STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145775	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Healthcare & Rehab Ctr	3919 West Foster Avenue Chicago, IL 60625

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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 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. 49486 Based on observation, interview, and record review, the facility: failed to ensure staff did not stand while feeding 2 (R34, and R95) residents that are dependent on staff for assistance with eating and Failed to treat one resident (R417) with respect and dignity by not passing out meals to all residents sitting at the same table at the same time during dining observation in a sample of 33. Findings include: 1. R34's face sheet documents in part; medical diagnoses including but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, Dysphagia, Acute Cough, and other Seizures. R34's physician orders sheet document in part; R34 requires total assistance with meals, strict aspiration precautions. On 09/03/24 at 12:24 PM, R34 was in bed with head of the bed elevated. R34's bed was close to the floor, and there was a chair at R34's bed side. V24 (Restorative Aide) stood on R34's right side and fed R34. V24 was standing and not at eye level with R34. V24 stated that V24 forgot to sit, and that V24 should be seated to feed R34 to keep R34 at eye level and to prevent R34 from choking. On 09/04/24 at 11:17 AM, V26 (Certified Nursing Assistant/CNA) stated when a resident is in bed or up in chair, the staff should be sitting at eye level when feeding the resident, and to prevent the resident from choking. On 09/05/24 at 10:48 AM, V2 (Director of Nursing) stated, if a resident is dependent on assistance with eating, the staff need to sit with the resident while providing feeding assistance to provide eye level contact for proper observation, to prevent choking and V2 stated it is a dignity issue which should be respected. Facility's Privacy and Dignity policy, last revised 8/16/24, documents in part: It is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times. Surveyor also reviewed facility's Restorative Nursing Program policy, last revised 8/19/24. No procedures on how to maintain a resident's dignity during meal assistance. 39779 (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R95 has diagnosis not limited to Congenital Kyphosis, Thoracic Region, Gastro-Esophageal Reflux Disease, Essential (Primary) Hypertension, Unspecified Protein-Calorie Malnutrition, Unspecified Dementia, Unspecified Severity, with Agitation, Restlessness and Agitation, Schizoaffective Disorder, Mood [Affective] Disorder, Hyperlipidemia, Alzheimer's Disease, Syncope and Collapse and Rectal Prolapse. R95's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) document 0, resident is rarely/never understood. R95's meal ticket document in part: Food tray set up, (Partial Feeding Assist). On 09/03/24 at 12:35 PM, R95 was observed sitting in a chair in the fourth-floor dining room with a lunch tray in front of her. There was a general mechanical soft meal that contained vegetables, ground meat on a bun, a chocolate ice cream cup and juice. V16 (Activity Aide) was observed standing next to and feeding R95. After V16 was observed standing feeding R95 a staff member brought a chair for V16 to sit in. V16 then sat in the chair next to R95 and continued to provide feeding assistance to R95. On 09/03/24 12:47 PM, V18 (Memory Care Director) was observed standing on R95's right side attempting to feed R95. Surveyor asked V18 the reason for standing next to R95 feeding her. V18 responded, I was encouraging R95. On 09/05/24 at 12:06 PM, V2 (Director of Nursing) stated when feeding a resident, it is common sense to maintain eye contact you have to sit down and maintain a level to see the resident reaction, for social interaction, how the resident eats and dignity with the resident. 47304 3. On 9/3/24 at 11:53 AM, R417 observed sitting up on wheelchair waiting for lunch tray. She is seated at the same table with R94, R135 and R158. At 12:18pm, R135 was served a meal tray. Lunch tray with rice, ground meat, and mixed vegetables, coffee and juice. She is able to spoon feed self post tray set up. At 12:19pm, Meal tray was served to R158. Lunch tray with rice, ground meat and mixed vegetables. She can spoon feed self post tray set up. At 12:21pm, Meal tray was served to R94. Lunch tray with Rice, 2 eggrolls, mixed vegetables, coffee, juice. R94 can feed self post tray set up with good appetite. At 12:48pm, Surveyor asked V7 (Certified Nursing Assistant / CNA) and stated R417 did not eat lunch yet, they are following up meal ticket to the kitchen and meal will be provided. At 12:50pm, Lunch tray was served to R417, other 3 residents (R94, R135 and R158) seated in the same table with R417 had finished eating already. R94, R135 and R158 with good appetite, consumed almost 100% of the food served. At 2:49pm, V2 (Director of Nursing / DON) said staff are expected to serve meal tray almost at the same time for those residents seated at one table. It is dignity issue if residents at the same table are almost done eating and another resident is not eating and waiting for meal tray. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/4/24 at 10:45am, V1 (Administrator) stated we don't have a policy for meal tray distribution, but it is a best practice that people sitting at the same table should be served at the same time. To ensure that no one is looking at someone else's food and wishing they had food to eat. Facility's policy for privacy and dignity dated 8/16/24 documented in part: It is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times.

