STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145752	A. Building B. Wing	07/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Forest View Rehab & Nursing Center	535 South Elm Itasca, IL 60143

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure residents were free of physical abuse. This applies to 4 of 4 residents (R10, R15, R21, and R24) reviewed for abuse in a sample of 25.The findings include: 1. Face sheet, dated 7/15/25, shows R10's diagnoses included major depressive disorder, anxiety disorder, alcohol abuse, and bipolar disorder. MDS (Minimum Data Sheet), dated 7/1/25, shows R10 was cognitively intact.Face sheet, dated 7/22/25, shows R17's diagnoses included chronic obstructive pulmonary disease, acute and chronic respiratory failure, and major depression. MDS, dated [DATE], shows R17 was cognitively intact.On 7/22/25 at 2:48 PM, R10 stated she and R17 got into a fight when R10 was sitting outside the facility front door and R17 appeared with sunglasses that R10 stated were glasses R10 was offering for sale in her personal store at the facility. R10 stated she told R17 that R17 owed her two dollars for the sunglasses and R17 replied, Come and get them! R10 stated she grabbed the sunglasses off R17's head and accidently grabbed some of R17's hair. R10 stated R17 then shoved her into a brick pillar and cement wall. R10 showed she had two bruises from the incident: 1. A vertical bruise on her right shoulder/back area which was measured by V34 (Wound Nurse) and measured 11 cm (Centimeters) long and 2.5 cm wide. V25 described the bruise as greenish yellow with purple and a 1cm red center, 2. A horizontal bruise on her right buttocks which was measured by 34 and measured 11.5 long and 5 cm wide. V25 described the bruise as yellow-green with purple discoloration and no red areas. R10 stated the areas were still painful and described her pain post medication as an 8 out of 10 with 10 being the worst pain. R10 stated prior to taking her pain medication, her pain felt like 10 out of 10. R10 stated the injury from the altercation aggravated a previous car accident injury to her back. R10 stated R17 had a history of assaulting her. R10 stated in April, 2025, R10 and R17 got into a disagreement and R17 grabbed the back of R10's shirt. R10 stated she reported the incident, and the two residents were told by administration not to talk to each other. R10 stated R17's friend, R20, lives next door to R10 and R17 frequently visits R20's room. Witness statement, dated 7/17/25, shows R10 reported that she was pushed by R17 during the altercation.Witness statement, dated 7/17/25, shows R17 stated she pushed R10 away during the altercation.Witness statement, dated 7/16/25, shows R20 stated R10 and R17 were arguing, R10 grabbed R17's hair, and R10 went up against the wall.On 7/22/25 at 3:20 PM, R17 stated R10 was smoking at the front door of the facility and R17 was pushing R20 into the front door of the facility. R17 stated R10 began verbally taunting R17 and then grabbed R10's hair. R17 stated she pushed R10 into the cement shelf / brick pillar. R17 stated she pushed R20's wheelchair into the front door and R10 followed R17 and R20. R17 stated, When I let loose on [R10] they will call the ambulance. It ain't a joke no more.On 7/22/25 at 3:12 PM, R12 stated she witnessed R17 push R10 into the brick post, R10 hit her back and then fell. R12 stated she told V1 (Administrator) and the police what happened. R12 stated, It was a major push! R12 stated R10 was complaining that she was hurting all over her body.On 7/22/25 at 4:08 PM with V26 (Consultant), V23 (Receptionist) stated she was sitting at the front desk of the facility lobby at the entrance to the facility when the incident between R10 and R17 occurred. V23 stated she watched the camera footage of the incident and saw R17 pushing R20 in his wheelchair through the front door when R10 grabbed R17s sunglasses and hair. V23 stated R17 began hitting R10 and then pushed R10 into the brick wall. V23 stated she believed R10 fell. V23 stated the two residents then began to hit each other and began to walk into the facility hitting each other. V23 stated she physically got between the two residents and separated them. V23 stated the police were called and the police also reviewed the camera footage. V23 