important to follow the resident's meal ticket and food preferences to meet nutritional needs and to make the best experience for the resident.<br><br>The facility's Week-At-A-Glance menu shows baked ham flat with glazed honey for lunch on 2/18/25. R81's lunch meal ticket for 2/18/25 does not show ham was listed as one of the food items to be served to R81. R81's nutrition progress notes documented by V31 (Registered Dietitian) reads in part: Discussed food preferences with resident and adjusted in meal tracker. [R81] does not eat beef or pork.<br><br>The facility's Dining and Food Preferences policy dated 10/19 documents in part: It is the center policy that individual dining, food, and beverage preferences are identified for all residents/patients. The Dining Services Director or designee will interview the resident or resident representative to complete a Food Preference Interview within 48 hours of admission. The purpose of identifying individual preferences for dining location, meal times, including times outside of the routine schedule, food, and beverage preferences. The Food Preference Interview will be entered into the medical record. Food allergies, food intolerance, food dislikes, and food and fluid preferences will be entered into the resident profile in menu management software system. |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342<br><br>Based on observations, interviews, and record reviews, the facility failed to provide therapeutic diets and dietary interventions as prescribed by the physician and Registered Dietitian for four residents (R31, R138, R158, R391) reviewed in a total sample of 35.<br><br>Finding include:<br><br>On 02/18/25 at 12:33 PM, observed R158 eating lunch in room. R158's meal ticket read in part to give soup at lunch & dinner, mechanically altered/ground baked ham 6 ounces (Double Protein), 8-ounces 2% milk, 4-ounces fortified pudding, Mrs. Dash Seasoning. R158 did not receive double portion of ground ham, and tray was missing soup, fortified pudding, dessert (missing standard dessert), milk and Mrs. Dash Seasoning packet. R158 stated he likes milk with every meal, soup with lunch & dinner and some kind of dessert. R158 stated that he likes pudding and I didn't get any type of dessert today, see? R158 stated sometimes I get those things, but sometimes I don't get them, like today and I just eat what they give me. I don't complain. R158 stated he thinks the food here is bland tasting, so he's supposed to get a flavor packet on his tray, but they forgot to send that today too.<br><br>R158 has diagnosis including but not limited to Hypertension, Type 2 Diabetes Mellitus with Hyperglycemia, History of Falling, Osteoarthritis, Chronic Kidney Disease, Chronic Pulmonary Edema, Anemia, Hyperparathyroidism, Systemic Disorders of Connective Tissue, Muscle Wasting and Atrophy, Difficulty in Walking, Lack of Coordination, Abnormal Posture, Pressure Ulcer of Sacral Region, Dysphagia. R158's MDS (Minimum Data Set) dated 11/27/24 documents intact cognitive function. R158's Nutrition Note completed by V30 (Registered Dietitian) on 11/27/24 documented in part for nutrition interventions to add double protein portions three times a day, fortified pudding twice a day, Mrs. Dash seasoning packets on tray twice a day, and whole milk and on 12/31/24 nutrition note documents R158 is underweight with undesirable weight loss, stage 4 pressure ulcer to sacrum and severe protein calorie malnutrition with nutrition plan to update kitchen computer program with food preferences.<br><br>On 02/18/25 at 12:38 PM, observed R391's meal ticket read CCHO, NAS. R391 received on lunch tray: slice of baked ham, carrots, sweet potato wedges, cornbread, lemon pudding, and pink juice in plastic cup. R391's tray did not contain any thickened liquids on it. Overheard R391 ask nursing for a carton of whole milk. At 2:01 PM, observed R391's lunch tray which had an empty whole milk container and empty plastic juice cup.<br><br>R391 has diagnosis including but not limited to Malignant Neoplasm of Prostate, Secondary Malignant Neoplasm of Bone, Moderate Protein-Calorie Malnutrition, Muscle Wasting and Atrophy Right and Left Shoulder, Abnormalities of Gait and Mobility, Lack of Coordination.<br><br>R391's Order Summary Report documents diet order as CCHO, NAS, Regular Texture, Nectar Thick Liquids consistency dated 02/16/25. R391's electronic health record entry dated 02/16/25 documents in part, choking episode this morning while drinking his meds with thin liquids with new order to update resident diet to crush meds with thicken(ed) liquids. Speech Therapy Evaluation and Treatment dated 02/19/25 documents in part, dysphagia, oropharyngeal phase coughing on thin liquids, disorganized mastication of regular solids, recommendations for mechanical soft solids and nectar thick liquids.<br><br>(continued on next page) |

