

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Waterford Care Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 7445 North Sheridan Road Chicago, IL 60626	

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)
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779</p> <p>Based on observation, interview, and record review, the facility failed to ensure a resident dignity was maintained by not covering the body of 1 (R6) to prevent exposure of their body to others, failed to address the behaviors of disrobing for 1 (R6) resident exposing their body and failed to ensure the urinary drainage bag (a device that urine drains into) was covered and/or placed in a dignity bag for 1 (R117) resident for residents reviewed for resident rights.</p> <p>Findings included:</p> <p>1. R6 was admitted to the facility on [DATE], with diagnoses onset date starting 10/01/13 not limited to Acquired Absence of Right Breast and Nipple, Personal History of Malignant Neoplasm of Breast, Parkinsonism, Hypokalemia, Fracture of Shaft of Right Tibia, Effusion, Right Knee, Cervical Disc Degeneration, Displaced Fracture of Lateral Condyle of Right Tibia, Displaced Fracture of Medial Condyle of Right Femur, Chronic Obstructive Pulmonary Disease, Dementia, Unspecified Severity, with Psychotic Disturbance, Hypertensive Heart Disease, Personal History of COVID-19, Gastro-Esophageal Reflux Disease, Anxiety Disorder, Weakness, Limitation of Activities due to Disability, Overactive Bladder, Insomnia, Schizoaffective Disorder and Hypothyroidism.</p> <p>R6's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response.</p> <p>R6's Care plan documents: Focus: R6 presents an impaired thought process and/or displays cognitive impairments r/t (related/to) dementia, schizoaffective. R6 has an ADL (Activities of Daily Living) self-care performance deficit r/t COPD (Chronic Obstructive Pulmonary Disease), Parkinson's disease, dementia. Interventions: Monitor/document/report PRN (as needed) any changes, any potential for improvement, reasons for self-care deficit, expected course, declines in function. Dressing: Assist the resident to choose simple comfortable clothing that enhances the residents' ability to dress self. Date Initiated: 10/21/23. Dressing: The resident requires assistance by 1 staff to dress. Focus: R6 has limited physical mobility r/t Disease Process; dx (diagnosis) Parkinson's disease, poor mobility, incontinence. R6 has limited physical mobility r/t Weakness upper/lower extremities, w/c (wheelchair) status DX. Parkinson's Disease. R6 has the potential to display verbal aggression r/t dementia (with behavioral disturbances), schizoaffective disorder, anxiety disorder. Interventions: Monitor behaviors regularly. Document observed behavior and attempted interventions.</p> <p>(continued on next page)</p>

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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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 12/17/24 at 10:58 AM, R6 was observed lying in bed with only socks and a diaper on, sitting on top of an under pad and folded sheet on a low air loss mattress. The privacy curtain was open, and R6 could be viewed from the doorway.</p> <p>On 12/17/24 at 11:01 AM, V12 (Registered Nurse) said to R6, Tell her (Surveyor) about your clothes. Where is your gown? There was no gown within view of R6 surroundings.</p> <p>On 12/17/24 at 12:31 PM, R6 was observed lying in bed with only diaper and socks on, sitting on top of an under pad and folded sheet on a low air loss mattress. The privacy curtain was open, and R6 could be viewed from the doorway.</p> <p>On 12/18/24 at 09:50 AM, V13 (Certified Nurse Assistant) stated, (R6) does have clothes but don't (sic) want to put them on.</p> <p>On 12/18/24 10:04 AM, V2 (Director of Nursing) stated, (R6) does not like to keep clothes on; this is why (R6's) privacy curtain is always drawn. (R6) will throw her gown across the room. If (R6) is disrobed and the privacy curtain is not drawn, that would be an issue of dignity.</p> <p>On 12/18/24 at 11:23 AM, Surveyor knocked on R6's door and V13, CNA, called out patient care. Surveyor opened the door and observed V13 approaching the door with no disposable gown on. V13 stated, I took care of (R6). (R6) likes taking her gown off. R6's privacy curtain was open, and R6 was observed with a diaper and socks on, with a gown across her waist area and her chest exposed. V16 (Maintenance Supervisor) was able to view R6 disrobed, and stated, They could close (R6's) curtain.