stated R10 showed V23 a bruise on her shoulder that measured approximately 8 inches and was green/yellow in color. On 7/22/25 at 3:55 PM, V22 (LPN) stated after the incident R10 had a bruise on her right shoulder but did not record measurements of the injury. V22 stated he obtained an order for an Xray at the time but R10 declined the procedure. V22 stated R10 reported her injuries from the altercation hurt her more than her injuries from her previous car accident hurt. On 7/22/25 at 3:07 PM, R19 stated she witnessed R17 hit R10 with her fist during the altercation.On 7/22/25 at 2:30 PM, R20 stated R17 was pushing his wheelchair through the front door when R10 grabbed R17's hair. R20 stated R17 twisted around and pushed R10 back against the concrete wall in defense of herself. R20 stated R10 was complaining about aches and pains.On 7/22/25 at 11:30 AM, V24 (Licensed Practical Nurse - LPN) stated after the incident with R17, R10 had superficial abrasions/scratches and complained of back pain.Progress note, dated 7/14/25, shows R10 was involved in an altercation and police arrived to take statements. The

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record reviews, the facility failed to provide dementia care and behavioral interventions to a resident who had chronic dementia-related behaviors. This applies to 1 of 3 residents (R25) reviewed for behavior management in a sample of 25. The findings include:Face sheet, dated 7/22/25, shows R25's diagnoses included alcohol use with alcohol-induced persisting dementia, psychosis, cerebrovascular disease, unsteadiness on feet, weakness, and major depressive disorder. The face sheet shows R25 was admitted to the facility on [DATE].MDS, dated [DATE], shows R25's cognition was moderately impaired. Pre-admission paperwork, dated 7/1/25, shows R25 showed agitation with combative behavior towards at the prior facility. The paperwork shows R25 fought with staff and hit, punched, cursed and threatened other residents at the prior facility. The paperwork showed R25 banged and punched walls and was sent to the hospital for the behaviors.Alzheimer's Special Care Unit Review, dated 7/22/25, shows R25 was easily annoyed, exhibited hallucinations/delusions, was restless and withdrawn, verbally/physically aggressive, and was resistant to care. The assessment shows the techniques to calm R25's behavior included, Sometimes will listen to staff members.R25's physical/verbal aggression care plan, initiated 7/22/25, shows R25 had a history of aggressive, inappropriate, attention-seeking and/or maladaptive behaviors, but demonstrated stability during the admission screening process and was considered appropriate for admission. The history included conflicts and altercations with others, threatening behavior, yelling, verbal and physical aggression, acting impulsive and erratically, and self-harmful and self-destructive behavior. The care plan showed R25 had a diagnosis of severe, chronic, persistent mental illness and a diagnosis of Alzheimer's disease or related dementia. Care plan interventions included conducting reviews of past behaviors and evaluating the likelihood of aggressive and inappropriate behaviors during the initial assessment process, intervene when inappropriate behaviors are observed, communicating assertively that the resident must exercise control over impulses and behavior, and refer the resident to a mental health professional such as a psychiatrist. The care plan shows if R25 is preoccupied by hallucinations and/or delusional thoughts, the staff were to remind him he was safe and secure in the facility.R25's anxiety and agitation care plan, initiated 7/22/25, shows R25 presented with moderate to extreme anxiety related to Alzheimer's disease or related dementia. The interventions included evaluating the potential causal factors contributing to feelings and anxiety, working with the resident to eliminate causes as possible, offering reassurance, teaching R25 stress-management techniques including deep breathing, counting to 10, reading, and journaling. Behavior notes, dated 7/17/25 at 17:37 on the day of admission to the facility, shows R25 received a physician order for Haldol related to wandering around the unit, going in and out of other resident rooms, and cursing and swearing at staff. The clinical