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	04/12/2024

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

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 31327 Based on observation, interview and record review, the facility failed to obtain physician orders for resident medications to be at the bedside. The facility also failed to complete self-administration of medication assessments for residents. This applies to 3 of 10 residents (R29, R45, R106) reviewed for medications in a sample of 32. The findings include: 1. On 4/9/24 at 10:14 AM, during initial tour, on top of R106's end table, there were two Albuterol Sulfate inhalers. R106 stated the inhalers are always in his room and prefers them in his room because it takes forever for the nurses to administer it to him. R106 stated that the nurses did not teach him how to do it. R106 stated he already knows how to use it. R106's face sheet shows a diagnosis of acute respiratory failure with hypoxia. R106's POS shows an order for Ventolin HFA Aerosol Solution 108 (90 Base) MCG/ACT (Albuterol Sulfate HFA)-2 puffs inhale orally every 6 hours as needed for wheezing. R106's MDS (Minimum Data Set) dated 2/6/24 shows a BIMS (Brief Interview for Mental Status) score of 15, which means he is cognitively intact. Review of R106's electronic medical record shows there was no order for his inhaler to be at the bedside. There was no self-administration of medication assessment. Neither was there a care plan discussing self-administration of medications. 2. On 4/10/24 at 10:40 AM, R45 was sitting on her bed and taking her morning medication pills that were in a medication cup. There was no nurse present while she was taking her medication. On her dresser, there was an Albuterol Sulfate inhaler. R45 said, It's usually in my room and I take it whenever I need it. R45 stated that V17 (LPN-Licensed Practical Nurse) just dropped of the medications and left. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145752	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/12/2024

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R45's face sheet shows diagnoses of major depressive disorder, anxiety disorder, bipolar disorder, and glaucoma. R45's MDS dated [DATE] shows a BIMS score of 15, which means she is cognitively intact. R45's POS show's orders of the following: Calcium 600 MG (Milligrams)---2 tablets by mouth one time a day, Furosemide 20 MG one time a day, Gemtesa oral tablet 75 MG one tablet in the morning, Lexapro 20 MG one tablet one time a day, Nifedipine ER (Extended Release) 30 MG (1 tablet) one time a day, Potassium Chloride 10 MEQ (Milliequivalents) one time a day, Metformin 500 MG 1 tab twice a day, Gabapentin 300 MG 1 capsule three times a day, Seroquel 50 MG three times a day, Tizanidine HCL 4 MG three times a day, Albuterol Sulfate HFA 108 (90 Base) MCG/ACT-2 puffs every 6 hours PRN (As Needed). Review of R45's electronic medical record shows there was no order for R45 to self-administer her own medications. There was no self-administration of medication assessment uploaded. There was no care plan regarding self-administration of medications. On 4/10/24 at 10:45 AM, V17 (LPN) stated, Yes, you have to watch residents take all their medications because they could spit it out, especially if you have dementia residents. 3. On 4/9/24 at 10:11 AM, during initial tour, surveyor went to R29's room. R29 was not in her room then. On top of her end table, there was an Albuterol Sulfate inhaler. On 4/10/24 at 10:40 AM, surveyor went back to R29's room. R29 was not in her room. R29's Albuterol Sulfate inhaler was still on top of her end table. R29's face sheet shows a diagnosis of chronic obstruct pulmonary disease. R29's POS (Physician Order Sheet) shows an order for Albuterol Sulfate HFA Aerosol Solution 108 (90 Base) MCG (Micrograms)/ACT-2 puffs inhale orally every 6 hours as needed for shortness of breath. Review of R29's electronic medical record shows that there is an order for R29 to self-administer her inhaler, but there was no self-administration of medication assessment uploaded in her chart. Neither was there a care plan regarding this. 04/9/24 at 1:08 PM, V22 (LPN-Licensed Practical Nurse) stated, We have to get an order from the doctor for residents to have meds at the bedside. We have to do a med self-admin assessment. On 4/10/24 at 1:19 PM, V2 (ADON-Assistant Director of Nursing) stated, We don't allow any medications at the bedside without any order. Of course! Absolutely! We have to get an order from the doctor for the medication to be at the bedside. The nurse has to do self-medication assessment, which is usually uploaded in the resident's chart. The resident has to do the return demo for us, so we know he or she can safely administer the medication. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled Self-Administration of Medications by Residents (Unknown Date) shows: 2. If the resident desires to self-administer medications, an assessment is conducted by an interdisciplinary team. This assessment includes the resident's cognitive, physical, and visual ability to carry out this responsibility. 3. An interdisciplinary team determines the resident's ability to self-administer medications by means of a skill assessment as follows d. The resident is asked to demonstrate the removal of the medication from the package and, in the case of nonsolid dosage forms, e.g., inhaler, to verbalize the steps above involved in administration. e. If bedside storage is to be used, the resident is asked to complete a bedside record indicating the administration of the medication. 4. If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside medication storage is conducted. 5. A physician order is obtained to self-administer medications if the above storage and skill assessment has been approved for the resident by the interdisciplinary team. The order is recorded on the MAR (Medication Administration Record). 6. Once the order has been obtained, the procedure is explained to the resident. 11. Update the residents' care plan quarterly or as indicated by the change in medication scheduling, dose, or a change in resident's condition with a reassessment of the resident's knowledge and ability to self-administer medications.

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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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review the facility failed to use the proper equipment to transfer a resident resulting in a left femur fracture that required surgical repair. This applies to 1 of 2 (R7) residents reviewed for hospitalization s in a sample of 32. Findings include: R7 was originally admitted to the facility on [DATE]. R7 has diagnoses that includes diabetes, obesity, anxiety, major depressive disorder, weakness, Parkinson's disease. R7 has previous documented fractures bimalleolar (ankle) fracture of lower leg (9/22/20) and a nondisplaced fracture the fifth metatarsal (foot) bone (7/1/23). R7's MDS (Minimum Data Set) dated 2/12/24 shows she is cognitively intact with a BIMS (Brief interview for Mental Status) score of 15. R7 is dependent on staff assistance for toileting, transfers, and repositioning. R7's care plan dated 2/29/24 documents current transfer needs of total assistance of two staff using a patient lift due to due to a femur fracture. On 4/10/24 at 1:56 PM, R7 stated she broke her leg while staff were transferring her to bed. R7 stated staff were supposed to use the sit-to-stand to transfer her but used a gait belt. R7 stated they now must use a patient lift to transfer her. Review of nursing progress notes documents on 2/5/24 R7 was transferred to the hospital emergency department for further evaluation and treatment due to a left acute femoral neck fracture. On 4/11/24 at 11:58 AM, V19 LPN (Licensed Practical Nurse) stated she recalled when R7 suffered a femur break. V19 stated V21 CNA. (Certified Nursing Assistant) asked her to assist in transferring R7 back to bed. V19 stated a few hours later R7 complained of left hip pain. V19 stated they used a gait belt to transfer R7 back to bed. V19 stated she did not know R7 was supposed to use the sit to stand for transfers until after the occurrence. R7's physical therapy discharge summary dated 7/26/23 documents for safe transfer techniques using sit to stand up lift transfers and safety precautions in order to preserve current level of function. On 04/11/24 at 2:59 PM, V2 ADON (Assistant Director of Nursing) stated R7 was transferred using a stand and pivot to the bed. V2 stated, If staff are supposed to use the sit to stand to transfer it is a problem not using the correct transfer mode. If the pivot is too intense it could contribute to the break. Staff should be following the proper transfer to assure residents are not injured. The mode of transfer is in the EMR (Electronic Medical Record) for staff to reference. Staff should reference the transfer mode before transferring the resident. On 04/12/24 at 9:34 AM, V20 stated she ordered an Xray for R7 when a nurse called and stated R7 had complaints of pain. The Xray results showed R7 had a left femur fracture and was sent out to the hospital. R7's fracture resulted in her having a surgery to repair the fracture. V20 stated R7 has decreased bone density making her bones more fragile and prone to break. V20 stated it is important to handle residents with decreased bone density carefully because they are at risk for fractures. Transferring someone with decreased bone density incorrectly could contribute to a fracture. V21 CNA was not able to be reached for interview during this survey. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	The facility initial investigation report prepared by V19 dated 2/4/24 at 10:00 PM documents R7 was assisted back to by V19 and V21 using a turn and pivot at which point R7's leg twisted. R7 complained of pain immediately complained of left hip pain when she was assisted to lay down. Witness interviews from the facility investigation showed V21 CNA stated she and V19 LPN transferred R7 back to bed using a stand and pivot. During the transfer R7's leg twisted. R7 complained of pain when V21 lifted her leg to assisted her to lay down. On 2/9/24 the facility investigation documents R7 denied having had any falls. R7 stated the fracture occurred during transfer by staff. R7 stated she had pain when her left leg twisted during the transfer. R7's physical therapy evaluation and plan of treatment for aftercare following joint replacement surgery dated 2/9/24 new recommendation for transfers is now the use of a mechanical patient lift. The facility policy and procedure, Sit to Stand Lift, dated 10/10/11 states the purpose is to assure that all residents that are assessed to require extensive high assistance in transfer are transferred safely with no injury to resident or care handler.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48944 Based on observation, interview, and record review, the facility failed to provide catheter cares for residents with indwelling urinary catheters, and failed to ensure a catheter collection bag was placed below the level of the bladder. This applies to 4 of 4 (R33, R39, R68, and R122) reviewed for catheters in a sample of 32. The findings included: 1. The EMR (Electronic Medical Record) showed R122 had multiple diagnoses including sepsis, urinary tract infection, and pressure ulcer of sacral region stage 4. The MDS (Minimum Data Set) dated 2/27/2024 showed R122 was incontinent of bowel and had a urinary indwelling catheter. The MDS showed R122 was dependent on facility staff with toileting hygiene and bed mobility. On 4/10/2024 at 1:38 PM, V15 (Certified Nurse Assistant/CNA) was rendering incontinence care to R122. R122's catheter anchoring device was detached and located in her right inner groin area and had a soiled incontinence brief with fecal material. V15 wiped R122's groin and perineal areas from front to back, then turned R122 on her right side and wiped R122's buttock area. V15 then applied a clean incontinence brief and said she was done providing incontinence care to R122. V15 did not provide catheter care and secure R22's catheter anchoring device. 2. The EMR showed R39 had multiple diagnoses including clostridium difficile infection, urinary retention, and pressure ulcers. The MDS dated [DATE] was incontinent of bowel and had a urinary indwelling catheter. The MDS continued to show R39 was dependent on toileting hygiene and required substantial to maximal staff assistance with bed mobility. On 4/11/2024 at 8:40 AM, V16 (CNA) was rendering incontinence care to R39. R39 had a soiled incontinence brief with fecal material. V16 wiped R39's groin and scrotal areas. V16 wiped R39's urinary catheter but failed to remove dry brown residue from the catheter and R39's outer meatus area. V16 then turned R39 on his right side and wiped R39's buttock area. V16 then applied a clean incontinence brief and said she was done providing incontinence care to R39. 3. The EMR showed R33 had multiple diagnoses including obstructive and reflux uropathy, benign prostatic hyperplasia, urinary retention, and a history of urinary tract infection. The MDS dated [DATE] was incontinent of bowel and had a urinary indwelling catheter. The MDS continued to show R33 required substantial to maximal staff assistance with toileting hygiene and was dependent on bed mobility. On 4/11/2024 at 8:50 AM, V16 (CNA) was rendering incontinence care to R33. V16 wiped R33's groin area, then turned R33 on his left side and wiped his buttock area. V16 applied a new clean incontinence brief. V16 did not provide catheter care to R33. On 4/11/2024 at 11:02 AM, V2 (Assistant Director of Nursing/ADON) said staff providing incontinence care to those with catheters needed to clean the catheter from the tip to the base. V2 said staff had to ensure that any buildup residue on the catheter be removed to prevent infections. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Indwelling Urinary Catheterization policies with a review date of 5/6/2023 showed Purpose: The facility will strive to prevent nosocomial infections and other complications of indwelling catheters .Note: Always place the collection bag below the bladder level so urine does not back flow into the bladder draping tubing as to flow with gravity-place anchor to prevent pulling . 31327 4. On 4/9/24 at 10:19 AM, during initial tour, R68 was lying in bed. R68's urine catheter bag was on top of his mattress. There was urine backflowing in the tubing to his penis. R68 stated that sometimes the CNAs (Certified Nursing Assistants) forget to put it under the rail of his bed. On 4/10/24 at 11:02 AM, during R68's pressure ulcer dressing change, his catheter bag was on top of the mattress until 11:15 AM. On 4/10/24 at 11:12 AM, V18 (LPN-Licensed Practical Nurse) stated, (R68's) catheter bag should be below the bladder and it should be hanging below the bed rail because the urine will reflux back and cause an infection if it's not in the right position. On 4/10/24 at 1:19 PM, V2 (ADON-Assistant Director of Nursing) stated, The catheter bag should be below the bladder. The urine can backflow and cause a bladder infection or urinary tract infection. That's why it should be below the bladder. R68's face sheet shows diagnoses of: urinary tract infection, site not specified, infection and inflammatory reaction due to indwelling urethral catheter, subsequent encounter, benign prostatic hyperplasia without lower urinary tract symptoms and neuromuscular dysfunction of bladder, unspecified. R68's POS (Physician Order Sheet) shows an order of changing indwelling catheter bag monthly and as needed every night shift every 30 day(s) for infection control. R68's MDS (Minimum Data Set) dated 1/14/24 shows a BIMS (Brief Interview for Mental Status) score of 15, which means he is cognitively intact. R68's care plan shows a focus of risk for complications related to catheter use and change indwelling catheter (16) French with (10) cc balloon as needed for obstruction. Leakage or malfunction related to neuromuscular dysfunction of bladder unspecified and history of UTI's (Urinary Tract Infections). Intervention: Monitor position of drainage bag and keep below waist to ensure proper drainage. Facility's policy titled Policy and Procedure: Indwelling Urinary Catheterization for Male Resident (5/6/23) shows: Note: Always place the collection bag below the bladder level so urine does not flow into the bladder draping tubing as to flow with gravity-place anchor to prevent pulling.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on observation, interview, and record review, the facility failed to properly label, date, seal, and store food items in the kitchen. This applies to all residents that receive oral nutrition and foods prepared in the facility kitchen. Findings include: The facility's Long-Term Care Facility Application for Medicare and Medicaid (Form CMS-Centers for Medicare and Medicaid Services-671) dated [DATE] documents that the total census was 118 residents. On [DATE] at 11:14 AM, V5 (Dietary Manager) said there are 3 residents that do not eat food from the facility kitchen. On [DATE] starting at 9:37 AM, the facility kitchen was toured in the presence of V4 (Dietary Manager), and the following was found: In the walk-in cooler: 1. Unlabeled and undated medium-sized silver bin of what V4 said was ground ham. 2. Undated and unsealed and opened processed oven-roasted turkey breast. 3. Unlabeled and undated sliced cheese. In the dry storage: 4. Opened, not sealed 32-ounce bag of sundried raisins with expiration date [DATE]. V4 said, I have to throw these out because the bag wasn't closed and we're inviting the critters. 5. Four additional 32-ounce bags of sundried raisins with expiration date of [DATE]. 6. A 32-gallon bin of flour, not dated, with lid and rim of bin noted with black/gray sticky substance on it. 7. A 32-gallon bin of oatmeal, not dated, and lid of bin noted with black/gray sticky substance on it. 8. Scooper for the flour and oatmeal bins was lying face down on the wire shelving rack, not contained or covered. 