</p> <p>On 12/19/24 at 09:21 AM, V16 (Maintenance Supervisor) was asked if R6 is usually in bed with only a diaper on. V16 (Maintenance Supervisor) responded, (R6) is like that often.</p> <p>On 12/19/24 at 10:47 AM, V10 (Social Services Director) stated, (R6's) mood and behavior fluctuate. (R6) is calm and pleasant some days, on other days, (R6) is agitated and verbally aggressive. Sometimes (R6) prefers to not have a gown on, and when she is in bed, she will take the gown off. We just pull (R6's) privacy curtain. That is just for dignity purposes, since she is without clothing, we do not want (R6) exposed to her other roommates or people walking pass in the hallway. It is (R6's) preference not to have the gown on. I believe it is care planned. We just kind of close the curtain, toilet (R6) and let (R6) do her thing.</p> <p>On 12/19/24 at 12:27 PM, V2 (Director of Nursing) presented the surveyor with an updated care plan that addresses R6 disrobing that included (taking off gown r/t (related to) dementia (with behavior disturbance). V2 stated, The care plan is about (R6) disrobing. It was added just today, just now by (V10, Social Service Director). I told (V10) to update the care plan quarterly and as needed to include (R6's) behavior of disrobing. There are no interventions for (R6) disrobing. Frequent behavior monitoring and encouraging should be added. Most days, (R6) will probably not keep her gown on. I can add for continued staff education to provide privacy at all times.</p> <p>2. R117 was admitted to the facility 11/07/23, with diagnoses not limited to Paraplegia, Complete, Paranoid Schizophrenia, Major Depressive Disorder, Recurrent, Collapsed Vertebra, Psychoactive Substance Abuse, Neuromuscular Dysfunction of Bladder, Presence of Urogenital Implants, Urinary Tract Infection and Schizoaffective Disorder, Bipolar Type.</p> <p>(continued on next page)</p>		

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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R117's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response.</p> <p>Order Summary Report order date 11/04/24 documents: Change catheter bag and securement device every week in the morning every Sunday for change catheter bag and securement device every week.</p> <p>Care Plan documents: R117 noted to have suprapubic catheter in place. Dx (diagnosis) Neurogenic bladder.</p> <p>On 12/17/24 at 10:44 AM, R117 was observed in a wheelchair in the facility basement waiting to catch the elevator, with a urinary catheter drainage bag hanging underneath the wheelchair with no privacy bag in use. R117 stated, I need a privacy bag with straps. The facility said they have given me a privacy bag, but it was useless because it does not have straps. R117 entered the elevator then exited the elevator on the third floor. R117 was observed propelling self in the wheelchair down the hallway with 300 ML (Milliliters) of clear yellow urine in the urinary drainage bag. V12 (Registered Nurse) was asked if a resident with a urinary catheter drainage bag be placed in a privacy bag. V12 responded, yes.</p> <p>On 12/17/24 at 10:53 AM, V12 (Registered Nurse) stated, The urinary drainage bag should be in a privacy bag. It should be in a black bag.</p> <p>On 12/17/24 at 11:17 AM, V12 (Registered Nurse) returned to the third floor with the privacy bag.</p> <p>On 12/17/24 at 11:35 AM, V12 (Registered Nurse) stated, I covered the urinary catheter drainage bag.</p> <p>On 12/18/24 at 10:47 AM, V2 (Director of Nursing) stated, The urinary drainage bag should be in a privacy bag for dignity issues. They are supposed to have the covers.</p> <p>Policy:</p> <p>Titled Activities of Daily Living (ADLs), Support Care, dated 02/24, documents: Residents will provided with care, treatment, and services as appropriate to maintain or improve their ability to carry out activities of daily living (ADLs). Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. 1. Residents will be provided with care, treatment, and services to ensure that their activities of daily living (ADLs) do not diminish unless circumstances of their clinical condition(s) demonstrate that diminishing out ADLs are unavoidable. 2. Appropriate care and services will be provided for residents who are unable to carry ADLs independently, with the consent of the resident and in accordance with the plan of care.