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review, the facility failed to ensure residents participated in care planning conferences for 5 (R14, R4, R136, R20, R59) out of 5 residents reviewed in a final sample of 33. Findings Include: On 9/4/24 at 9:52 AM, interviewed R14 and stated admitted in the facility four months ago. R14 stated has not attended any care plan meeting to discuss R14's plan of care. R14's electronic health records show R14 was admitted in the facility on 4/30/24 with diagnoses included but not limited to acute and chronic respiratory failure with hypoxia, dysphagia, major depressive disorder, generalized anxiety, and schizoaffective disorder. R14 had a completed quarterly Minimum Data Set (MDS) assessment with assessment reference date (ARD) of 7/22/24. R14's Brief Interview for Mental Status (BIMS) was coded as 13, which means R14 is cognitively intact. R14's EHR lacked documentation if a care conference was conducted for R14. On 9/4/24 at 9:56 AM, interviewed R136 and stated admitted in the facility two months ago. R136 stated that the facility has not conducted any care plan meeting since R136's admission. R136's EHR shows R136 was admitted in the facility on 5/30/24 with diagnoses included but not limited to chronic obstructive pulmonary, pulmonary hypertension, adult failure to thrive, and emphysema. R136 had a completed admission MDS assessment with ARD of 6/1/24. R136's BIMS was coded as 11 which means R136 has moderately impaired cognition. R136's EHR lacked documentation if a care conference was conducted for R136 since admitted . On 9/4/24 at 10:01 AM, interviewed R4 and stated was admitted in the facility back in December 2023. R4 stated that the last care plan meeting R4 received was four months ago. R4's EHR shows R4 was admitted in the facility on 12/6/23 with diagnoses included but not limited to metabolic encephalopathy, chronic respiratory failure, essential hypertension, type 2 diabetes mellitus, and anxiety disorder. R4 had a completed quarterly MDS assessment with ARD of 8/22/24. R4's BIMS was coded as 12 which means R4 has moderately impaired cognition. R4's EHR lacked documentation if a care conference was conducted for R4. On 9/4/24 at 10:07 AM, interviewed R20 and stated was admitted in the facility one year ago. When asked about a care plan conference R20 attended recently with the interdisciplinary team, R20 stated, I don't think they ever did one. R20's EHR shows R20 was admitted in the facility on 8/23/23 with diagnoses included but not limited to end-staged renal disease, essential hypertension, spinal stenosis, obesity, and type 2 diabetes mellitus. R20 had a completed annual MDS assessment with ARD of 7/3/24. R20's BIMS was coded 10 which means R10 has moderately impaired cognition. R20's EHR lacked documentation if a care conference was conducted for R20. (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/5/24 at 9:44 AM, interviewed R59 and stated R59 was admitted in the facility in March. R59 stated has not attended any care plan meeting to discuss R59's plan of care. R59 stated, They have not done that with me. R59's EHR shows R59 was admitted in the facility on 3/6/24 with diagnoses included but not limited to dysphagia, malignant neoplasm of pancreas, anxiety disorder, and severe protein-calorie malnutrition. R59 had a completed quarterly MDS assessment with ARD of 6/7/24. R59's BIMS was coded as 12 which means R59 had moderately impaired cognition. R59's EHR lacked documentation if a care conference was conducted for R59. On 9/4/24 at 11:30 AM, interviewed V19 (MDS Coordinator) and stated V19 is responsible in scheduling and sending out invites for the long-term care residents' care plan conferences. V19 stated, We mail the invites to the responsible parties. We verbally invite the residents. Care plan conference are held every quarter. For new admits the social service department schedules it. They are the ones that send invites also. V19 stated V19 is not sure how care plan conferences are scheduled for new admissions. V19 stated normally within 7 days. V19 stated care plan conferences are scheduled and should be held quarterly according to the MDS calendar and as requested. V19 stated care plan conferences should be attended by the interdisciplinary team (IDT) someone from nursing, social worker, dietary, restorative, activity, and therapy if resident is on therapy. V19 stated care plan conferences calendar is emailed and shared to the department heads. V19 stated there are no documentation that the invites are sent. V19 stated all documentation of care plan conference minutes are electronic. V19 stated care plan conference is documented that it was held in the resident's EHR under assessment titled; LCHC-Multidisciplinary Care Conference. V19 stated even if the resident or the family did not attend, care plan conference still should be held with the IDT to discuss the resident's plan of care. Surveyor reviewed R14, R4, R136, R20, and R59's EHR together with V19. V19 confirmed these residents had no documentation indicating care plan conferences were held according to the MDS calendar. V19 stated R14 had MDS in 7/22/24 and should have had a care plan conference in July. V19 stated R4 had MDS completed on 8/22/24 and should have had a care plan conference in August. V19 stated R136 was admitted on [DATE] with the last quarterly MDS review on 8/27/24, but no documentation if R136 had care plan conferences for both the admission and quarterly review. V19 stated R20 had a completed MDS on 7/3/24 and should have had a care plan conference in July. V19 stated R59 had a completed MDS on 6/7/24 and should have had a care plan conference in June. The facility's policy titled; Care Plan Conference dated 7/26/24 reads in part: (continued on next page)

