STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145765	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Rehab Center	5888 North Ridge Chicago, IL 60660

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 50728 Based on observation, interview, and record review, the facility failed to ensure a resident's urinary drainage bag was kept privately. Thais failure affects 1 resident (R59) in a sample of 58. Findings include: R59's admission record, documents the following diagnosis: paraplegia, flaccid neuropathic bladder, neuromuscular dysfunction of bladder, and obstructive and reflux uropathy. R59's Minimum Data Set (dated 6/20/2024) documents a Brief Interview of Mental Status summary score of 15, indicating R59 is cognitively intact, and R59 utilizes an indwelling urinary catheter. On 8/18/2024 at 10:32 AM, observed an exposed urinary drainage bag attached to the frame of R59's bed. R59 affirmed R59 wanted facility staff to keep R59's urinary drainage bag in a privacy bag. On 8/18/2024 at 10:40 AM, V11 (Certified Nursing Assistant) checked R59's bedframe and confirmed there was no privacy bag to put the urinary drainage bag in. V11 stated, sSmeone must have taken it off and not put it back on. V11 affirmed R59's urinary drainage bag should have been put into a privacy bag. On 8/20/2024 at 11:01 AM, V2 (Director of Nursing) affirmed residents with urinary drainage bags should be kept in a privacy bag to promote the resident's dignity. Record review of facility policy titled Dignity (dated 1/2015) documents, Policy: Each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality . 11. Urinary catheter bags shall be covered.

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. 43351 Based on observation, interview, and record review, the facility failed to assess a resident the ability to safely self-administer medication. This failure affects 1 (R83) resident reviewed for self-administration of medications in the total sample of 58 residents. Findings include: R83's (08/08/2023) Minimum Data Set documented, in part Section C0500. BIMS (Brief Interview for mental status) Summary Score: 15. Indicating R83's mental status as cognitively intact. R83's (Active Order As Of: 08/19/2024) Order Summary Report documented, Diagnoses: (include but not limited to) Chronic Obstructive Pulmonary Disease with exacerbation. Pharmacy. Order Summary. Advair HFA Inhalation Aerosol 115-21 MCG/ACT (Fluticasone-Salmeterol) 2 puff inhale orally two times a day for COPD (chronic obstructive pulmonary disease)/Asthma. Order Status. Active. Order Date. 06/14/2024. Start Date. 06/15/2024. There was no order to may self-administer this medication. R83's (Revision on: 08/19/2024) care plan documented, (R83) is at respiratory risk r/t (related to) asthma. Respiratory risks will be minimized with nursing and medical interventions. R83 was not care planned for self-administration of medication. On 08/18/2024 at 11:20 AM, R83 showed this surveyor the content of her (R83) drawer. Inside the drawer was R83's Fluticasone/Salmeterol inhaler. R83 stated, The first floor nurse gave it to me in case I need it. On 08/19/2024 at 9:45 AM, V3 (Assistant Director of Nursing) took the inhaler out of R83's drawer and stated, She is not supposed to have this (inhaler) in her room. She is not on self-administration of medication. She needs to be assessed for self-administration of medication and we (facility staff) need a doctor's order that she may self-administer this medication. On 08/19/2024 at 11:56 AM, V10 (Licensed Practice Nurse) checked for R83's Fluticasone/Salmeterol inhaler in the medication cart and stated, I don't have her (R83) inhaler in the cart. I remember she keeps some of her meds in her room. I usually ask her if she got the med, and she would say 'I got it'. We (facility) need to assess her if she can administer the medication, get order from the doctor to may keep the medication at bedside, and it has to be care planned that she may keep medication at bedside. On 08/19/2024 at 12:03 PM, V10 checked R83's electronic health record and stated, I don't think there is an order that she can keep the medication at bedside. On 08/19/2024 at 12:05 PM, V10 stated, There is careplan that she can keep the medication at bedside. It is initiated today (08/19/2024). (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/20/2024 at 11:55 AM, V2 (Director of Nursing) stated, There should be an assessment to self-administer the medication, there should be a doctor's order, and absolutely care plan the self-administration of medication. The importance of assessing the resident about self-administration is to know if the resident is alert and oriented enough to understand why they are taking the medication and how to administer the medication. The doctor's order to self-administer the medication should be specific to a medication to be self-administered. The importance of care planning the self-administration of medication so staff will know what is going on, what is the plan of care for the resident. The (undated) Residents' Rights for People in Long-Term Care Facilities documented, As a long-term care resident, you are guaranteed certain rights, protections and privileges according to state and federal laws. Your rights to participate in your own care. You have the right to be in charge of taking your own medicine if your care plan team and your doctor say that you are able to do so. The (undated) Medication Administration Policy documented, Policy: II. Administration of Medications. Residents may self-administer medication if the interdisciplinary team has determined that this practice is safe. The (undated) Self-Administration of Medication Procedure documented, Purpose: Residents have the right to self-administer their medications if they have the cognitive, physical and visual ability and the interdisciplinary team has determined the practice is safe for the resident. Procedure: 1. Residents who request to self-administer drugs will be assessed at the time of admission or thereafter, to determine if the practice is safe. 2. The assessment results will be discussed with the attending physician and an order obtained to self-administer, if appropriate. 8. Drugs in the room should be written on the medication record as may keep at bedside and the expiration date. 12. A care plan indicates the resident's self-administering of medications.