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000</p> <p>Based on interview and record review, the facility failed to initiate a new Level I screen for four (R6, R7, R11, R32) residents reviewed for Pre-Admission Screening and Record Review (PASARR) in a total sample of 26 residents reviewed.</p> <p>Findings include:</p> <p>1. R11s' Face sheet documents R11 was admitted to the facility on [DATE], with diagnoses not limited to: schizoaffective disorder, bipolar type, major depressive disorder, and bipolar disorder.</p> <p>On 12/18/2024 at 10:30AM, surveyor requests the PASARR screenings for R11 from V1 (Administrator).</p> <p>On 12/18/2024 at 11:00AM, V1 provided R11s' PASARR screenings to surveyor.</p> <p>R11s' PASARR screening, dated 12/18/2024, titled Notice of PASRR Level I Screen Outcome documents to refer R11 to Level II Onsite.</p> <p>There is no documentation to show R11 was referred to the appropriate state-designated authority for a Level I or Level II PASARR evaluation and determination prior to 12/18/2024.</p> <p>39779</p> <p>2.R6 was admitted to the facility on [DATE], with diagnoses onset date starting 10/01/13 not limited to Acquired Absence of Right Breast and Nipple, Personal History of Malignant Neoplasm of Breast, Parkinsonism, Hypokalemia, Fracture of Shaft of Right Tibia, Effusion, Right Knee, Cervical Disc Degeneration, Displaced Fracture of Lateral Condyle of Right Tibia, Displaced Fracture of Medial Condyle of Right Femur, Chronic Obstructive Pulmonary Disease, Dementia, Unspecified Severity, with Psychotic Disturbance, Hypertensive Heart Disease, Personal History of COVID-19, Gastro-Esophageal Reflux Disease, Anxiety Disorder, Allergic Rhinitis, Weakness, Limitation of Activities due to Disability, Overactive Bladder, Insomnia, Schizoaffective Disorder and Hypothyroidism.</p> <p>R6's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response.</p> <p>R6's Care plan document in part: R6 is being prescribed psychotropic medications r/t (related/to) behavior/mood management, schizoaffective disorder, anxiety disorder, insomnia.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R6's Notice of PASRR (preadmission screening and resident review) Level I Screen outcome dated 12/18/24 documents PASRR Level I Review date: 12/18/24. PASRR Level I Determination: Refer for Level II Onsite. Suspected or confirmed PASRR condition(s): (MH) Mental Health Disability. Your health care professional and Maximus completed a Preadmission Screening and Resident Review (PASRR) Level I screen for you. This screen shows that you need a face-to-face Level II evaluation. You need this evaluation because you may have serious mental illness or an intellectual/developmental disability. Reason for Screening: This nursing facility resident has never had a PASRR Level I screen. Level I outcome: Refer for Level II Onsite. Rationale: A PASRR Level II evaluation must be conducted. That evaluation will occur as an onsite/face-to-face.</p> <p>3. R7 was admitted to the facility on [DATE] with diagnosis onset date starting 10/10/13 with diagnosis not limited to Bipolar Disorder, Vitamin D Deficiency, Peripheral Vascular Disease, Gout, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Type 2 Diabetes Mellitus with Diabetic Chronic Kidney Disease, Anxiety Disorder, Schizoaffective Disorder and Major Depressive Disorder, Recurrent.</p> <p>R7's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) score is 15, indicating intact cognitive response.</p> <p>R7'sCare Plan documents: R7 has a history of self-harmful ideation (thoughts) and/or behavior. This appears related to a severe mental illness and poor impulse control. The resident has depression r/t Disease Process Bipolar. 02/27/23 Resident observed punching the nursing desk with right hand, upset about something that happened yesterday. R6 uses psychotropic medications r/t mood/behavior management; dx Bipolar, schizoaffective d/o anxiety disorder, depression.</p> <p>R7's Notice of PASRR (preadmission screening and resident review) Level I Screen outcome, dated 12/18/24, documents: PASRR Level I Review date: 12/18/24. PASRR Level I Determination: Refer for Level II Onsite. Suspected or confirmed PASRR condition(s): (MH) Mental Health Disability. Your health care professional and Maximus completed a Preadmission Screening and Resident Review (PASRR) Level I screen for you. This screen shows that you need a face-to-face Level II evaluation. You need this evaluation because you may have serious mental illness or an intellectual/developmental disability. Reason for Screening: This nursing facility resident has never had a PASRR Level I screen. Level I outcome: Refer for Level II Onsite. Rationale: A PASRR Level II evaluation must be conducted. That evaluation will occur as an onsite/face-to-face.