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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident care conferences are held within the first 72 hours of admission, upon completion of the comprehensive care plan and at least quarterly thereafter in coordination with the MDS schedule and process. Resident / Resident Representative will be invited to the care conference. The care conference is intended to be an interactive meeting with the resident, resident representative(s), and interdisciplinary team representatives to review the care plan, clarify service and contact information, and provide a forum for the resident and/or resident representative(s) to relate satisfaction or dissatisfaction with care. Social Services staff follow up with any complaints or concerns aired during care conference following the facility grievance procedure. Those attending the care conference or participating in the development of the care plan includes but is not limited to the attending physician, a licensed nurse with knowledge of the resident, a nurse aide with responsibility for the resident, a member from dietary, a member of the activity department, a member of the therapy/restorative department, social services personnel, the resident is practicable, the resident's representative if possible. During the care conference the care plan is reviewed with the resident and/or resident's representative.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observation, interview, and record review the facility failed to determine self-administration of medication was appropriate for one resident (R70) in a sample of 33. Findings include: R70's face sheet documents in part medical diagnoses including but not limited to Hemiplegia and Hemiparesis following Cerebral Infarction, flexion deformity left fingers joints, pain in left fingers, and adult failure to thrive. R70's Minimum Data Set (MDS) dated [DATE] shows R70 is moderately cognitively intact. On 09/03/24 at 10:48 AM, surveyor observed Lidocaine 4% External Analgesic Cream on R70's bed side table. R70 stated one of the nurses gave R70 the Lidocaine cream couple of months ago for R70's left finger pain. R70 stated R70 uses the cream every other day, and R70 had used the cream this morning. On 09/03/24 at 2:53 PM, interviewed V12 (Registered Nurse/RN) who stated that all medications must have a doctor's order, and no medication either over the counter (OTC) or prescription should be kept at the bed side. V12 stated there should be an order for self-administration. On 09/03/24 at 3:40 PM, when V23 (Licensed Practical Nurse/LPN) was asked if medication should be kept at bed side. V23 stated no medication should be placed at bed side without doctor's order. V23 stated Normally, we are supposed to get an order for the resident to self-administer medicine. V23 stated that R70 did not have an order to self-administer the medication. V23 stated the potential problem is that any confused resident can walk into R70's room to swallow the medication, R70 can overdose the medication, and it is a safety issue. On 09/03/24 at 3:47 PM, V2 (Director of Nursing/DON) stated that for medication administration, the nurse is expected to complete hand hygiene, check the five rights before administering any medications. V2 stated it is V2's expectation that nurses will not leave any medication at bed side without a doctor's order. V2 stated that the potential problem is medication error, other resident could take wrong medication, and could cause medical problem. On 09/03/24 at 3:50 PM, R70's Physician Order Sheet (POS) with active order as of 9/3/24 shows no order for self-administration of Lidocaine 4% cream and to keep medication at bed side. R70's electronic health record (EHR) was reviewed, no Medication Self-Administration Evaluation Form was completed. Review of Medication Pass policy revised 8/16/24. Policy statement: It is the policy of the facility to adhere to all federal and state regulations with medication pass procedures. Review of Self-Administration of Medication policy revised 6/2/24, states: The resident may store the medication at bedside if there is a physician order to keep it at bedside. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy Statement: A resident who requests to self-administer medications will be assessed to determine if resident is able to safely self-medicate. Procedure 1. The IDT will assign a staff to evaluate resident's ability to safely administer medication. A self-administration evaluation will be filled out to determine capability. A return demonstration will be done to accurately evaluate resident's ability after the health teaching.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779 Based on interview and record review the facility failed to obtain a Physician order and update the resident record with the correct code status for 1 (R85) resident reviewed for Advance Directives in a sample of 33. Findings Include: R85 has diagnosis not limited to Primary Osteoarthritis, Right Ankle and Foot, Alzheimer's Disease with Late Onset, Type 2 Diabetes Mellitus, Hyperlipidemia, Essential (Primary) Hypertension, Nontoxic Single Thyroid Nodule, Chronic Kidney Disease, Stage 3, Dementia, Long Term (Current) use of Oral Hypoglycemic Drugs, Long Term (Current) use of Insulin, Primary Generalized (Osteo) Arthritis, Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Major Depressive Disorder, Hypothyroidism, Long Term (Current) use of Anticoagulants, Localized Edema, Anxiety Disorders, Muscle Wasting and Atrophy, Need for Assistance with Personal Care, Difficulty In Walking and Abnormalities of Gait and Mobility. R85's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) document 04 indicating cognitive function as severely impaired. On [DATE] at 10:29 AM, surveyor asked V14 (Registered Nurse) R85's code status. V14 looked in the computer. V14 stated R85 has no code status. Let me check. V14 called admissions/social service and asked can they check the code status for R85 because it's not there. The surveyor asked V14 to print R85's face sheet and physician orders prior to making any changes. The surveyor then asked V14 if a resident was observed unresponsive without a code status what would be done. V14 responded, If I observed the resident with no code status