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Warren Barr South Loop | 1725 South Wabash<br>Chicago, IL 60616 |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/18/25 at 12:40 PM, observed R138 sitting in room eating lunch. R138's meal ticket list Cardiac-Pureed diet order and in part the following items to be served: pureed baked pork chop, 8-ounces whole milk, and double vegetables and fruit portions. R138 received portion of pureed ham based on the bright pink color (not baked pork chop), pureed carrots, pureed potatoes, pureed corn bread, lemon pudding, juice. The tray did not contain any whole milk or fruit. R138 stated she did not receive any milk and she really likes whole milk and would drink it if they gave it to her.<br><br>R138 diagnosis includes but not limited to Chronic Kidney Disease, Dementia, Severe Protein-Calorie Malnutrition, Muscle Wasting and Atrophy, Unsteadiness on Feet, Lack of Coordination, Abnormal Posture, Reduced Mobility, Visual Loss, Dysphagia, Adult Failure to Thrive. R138's MDS dated [DATE] documents intact cognition based on BIMS (Brief Interview for Mental Status).<br><br>R138's Order Summary Report dated 02/19/25 lists diet order as Cardiac Diet - 2 gm Na (Sodium), Low Fat, Low Cholesterol, Pureed texture, thin liquids. R138's Nutrition Note dated 12/13/24 completed by V31 (Registered Dietitian) documents in part, R138 will drink milk and wants more fruits and vegetables on her trays (adjusted in kitchen computer system) double fruit and vegetable portions and to continue with Cardiac Diet - 2 gm sodium, low fat, low cholesterol, pureed texture, thin liquids.<br><br>On 02/18/25 at 12:51 PM, observed R31's meal ticket which read in part, Renal Diet and to provide Hamburger Patty as main entree. R31 received ground ham as main entree.<br><br>R31's diagnosis include but not limited to End Stage Renal Disease, Dependence on Dialysis, Adult Failure to Thrive, Hyperlipidemia, Hypertension, Myocardial Infarction, Personal History of Transient Ischemic Attack and Cerebral Infarction without Residual Deficits. R31's Order Summary Report dated 02/19/25 lists diet order as Renal Diet, Regular Texture, Thin Liquids Consistency.<br><br>On 02/18/25 at 12:54 PM, V11 (Food Service Manager) observed R31's meal tray and meal ticket and then stated he (R31) should not have received ham because he's on a renal diet and the ham has too much sodium in it. V11 stated R31 should have received a hamburger patty as listed on R31's meal ticket and he should not have received any food in ground form because R31 is on a regular diet consistency. V11 stated that tray was a mistake, it must have been meant for someone else. V11 stated it is important for the kitchen to follow the diet order as prescribed by the resident's physician.<br><br>On 02/18/25 at 12:58 PM, V11 observed R158's tray and meal ticket and stated he (R158) should have received double portions of the ham, fortified pudding, and whole milk because that is what is listed on his meal ticket. V11 stated kitchen staff should be putting the items on the tray based on what is listed on the meal ticket and this is important to make sure the residents are getting the right items to give them the right amount of calories/protein they need based on Registered Dietitian recommendations.<br><br>(continued on next page) |

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| F 0808<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 02/19/25 at 3:07 PM, V30 (Registered Dietitian-RD) stated when a resident's nutritional assessment is completed the RDs take into account the resident's food preferences and may recommend fortified foods such as whole milk, fortified pudding, fortified oatmeal to add extra calories and protein to the resident's diet for weight maintenance or to promote weight gain. V30 stated sometimes she uses the intervention of adding double protein at meals for a resident with a pressure wound to get more protein into them for wound healing. V30 stated dietary interventions are added to the resident's meal ticket and residents should be receiving all the food items listed on their meal ticket at mealtimes. V30 stated the potential problem of a resident not receiving the items listed is that they would not be provide the additional calories, protein, fat and carbohydrate the interventions were intended to do to promote wound healing and weight gain/maintenance.