record failed to show any evidence of individualized behaviors interventions attempted.MAR, dated 7/17/25 at 19:00, shows R25 re3cieved PRN (as needed) Haldol.Nursing progress note dated 7/17/25 at 21:59, R25's behavior escalated and R25 began swinging at staff when being removed from other resident rooms. R25 was unable to be redirected and was pacing and cursing in the hallways. R25 continued to be physically and verbally aggressive when followed by staff so 911 was called. The progress notes show R25 was discharged to the hospital, returned on 7/18/25, and continued to pace in the hallways and be combative when redirected. The clinical record failed to show any evidence of individualized behaviors interventions attempted.Nursing progress note, dated 7/18/25, shows R25 continued to wander into resident rooms taking resident items and was difficult to redirect. The note shows R25 was brought into his room several times but left his room after a few minutes. The 7/18/25 progress notes showed R25 continued to wander and go into resident rooms and became combative when asked to leave a room. The clinical record failed to show any evidence of individualized behaviors interventions attempted.Nursing progress notes, dated 7/19/25, showed R25 received a physician order for Depakote Delayed Release and his Haldol order was changed to every 6 hours as needed. Review of R25's MAR showed no use of R25's PRN Haldol on 7/18/25 or 7/19/25.R25's clinical record, dated 7/20/25, showed R25 continued to wander, curse, and threaten staff with harm when he was reprimanded. The progress notes show R25 received PRN Haldol on 7/20/25 at 6:00 AM. The clinical record failed to show any evidence of individualized behaviors interventions attempted.R25's clinical record, dated 7/21/25, showed R25 received Haldol at 2:45 AM and his Depakote dose was increased at 10:24 AM. The record shows at 5:00 PM, R25 hit a resident, and was sent to the hospital for aggression. No PRN Haldol was shown to be administered since his 2:45 AM dose. The

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review, the facility failed to plan and serve resident menus and food portions per facility policy. This applies to all 128 facility residents receiving oral diets. The findings include:Facility resident roster, provided 7/10/25, shows the facility census was 129 residents. Facility document, dated 7/15/25, shows one resident had physician diet orders for NPO (nothing by mouth.)1. On 7/10/25, the following residents expressed concerns:- R7 stated the facility serves only small portions of meat and vegetables.- R5 stated the facility never served fresh fruits even in the summer when fruits are available. R5 stated the residents were rarely served vegetables.- R2 stated the facility only provided menus for review the day of service and not prior. R2 stated she and other residents asked for weekly planned menus but the facility will not provide menus in advance because they often serve something different than the planned menu. R2 stated the facility served small portions of vegetables.Review of the facility four-week menu cycle, dated 6/22/25 to 7/19/25, show the following: - Only four fruits/vegetables were offered on 6/24/25, 6/25/25, 6/26/25, 6/28/25, 7/10/25, 7/14/25, 7/17/25- Only three fruits/vegetables were offered on 7/12/24, 7/13/25 - Only five grains/breads were offered on 7/3/25, 7/6/25, 7/7/25, 7/16/25, 7/17/25, 7/19/25Review of the facility four-week menu cycle, dated 6/22/25 to 7/19/25, showed the following foods were repetitively served within the four-week menu cycle:- Waffles were repeated three times (6/25/25 and 6/27/25, 7/16/25)- Sausage gravy and biscuit were repeated five times (6/30/25, 7/1/25, 7/6/25, 7/11/25, 7/17/25)- Cheese Scrambled Eggs II was repeated five times (6/22/5, 6/23/25 6/28/25, 7/9/25, 7/13/25)- Egg and Cheese Croissant was repeated three times (6/29/25, 7/3/25, 7/8/25)- BBQ chicken was repeated three times (6/28/25, 7/11/25, 7/19/25)- Pears/blushing pears were served six times (6/22/25, 6/26/25, 7/2/25, 7/9/25, 7/16/25, 7/19/25)- Peaches/Blushing peaches were repeated three times (6/30/25, 7/4/25, 7/11/25)- Mandarin Oranges were repeated 5 times (6/22/25, 6/26/25, 7/1/25, 7/8/25, 7/13/25)- Mixed fruit was served on 6/23/26 and 6/29/25, fruit cup was served