unresponsive and they needed CPR (Cardiopulmonary Resuscitation) I still have to assess the resident. I understand you need that code status, and it is very important. It is still my judgement if the resident does not have the Do Not Resuscitate POLST (Physician Order for Life Sustaining Treatment) form. On [DATE] at 10:39 AM, V4 (Social Service Director) arrive to the fourth floor and stated there is no code status order for R85 at the moment. The code status is usually just on the POS (Physicians Order Sheet) if they are a full code or Do Not Resuscitate. The responsibility for the code status would be conjoined between social service and nursing to make sure the POS matches the care plan. If there is no code status that would be an error on our part, that we did not audit. It may have been from a readmission, and it was not caught that the code status was not in place. On [DATE] after V14 (Registered Nurse) spoke to V4 (Social Service Director) and V14 was instructed by V4 to enter the physicians order for R85's code status. V14 entered R85's physician order for the code status of Full Code then printed R85's Face Sheet and Physicians Order to reflect R85' code status as Full Code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:06 PM, V2 (Director of Nursing) stated Advance directives for the patient are the DNR (Do Not Resuscitate) status and we call the doctor for the order. Surveyor asked V2 the policy for Advance Directives. V2 stated, we always presume if a resident is a full code, they do not have to have an order. R85's care plan was not updated because there was no change of code status, that is what I am presuming. If a resident needs CPR (Cardiopulmonary Resuscitation) the first thing the nurse does is go to the computer, the POLST (Physicians Order for Life Sustaining Treatment) binder is the back up if the computer is down. If a resident is admitted to the hospital all the orders are discontinued. When the resident is readmitted , the nurse has to get new orders and look at the discharge orders from the hospital. The care plan is focused on the physician orders and the resident needs. The care plan and the physician orders should match. Care Plan document in part: Focus: Advance Directives - R85 has appointed her POA (Power of Attorney) of healthcare and he wishes for R85 to remain a full code at this time. Date Initiated: [DATE]. Interventions: All staff will be made aware of the resident's wishes related to Advance Directives Date Initiated: [DATE]. Review directives with family as needed. Document titled Order Details dated [DATE] at 10:39 document in part: Order Type: Advance Directives. Order Summary: Full Code Document titled Order Listing Report document in part: R85's Full Code Status dated [DATE]. Policy: Titled Advance Directives revised [DATE] document in part: 5. Appropriate information will be added to Physician Order Sheet (POS). 6. The resident's Advance Directive choices/options shall be reviewed during the reassessment and quarterly care planning process. 7. Discussion of Advance Directives and treatment options/refusals will be addressed in appropriate chart documentation as well as care planning during the admission process, as indicated. Review of Advance Directives: 1. Advance Directive information shall be reviewed periodically during the resident's stay, but no less than once a year.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39779 Based on interview and record review the facility failed to ensure a resident's Advance Directives care plan was revised after three hospitalization s and readmissions to the facility for 1 (R85) resident reviewed for Advance Directives in a sample of 33. Findings Include: R85 has diagnosis not limited to Primary Osteoarthritis, Right Ankle and Foot, Alzheimer's Disease with Late Onset, Type 2 Diabetes Mellitus, Hyperlipidemia, Essential (Primary) Hypertension, Nontoxic Single Thyroid Nodule, Chronic Kidney Disease, Stage 3, Dementia, Long Term (Current) use of Oral Hypoglycemic Drugs, Long Term (Current) use of Insulin, Primary Generalized (Osteo) Arthritis, Cerebral Infarction due to Thrombosis of Right Middle Cerebral Artery, Hemiplegia and Hemiparesis Following Cerebral Infarction Affecting Left Non-Dominant Side, Major Depressive Disorder, Hypothyroidism, Long Term (Current) use of Anticoagulants, Localized Edema, Anxiety Disorders, Muscle Wasting and Atrophy, Need for Assistance with Personal Care, Difficulty In Walking and Abnormalities of Gait and Mobility. R85's MDS (Minimum Data Set) BIMS (Brief Interview for Mental Status) document 04 indicating cognitive function as severely impaired. Care Plan document in part: Focus: Advance Directives - R85 has appointed her POA (Power of Attorney) of healthcare and he wishes for R85 to remain a full code at this time. Date Initiated: [DATE]. Interventions: All staff will be made aware of the resident's wishes related to Advance Directives Date Initiated: [DATE]. Review directives with family as needed. R85 was admitted to the facility on [DATE]. R85 was hospitalized three times on [DATE], readmitted [DATE], [DATE] readmitted on [DATE] and [DATE] readmitted [DATE]. On [DATE] at 10:29 AM, surveyor asked V14 (Registered Nurse) R85's code status. V14 looked in the computer. V14 stated R85 has no code status. Let me check. V14 called admissions/social service and asked can they check the code status for R85 because it's not there. The surveyor asked V14 to print R85's face sheet and physician orders prior to making any changes. The surveyor then asked V14 if a resident was observed unresponsive without a code status what would be done. V14 responded, If I observed the resident with no code status unresponsive and they needed CPR (Cardiopulmonary Resuscitation) I still have to assess the resident. I understand you need that code status, and it is very important. It is still my judgement if the resident does not have the Do Not Resuscitate POLST (Physician Order for Life Sustaining Treatment) form. On [DATE] at 10:39 AM V4 (Social Service Director) arrive to the fourth floor and stated there is no code status order for R85 at the moment. The code status is usually just on the POS (Physicians Order Sheet) if they are a full code or Do Not Resuscitate. The responsibility for the code status would be conjoined between social service and nursing to make sure the POS matches the care plan. If there is no code status that would be an error on our part, that we did not audit. It may have been from a readmission, and it was not caught that the code status was not in place. (continued on next page)