<br><br>On 02/19/25 at 3:45 PM, reviewing R391's EHR, V31 (Registered Dietitian) stated R391's liquid consistency was downgraded from thin to NECTAR thick liquids on 02/16/25, and on 02/19/25 R391's diet was changed again from regular to mechanical soft, NECTAR consistency. Surveyor showed V31 R391's lunch meal ticket from 02/18/25 and 2/19/25 and V31 stated the physician order from 02/16/25 and 02/19/25 did not transfer from R391's EHR to the kitchen's computer system so that is why R391's meal tickets were incorrect. V31 stated sometimes there is a problem with two computer systems communicating with each other. V31 stated R391 should have been receiving nectar thick liquids since 02/16/25 per the physician order and mechanical soft, nectar thick liquids as of 02/19/25. Observed V31 typing on laptop computer and V31 stated, I just changed it in the kitchen computer now.<br><br>Kitchen Week-At-A-Glance Week 1 Tuesday, 02/18 Cardiac and Renal Diet both list for Baked Pork Chop to be served as main entree. Regular diet orders received Baked Ham with Glazed Honey.<br><br>Facility provided policy titled, Therapeutic Diets dated October 2019 which documents in part, diets are prepared in accordance with guidelines in the approved diet manual and the individualized plan of care and therapeutic diet is defined as a diet ordered by a physician or delegated registered or licensed dietitian as part of the treatment for a disease or clinical condition to eliminate or decrease specific nutrients in the diet or to increase specific nutrient in the diet or to provide food that a resident is able to eat.<br><br>Facility provided policy titled, Diet Manual/Fortified Foods undated which documents in part, fortified foods have protein, carbohydrates and/or fats added to increase the total nutritional value of the food and fortified foods are indicated for individuals who have inadequate intake who are at risk for malnutrition, or who have increased energy and/or protein needs.<br><br>Facility policy titled, Meal Distribution dated October 2019 documents in part, the Dining Services Director will ensure that all meals are assembled in accordance with the individualized diet order, plan of care and preferences and the nursing staff shall be responsible for verifying meal accuracy and delivery of meals to residents/patients. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure food items were properly labeled and dated, and failed to ensure kitchen staff wore appropriate hair covering. These failures have the potential to affect all 153 residents receiving food prepared in the facility's kitchen.<br><br>Findings include:<br><br>On [DATE] at 9:21 AM, upon entering the kitchen to conduct initial kitchen tour observed V11 (Food Service Director) walking around the kitchen without any hair coverings (no hairnet, no beard or mustache covering). When V11 saw surveyor, he immediately left the kitchen and reentered the kitchen at 9:25 AM wearing a beard protector covering his heard but not covering his mustache and he was not wearing a hairnet to cover the hair on his head.<br><br>On [DATE] at 9:28 AM, V11 stated anyone who enters the kitchen must wear a hair net and any staff with facial hair should wear a beard guard. V11 stated the purpose of wearing hair coverings is to prevent hair from falling into the food being prepared for the residents. Surveyor brought to V11 attention that he was not wearing any hairnet and asked him to put one on. V11 left the kitchen immediately and returned wearing a hairnet. V11's protector continue to be worn but only covered beard, not his mustache.<br><br>On [DATE] at 10:35 AM, surveyor brought to V11's attention that he does not have his mustache covered with any hair covering. V11 stated it should be covered because it is facial hair, and all facial hair should be restrained.<br><br>On [DATE] at 9:35 AM, V11 stated all refrigerated items which are opened should have a label which lists what the food item is, the prepared or opened date and a use by/expiration/end date and most foods have an expiration or use by date of seven days of being opened or prepared. V11 stated it is important for all opened or prepared food items to be labeled with this information so that staff can keep track of the food and knows when to discard expired items. V11 stated, we don't want anything going up to the residents spoiled and we want to avoid food borne illnesses.