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 43351 Based on observation, interview, and record review, the facility failed to ensure a light fixture has no missing fluorescent tube light and cover; failed to ensure the encasement of the air conditioning unit was appropriately sealed; and failed to ensure the dresser has no missing drawer/s in an effort to provide a homelike environment for 2 (R83 and R99) residents reviewed for homelike environment in the total sample of 58 residents. Findings include: 1. R83's (Active Order As Of: 08/19/2024) Order Summary Report documented Diagnoses of Chronic Obstructive Pulmonary Disease with exacerbation, chest pain and cerebral infarction. R83's (08/08/2023) Minimum Data Set documented, Section C0500. BIMS (Brief Interview for mental status) Summary Score: 15., indicating R83's mental status as cognitively intact. On 08/18/2024 at 11:19 AM, R83's light fixture was missing a fluorescent tube light and cover, and the air conditioning (AC) unit was mounted on a bigger encasement. There was a folded pillow on the right side of the AC unit. R83 stated, I informed (V3-Assistant Director of Nursing) about the missing light and cover about two weeks ago and they (facility) have not replaced them yet. The pillow on the AC has been there since I was moved to this room. They use the pillow to seal the hole on the AC unit. On 08/18/2024 at 11:28 AM, V3 (Assistant Director of Nursing) stated, We fill out the Maintenance Log if there are something that need to be fixed. If she said that she reported it to me a couple of weeks ago, she might have reported it to me, and forgot about it. The light fixture is missing a (tube) light, and has no cover. On 08/18/2024 at 12:00 PM, V14 (Maintenance Manager) stated, One of the CNAs informed me last Friday (08/16/24) that the cover on the light fixture was missing. I will buy and get it right away. On 08/18/2024 at 12:02 PM, this surveyor pointed out to V14 the folded pillow on R83's AC unit. V14 stated, I will buy something to seal the gap. I will buy them right away. V14 refused to answer whether or not hte facility was providing a home-like environment. On 08/20/2024 at 11:42 AM, V1 (Administrator) stated, The expectation is for the staff, who was made aware of the issue, to write down the issue in the Maintenance log. With a pillow on the AC and with missing light and cover on the light fixture, we are not providing a home-like environment to the resident. It is a residents' right that provide a home-like environment to them. The (01/2024 - 08/2024) Maintenance Log did not indicate problems with R83's light fixtures and air conditioning unit. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The (undated) Maintenance Director Job Description documented, Job Summary: The maintenance director is responsible for the day-to-day activities of the maintenance department in accordance with current federal, state, and local standards, guidelines and regulations governing our facility and maintained in a clean, safe, and comfortable manner. Essential duties and responsibilities: 2. Maintains the building in good repair and free of hazards such as those caused by electrical, plumbing, heating and cooling systems, life safety, etc. The (undated) Residents' Rights for People in Long-Term Care Facilities documented, As a long-term care resident, you are guaranteed certain rights, protections and privileges according to state and federal laws. Your rights to safety. Your facility must be safe, clean comfortable and homelike. 41611 2. R82 has a diagnoses of but not limited to Polyneuropathies, Acquired Absence of Left Leg Above Knee, Hypertension, Anxiety Disorder, Neuromuscular Dysfunction of Bladder, and Muscle Weakness. R82 has a Brief Interview of Mental Status score of 15. On 8/18/2024 at 11:59am surveyor observed R82's clothing dresser drawer (2nd from the top) missing. On 8/18/2024 at 12:02 PM, R82 stated it (the dresser drawer) broke a couple of days ago, and that he would like a complete functioning dresser, even though he may be moving out of the room in a couple of days. On 8/19/2024 at 12:41 PM, V14 (Maintenance Manager) said, No, it is not a home-like environment with a clothing dresser missing a drawer, and I will take it downstairs to the basement to fix. On 8/20/2024 at 10:36 AM, V16 (Licensed Practical Nurse-LPN) stated nothing had been reported to her about R82's dresser. On 8/20/2024 at 10:40 AM, surveyor reviewed Maintenance log for the first floor, and there was nothing reported R82's broken dresser drawer. On 8/20/2024 at 12:41 PM, V2 (Director of Nursing-DON) stated if there is damaged property in a residents room, it would not make it a home-like environment. Job description titled Maintenance Director documents, the maintenance director is responsible for the day-to-day activities of the Maintenance Department in accordance with current federal, state and local standards, guidelines and regulations governing our facility and maintained in a clean, safe and comfortable manner and maintains the building in good repair and free of hazards such as those caused by electrical. Resident Rights' for People in Long-Term facilities documents, Your rights to safety: your facility must be safe, clean, comfortable and homelike.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 50728 Based on interview and record review, the facility failed to complete the MDS (Minimum Data Set) accurately. This failure affects 1 resident (R60) in the sample of 58. Findings include: Record review of R60's admission record documents the following diagnosis: schizophrenia, unspecified psychosis, and bipolar disorder. R60's MDS (Minimum Data Set), dated 7/3/2024, documents in section A1500 the resident is not currently considered by the state level II PASSR (Preadmission Screening and Resident Review) to have a serious mental illness and/or intellectual disability or a related condition. Record review of facility provided Notice of PASRR Level II Outcome for R60 (dated 9/02/2022) documents in part, .PASRR Determination Explanation You have a Level II PASRR Condition of Schizophrenia . On 8/19/2024 at 12:21 PM, V24 (MDS Nurse/Restorative Nurse, Licensed Practical Nurse) affirmed V24 completes MDS assessments for the residents. V24 stated A1500 should be coded as yes whenever a resident has a serious mental illness identified by the PASRR. On 8/20/2024 at 11:01 AM, V2 (Director of Nursing) stated MDS assessments are used to guide the plan of care for a resident and should be completed accurately. V2 affirmed if MDS are not completed correctly, the facility may not identify all the care the resident may need. Record review of CMS's RAI (Resident Assessment Instrument) Version 3.0 Manual (October 2023) Page A-32 titled, A1500: Preadmission Screening and Resident Review (PASRR) (cont.) documents in part the following, .Coding Instructions .Code 1, yes: if PASRR Level II screening determined that the resident has a serious mental illness and/or ID/DD related condition, and continue to A1510, Level II Preadmission Screening and Resident Review (PASRR) Conditions .