</p> <p>4. R32 has diagnoses not limited to Long Term (Current) use of Anticoagulants, Hemiplegia and Hemiparesis Following other Cerebrovascular Disease Affecting Right Dominant Side, Anemia, Chronic Kidney Disease, Blind Loop Syndrome, Diverticulosis of Large Intestine, Spondylosis, Atherosclerosis of Aorta, Calculus of Gallbladder, Gastro-Esophageal Reflux Disease, Hyperlipidemia, Insomnia, History of Falling, Interstitial Pulmonary Disease, Contracture of Muscle, Left Lower Leg, Gastrostomy, Dysphagia, Aphasia Following Cerebral Infarction, Major Depressive Disorder, Dementia, Unspecified Severity, with other Behavioral Disturbance, Hypertensive Chronic Kidney Disease, Psychosis, Dry Eye Syndrome of Bilateral Lacrimal Glands, Parkinson's Disease, Contracture of Muscle, Right Lower Leg, and Protein-Calorie Malnutrition.</p> <p>(continued on next page)</p>		

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<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>R32's Care Plan documents: R32 has the potential to be aggressive towards staff related to Dementia. R32 is aggressive during care and would scratch staff. R32 uses psychotropic medications r/t (related/to) Behavior/mood management; dx (diagnosis) depression, dementia, Parkinson's disease., hx (history) of behavioral s/s (signs/symptoms) such as pulling GT (gastric tube)/resisting care/spitting/scratching staff; dx insomnia, psychosis.</p> <p>R32's Notice of PASRR (preadmission screening and resident review) Level I Screen outcome, dated 12/18/24, documents: PASRR Level I Review date: 12/18/24. PASRR Level I Determination: Refer for Level II Onsite. Suspected or confirmed PASRR condition(s): (MH) Mental Health Disability. Your health care professional and Maximus completed a Preadmission Screening and Resident Review (PASRR) Level screen for you. This screen shows that you need a face-to-face Level II evaluation. You need this evaluation because you may have serious mental illness or an intellectual/developmental disability. Reason for Screening: This nursing facility resident has never had a PASRR Level I screen. Level I outcome: Refer for Level II Onsite. Rationale: A PASRR Level II evaluation must be conducted. That evaluation will occur as an onsite/face-to-face.</p> <p>On 12/19/2024 at 11:39AM, V10 (Social Services Director) stated she is responsible for completing and submitting the PASARR screenings to the screening agency. V10 stated residents should have a Level I PASARR screening prior to admission or upon admission to the facility. V10 stated a Level I PASARR screening determines if a Level II PASARR screening should be completed. V10 stated if a Level II PASARR is recommended, then the resident is referred for a Level II screening. V10 stated all residents should have a Level I PASARR screening. V10 stated there is no particular reason why the residents' PASARR screenings were not completed</p> <p>Facility Policy, dated 03/2024, titled Admission Criteria documents, 9. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-Admission Screening and Resident Review (PASARR) process. a. The facility conducts a Level I PASARR screen for all potential admissions, regardless of payor source, to determine if the individual meets the criteria for a MD, ID, or RD. b. If the Level I screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process. c. upon completion of the Level II evaluation, the State PASARR representative determines if the individual has a physical or mental condition, what specialized or rehabilitative services he or she needs, and whether placement in the facility is appropriate.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>44103</p> <p>Based on observation, interview, and record review, the facility failed to ensure low air loss mattress devices were on the correct weights setting for four residents (R2, R29, R40, R122) out of four who are high risk in developing pressure ulcers in a final sample of 26 residents.</p> <p>Findings Include:</p> <p>1. On 12/17/24 at 11:29 AM, R29 was sleeping in bed on a low air loss mattress, with the machine set to 290 pounds (lbs.).</p> <p>On 12/18/24 at 10:17 AM, Surveyor entered R29's room with V8 (Registered Nurse) and noted R29 was lying in bed on a low air loss mattress with the machine set to 290 lbs.