<br><br>On [DATE] at 9:45 AM, observed the following items in the walk-in cooler:<br><br>1.) Opened package of deli ham wrapped in plastic with no label or dates. V11 stated the opened deli ham package should have been labeled because without a label with dates he cannot tell when the item was opened and once opened it should be discarded after seven days. V11 stated the deli ham would be thrown out right away.<br><br>2.) Opened package of sliced American/Swiss cheese wrapped in plastic with no label or dates. V11 stated cheese should be discarded after five days and he does not know when the package was opened because there is no label or opened date marked on the plastic. V11 stated because it is not labeled, he cannot tell how long it has been in there. V11 said, it is going in the garbage.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 3.) Large, opened box labeled Folded Cheese Omelet with manufacturer's guidelines printed on the outside of the box printed Keep frozen 0 degrees or below. The outside of box was dated [DATE] and inside the box were defrosted cheese omelets. Observed some of the defrosted cheese omelets to have areas of brown spots on them. V11 stated the omelets in the box were delivered and defrosted on [DATE] because the omelets were needed right away. V11 stated the kitchen usually keep these in the refrigerator, not the freezer and cook them thawed/defrosted. V11 stated he does not know how long the omelets are good for once they have been defrosted, two weeks at the most. V11 viewed omelets inside with brown spots on them and stated, these are going bad, I need to throw them out. V12 (Regional Director of Operations) stated the Folded Cheese Omelets should be cooked from a frozen state, not thawed out ahead of time.<br><br>4.) Opened plastic package of sausage links without a label/date.<br><br>5.) Opened package of bacon without a label/date. V11 stated both sausage and bacon packages should be labeled and dated with an opened date and use by date. V11 stated it is the responsibility of the staff who opened the package to label and date the items.<br><br>On [DATE], facility provided list of diet orders for all residents in the facility. The diet order list indicates there are 37 residents receiving nothing by mouth (NPO).<br><br>Facility provide policy titled, Staff Attire undated which documents in part, the Dining Services Director insures (ensures) that all staff members have their hair off the shoulders, confined in a hair net or cap and facial hair properly restrained and staff will exhibit appropriate personal hygiene.<br><br>Facility provide signage titled SAFE Brief Personal Hygiene dated 2022 which documents in part, poor personal hygiene (cleanliness and personal appearance) can spread harmful bacteria and viruses to food and surfaces you touch. Washing hands correctly, restraining hair .are a few important activities that can prevent illness from spreading. Examples of poor personal hygiene included but not limited to unrestrained hair.<br><br>Facility provided policy titled Food Handling Standards and Procedures - Food Safety dated 2024 which documents in part TCS (Time/Temperature Controlled for Safety) foods intended for storage must be labeled with a use by date no more than 7 days from the preparation (prep) date and these food labels intended for storage must include this information: item name, preparation date, use by date (within 7 days of preparation or opening commercially-prepared TCS foods), employee initials.<br><br>Facility provided signage titled TCS Food and 7-Day Labeling dated 2024 documents in part:<br><br>1) TCS foods can grow harmful bacteria if stored or labeled incorrectly,<br><br>2) TCS foods include items like meat, eggs, dish, dairy, rice and cut or prepped fruits and vegetables,<br><br>3) Labeling TCS foods we prepare helps us know when they were made and when they might spoil,<br><br>4) We must label and use TCS food within 7 days from preparation to stay safe,<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | 5) When in Doubt, Throw It Out! - Follow the 7-day rule but trust your senses. If food looks, seems, or smells bad before then, throw it out or ask supervisor if you're unsure.<br><br>Facility provided signage titled TCS Food Labeling Guide dated 2024 which documents in part, labeling and storing TCS food correctly ensure our ingredients are safe to use in food served to customers. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide and implement an infection prevention and control program.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40061<br><br>Based on observations, interviews and record reviews, the facility failed to follow their infection control policies and procedures by not having the correct transmission-based precaution signage for two residents (R151, R290), failed to place an isolation cart outside a resident's (R290) room who was on contact isolation, failed to ensure two residents (R16, R181) were placed on Enhanced Barrier Precautions (EBP), and failed to wear the appropriate personal protective equipment when entering a COVID-19 positive resident's (R151) room. The facility also failed to have policies and procedures for distributing information regarding the risks associated with shingles and how to protect the residents against the varicella-zoster virus, HIV, Hepatitis B, and Hepatitis C screening and (c) Hepatitis B immunization. These failures have the potential to affect all the residents that reside in the facility.<br><br>Findings include:<br><br>R151's Point of Care Test Results for SARs-CoV2 document in part that R151 tested positive for COVID-19 on 2/16/2025.<br><br>R151's Order Summary Report documents an active order for Isolation - Droplet/Contact Reason: Active COVID (order date 2/16/2025).<br><br>R151's Care Plan Report documents in part that R151 requires contact/droplet precautions related to COVID (initiated 2/16/2025). Interventions initiated 2/16/2025 include: Use appropriate protective equipments and Utilize proper hand washing technique.<br><br>On 2/18/2025 at 12:26 PM, the signage posted outside R151's door included Enhanced Barrier Precautions and Contact Precautions. There was no signage for Droplet Precautions. Isolation bin outside the room had N95s, face shield, gown, and gloves.<br><br>On 2/18/2025 at 12:28 PM, R151 stated testing positive for COVID-19 over the weekend. R151 reported runny nose and leg weakness. At 12:29 PM, V8 (Staffing Coordinator) entered R151's room with a regular mask (not N95) and a face shield. V8 stated R151 had the call light on. R151 stated [R151] was done with the lunch tray and asked for more water. V8 grabbed the lunch tray and exited the room without performing hand hygiene. V8 came back into the room without a gown and N95 to collect R151's water pitcher. V8 exited the room without performing hand hygiene. V8 returned to the room without a gown and N95 with a full water pitcher. V8 exited the room prior to performing hand hygiene.<br><br>On 2/19/2025 at 11:19 AM, there was a Contact Isolation sign outside of R151's room but no Droplet Precaution sign.<br><br>On 2/19/2025 at 11:21 AM, V22 (Nurse) stated R151 is on contact isolation for COVID-19. V22 stated staff are supposed to go in there with gown, gloves, N95 mask, and face shield. Staff are to perform hand hygiene before donning PPE (Personal Protective Equipment) and after doffing PPE.<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 2/19/2025 at 12:29 PM, V2 (Director of Nursing) stated when a resident tests positive for COVID-19, the protocol is to put them on contact and droplet isolation. Signs should be at the door alerting staff and visitors about the proper PPE to wear prior to entering. Staff are to use N95 mask, face shield, gown, and gloves when entering the room. V2 stated staff should also be doing hand hygiene before putting on the PPE and after taking it off.<br><br>Facility's Infection Prevention and Control policy, last revised 2/10/2025, documents in part: If the resident with infection needs transmission-based precaution, the facility will provide the transmission-based precaution set required. A sign will be provided outside the room for residents on transmission-based precaution indicating the type of the precaution (Contact, Droplet, or EBP [Enhanced Barrier Precaution]).<br><br>Facility's COVID 19 Testing Plan and Response Strategy, last revised 7/16/2024, documents in part: The PPE to be used for residents on Contact and Droplet Isolation and quarantine includes a pair of gloves, gown, eye protection, and N95 (if unavailable, surgical mask is an acceptable alternative per CDC only during crisis shortage situations).<br><br>Facility Assessment Tool (last updated 8/09/2024) documents in part that the facility's average daily census is 186 with a license to provide for 210 (licensed)/206 (operational). The facility takes care of multiple residents with different diseases/conditions including infectious diseases such as skin/soft tissue infections and viral hepatitis.