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 50728 Based on interview and record review, the facility failed to conduct care plan conferences timely and involve the resident in the development of their plan of care. This failure affects 4 residents (R2, R27, R25, R59) in a sample of 58. Findings include: 1. R2's admission record documents in part the following diagnosis: schizoaffective disorder, bipolar type, acute combined systolic and diastolic heart failure, chronic obstructive pulmonary disease, and depression. R2's Minimum Data Set (dated 5/23/24) documents a Brief Interview for Mental Status (BIMS) summary score of 15, indicating R2 is cognitively intact. On 8/18/2024 at 10:58 AM, R2 stated R2 has not been invited to develop R2's plan of care or attend any care plan meeting regarding R2's care. R2 affirmed R2 would want to attend if there was any meeting about R2's care, and wants to be involved with R2's care. On 8/19/2024 at 12:21 PM, V24 (MDS Nurse/Restorative Nurse, Licensed Practical Nurse) could not recall having a care plan meeting for R2. On 8/19/24 at 1:36 PM, record review of R2's progress notes and care plan sign in sheet provided by V24 indicates R2's last care conference was held on 6/20/2023. 2. R27's admission record documents the following diagnosis: COVID-19, schizophrenia, major depressive disorder, anemia, and type 2 diabetes mellitus. R27's Minimum Data Set (dated 7/11/2024) documents a BIMS summary score of 12, indicating moderate cognitive impairment. On 8/18/2024 at 10:49 AM, R27 stated R27 has never meet with staff to discuss R27's plan of care and R27 has been here a long time. R27 affirmed if staff were developing R27's plan of care, R27 would want to be included and invited. On 8/19/2024 at 12:21 PM, V24 (MDS Nurse/Restorative Nurse, Licensed Practical Nurse) could not recall having a care plan meeting for R27. On 8/19/24 at 1:36 PM, record review of R27's progress notes provided by V24 indicates R27's last care conference was held on 3/22/2017. No care plan sign in sheet was presented. 3. Record review of R59's admission record, documents the following diagnosis: paraplegia, flaccid neuropathic bladder, stage 4 pressure ulcer of sacral region, stage 4 pressure ulcer of the left lower back, stage 4 pressure ulcer of right lower back, major depressive disorder, neuromuscular dysfunction of bladder, and obstructive and reflux uropathy. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of R59's Minimum Data Set (dated 6/20/2024) documents a BIMS summary score of 15, indicating R59 is cognitively intact. On 8/18/2024 at 10:32 AM, R59 explained R59 has been a resident of the facility for many years and the facility used to conduct care plan meetings to discuss R59's plan of care. R59 stated it has been a very long time, definitely over a year since R59's plan of care was discussed with R59. R59 affirmed R59 would like to be invited and attend any discussions regarding R59's plan of care. On 8/19/2024 at 12:21 PM, V24 (MDS Nurse/Restorative Nurse, Licensed Practical Nurse) affirmed V24 helps to arrange care plan meetings with the Social Services Department. V24 stated all records of care plan meetings are documented within the resident's progress notes and care plan meetings occur at least every 90 days and as needed. V24 could not recall having a care plan meeting for R59. V24 affirmed it is the resident's right to participate in their plan of care and to be invited/attend care plan meetings. On 8/19/24 at 1:36 PM, record review of R59's progress notes and care plan sign in sheet provided by V24 indicates R59's last care conference was held on 3/31/2023. 4. Record review of R27's admission record, documents in part the following diagnoses: schizophrenia, hypothyroidism, hyperlipidemia, and osteoarthritis of the left knee. Record review of R27's Minimum Data Set (dated 5/27/2024) documents a BIMS summary score of 15, indicating R27 is cognitively intact. On 8/20/2024 at 9:38 AM, R27 affirmed R27 had not been to a care plan meeting or invited to participate in developing R27's plan of care. R27 affirmed R27 would like to be included in plan of care meetings and developing R27's care plan. On 8/20/2024 at 11:01 AM, V2 (Director of Nursing) affirmed residents are supposed to have a care plan meeting to discuss their plan of care quarterly (every 90 days) and as needed. V2 stated it is the responsibility of V24 to invite residents and their family/responsible parties to the care plan meetings. V2 affirmed care plan meetings are important so residents are able to participate in developing their plan of care, seeing if the resident is meeting goals, or if changes need to be made to the resident's care plan based on their preferences. On 8/20/24 at 2:45 PM, record review of R27's progress notes provided by V2 indicates R27's last care conference was held on 3/22/2018. No care plan sign in sheet was produced. Record review of the facility provided job description (dated 2/2016) for Minimum Data Set/Care Plan Coordinator documents, .12. Notifies Resident and/or Family of care plan conferences at least seven (7) days in advance and maintains record of the notices. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of facility policy titled Care Plan Participation (dated 4/2014) documentsn part, Policy: The resident and/or family will be invited to participate in the care plan conference at least annually. Purpose: 1. The Resident Care Coordinator will notify the resident and/or legal representative at least seven (7) days in advance that the quarterly care conference is to be held. 2. The notification will either be by phone or letter. 3. The Resident Care Coordinator will maintain a record of notices that include conference: date, time, location, name of family member contacted, input from family member and resident when they are not able to attend, refusal to participate, date and signature of individual making contact.