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	145775	A. Building B. Wing	09/06/2024

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] after V14 (Registered Nurse) spoke to V4 (Social Service Director) and was instructed to enter the physicians order for R85's code status by V4, V14 entered then printed R85's Face Sheet and Physicians Order to reflect R85' code status as Full Code. On [DATE] at 12:06 PM, Surveyor asked V2 (Director of Nursing) the policy for Advance Directives. V2 stated, we always presume if a resident is a full code, they do not have to have an order. R85's care plan was not updated because there was no change of code status, that is what I am presuming. If a resident is admitted to the hospital all the orders are discontinued. When the resident is readmitted , they have to get new orders and look at the discharge orders from the hospital. The care plan is focused on the physician orders and the resident needs. The care plan and the physician orders should match. Document titled Order Details dated [DATE] at 10:39 document in part: Order Type: Advance Directives. Order Summary: Full Code Document titled Order Listing Report document in part: R85's Full Code Status dated [DATE]. Policy: Titled Advance Directives revised [DATE] document in part: 5. Appropriate information will be added to Physician Order Sheet (POS). 6. The resident's Advance Directive choices/options shall be reviewed during the reassessment and quarterly care planning process. 7. Discussion of Advance Directives and treatment options/refusals will be addressed in appropriate chart documentation as well as care planning during the admission process, as indicated. Review of Advance Directives: 1. Advance Directive information shall be reviewed periodically during the resident's stay, but no less than once a year. Titled Care Plan revised [DATE] document in part: It is the policy of the facility to ensure that all care plans including base line care plans are in conjunction with the federal regulations. A comprehensive care plan must be developed after the comprehensive assessment of the resident. 5. These will be periodically reviewed and revised by a team of qualified person after each assessment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview and record review the facility failed to ensure oxygen tubing was properly labeled for 1 (R136) resident, and to ensure residents received the correct oxygen flow rate as ordered by the physician for 2 (R50, R136) out of 2 residents reviewed for respiratory care. Findings Include: 1. On 9/3/24 at 10:51 AM, R136 was lying in bed alert and able to verbalize needs. R136 was using oxygen via nasal cannula. R136's oxygen concentrator flow rate was set to 3.5 liters per minute (LPM). R136's oxygen tubing was not labeled when it was last changed. R136 stated R136 has Chronic Obstructive Pulmonary Disease (COPD) and nursing staff sets R136's oxygen. R136 denied changing the flow rate of the oxygen concentrator. At 10:53 AM, interviewed V21 (Registered Nurse) and stated oxygen tubing is changed weekly and as needed. V21 stated oxygen tubing is supposed to be labeled to let the staff know when it was last changed. V21 stated R136 is supposed to be getting oxygen at 3LPM continuously. R136's electronic health records show R136 was admitted in the facility on 5/30/24 with diagnoses included but not limited to chronic obstructive pulmonary, pulmonary hypertension, adult failure to thrive, and emphysema. R136's Minimum Data Set (MDS) dated [DATE] shows R136 has moderately impaired cognition. R136's physician order reads in part: Oxygen 3L/min continues for CHRONIC OBSTRUCTIVE PULMONARY DISEASE WITH (ACUTE) EXACERBATION. R136's care plan date initiated on 6/3/24 reads in part: Give oxygen as ordered by the physician at 3LPM continuously. On 9/3/24 at 2:41 PM, interviewed V2 (Director of Nursing) and stated that it is the facility's policy to change the oxygen tubing weekly and as needed. V2 stated nurses must label the tubing when it was changed. V2 stated the purpose for that is for infection control that it's changed timely when it's supposed to be. V2 stated, nurses must follow the physician's order when administering the oxygen and should monitor the residents' oxygen that it's on the correct setting. The facility's policy titled; Oxygen Therapy and Administration dated 8/16/24 reads in part: Oxygen therapy shall be administered to patients as indicated and upon a physician's order. Confirm order from physician. Assemble equipment as needed. Date your equipment. Oxygen setups should be changed every seven days and as needed if heavy soiling is present. 46342 2. On 09/03/24 at 11:02 AM, observed R50 sleeping in bed with oxygen infusing per nasal cannula. Observed oxygen concentrator infusing at 3.5 liters per minute. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/03/24 at 11:23 AM, with surveyor V13 (Registered Nurse) observed R50's oxygen infusing rate and stated, it's set at 3.5 liters per minute. V13 then went to medication cart and looked up R50's oxygen order in R50's electronic health record (EHR). V13 stated R50's order is for 2 liters per minute PRN. V13 stated V13 does not know how the oxygen rate got up to 3.5 liters per minute because when V13 checked R50's rate earlier this morning it was set at 2 liters per minute. V13 stated R50 cannot reach the oxygen concentrator so R50 could not have changed the rate. V13 stated the rate should not be that high based on the doctor's order, it should be infused at 2 liters per minute. On 09/03/24 at 11:27 AM, V13 checked R50's oxygen saturation rate which was 99%. V13 turned down R50's oxygen rate to 2 liters per minute. R50's diagnosis included but not limited to Cerebral Infarction, Type 2 Diabetes Mellitus with Diabetic Neuropathy, Hyperlipidemia, Peripheral Vertigo Unspecified Ear, Hearing Loss Bilateral, Tinnitus, Unspecified Ear, Hypertension, Cerebral Infarction Due To Unspecified Occlusion Or Stenosis Of Basilar Artery, Cerebral Infarction Due To Unspecified Occlusion Or Stenosis Of Unspecified Cerebral Artery, Asthma, Dysphasia, Dizziness And Giddiness, Syncope And Collapse, Long Term Use Of Insulin, Acquired Claw Hand, Left Hand R50's Order Listing Report dated 09/03/24 documents in part, oxygen 2L/min via nasal cannula to maintain oxygen saturation level equal or above 92% as needed for asthma. R50's oxygen care plan dated 09/03/24 documents in part, give oxygen as ordered by the physician at 2 LPM (liters per minute) via nasal cannula.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 46342 Based on observation, interview, and record review the facility failed to ensure resident individualized diet order and food plan was followed affecting one resident (R159) out of 6 residents reviewed for nutrition. The facility also failed to ensure the diet spreadsheet and recipes were followed for pureed food preparation affecting all 22 residents receiving pureed diets in the facility's kitchen. Findings Include: On 09/03/24 at 10:41 AM, R159 said, all my meals are pureed, and I get mashed potatoes at almost all my meals which I am really sick of. I don't know why they cannot puree other things for me, so I don't get the same thing every day. R159 stated R159 is not allowed any liquids except water and is only allowed to have ice cream once a day. R159 said, it's because of my swallowing. Sometimes thin liquids go into my lungs instead of into my stomach. On 9/03/24 12:37 PM, observed R159 eating lunch in R159's room. R159 received single portions of pureed pork, what appeared to be mashed potatoes (pureed rice listed on menu), pureed vegetable, ice cream, yellowed colored juice, applesauce, fortified pudding. No water on tray was provided on R159's tray. No gravy was seen on R159's pureed food. Observed R159's meal ticket documented in part, TRIPLE PORTIONS (3X) Food Serving, Fortified Pudding, Applesauce and Only Water for Liquids on Tray. Extra gravy is not listed on meal ticket. R159 stated I should not have been given the juice; I'm only supposed to get water. R159 says R159 gets given cartons of milk, juice, and coffee on R159's meal tray way too often. R159 stated, that juice shouldn't be on my tray. It is a mistake. R159 stated the amount of food R159 received does not look like triple portions to him and that R159 usually only receives single portions. R159 stated R159 usually eats 100% of his meals. On 09/03/24 at 12:56 PM, observed R159's lunch tray. R159 had consumed 100% of all the pureed food on his tray, 100% ice cream, 0% juice, 100% applesauce, 100% fortified pudding. On 09/04/24 at 12:45 PM, observed R159's lunch tray. R159 received singled portions of pureed meat with gravy, pureed green vegetable, pureed bread, mashed potatoes with gravy, fortified pudding, vanilla pudding. There was no water or applesauce on R159's tray. On 09/04/24 at 12:47 PM, surveyor observed with V27 (Certified Nursing Assistant), R64's pureed lunch tray. R64 received single portions of pureed food. On 09/04/24 at 12:50 PM, surveyor observed with V27, R159's pureed lunch tray and V27 stated the portions R159 received looked the same as the portions R64 received. V27 stated R159 did not receive double or triple portions of pureed food. V27 stated V27 gives R159 ice cream after R159 finishes R159's meal because R159 does not like it melted. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/04/24 at 12:55 PM, V13 (Registered Nurse) viewed R159's lunch tray and reviewed R159's meal ticket and stated R159 is only allowed water based on R159's meal ticket and R159 should be provided with water on R159's tray. V13 stated R159 was not provided with any water on R159's tray and V13 does not know why it is missing. On 09/04/24 at 12:57 PM, R159 stated, I'm also missing applesauce from my tray which I use because it helps me swallow my food better. R159 looked at the mashed potatoes on R159's tray and stated, see? They gave me mashed potatoes again. Scalloped pureed potatoes sound very good to me. Some variety would be good! R159 stated R159 is not aware of R159 ever being given triple portions and said, that would be a lot of food on my plate and would be something I'd notice. R159 stated R159 usually eats 100% of the pureed food and stated R159 feels R159 could eat more food than is provided to R159. R159 stated the staff always gives R159 ice cream after R159 eats R159's lunch meal. On 09/04/24 at 2:00 PM, V28 (Registered Dietitian) stated the kitchen should be following the menus and recipes to make sure the residents are receiving a variety of food and the appropriate nutrition for the day. V28 stated residents on pureed diets should not receive mashed potatoes every day and today residents on pureed diets should have received pureed scalloped potatoes if that is what the other residents are receiving. V28 stated residents on pureed diets should receive the same items served to residents on regular diet consistency except in a pureed form, assuming the food can be pureed safely. V28 stated the staff should be following the meal tickets and provide the food listed on the meal tickets because the meal tickets list the resident's diet order and any other special instructions specific to that resident. V28 stated based on R159's meal ticket R159 should have received triple portions of pureed foods, applesauce, and water with meals, no juice or other type of liquid. V28 stated it is important to provide R159 with water on R159's tray because this is R159's primary source of water which R159 needs for hydration. V28 