</p> <p>R29's BRADEN score dated 9/29/24 is 12. V7 stated 12 means high risk for developing pressure ulcer. R29 needs assistance with bed mobility and R29's current weight is 219 pounds (lbs.) dated 12/4/24.</p> <p>2. On 12/17/24 at 11:26 AM, R122 was sleeping in bed on a low air loss mattress, with the machine set to 120 lbs.</p> <p>R122's BRADEN score dated 9/25/24 is 12 (high risk for developing pressure ulcer). R122 needs assistance with bed mobility and R122's current weight is 86 lbs. dated 12/4/24.</p> <p>3. On 12/17/24 at 11:39 AM, R2 was sleeping in bed on a low air loss mattress, with the machine set to 160 lbs.</p> <p>On 12/18/24 at 10:20 AM, Surveyor entered R2's room with V8, and noted R2 was lying in bed on a low air loss mattress, with the machine set to 160 lbs. V8 stated wound care team is monitoring the settings of the low air loss mattresses.</p> <p>R2's BRADEN score dated 12/12/24 is 11. V7 stated that 11 score also means high risk for developing pressure ulcer. R2 needs total assistance with bed mobility and R2's current weight is 128.5 lbs. dated 12/4/24.</p> <p>4. On 12/17/24 at 11:45 AM, R40 was sitting up in bed alert and able to verbalize needs. R40 was on a low air loss mattress, with the machine set to 220 lbs.</p> <p>On 12/18/24 at 10:19 AM, Surveyor entered R40's room with V8 and noted R40 was lying in bed on a low air loss mattress with the machine set to 220 lbs.</p> <p>R40's BRADEN score dated 11/7/24 is 12 (high risk for developing pressure ulcer). R40 needs assistance with bed mobility and R40's current weight is 162 lbs. dated 12/4/24.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103</p> <p>Based on observation, interview, and record review, the facility failed to follow the resident's care plan to ensure physician order was followed and administer the correct oxygen (O2) flow rate for one (R29) out of one resident reviewed for respiratory care in the final sample of 26.</p> <p>Findings Include:</p> <p>R29's clinical records show R29 has included diagnoses but not limited to acute and chronic respiratory failure with hypoxia and unspecified asthma.</p> <p>R29's Minimum Data Set (MDS), dated [DATE], shows R29 is cognitively intact and is dependent with staff assistance for transfers and bed mobility.</p> <p>R29's comprehensive care plan reads in part: R29 presents with altered respiratory function secondary to COPD requiring O2 as ordered for shortness of breath with one intervention that reads, Administer oxygen per MD orders. Assist with application as needed (date initiated 4/29/23).</p> <p>On 12/17/24 at 11:29 AM, R29 was sleeping in bed, using oxygen via nasal cannula. R29's oxygen flow rate was set to 2 liters per minute (LPM).</p> <p>On 12/18/24 at 10:12 AM, R29 was resting in bed alert and able to verbalize needs. R29's oxygen cannula tubing was hanging by R29's bed rail, not inside R29's nose. R29 stated R29 did not remove the oxygen tubing from R29's nose. R29 stated the Certified Nursing Assistant (CNA) might have taken it off when R29 was being changed. R29 stated R29 should be using the oxygen all the time for shortness of breath. R29 stated R29 has Asthma and Chronic Obstructive Pulmonary Disease. Surveyor also noted R29's oxygen flow rate was set to 2 LPM.</p> <p>At 10:17 AM, V8 (Registered Nurse) entered R29's room and confirmed R29's oxygen flow rate was set to 2 LPM. V8 placed the oxygen tubing back in R29's nose.</p> <p>At 10:23 AM, V8 checked R29's physician orders in the electronic health records and revealed R29 has an order for O2 at 3 LPM via nasal cannula (ordered 7/1/24). V8 stated V8 will change and correct R29's oxygen flow rate.</p> <p>At 12:01 PM, V2 (Director of Nursing) stated oxygen flow rate is based on the doctor's order. V2 stated it's important to follow the doctor's orders for individual needs of the residents as far as diagnoses to reach normal saturation level. V2 stated the nurses should be monitoring the residents' oxygen are set in the correct flow rate. V2 stated the CNAs should not be removing the oxygen tubing, and should be letting the nurse know to make sure it's in the right place and it's administered correctly.</p> <p>The facility's Oxygen Administration policy, dated 10/24, reads: The purpose of this procedure is to provide guidelines for safe oxygen administration. Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration. Review the resident's care plan to assess for any special needs of the resident.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145659	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/20/2024