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 45196 Based on observation, interview, and record review, the facility failed to ensure medications were signed out when administered for two residents (R71 and R91). This failure affected two residents in the sample of 58. Findings include: 1. R71 has diagnoses which includes: fracture of other specified skull and facial bones, right side, sequela, depression, asthma, personal history of traumatic brain injury, muscle weakness, chronic pain, essential hypertension, gastro-esophageal reflux disease without esophagitis, neuralgia and neuritis, prediabetes, acquired absence of eye, and anxiety disorders. R71's Brief Interview for Mental Status (BIMS), dated 06/6/24, shows R71's has a BIMS of 12, which indicates R71 has some cognitive impairments. On 08/18/24 at 10:45 AM, R71 stated, I did not receive my medications today. Surveyor asked V15, Registered Nurse/RN regarding R71's medication, and V15 stated, I gave (R71) all of her morning medications except for (R71's) clonazepam. Upon review of R71's eMar (Electronic Medication Administration Record), the following morning medications were not signed as administered to R71: Colace Oral Capsule 100 MG (milligram) (Docusate Sodium) Give 1 capsule by mouth one time a day for Constipation. Lidocaine External Patch 4 % (Lidocaine) Apply to lower back topically one time a day for pain. Mirabegron ER (extended release) Oral Tablet Extended Release 24 Hour 50MG (Mirabegron) Give 50 mg by mouth in the morning for urinary antispasmodic. Multivitamin Oral Tablet (Multiple Vitamin) Give 1 tablet by mouth one time a day for supplement. Sertraline HCl (Hydrochloride) Oral Tablet 100 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for antidepressant take with 50mg for total of 150mg. Sertraline HCl Oral Tablet 50 MG (Sertraline HCl) Give 1 tablet by mouth one time a day for depression take with 100 making a total of 150mg. Clonazepam Oral Tablet 0.5 MG (Clonazepam) Give 1 tablet by mouth two times a day for antianxiety. Gabapentin Oral Tablet 600 MG (Gabapentin) Give 600 mg by mouth two times a day for antianxiety. Pregabalin Oral Capsule 50 mg (Pregabalin) Give 1 capsule by mouth two times a day for antoanxiety (antianxiety). Prostat two times a day for Wound therapy Give prostat 30ml (milliliter)po bid. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Vitamin C Oral Tablet 500 MG(Ascorbic Acid) Give 1 tablet by mouth two times a day for Supplement. On 08/18/24 at 10:46 AM, V15 stated, I forgot to sign them (referring to R71's morning medications) out. When V15 was asked regarding when medications should be signed out, V15 stated, Meds (Medications) should be signed out when you (referring to the nurse) give them. When V15 was asked regarding the importance of signing medications out when administered V15 stated, So I won't make a med error. 2. R91 has diagnoses which includes: chronic obstructive pulmonary disease, and schizophrenia. R91's Brief Interview for Mental Status (BIMS), dated 07/30/24, shows R91's does not have a BIMS score, and indicates R91's memory is ok. On 08/19/24 at 8:54 AM, Surveyor requested to observe R91's Breo Ellipta inhalation Aerosol Powder Breath Activated 100-25 mcg (microgram), and V16, Licensed Practical Nurse/LPN, stated, Oh, I already gave it to at 7:45 am this morning when I got here. V16 then stated, Oh I did not sign it out (referring to R91's Breo Ellipta inhalation Aerosol Powder Breath Activated 100-25 mcg medication). When V16 was asked regarding the importance of signing medications when medications are administered V16 stated, So they (referring to nurses) know when they (referring to medications) are given. It can be a double dose. On 08/20/24 at 2:21 PM, V2 (Director of Nursing/DON, Registered Nurse/RN) stated medications are administered according to the physicians order and signed out after as soon as the medication is administered. When V2 was asked regarding the importance of the nurse signing out a medication once the nurse administers the medication, V2 stated, To prove the resident took the medication and that the medication was administered. When V2 asked regarding if a medication is not signed out what could happen to the resident, V2 stated, It could be assumed that they (the resident) didn't receive it (the medication) and a double dose could occur. The facility's undated policy titled Medication Administration Policy documents: Policy: I. Level of Responsibility: Only a licensed nurse (RN, LPN (Licensed Practical Nurse) may : a.) prepare, b) administer, and/or record the administration of medications (prescriptions ointments are considered medications) . Medications should always be prepared, administered, and recorded by the same licensed nurse. Documentation of medications administration is recorded on the Medications Administration Record (MAR) or Treatment Record and includes the date, time, and initials of the licensed nurse who administered the medications. The facility's job description titled (RN, LPN, Charge Nurse) documents, Job summary: The primary purpose of your job position is to provide direct nursing care to the residents and to supervise the day-to-day nursing activities performed by the nursing assistants. Essential Duties and Responsibilities: 16. Prepare and administer medications and treatments as ordered by physicians.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 41611 Based on observation, interview, and record review, the facility failed to ensure the resident's environment remained free of hazards for 1 resident (R82). This failure has the potential to affect all residents residing on the first floor. Findings include: On 8/18/2024 at 12:10PM, an uncovered cable box receptacle was observed with wires and cable cord connectors exposed. On 8/18/2024, R82 stated the box has been uncovered since he has been in that room, and he has been there for 8 months. On 8/19/2024 at 12:41 PM, V14 (Maintenance Director) stated, The cable box is supposed to be covered. On 8/20/2024 at 10:36 AM V16 ((Licensed Practical Nurse-LPN) said, No, I was not aware of a cable box receptacle was uncovered and a resident can get electrocuted if it does not have a cover. V16 stated damaged furniture or missing cable box receptacles or outlet cover should be reported to Maintenance and included on the Maintenance Log, and nothing is reported for that room. On 8/20/2024 at 10:40 AM, the Maintenance Log for the first floor was reviewed, and there was nothing reported for the cable box (receptacle). On 8/21/2024 at 11:03 AM, via email, V1 (Administrator) stated, As part of our preventative maintenance program receptacle testing pertains electrical inspections - checking all receptacles and switches for cracks, condition of cover plates, and any signs of shorts and this includes cable boxes as well. Receptacle Testing for May 2024 documents, receptacle #4 in (room number) was replaced on 5/15/2024. Policy, with a revision date of 2/24, titled Supervision and Safety documents, our policy strives to make the environment as free from hazards as possible. Resident safety and supervision are facility-wide priorities. Job description titled Maintenance Director documents, The maintenance director is responsible for the day-to-day activities of the Maintenance Department in accordance with current federal, state and local standards, guidelines and regulations governing our facility and maintained in a clean, safe and comfortable manner and maintains the building in good repair and free of hazards such as those caused by electrical. Resident Rights' for People in Long-Term facilities documents, Your rights to safety: your facility must be safe, clean, comfortable and homelike.