stated R159 should not have been provided juice because this has the potential to cause an infection if R159 aspirated the juice. V28 stated R159 should have received applesauce on R159's tray because it is listed on R159's meal ticket. V28 stated R159 is eating well and meeting baseline nutritional needs but if R159 received double or triple portions this could potentially promote weight gain which would be beneficial to R159. On 09/04/24 at 1:18 PM, V29 (Speech Language Pathologist) stated R159 recently had a Modified Barium Swallow Study, and the recommendations were for R159 to stay on pureed diet consistency and with thin water only with meals (no other liquids), one ice cream per day and extra gravy with meals. V29 stated it is safer to aspirate water versus something that is different than what the body normally has inside it compared to the juice which has sugar and coloring in it. V29 stated if R159 aspirated juice it could go into his lungs which could be painful, and water is safer. V29 stated R159 has a very good appetite and when V29 was working with R159 he routinely consumed 100% of the meal. V29 stated applesauce was R159's preference and if R159 feels like the applesauce helps R159 facilitate swallowing then it definitely could and should be provided to R159. V29 stated R159 should not have received the juice on R159's tray and R159 should have received water on R159's tray. V29 stated R159 should be receiving extra gravy with all meals to help the food go down better. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/05/24 at 9:57 AM, V31 (Dietary Director) stated the meal tickets reflect the physician generated diet order and any recommendations which come from the Registered Dietitian including food preferences and additional food items. V31 stated it is important for the staff to read the meal tickets carefully to make sure they pick up details of the resident's meal plan. V31 stated it is important for the staff to follow the meal tickets, so the resident receives the correct diet order and dietary interventions based on the physician diet order and Registered Dietitian's recommendations. V31 stated the potential problem of a resident not receiving extra portions when its part of their diet order is that their intake would be lesser than what they should receive for that meal which over time could potentially lead to weight loss. V31 stated R159 should have received triple portions and applesauce as listed on the meal ticket. V31 stated the kitchen staff is not responsible for putting liquids on resident meal trays, that is something the nursing staff does. R159's diagnosis includes but not limited to Pneumonitis Due To Inhalation Of Food and Vomit, Muscle Wasting And Atrophy, Dysphasia Oropharyngeal Phase, Difficulty Walking, Cognitive Communication Deficit, Needs For Assistance Personal Care, Chronic Idiopathic Constipation, Anemia, Severe Protein Calorie Malnutrition, Disorders of Electrolyte and Fluid Balance, Disturbance of Salivary Secretion, Repeated Falls, Cachexia, Reduced Mobility, Specified Disorders Of Bone Density And Structure, Adult Failure To Thrive, Sepsis. R159's MDS (Minimum Data Set) dated 06/14/24 BIMS (Brief Interview for Mental Status) was 12 out of 15 indicating moderately impaired cognition. R159's Order Listing Report printed 09/03/24 documents in part, general diet pureed texture, thin liquids consistency, WATER ONLY. Triple portions with all meals. Applesauce with all meals. Mashed banana with breakfast, extra gravy with meal, may have 1 ice cream per day and fortified pudding with meals for supplementation. R159's meal tickets document in part, general type diet pureed consistency, (3x) TRIPLE PORTIONS food serving applesauce with all meals, ONLY water for liquids on tray. Mashed banana with breakfast and extra gravy with meals are not listed on R159's meal tickets. R159's swallowing/nutrition care plan documents in part, R159 is at risk to potentially choke or aspirate food or liquids. This problem is related to dysphagia. BMI 17.2 underweight. Potential for weight changes due to disease and age process. R159 is malnourished. Interventions include double portions with all meals, applesauce with all meals, pudding with all meals, mashed banana with breakfast when available and prepare/serve the resident's nutritional diet as ordered. 44103 (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/4/24 at approximately 10:39 AM, Surveyor observed the pureed preparation in the kitchen. V33 (Assistant Cook) pureed the braised beef tips with gravy and the garlic green beans. V33 did not prepare the pureed scalloped potatoes. V33 stated that V33 only prepared the pureed braised beef and the green beans because V33 already prepared the powdered mashed potato from the box, and this will be served to all residents on pureed diet. V33 stated that V33 used the powdered prepacked mashed potato and poured it with boiled water. V33 stated did not put any other ingredients because it's in a pack, just mix the powder with water and its instant mashed potato. V33 stated will not prepare the pureed dinner roll because there is already the mashed potato to be served. V33 and V31 (Dietary Director) stated that the recipe book and the diet spreadsheets are followed when preparing pureed food. V31 further stated that the residents' meal tickets should be followed, and everything listed on the meal ticket should be served to the resident. On 9/4/24, during lunch observation on the 3rd and 4th floors, survey team observed mashed potatoes being served to residents on pureed diet. At 3:07 PM, a follow up visit was conducted in the kitchen and obtained a copy of the Pureed Scalloped Potatoes. V31 stated that V33 added a scalloped seasoning when preparing the powdered mashed potato. Surveyor asked V31 to show the scalloped seasoning that was used. V31 stated it's not available since it was all used up this morning. The facility's Diet Spreadsheet shows for Day: 11 - Wednesday lunch, residents on pureed diet to receive pureed braised beef tips with gravy, pureed scalloped potatoes, pureed garlic green beans, pureed creamy custard pie, pureed buttered dinner roll, and beverage. The facility's Pureed Scalloped Potatoes recipe reads in part: Place prepared scalloped potatoes in a clean and sanitized food processor. Add milk gradually, as needed and blend until smooth. The facility's Diet Type Report printed on 9/5/24 shows there are 22 residents receiving pureed diet in the facility. The facility's job description for the [NAME] dated 12/1/19 shows that it is the Cook's duties and responsibilities to ensure trays are prepared according to diet cards in an efficient manner to meet scheduled meal and snack times.