<br><br>On 2/20/2025 at 11:28 AM, V42 (Nurse Consultant) stated the facility did not have policies and procedures for HIV, Hepatitis B, and Hepatitis C screening. V42 also stated the facility did not have policies and procedures for distributing information regarding the risks associated with shingles and how to protect the residents against the varicella-zoster virus. During immunization review, the facility did not provide evidence that they offered education on the Shingles vaccine to R66, R93, R118, R150, R151.<br><br>On 2/20/2025 at 12:07 PM, V2 (Director of Nursing) stated facility can provide the Shingles vaccine information if residents request it. V2 stated they did not have a policy regarding information distribution to all newly admitted residents. V2 also stated the facility does not have policies and procedures for HIV, Hepatitis B, and Hepatitis C screening or Hepatitis B immunization. V2 stated nurses will sometimes ask the questions during admission but don't have policies or procedures for it.<br><br>Facility's Infection Prevention and Control policy, last revised 2/10/2025, documents in part: The facility shall comply with infection control recommendations provided by the [Illinois Department of Public Health] or certified local health department, including, but not limited to, testing plans, infection control assessments, training or other measures designed to reduce infection rates and disease outbreaks.<br><br>Illinois Administrative Code TITLE 77: PUBLIC HEALTH / CHAPTER I: DEPARTMENT OF PUBLIC HEALTH / SUBCHAPTER c: LONG-TERM CARE FACILITIES / PART 300 SKILLED NURSING AND INTERMEDIATE CARE FACILITIES CODE / SECTION 300.1060 VACCINATIONS:<br><br>(continued on next page) |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | e) A facility shall distribute educational information provided by the Department on all vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices (available at: https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule.pdf), including, but not limited to the risks associated with shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act)<br><br>f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act)<br><br>g) All persons determined to be susceptible to the hepatitis B virus shall be offered immunization within 10 days after admission to any nursing facility. (Section 2-213(c) of the Act).<br><br>44103<br><br>On 02/18/25 at 11:54 AM, R16 was noted lying in bed alert and verbally responsive. Surveyor noted R16 with enteral feeding. Surveyor observed R16's room and door with no EBP signage and no isolation cart set up.<br><br>R16's physician order sheet (POS) printed on 2/19/25 shows R16 has enteral feeding and sacral wound but no order for EBP.<br><br>On 02/18/25 at 12:24 PM, R290 was sitting up in bed alert and able to verbalize needs. R290 stated R290 came in the facility last Thursday and goes to dialysis three times a week. R290 was noted with right arm fistula for hemodialysis. R290 stated that R290 is also receiving antibiotic treatment for his watery stools. Surveyor observed R290's door with no transmission-based precaution signage and no isolation cart set up outside R290's room.<br><br>R290's Minimum Data Set, dated dated dated [DATE] shows R290 is cognitively intact. R290's POS printed on 2/19/25 reads in part: Strict Contact Isolation (Clostridium Difficile/C.DIFF): Monitor loose consistency every shift until 3/12/25 (order date 2/13/25). R290's POS also shows R290 is still on Vancomycin antibiotic for C. DIFF until 3/12/25.<br><br>On 2/19/25 at 10:56 AM, a follow-up observation conducted with R290. R290 still had no contact isolation signage posted on the door and no isolation cart set up outside R290's room.<br><br>On 2/18/25 at 1:11 PM, R181 was lying in bed and noted with right lower leg wound dressing. R181's right leg wound dressing was noted with red colored drainage. R181 stated that R181 came in the facility 2 or 3 weeks ago for R181's infected right leg open wound. Surveyor observed R181's room and door with no EBP signage and no isolation cart set up.<br><br>R181's POS printed on 2/19/25 shows R181 has a right calf wound but no EBP order. R181's comprehensive care plan does not address EBP.<br><br>(continued on next page) |

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|---|---|
| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | On 2/19/25 at 1:08 PM, interviewed V2 (Director of Nursing) and V2 stated that residents with open wounds like surgical and ulcers, gastrostomy tubes, urinary catheters, any kind of IV (Intravenous) lines, and dialysis lines should be placed on EBP. V2 stated that the purpose of the EBP is for prevention of transmitting any diseases to residents with open areas. The staff should be wearing gloves and gown during care. V2 stated for contact isolation, anyone entering the resident's room should be wearing at least gown and gloves even if they are not providing care. V2 stated that the residents on EBP should have an EBP signage posted on the door. V2 stated that the residents on contact isolation should have a contact isolation signage posted on their doors and should have individual isolation carts set up outside their rooms. V2 stated that the purpose of the signage is to make people aware that someone in the room is on isolation precaution and that they should wear proper protective personal equipment (PPE). V2 stated that if there is no signage, visitors and staff would not know if a resident were on isolation or not. V2 stated all transmission-based precautions such as EBP and contact isolation should be in the resident's physician orders and are care planned. V2 stated that R16 should be on EBP related to R16's wounds and tube feeding. V2 stated R181 should also be on EBP because of R181's open wound. V2 stated that R290 should be on contact isolation until March for C.DIFF.<br><br>The facility's Enhanced Barrier Precaution policy dated 7/26/24 documents in part: The facility will use Enhanced Barrier Precautions (EBP) to reduce transmission of multi-drug resistant organisms in the nursing homes.<br><br>EBP will be used for any resident in the facility:<br><br>- With Open wound/s (pressure, diabetic ulcer, venous ulcer, arterial ulcer, unhealed surgical wounds, etc) whose drainage can be contained by dressing.<br><br>- Has indwelling medical devices (e.g. central line, urinary catheter, feeding tube, tracheostomy/ventilator) regardless of XDRO colonization status.<br><br>The facility's Infection Prevention Control policy dated 2/10/25 documents in part: A transmission-based precaution set up will be provided outside the resident's room to provide Personal Protective Equipment (PPE) like gown and gloves to staff including contracted workers and visitors entering the resident's room. A sign will be provided outside the room for residents on transmission-based precaution indicating the type of precaution (Contact, Droplet, or EBP). Contact Precaution - intended to prevent transmission of infectious agents spread by direct or indirect contact with patient or the environment. Examples of infectious organisms requiring contact precaution are C. Difficile, Scabies, Norovirus, etc and are outlined in CDC Appendix A (type and Duration of Precautions Recommended for Selected Infections and Conditions). |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145632 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Warren Barr South Loop | 1725 South Wabash<br>Chicago, IL 60616 |

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 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Develop and implement policies and procedures for flu and pneumonia vaccinations.<br><br>40061<br><br>Based on interviews and record reviews, the facility failed to administer influenza and pneumococcal vaccines in a timely manner for three residents (R93, R118, R151) out of five residents reviewed for immunizations.<br><br>Findings include:<br><br>On 2/19/2025 at 12:29 PM, V2 (Director of Nursing) stated facility holds immunization clinics if there are enough people that consent to the vaccines. If there are only a few residents interested, then the facility will get the vaccines from the pharmacy. The facility will special order them and facility staff will then administer them.<br><br>On 2/20/2025, facility provided sampled residents' influenza and pneumococcal consents.<br><br>R93's Informed Consent for Vaccination - influenza was signed on 9/18/2024. There is no facility representative signature listed as a witness. R93 did not receive the vaccine until 11/15/2024. Facility's Immunization Monitoring - Current Residents also documents administration date of 11/15/2024.<br><br>R118's Informed Consent for Vaccination - influenza was signed on 9/17/2024. R118 did not receive the vaccine until 10/25/2024. Facility's Immunization Monitoring - Current Residents also documents administration date of 10/25/2024.