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 50662 Based on observation, interview, and record review, the facility failed to date the humidifier bottle for one resident (R36), in a sample reviewed for respiratory care. Findings include: R36 has diagnoses which include Seizures, Constipation, Essential Hypertension, Morbid Obesity, Lymphedema, Congestive Heart Failure, and Schizoaffective Disorder. R36 has a physician order, dated 11/02/23, which documents, O2 (oxygen) by nasal canula (n/c) for comfort and on excertion every 1 hours as needed. R36's care plan, dated 05/13/24, documents, (R36) has chest pain .Give oxygen as ordered by the physician. R36's Minimum Data Set (MDS) has a Brief Interview for Mental Status (BIMS) score of 15, which indicates R36 's cognition is intact. On 08/18/24 at 10:45 AM, R36 was lying in bed, well-groomed, receiving oxygen by nasal cannula. R36's oxygen cannula connected to humidifier bottle. R36's humidifier bottle observed with no date. On 08/18/24 at 10:53 AM, V15, Registered Nurse (RN), stated, There is no date on (R36's) humidifier bottle, but there should be a date on the humidifier bottle. There should be a date on the humidifier bottle to know when it was changed. The humidifier bottle should be changed every 24hrs; I'm just guessing. Facility's policy titled Night Nurse's Responsibilities, dated 9/1,5 documents, Weekly on Sunday .Change and Date: Humidifier Bottle. Facility's policy titled Oxygen Therapy, dated 9/19, documents, Objective: To administer oxygen in conditions in which insufficient oxygen is carried by the blood to the tissues .Equipment: Humidifier bottles .Procedure: 3. Humidifier Bottles: Prefilled bottles will be changed and dated when empty. Other bottles will be changed and dated weekly and prn.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 50662 Based on observation, interview, and record review, the facility failed to discard expired medication from the medication cart, and failed to ensure medication cart was free of loose pills. These failures have the potential to affect all 41 residents assigned to the 3rd floor medication cart. Findings include: On 08/19/24 at 11:16 AM, the 3rd floor medication cart had twenty-three loose pills in the medication drawers, Bisacodyl 5mg tablet bottle with expiration date unreadable and Ferrous Sulfate 325mg bottle with date unreadable. (V10) Licensed Practical Nurse (LPN) stated, The expiration dates on the pill bottles are faded. I cannot see them. It is important to know the expiration date because after the expiration date the medication is less effective. We (nurses) cannot pick pills from the bottom of the drawer; it is a medication error if we do. The pills are not clean. We won't be able to tell what each medication is if the medication is not in its original package. On 08/20/24 at 3:02 PM, V2, Director of Nursing (DON), stated, Expired medications should be removed from the medication carts. Medications become less potent after the expiration date which changes the dosage of the medication. Loose pills found in the medication cart should be discarded. The medications should be reordered to assure that the resident has enough pills for the month. If a medication is not in its original package, then the nurse may not be able to tell what the medication is or the strength of the medication. I could not find a medication storage policy, but I will continue to look for it. Facility's policy title Labeling/Dating Meds, dated 8/18, documents, Purpose: To ensure that medications are being used timely in accordance to manufacturer's recommendations .The following medications must be dated when first opened: .Multidose pills, Capsules, Creams, Ointments .Expiration date is manufacturer's date on bottle.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50662 Based on observation, interview, and record review, the facility failed to provide one resident (R100) the correct consistency diet. This failure affected one resident in a total sample size of 58 reviewed for diets. Findings include: R100 has medical diagnoses which include Acute ischemic heart disease, Dysphagia, Spinal stenosis, Dementia, Seizures, History of falling, and chronic kidney disease. R100's physicians order dated 2/14/24 documents, No added salt diet, mechanical soft, ground meat texture, thin liquids consistency. R100's care, plan dated 08/10/24, documents in part, I (R100) demonstrate some or high risk to potentially choke, aspire foods or liquids. This problem is related to diagnosis of Dysphagia .Provide diet as ordered NAS (no added salt), mechanical soft diet .At risk for aspiration related to diagnosis of dysphagia .Diet as order: Mechanical soft, thin liquids. R100's Minimum Data Set (MDS), dated [DATE], documents R100 has a Cognitive Skill for Daily Decision Making score of 3, which indicated Severely impaired. On 08/18/24 at 12:05 PM, V18, Certified Nursing Assistant (CNA), was observed assisting R100 with meal. R100 requested a substitute meal. V18 returned to dining area with a turkey and cheese sandwich. V18 broke sandwich in half and gave the sandwich to R100. On 08/18/24 at 12:51 PM, V18 stated, (R100) is on a mechanical soft diet. I gave (R100) a turkey sandwich. I would consider the turkey sandwich mechanical soft because the bread is soft. I am always told to give (R100) a turkey sandwich when he doesn't eat what's on (R100's) tray. On 08/19/24 at 1:54 PM, V20, Dietary Manager, stated, (R100's) diet is no added salt, mechanical soft with thin liquids. For (R100), I would have to chop up the turkey meat on the turkey sandwich. Residents on mechanical soft diets usually have swallowing problems. If (R100) receives the wrong food consistency, then (R100) could probably choke if he (R100) has some swallowing difficulties. The facility has tickets with the resident's name and the ticket has the resident's diet. The activity person or the CNA comes down to the kitchen and asks for a sandwich and that's why (R100) received the sandwich. The CNA didn't say who the sandwich was for, so I just gave the sandwich. It's probably a good idea to ask the staff who the sandwich is for. On 08/20/24 at 2:14 PM, V2, Director of Nursing (DON), stated, A resident could possibly aspirate if the diet consistency is not followed. A turkey sandwich is not considered mechanical soft minced meat consistency. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's policy titled Food and Nutrition Services Diets and Diet orders, dated 2017, documents, Mechanical Soft Diet .Policy: Food will be provided in a form designed to meet individual needs .The texture of the food may be altered to mechanical soft consistency .Procedure: The texture may be altered by one of the following methods: Unless otherwise indicated, meat and meat substitutes will be mechanically ground.