NAME OF PROVIDER OR SUPPLIER Waterford Care Center, The		STREET ADDRESS, CITY, STATE, ZIP CODE 7445 North Sheridan Road Chicago, IL 60626	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>44103</p> <p>Based on observation, interview, and record review, the facility failed to dispose a house stock medication after the expiration date, and failed to ensure medications were locked and secured while unattended for two out of three carts reviewed for medication storage and labeling. These failures have the potential to affect 86 residents residing in the facility.</p> <p>Findings Include:</p> <p>On 12/17/24 at 9:47 AM, Surveyor observed a medication cart in the first-floor hallway unattended and unlocked. V6 (Licensed Practical Nurse) stated V6 was responsible for this medication cart. V6 stated, This medication cart stores medications for residents on the first floor of the facility.</p> <p>On 12/17/24 at 11:45 AM, second floor medication cart was inspected with V8 (Registered Nurse) and found a bottle of vitamin D tablets, with expiration date of 11/24 on the label. V8 stated expired medications should be discarded on the expired date to prevent it for being administered to the residents.</p> <p>On 12/18/24 at 12:01 PM, V2 (Director of Nursing) stated, When medication cart is left unattended, there should be nothing on top of the cart, the medication cart should be locked, nothing exposed that the resident would have access to. It is important to lock the medication cart when unattended because it's a risk that a resident or a visitor can pass by and open any of the drawer and can access the medications stored inside. Expired medications should be discarded by the expiration date and should not be stored in the medication cart anymore the day after the expiration date. It is important to discard expired medications to make sure that the residents are not getting expired medications that could possibly cause adverse reactions.</p> <p>The facility's Storage and Labeling of Medications policy, dated 04/24, documents: The facility stores all drugs and biologicals in a safe, secure, and orderly manner. 1. Drugs and biologicals used in the facility are stored in locked compartments under proper temperature, light and humidity controls. 5. Discontinued, outdated, or deteriorated drugs or biologicals are returned to the dispensing pharmacy or destroyed. 8. Compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing drugs and biologicals are locked when not in use. 9. Unlocked medication carts should be within the visible supervision of the nurse.</p> <p>Facility census, dated 12/17/2024, documents a total of 45 residents reside on the first floor and 41 residents reside on the second floor of the facility.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45110</p> <p>Based on observation, interview, and record review, the facility failed to follow proper sanitation and food storage practices as evidenced by food not properly labeled, and food not properly stored. These deficient practices have the potential to affect all 128 residents receiving food prepared for the nursing skilled facility.</p> <p>Findings include:</p> <p>On 12/17/24 at 9:11 AM, during initial kitchen tour with V17 [Dietary Manager], the following items were found in walk-in freezer:</p> <p>Box of turkey [NAME] hot dogs uncovered with no open or discard date.</p> <p>Box of chicken patties uncovered with no open or discard date.</p> <p>Box of chicken leg quarters uncovered with no open or discard date.</p> <p>On 12/17/24 at 9:33 AM, on the clean dish rack, surveyor and V17 observed two cell phones and pair of eyeglasses next to the clean dishes.</p> <p>On 12/17/24 at 9:45 AM, V17 [Dietary Manager] stated, All food items, once removed from the box, the items need to be dated. The food items should have a label with an open date and expiration date. If dietary staff prepare food, not knowing how long the food has been open, it could potentially cause a food born illness. The two cell phones and eyeglasses belong to dietary employees, and personal food items should not be stored in the dietary kitchen to prevent cross contamination.</p> <p>Policy: Documents in part</p> <p>Food Storage dated 2017.</p> <p>-This policy outlines safe food handling and storage practices for the Food and Nutrition Services Department.</p> <p>First in, first out. If taken out of original container, food is tightly wrapped and labeled with the name of the item and the use by date.</p> <p>-Open products that have not been properly sealed and dated are discarded.