9. An opened and unsealed bag of potato chips. V4 removed the bag from the dry storage and put it in her office and said, I put the bag in my office because that was staff food, not resident food. 10. An opened 8.8 ounce of British Tea with expiration date of ,d+[DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 12:41 PM, V5 (Dietary Manager) said all food items in the kitchen should be labeled and dated so that kitchen staff know how long the item is good for and they know when to discard it. V5 said all expired items should be discarded so they are not accidentally given to the residents with the potential to make the residents sick. V5 said the scooper should be stored contained/covered in a bag or in the bin in a scooper holder, not touching the food item in the bin. V5 said the scooper should not be stored on the wire shelving rack because that is contaminating the scooper. V5 said the bins that the flour and oatmeal are stored in need to be cleaned to remove the gray/black sticky residue. V5 said the residue poses a contamination risk. V5 said the kitchen should only have resident food because the residents are a vulnerable population, and it is easier for them to get sick, and their food has strict food storage guidelines. V5 said all foods should be sealed to prevent contamination by dust or insects and to preserve the quality of the food. The facility's policy titled, Storage of Dry Foods/Supplies (revised [DATE]) states, Policy: Dry foods and supplies will be properly stored to keep foods safe and preserve flavor, nutritive value, and appearance. Procedure: .routine cleaning .procedures are followed Dry goods will be handled and stored to maintain the integrity of the packaging until the item is ready to use .Dry bulk foods are stored in plastic containers with tight containers with tight covers or bins which are easily sanitized. Containers are clearly labeled, and scoops are stored separately in a covered, protected area .Employees are not permitted to eat/drink in the dry food storage area . The facility's policy titled, Date Marking and Labeling (revised [DATE]) states, Policy: All foods that are stored will be properly dated and labeled to ensure food safety. Procedure: 1. Date marking is an identification system that helps identify the name of the food, when the food was prepared, and when it is to be discarded. 2 When to date mark: .b. the food requires refrigeration .e. when potentially hazardous (PHF/TCS) foods are stored f. when leftovers are stored .3. When to discard .b. The item has expired according to the manufacturer's expiration date .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. 39182 Based on observation, interview, and record review, the facility failed to ensure linens were handled in a manner to prevent transmission of micro-organisms and failed to cleanse and sanitize hands to prevent cross-contamination. This applies to 3 of 3 residents (R114, R97 and R122) reviewed for infection control in the sample of 32. Findings include: 1) On 4/9/24 at 11:20 AM, R114 was in wheelchair and V11(CNA-Certified Nursing Assistant) made his bed. In the process, V11 threw a soiled sheet on the floor. 2) On 4/10/24 at 12:45 PM, V11 gave perineal care to R97. When V11 had finished wiping the anal area of R97, V11 did not do hand hygiene or change gloves. With same gloves, V11 touched other surfaces when she put R97's clean brief on, repositioned R97, and changed the bed linen. When V11 was making the bed for R97, V11 threw a soiled sheet on the floor. On 4/10/24 at 12:55 PM, V11 stated she should have changed her gloves and done hand hygiene after providing perineal care to R97 to prevent potential cross-contamination. V11 stated throwing the linen on the floor is her usual practice. V11 stated after her work is done, she would pick up the linen off the floor and put the soiled linen into a plastic bag and dispose it in the hamper kept in the linen room. Guidelines for incontinence care dated 9/21/23 showed, ' .15. Remove linen or under pad and discard properly. 16. Remove and discard gloves. 17. Perform hand hygiene'. 48944 3. On 4/10/2024 at 1:38 PM, V15 (Certified Nurse Assistant/CNA) performed incontinence care to R122. V15 removed a soiled incontinence cloth pad with a visible brown stain from underneath R122. V15 placed the soiled cloth pad directly on the floor and continued to render incontinence care. V15 finished providing incontinence care and then walked down the hallway to transport the unbagged soiled incontinence cloth pad for disposal in the soiled utility room. On 4/11/2024 at 11:02 AM, V14 (Regional Nurse Consultant/RNC) said soiled linens should never be placed directly on surfaces like the floor because they are contaminated. V14 continued to say soiled linens should be bagged and disposed of accordingly for infection control. V2 (Assistant Director of Nursing/ADON) said staff providing incontinence care should remove their soiled gloves and wash their hands before continuing with incontinence care. The facility's Guidelines for Linen Handling/Storage/Transport policy with a review date of 8/17/2023 showed Procedure: 3) Soiled linen should be immediately placed into bags or collection containers able to contain wet and/or soiled linen in such a way as to prevent contamination of the environment during collection, transportation and storage prior to processing (being laundered).