on 6/27/25, 7/3/25 and fruit cocktail was served on 7/3/25 and 7/7/25- Apple crisp/cobbler was served three times in one week (7/13/25, 7/14/25, 7/17/25)- Turkey Noodle Casserole was served at dinner on 6/26/25 and Turkey [NAME] Casserole was served the following day at lunch- The only fresh fruit offered on the four-week menu cycle was on 6/28/25 (fresh grapes)On 7/14/25 at 1:58 PM, V9 (Corporate Food Service Manager) stated the canned fruit cocktail was served using canned fruit cocktail, the mixed fruit recipe showed canned fruit cocktail was to be served, and the fruit cup recipe showed canned fruit cocktail was to be served.On 7/14/25 at 12:00 PM, V5 (Dietitian) stated the facility menus were expected to serve 5 servings of fruits/vegetables and 6 servings of grains daily. V5 stated she had not seen the facility serve fresh fruit when mixed fruit was on the menu. V5 stated the only fresh fruit served to residents were bananas, grapes, and watermelon. V5 stated the facility food service did not provide weekly menus and the menus were changed often. Policy/Procedure, revised 9/25/23, shows, Menus are developed to meet the Daily Recommended Intake national guidelines, regional food preferences, resident input, and regulatory parameter. The policy/procedure shows the menus should include five or more servings of fruit or vegetables and six or more servings of whole grain/Enriched Bread, Cereal, [NAME] or Pasta daily. The policy shows the Menus will be planned 4 weeks in advance. 11. The daily and weekly menus will be posted in all dining room sand other designated locations at heights where they can easily be viewed by the residents. 2. On 7/14/25 during lunch service in the kitchen with V9 (Corporate Food Service Director), bone-in chicken thighs were being served to residents during lunch. The meat from one chicken thigh was removed from one serving and was weighed. The chicken thigh meat weighed a total of 2.5 oz. V9 stated the meat should weigh 3 oz at that meal. On 7/14/25 at 12:35 PM with V9, the fruit from 1 serving of gelatin was measured and the serving contained less than 1/4 cup of total watermelon in the serving. Facility Menu Extension, dated 7/10/25, shows all resident diets, except vegetarians, were to receive a minimum of one portion of herb baked chicken thigh which included 3 oz of edible meat.Facility List of Current Resident Diets, dated 7/10/25, show only two residents were receiving vegetarian diets.On 7/14/25 at 1:58 PM, V9 stated the pureed and mechanical diets were expected to be served one full portion of chicken thighs as per the regular diets at lunch on 7/10/25.Policy/Procedure Portion Control, developed 9/26/23, shows, Residents will receive the correct portions for food through adherence to planned menus and standardized recipes and utilization of proper serving utensils. Procedure 1. Staff will serve portions to residents based on planned menus that list the portion size for each food item.3. On 7/10/25 at 10:56 AM, chopped broccoli was boiling in a pot of water on the stove. The broccoli had few florets and consisted mostly of wide stem pieces On

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview and record review, the facility failed to serve palatable meals per facility policy. This applies to all 128 facility residents receiving oral diets. The findings include:Facility resident roster, provided 7/10/25, shows the facility census was 129 residents. Facility document, dated 7/15/25, shows one resident had physician diet orders for NPO (nothing by mouth.)1.On 7/10/25 at 11:57 AM during lunch tray service in the kitchen, the broccoli in the steamtable pan on the steamtable looked very pale green/gray and consisted mostly of cut broccoli stems and few broccoli florets. The pureed meatloaf was in a steamtable pan being served to residents. The pureed meatloaf appeared to be separated from a reddish-brown greasy-looking liquid floating at the top of the pureed meatloaf. V10 (Corporate Food Service Manager) stated the product needed further pureeing. V10 removed the product from the steamtable, strained the greasy-looking liquid from the product, re-pureed the product, and placed the product back on the steamtable. The re-pureed and strained pureed meatloaf tasted very greasy and unseasoned. V10 tasted the product