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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. 45644 Based on observation, interview, and record review, the facility failed to date prepared food items in the refrigerator, and failed to ensure Dietary staff wear hair covering. These failures have the potential to affect all 119 residents receiving an oral diet in the facility. On 8/18/24 at 9:30 AM in the walk-in refrigerator, surveyor observed 4 green leaf salads, 5 cold cut sandwiches wrapped in plastic wrap, and a bowel of egg salad covered with plastic wrap, not dated. On 8/19/24 at 11:00 AM, V26 (Cook) was pureeing food with mask hanging at the chin level, and hair above upper lip not covered. On 8/18/24 at 9:35 AM V25 (Cook) stated, The salads, sandwiches, and egg salad in the refrigerator should have been dated. The staff know that their supposed to date open and prepared items. The cook from last night did not put a date on those items. On 8/20/24 at 10:20 AM, V20 (Dietary Manager) stated food that is in the refrigerator should be labeled and dated with the date it was prepared. V20 stated everyone working in the Dietary Department should have a hair net on. All hair should be covered. On 8/18/24 at 3:00 PM, V27 (Dietary Aide) stated food items put in the refrigerated should be dated. Facility's (8/20/24) client list report for active diets in the facility is 119 residents who receive oral diets. Facility policy titled Refrigerated Food undated, documents, refrigerated food prepared in the healthcare community is labeled with the date to discard or to use by. Facility policy titled Hair Restraints/ Jewelry/Nail Polish undated, documents, Policy: food and nutrition services employees shall wear hair restrains and beard guards .Procedures: Hairnets will be worn at all times in the kitchen. Beards guards or masks will be worn as indicated. Facility job description titled Food Service Director documents, Responsibilities/ Accountabilities: 2. Adheres to all sanitary and food safety regulations governing handling and serving of food. Facility job description titled [NAME] documents, Responsibilities/ Accountabilities: 1. Handles and prepares food in accordance with sanitary regulations. Facility jog description titled Dietary Aide documents, Responsibilities/ Accountabilities: 2. Handles food and equipment according to sanitation policies and procedures.

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. 50728 Based on observation, interview, and record review, the facility failed to ensure personal refrigerators were kept at safe temperatures. This failure affects 1 resident (R59) in a sample of 58. Findings include: Record review of R59's admission record, documents the following diagnosis: paraplegia, flaccid neuropathic bladder, stage 4 pressure ulcer of sacral region, stage 4 pressure ulcer of the left lower back, stage 4 pressure ulcer of right lower back, major depressive disorder, neuromuscular dysfunction of bladder, and obstructive and reflux uropathy. R59's Minimum Data Set (dated 6/20/2024) documents a brief interview of mental status summary score of 15, indicating R59's is cognitively intact. On 8/18/2024 at 11:29 AM, R59's personal refrigerator in R59's room contained multiple containers of leftover food and beverages. The thermometer inside the refrigerator was at 44 degrees Fahrenheit. V12 (Certified Nursing Assistant) confirmed the thermometer inside the refrigerator indicated 44 degrees Fahrenheit. On 8/18/2024 at 11:36 AM, V10 (Licensed Practical Nurse) affirmed 44 degrees Fahrenheit was too high of a temperature for a refrigerator. V10 stated temperatures that high could cause food to spoil. V10 was not sure who was responsible for monitoring the temperatures of the refrigerator to ensure food was being stored safely. Record Review of R59's DAILY TEMPERATURE MONITORING OF REFRIGERATION/FREEZER indicates no temperature monitoring was completed on 8/17/2024 and 8/18/2024. On 8/20/2024 at 11:04 AM, V2 (Director of Nursing) stated V2 was unsure which staff was supposed to be monitoring the temperatures of personal refrigerators, but staff should be monitoring the temperature at least daily. V2 affirmed if temperatures are not monitored, the refrigerator may be too warm which would cause food borne illness. Review of facility policy titled, FOOD BROUGHT IN BY FAMILY OR VISITORS PERSONAL REFRIGERATORS documents in part, Personal refrigerator temperatures are maintained at 41 F or below.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50728 Based on observation, interview, and record review, the facility failed to ensure enhanced barrier precautions (EBP) signs were placed on the resident's door, failed to don appropriate personal protective equipment while caring for a resident on EBP, failed to change gloves after touching dirty surfaces while providing incontinence care to a resident on EBP, failed to perform hand hygiene after doffing gloves during wound care, and failed to ensure linen was handled in a manner that prevents contamination. These failures affects 6 residents (R59, R68, R98, R96, R48 and R33), in a sample of 58, and has the potential to affect all residents within the facility. Findings include: 1. On 8/19/2024 at 11:00 AM,V23 (Housekeeper) opened the door to the area containing the laundry chute. There was a bag of visibly soiled linen sitting on the ground, and a cart containing bagged and unbagged articles of clothing (shirts, pants) and linen. V23 was asked if clothing items/linen needed to be bagged before entering the chute, and V23 responded no. V23 explained the bag with linen was soiled with feces and needed to be separated from the other soiled laundry but V23 was getting to that bag of linen next.V23 donned gown/gloves and dragged the bag forward into the laundry area. V23 stated it was okay to drag it (the bag of soiled linen). After, V23 doffed V23's gloves into the trash can after touching the bag of soiled linen, and began to touch the clean linens, and the clean linen cart near the driers. After V23 began touching the clean linen and cart, V14 (Maintenance Manager) instructed V23 to wash V23's hands. V23 performed hand hygiene and stated, I should have washed my hands. On 8/20/2024 at 11:06 AM, V2 (Director of Nursing) affirmed hand hygiene should always be performed when doffing gloves to prevent contamination and infections. Record review of facility policy titled, Laundry Services documents, It is the policy of this facility that all linen is handled in a manner to prevent the spread of infection .2. Routine handling of soiled linen a. Soiled linen should be handled as little as possible and with minimum agitation to prevent cross contamination of the air and persons handling linen . c. Hand hygiene will be performed upon removal of personal protective equipment . 3. Transportation of Linen . c. If laundry chutes are used, linen should be bagged. 