</p> <p>-Frozen foods can deteriorate in quality the longer they are stored. Frozen food is discarded after three months.</p> <p>Storage of Employee Personal items:</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Food services employees should not store or keep any personal belongings in the kitchen. Food and nutrition services and employee will store their personal items in the locker room, or another location designated for that use.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>39779</p> <p>Based on observation, interview, and record review, the facility failed to ensure the facility linen was stored on a linen cart to prevent contamination and failed to ensure staff wore the proper PPE (Personal Protective Equipment) while caring for 1 (R32) resident on Enhanced Barrier Precautions. These failures have the potential to affect 49 residents residing on the third floor based on the facilities census.</p> <p>Findings Include:</p> <p>1. R32 was admitted to the facility 09/22/08, with diagnosis onset dates starting 10/01/13, that is not limited to Long Term (Current) use of Anticoagulants, Hemiplegia and Hemiparesis Following other Cerebrovascular Disease Affecting Right Dominant Side, Anemia, Chronic Kidney Disease, Blind Loop Syndrome, Diverticulosis of Large Intestine, Spondylosis, Atherosclerosis of Aorta, Calculus of Gallbladder, Gastro-Esophageal Reflux Disease, Hyperlipidemia, Insomnia, History of Falling, Interstitial Pulmonary Disease, Contracture of Muscle, Left Lower Leg, Gastrostomy, Dysphagia, Aphasia Following Cerebral Infarction, Major Depressive Disorder, Dementia, Unspecified Severity, with other Behavioral Disturbance, Hypertensive Chronic Kidney Disease, Psychosis, Dry Eye Syndrome of Bilateral Lacrimal Glands, Parkinson's Disease, Contracture of Muscle, Right Lower Leg, Protein-Calorie Malnutrition.</p> <p>R32's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) indicate resident is rarely/never understood.</p> <p>R32's Care Plan documents: R32 has an ADL (activities of daily living) self-care performance deficit r/t (related/to) dx (diagnosis) Parkinson's disease, CVA (cerebral vascular accident) with resultant right hemiparesis, dysphagia; HTN (hypertension), CKD (chronic kidney disease), dementia, ILD (interstitial lung disease), spondylosis. R32 placed on Enhanced Barrier Precaution per facility protocol d/t (due/to) long term use of enteral feeding and hx (History) of MRSA (Methicillin-resistant Staphylococcus aureus).</p> <p>On 12/17/24 at 11:23 AM, Enhanced Barrier Precaution signage was observed on R32's door. Surveyor knocked on R32's door and V13 (Certified Nurse Assistant) called out patient care. Surveyor opened the door and observed V13 approaching the door with no disposable gown on. Surveyor asked V13 if he was providing care to R32, V13 responded, yes.</p> <p>2. On 12/18/24 at 09:52 AM on the third-floor north hallway, there was a linen cart observed in the hallway, with no side covering, containing towels, sheets, pillowcases, and gowns.</p> <p>On 12/18/24 at 09:55 AM, V12 (Registered Nurse) stated, This (referring to the linen cart) has to go to laundry, and it has no cover. V12 then proceeded down the hallway with the linen cart.</p> <p>On 12/18/24 10:04 AM, V2 (Director of Nursing) stated, When caring for a resident on Enhanced Barrier Precautions (EBP) everyone should wear a mask, gloves, and a disposable gown. (R32) has a peg tube and V13 (Certified Nurse Assistant) would have to wear a mask, gown and gloves when giving care.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 12/18/24 at 10:47 AM, V2 (Director of Nursing) stated, If the linen on the linen carts is not covered it can become contaminated.</p> <p>On 12/18/24 at 11:08 AM, V16 (Maintenance Supervisor). V16 stated, When the linen is stored on the linen carts all of the flaps should be closed. The linen cart with the missing flap needs to be replaced. The flap was missing and when the linen cart is open all the germs come to the linen, and it gets contaminated.</p> <p>Signage indicating Enhanced Barrier Precautions (STOP) Providers and staff must also: Wear gloves and a gown for the following High-Contact Resident Care Activities. Dressing, Bathing/Showering, Transferring, Changing Linen, Personal Hygiene, Changing Brief or assisting with toileting.</p> <p>Policy:Titled Laundry and Bedding, dated 10/24, documents: Transport: 5. Clean linens are protected from dust and soiling during transport and storage to ensure cleanliness.</p>		