and stated it tasted greasy, but the food service had no other products to puree and serve the residents for lunch. On 7/15/25, V9 (Corporate Food Service Manger) stated the facility utilized ground beef product that consists of 73% beef and 27% fat.Menu and Nutritional Adequacy Resident Satisfaction, revised 10/2/23, shows, Policy The facility will serve foods that are palatable, attractive, and at proper temperature to ensure resident satisfaction. Resident preferences will be provided to the degree possible. Procedure .3. The facility will make an effort to hold regular Menu Committee meetings to address resident satisfaction and likes and dislikes. 4. Menus will be adjusted based on resident input to the degree possible and signed off ono by the Registered Dietitian.2. On 7/10/25 at 12:35 PM during lunch service, a test tray was performed and included baked meatloaf, mashed potatoes and gravy, cooked broccoli, and fruited gelatin. At 1:13 PM, the test tray was served, and the meatloaf temperature measured 120 degrees F, the mashed potatoes measured 125 degrees F, and the broccoli measured 110 degree F. The meatloaf and broccoli tasted only lukewarm. The meatloaf tasted very greasy and unseasoned, the mashed potatoes tasted bland and unseasoned, and the broccoli tasted very mush and soft. The broccoli consisted of mostly stem pieces and very few florets. On 7/14/25 at 12:00 PM, V5 (Dietitian) stated the food service did have pellet warmers however she did not think the pellet heater was working. Food Temperature Resident Service, revised 9/18/23, shows, The facility will ensure foods are served in an attractive and at temperature that is palatable and acceptable to the resident. Procedure: 3. Food will be transported to the dining rooms or resident rooms in methods that maintain the proper temperature of the food. Hot foods will be served to the resident at a temperature palatable and acceptable to the resident, general practice should not be less than 125 Fahrenheit. 3. On 7/10/25 at 10:56 PM, a white bouffant hairnet was in the coffee brew basket of the coffee machine and had wet coffee grounds in the hairnet. There were white coffee filters on top of the coffee machine in packages. V6 (Dietary Aide) stated the staff had used the white bouffant hairnets in the coffee machine to brew resident coffee for approximately two weeks because they felt the coffee filters being provided were too small to brew enough coffee. V5 (Dietitian) stated the hairnets were not designed to be used as coffee filters and should not be used as such at the facility. V5 stated the staff should use the coffee filters that were located on top of the coffee machine.On 7/10/25 R7 stated the facility coffee did not taste good and the eggs are served discolored and have no taste.On 7/10/25 at 1:00 PM, R5 stated some facility foods taste OK but some do not. R5 stated the staff served tomato soup with leftover chicken pieces in it. R5 stated sometimes the hot foods are not served hot, all the fruit is canned and served in little pieces.On 7/10/25 at 1:06 PM, R2 stated the facility food did not taste appetizing and needed more spices.On 7/10/25 at 3:22 PM, R2 stated, The meatloaf tasted like ground beef! R2 stated the meatloaf tasted like it had no seasoning, the facility coffee was horrible, and the food was not served hot. On 7/10/25 at 10:33 AM, R3 stated the food quality and flavor was declining at the facility. R3 stated residents refused to at the food at the facility because it was not good. R3 stated the hot food is served cold at meals and the coffee is so bitter R3 and R4 make their own coffee in their room. On 7/10/25 at 10:37 AM, R8 stated the food at the facility was awful and hot food was often served cold. R8 stated the ham loaf did not taste like ham or loaf and the facility served a cup of cake that was made from flimsy batter that did not hold up, so the staff push the cake into a cup and serve it. R8 stated the facility coffee was also awful and the creamer only floats on top of the coffee. R8 stated the broccoli served at the facility was only squares of broccoli stems and have no florets included On 7/10/25 at 3:32 PM, R6 stated the facility food was not usually served hot and the vegetables