<br><br>R151's Informed Consent for Vaccination - influenza documents in part a date of 10/3/2024. R151 did not receive the vaccine until 12/12/2024. Facility's Immunization Monitoring - Current Residents also documents administration date of 12/12/2024. R151's Informed Consent for Vaccination - pneumococcal was signed on 1/06/2025. Facility's Immunization Monitoring - Current Residents document in part that R151 has not received the vaccine.<br><br>On 2/20/2025 at 12:07 PM, V2 stated the facility started getting consents for the influenza vaccine in September. Their window to administer the vaccine opened 10/01/2024. V2 did not know why there was a delay in administering them. V2 stated V40 (Infection Preventionist) will probably know but V40 is out of the country. V2 stated the facility probably reached out to the pharmacy and didn't have it available. Surveyor requested correspondents or progress notes related to delay in vaccine administration. V2 stated [V2] will check. Facility did not provide any before the conclusion of the survey.<br><br>On 2/20/2025 at 1:14 PM, V2 stated R151 consented for the pneumococcal vaccine on 1/06/2025 but did not receive it yet. V2 did not know why staff hasn't administered it.<br><br>(continued on next page) |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145632 | A. Building<br>B. Wing | 02/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Warren Barr South Loop | 1725 South Wabash<br>Chicago, IL 60616 |

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

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|---|---|
| F 0883<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Facility's Influenza Vaccination policy, last revised 9/16/2024, documents in part: Influenza vaccination will be offered to residents seasonally when it becomes available, in preparation for flu season which is typically from October 1 to March 31. If there is a national shortage of influenza vaccine or other issue with availability leading to an inability to implement the influenza vaccine program, the facility will show proof that the vaccine has been ordered and the facility received confirmation that it is on its way, or the vaccine is not available and will be shipped when the supply is available.<br><br>Facility's Pneumococcal Vaccination policy, last revised 9/16/2024, documents in part that it is the policy of the facility to offer and administer pneumococcal vaccinations to each resident. |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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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 0887<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status.<br><br>40061<br><br>Based on interviews and record reviews, the facility failed to administer a COVID-19 vaccination in a timely manner for one resident (R118) out of five residents reviewed for immunizations.<br><br>Findings include:<br><br>R118's Admission Record documents in part diagnoses of cerebral infarction (stroke), muscle wasting, muscle atrophy, hypertension (high blood pressure), and seizures.<br><br>R118's Informed Consent for COVID-19 Vaccine documents in part that it was signed on 10/22/2024. Facility did not administer the vaccine until 1/17/2025.<br><br>The facility's Immunization Monitoring - Current Residents form also documents in part that R118 received the COVID-19 vaccine on 1/17/2025.<br><br>On 2/19/2025 at 12:29 PM, V2 (Director of Nursing/acting Infection Preventionist) stated the facility does COVID-19 clinics when there are enough people that consent to it. If there are only a few residents interested, then the facility will get the vaccines from the pharmacy. The facility will special order them and facility staff will then administer them.<br><br>On 2/20/2025 at 12:07 PM, V2 stated [V2] did not know why there was a delay in administering R118's COVID-19 vaccination. V2 stated V40 (Infection Preventionist) will probably know but V40 is out of the country. V2 stated the facility probably reached out to the pharmacy and didn't have it available. Surveyor requested correspondents or progress notes related to delay in vaccine administration. V2 stated [V2] will check. Facility did not provide any before the conclusion of the survey.<br><br>Facility's COVID 19 Vaccination Policy, last revised 7/16/2024, documents in part the facility will continue to promote and provide COVID-19 vaccination whenever the vaccine is available, and individuals consent to COVID vaccination. The facility will work with their chosen pharmacy to ensure there is COVID 19 vaccine available for residents, if the resident or representative consents to it. |