2. R59's admission record documents the following diagnosis: paraplegia, flaccid neuropathic bladder, stage 4 pressure ulcer of sacral region, stage 4 pressure ulcer of the left lower back, stage 4 pressure ulcer of right lower back, major depressive disorder, neuromuscular dysfunction of bladder, and obstructive and reflux uropathy. R59's Minimum Data Set (dated 6/20/2024) documents a Brief Interview of Mental Status summary score of 15, indicating R59 is cognitively intact. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 8/18/2024 at 11:06 AM, V9 (Registered Nurse) completed wound care for R59. V9 assisted R59 into a right side-lying position and doffed V9's gloves. V9 donned a new pair of gloves and did not complete hand hygiene. V9 then removed the prior dressing to R59's sacrum, and doffed V9's gloves into the trash can. V9 donned a new pair of gloves and did not complete hand hygiene. V9 carried out the wound care per physician order to R59's sacrum and doffed V9's gloves into the trash can. V9 donned a new pair of gloves and did not complete hand hygiene. V9 then removed the prior dressing to R59's left ischium, and doffed V9's gloves into the trash can. V9 donned a new pair of gloves and did not complete hand hygiene. V9 carried out the wound care per physician order to R59's left ischium and doffed V9's gloves into the trash can. V9 donned a new pair of gloves and did not complete hand hygiene. V9 then removed the prior dressing to R59's right ischium, and doffed V9's gloves into the trash can. V9 donned a new pair of gloves and did not complete hand hygiene. V9 carried out the wound care per physician order to R59's right ischium and doffed V9's gloves into the trash can. V9 collected V9's wound care supplies and exited R59's room, without performing hand hygiene. On 8/18/2024 at 11:19 AM, V9 affirmed when V9 doffed V9's gloves during wound care, V9 should have completed hand hygiene. On 8/20/2024 at 11:06 AM, V2 (Director of Nursing) affirmed hand hygiene should always be performed when doffing gloves to prevent contamination and infections. Record review of facility policy titled, HAND WASHING POLICY (dated 9/2014), documents, Policy: All facility staff will practice hand washing activities with an anti-microbial agent or water-less antiseptic agent in accordance to this policy. Standards: 1. Hand washing will be practiced as follows: . d. Immediately after glove removal. 43351 3. R96's (Active Order As Of: 08/19/2024) Order Summary Report documented, Diagnoses: (include but not limited to) muscle weakness, glaucoma, and unsteadiness on feet. R96's (07/25/2024) Minimum Data Set documented, Section C0500. BIMS (Brief Interview for mental status) Summary Score: 11. Indicating R96's mental status as moderately impaired. Section GG. Functional Abilities and Goals. GG0130. Self-Care. C. Toileting hygiene (the ability to maintain rabbinical hygiene, adjust clothes before and after voiding or having a bowel movement): 03 - partial/ moderate assistance. R96's (07/22/2024) care plan documented, at has an ADL self-care performance deficit. Will remain free of complications. Dressing/grooming - requires extensive assist from staff. Toilet use requires extensive assist from staff. R96's (05/11/2024) care plan, documented, at higher risk for infection secondary to wound care. Will be free from new infection. Enhanced barrier precautions are to be maintained for duration of nursing home stay or until etiology has been discontinued. PPE (gown and gloves) to be worn during high contact resident care (ADLs, transfer, linen change, toileting, incontinent (incontinence) care). THE (undated) ENHANCED BARRIER PRECAUTIONS sign posted by R96's room documented, PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following high contact resident care activities. Dressing, changing linens, providing hygiene, changing linens or assisting with toileting. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/18/2024 at 10:42 AM, there was an EBP (Enhanced Barrier Precautions) sign posted by R96's room. Inside R96's room, V6 was wearing a mask and gloves; V6 was not wearing a gown. V6 was wiping the feces off R96 anus and buttocks with a wet wash cloth, dried R96 anus and buttock without changing her (V6) gloves. V6 turned R96 and removed R96 shirt without changing her gloves. V6 put grip socks on R96 and put new shirt on R96 without changing her gloves; put black jeans on R96 without changing her gloves; fixed and buttoned R96's shirt without changing her gloves. On 08/18/2024 at 10:51 AM, V6 was asked how many times V6 changed her gloves while providing patient care to R96. V6 stated, I didn't. I forgot to change my gloves. I am supposed to change my gloves after cleaning his butt to prevent passing some type of infection to another resident. On 08/18/2024 at 10:52 AM, V6 was aksed if V6 was supposed to wear a gown when providing patient care to R96. V6 stated, I thought they (facility) said if I do patient care to EBP resident, I don't need to wear a gown; and mask and gloves are all right. On 08/20/2024 at 12:03 PM, V2 (Director of Nursing) stated, The expectation is for the staff to follow the policy on EBP, which requires donning gown and gloves before entering the resident's room. The staff must don gown and gloves whenever the staff is giving or providing ADL care to a resident on Enhanced Barrier Precautions. Toileting, dressing, and grooming a resident requires the use of gown and gloves when giving ADL care to resident on EBP (Enhanced Barrier Precautions). The importance of donning the gown and gloves when providing care is to prevent the resident from getting something from the staff, like getting a nursing home acquired infection and to prevent staff from getting infection from the resident. On 08/20/2024 at 12:10 PM, V2 stated, The expectation, after wiping the feces off the resident, is for staff to remove the gloves and washed their hands and don a new pair of gloves, then continue the patient care. We (facility staff) want to prevent the spread of infection. Because if you touched something dirty like feces, the staff is transferring the germs on the clean clothes or clean surface if you don't wash your hands and change your gloves. The (undated) Certified Nursing Assistant Job Description documented, Purpose: To assist the charge nurse in providing nursing care to residents as assigned under the direct supervision of the Director Of Nursing. Services are to be in accordance with nursing standards, policy and procedure and practices of the facility and state requirements. Duties and responsibilities: Infection Control: Follow isolation precautions. The (undated) Glove Use-Nursing documented, Non-sterile. Policy: Non-sterile gloves shall be worn for procedures involving contact with mucous membranes. 5. Gloves used for contact shall be removed and discarded after contact with each person, fluid item, or surface. Hands shall be thoroughly washed immediately after gloves are removed. The (undated) Hand Washing Policy documented, Purpose: To remove dirt, organic material, and transient microorganism which are found on the hands and to reduce the potential of resident morbidity and mortality from nosocomial infection. Policy: All facility staff will practice hand washing activities with an antimicrobial agent or waterless antiseptic agent in accordance with this policy. Standards: 1. Hand washing will be practiced as follows: d. Immediately after glove removal. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145765	A. Building B. Wing	08/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park View Rehab Center	5888 North Ridge Chicago, IL 60660