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure meals and snacks are served at times in accordance with resident's needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on observation, interview and record review, the facility failed to serve meals on time to residents per the facility meal schedule. This applies to all 128 facility residents receiving oral diets. The findings include: Facility resident roster, provided 7/10/25, shows the facility census was 129 residents. Facility document, dated 7/15/25, shows one resident had physician diet orders for NPO (nothing by mouth.) On 7/10/25 at 1:13 PM, the last lunch tray was served to residents on 1 South. Facility mealtime document, undated, shows the 1 South unit was to be served their lunch meals between 12:25 to 12:35 PM. The document shows the facility was to serve breakfast between 7:45 AM and 9:10 AM, lunch between 11:30 AM and 12:45 PM, and dinner between 4:45 PM and 5:55 PM. On 7/10/25 during resident interviews, R2, R5, R6, and R8 all stated the facility meals were often served late. On 7/10/25 at 3:21 PM, R2 stated her dinner was sometimes served at 7:00 PM. 0n 7/10/25 at 3:32 PM, R6 stated he sometimes received his dinner after 7:00 PM. On 7/14/25 at 1:58 PM, V9 (Corporate Food Service Manager stated he was recently made aware of resident concerns regarding meals being served late at the facility. Resident council meeting minutes, dated 2/19/25, showed a resident expressed concerns that CNAs took too long to serve food.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to perform hand hygiene after touching soiled dishes and failed to store foods to prevent cross contamination. The facility also failed to sanitize equipment prior to use and failed to utilize food service supplies to avoid potential chemical contamination of foods. This applies to all 128 facility residents receiving oral diets.The findings include:Facility resident roster, provided 7/10/25, shows the facility census was 129 residents.Facility document, dated 7/15/25, shows one resident had physician diet orders for NPO (nothing by mouth.)1. On 7/10/25 at 10:56 PM, a white bouffant hairnet was located in the coffee brew basket of the coffee machine and had wet coffee grounds in the hairnet. There were white coffee filters on top of the coffee machine in packages. V6 (Dietary Aide) stated the staff had used the white bouffant hairnets in the coffee machine to brew resident coffee for approximately two weeks because they felt the coffee filters being provided were too small to brew enough coffee. V5 (Dietitian) stated the hairnets were not designed to be used as coffee filters and should not be used as such at the facility. V5 stated the staff should use the coffee filters that were located on top of the coffee machine. 2. On 7/10/25 at 11:18 AM, V8 (Cook) was standing at the soiled end of the dish machine spraying down soiled food equipment and placing the equipment into dishracks. V8 was not wearing disposable gloves. Without washing his hands, V8 then took a clean/sanitized blender and utensils out of the dish machine and brought the equipment to the cook's station. V8 placed the blender on the blender base and stated he was going to use the blender to begin pureeing resident foods for lunch. 3. On 7/10/25 at 11:32 AM, V7 (Cook) removed a 1/3 steamtable pan from the second (rinse) compartment of the three-compartment sink. There was no sanitizing solution or any other liquid in the third compartment of the three-compartment sink. V5 (Dietitian) stated the pan should have been sanitized prior to removing it from the three-compartment sink and before use.4. On 7/10/25 at 11:04 AM with V9 (Corporate Food Service Manager) in the kitchen walk in cooler, there were 5 dish machine racks that had bowl of gelatin stored in the racks. The bowls of gelatin were not covered, and the food was exposed to air. There was also a 1% milk carton without a cap on the opening to the carton. In the back of the cooler there were flour tortillas, a case of hot dogs, and a case of deli turkey stored beneath uncooked cases of bacon. At 11:04 AM, V9 stated the bowls of gelatin should have been stored covered and the uncooked bacon should have been stored beneath the ready to eat foods. On 7/14/25 at 12:00 PM, V5 (Dietitian) stated the gelatins should have been stored covered and dated in the cooler.