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The (undated) Enhanced Barrier Precautions documented, Purpose: Recommendation from CDC (Center for Disease Control and Prevention) to protect residents from multi drug resistant Organism (MDROs). Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents at increased risk of acquiring MDRO. Gloves and gown required for high contact activities only. During care: Gown And Gloves for these resident care activities: ADL care/hygiene, changing linen, toileting/incontinent care. 45196 4. R48 has a diagnoses which includes: dysphagia, oropharyngeal phase, and gastrostomy status. R48's Brief Interview for Mental Status (BIMS), dated 07/31/24, shows R48's does not have a BIMS score, and indicates R48 has memory problems. On 08/18/24 at 10:34 AM, R48 was in bed awake and alert with Gastrostomy Tube (G-tube) in place, with no Enhanced Barrier Precaution (EBP) sign on R48's room door or Personal Protective Equipment (PPE) bin outside of R48's room door. On 08/18/24 at 11:02 AM, V3 (Assistant Director of Nursing ,ADON, Licensed Practical Nurse, LPN) stated, There should be a sign on the door for EBP and the PPE bin doesn't need to be directly outside the door. On 08/20/24 at 9:03 AM, V4 (Infection Preventionist/IP, Licensed Practical Nurse/LPN) stated residents with indwelling catheters, wound dressings, PICC (Peripherally Inserted Central Catheter) lines, and G-tubes require EBP and a sign on the residents door so that staff is aware of the residents EBP. When V4 was asked if a resident who requires EBP doesn't have a sign on the residents door to alert the staff regarding the residents EBP what could happen and V4 stated, They (referring to the staff) wouldn't know the resident was on EBP and they (referring to staff) can go in the residents room without proper PPE which could possibly increase infection amongst residents and staff. The facility's undated policy titled Enhanced Barrier Precautions documents, Purpose: Recommendation from CDC (Center for Disease Control) to protect resident from multidrug resistant organisms (MDROs) . Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as with a MDRO as well as those at increased risk of acquiring MDRO. 45644 5. R98's diagnoses include stage 4 pressure ulcer, gout, benign prostatic hyperplasia, chronic obstructive pulmonary, acute kidney failure, respiratory failure, seizures, and depression. R98's Brief Interview of Mental Status (BIMS) score is 14. On 8/18/24 at 11:05 AM, R98's room did not display a EBP (Enhance Barrier Precaution) sign on the door. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	R98's Physician Order Sets (POS) documents, site: sacrum cleanse with ns (normal saline), pat dry apply lodoscorb packing strips daily and prn (as needed) then cover dry protective dressing. Moisture Barrier Cream/Ointment to buttocks and groin areas as needed. CNA (Certified Nursing Assistant) may apply. May keep at bedside. On 8/20/24 at 9:20 AM, V4, LPN (License Practical Nurse), stated residents who have a Foley, feeding tube, and wounds should have an EBP sign on their room door. If a resident is moved to another room than the sign should also move with them. V4 stated R98's room should have an EBP sign on the door because he (R98) gets dressing changes daily. R98's (5/11/24) care plan documents, Focus: R98 is at higher risk for infection secondary to wound care. Intervention: Enhance Barrier Precautions are to be maintained for duration of nursing home stay or until etiology has been discontinued. Facility policy (revised 12/23) titled Enhanced Barrier Precautions documents, Purpose: Recommendations from CDC (Center Disease Control) to protect residents from multidrug resistant organisms (MDROs) .EBP involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of acquiring MDRO. Examples include, but not limited to wounds, indwelling medical devices. 50662 6. R68 has diagnosis's that include Hyperlipidemia, Essential Hypertension, Type 2 Diabetes mellitus, Heart Failure, Bipolar Disorder, Chronic Obstructive Pulmonary Disease, Cerebral Infarction, and Dysphagia. R68's MDS, dated [DATE], has a Staff Assessment for [NAME] Status Cognitive Skills for Daily Decision Making score of 0, which indicates R68's decision making is independent. R68's care plan, dated 5/16/24, documents, (R68) is at a higher risk for infection secondary to feeding tube . Enhanced Barrier Precautions are to be maintained for duration of nursing home stay or until etiology has been discontinued .PPE(Gown and gloves with face shield if splashing likely) to be worn during high contact activities such as device care (catheter, feeding tube, trach, central line) high contact resident care (ADLs, transfer, linen change, toileting, incontinent care), wound care. On 08/18/24 at 10:51 AM, V15, Registered Nurse (RN), stated, (R68) is on Enhanced Barrier Precautions (EBP). (R68) has a gastrostomy tube (GT). They moved the PPE (personal protective equipment); it was here. I would unfortunately walk down the hall to a PPE bin and get PPE. On 08/18/24 at 11:02 AM, V3, Assistant Director of Nursing (ADON), stated, EBP is used when someone has a GT, Foley, IV (intravenous therapy), wounds or colostomy. There should be an EBP sign on the door. I want to say that (R68) had a room change and that's why (R68) doesn't have an EBP sign on the door, but that's not an excuse though. On 08/18/24 at 12:39 PM V19 Certified Nursing Assistant (CNA) was observed cleaning R68 without PPE gown on. V19 stated, PPE is used with an infection like covid. I was only told to use gowns for isolation residents, not residents with a GT. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 08/18/24 at 12:45 PM, V19 observed placing a PPE bin outside of R68's room. Facility's undated policy titled Enhanced Barrier Precautions documents, Purpose: Recommendation from CDC to protect residents from multidrug resistant organisms (MDRO's). Enhanced Barrier Precautions do not impose the same activity and room placement restrictions as contact precautions. Enhanced Barrier Precautions involve gown and glove use during high contact resident care activities for residents known to be colonized or infected with a MDRO as well as those at increased risk of acquiring MDRO .Examples include, but not limited to wounds, indwelling medical devices .Gloves and gowns required for high-contact activities only .Precautions are intended to be in place for duration of stay or until resolution of or discontinuation of the cause for the precaution .During Care: Gown and gloves for these resident care activities .ADL (activities of daily living) care/hygiene, changing linen, toileting/incontinent care, feeding tubes. 41611