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview, and record review, the facility failed to ensure adaptive eating equipment was provided to 2 (R96 and R135) residents to facilitate self-feeding. This failure affected 2 (R96 and R135) of 2 residents reviewed for assistive device during mealtime in the sample of 33 residents. The findings include: R96's admission record documented admitted on 10/21/2023 with diagnoses not limited to Parkinson's disease without dyskinesia, Difficulty in walking, Alzheimer's disease, Unspecified dementia, Adult failure to thrive, Anemia, Presence of cardiac pacemaker. R135's admission record documented admitted on 6/7/2023 with diagnoses not limited to Huntington's disease, Adjustment disorder with depressed mood, Dysphagia, Anemia, Unspecified dementia. On 9/3/24 at 12:18 PM, During dining observation, R135 sitting up on wheelchair in the dining room. Lunch tray served with divider plate with rice, ground meat, mixed vegetables, juice, coffee. R135 observed with involuntary movements, able to spoon feed self post tray set up. R135 wearing protective clothing with food spillage on it. R135's meal ticket showed Divider plate to use + adaptive utensils (silver wares with rubber handles). Adaptive utensil was not provided at mealtime. R135 was using regular silver with no rubber handles and food was falling / spilling on her protective clothing. V5 (Registered Nurse / RN) requested to the dining room and confirmed adaptive utensil was not available for R135. V5 said she will follow up in the kitchen. At 12:33 PM, R96 observed sitting up on wheelchair in the dining room. Lunch tray served with divider plate with rice, ground meat, mixed vegetables. Observed R96 feeding self and having difficulty scooping out food. Observed spillage of food on lunch tray and clothing. Meal ticket indicated plate guard, but no plate guard was provided. On 9/3/24 at 2:49 pm, V2 (Director of Nursing / DON) said adaptive eating equipment is recommended by therapist. Kitchen is responsible for providing and cleaning the equipment. Adaptive eating equipment helps or assist resident during mealtime, maintain level of functioning and promote independence at mealtime. On 9/4/24 at 10:50 am, V11 (Director of Therapy) said has been working in the facility about 2 years. Adaptive eating equipment is recommended by OT (Occupational Therapist) to promote independence at mealtime. He said example of adaptive eating equipment is weighted utensil and plate guard. Weighted utensil is recommended for resident who have tremors, easier for the resident to bring food into their mouth to prevent spillage of food and better control from hand to mouth. It will provide more independence with eating. Possible more spillage of food when eating adaptive equipment was not provided. The use of plate guard is for resident having a hard time scooping food. Plate guard is use for easier scooping of food to prevent spillage and promote independence with feeding. V11 stated R135 was recommended with adaptive eating utensil due to her diagnosis of Huntington's disease, she has involuntary movements. (continued on next page)

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R96's POS (physician order sheet) showed active order not limited to general diet, mechanical soft texture. MDS (minimum data set) dated 7/5/2024 showed R96's cognition was severely impaired. He needed partial / moderate assistance with eating. R96's meal ticket showed adaptive equipment: Plate guards. R135's POS (physician order sheet) showed active order not limited to general diet, mechanical soft texture. Divider plate, adaptive utensils / spoon. Care plan dated 6/8/23 documented in part: R135 have an ADL (activities of daily living) self-care performance deficit and impaired mobility. Eating: require partial weight assistance to eat using a weighted utensils for good holding and grip and divider plate to keep the food from spilling. R135's meal ticket showed divider plate to use + adaptive utensils (silver wares with rubber handles). MDS dated [DATE] showed R135's cognition was moderately impaired. She needed Supervision / touching assistance with eating. Facility's policy for restorative nursing program dated 8/19/24 documented in part: Evaluation as to the need of adaptive equipment / enabling devices to help accommodate the resident's needs, promote optimal functioning and self-sufficiency in ADL's.

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	145775	A. Building B. Wing	09/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Healthcare & Rehab Ctr	3919 West Foster Avenue Chicago, IL 60625

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on observation, interview, and record review the facility failed to (a) ensure staff handled medications in a sanitary manner and performed hand hygiene for 4 (R53, R99, R114, R153) of 5 residents reviewed during the medication administration; (b) post Enhanced Barrier Precautions (EBP) signage for 2 (R30 and R64) residents with an indwelling medical device, and (c) wear proper PPE (Personal Protective Equipment) during high contact resident care activities. These failures have the potential to affect 55 residents residing on 3rd floor and 59 residents residing on 4th floor as of census dated 9/3/24. The findings include: On 9/03/24 at 10:18 AM, R30 Observed lying in bed, head of bed slightly elevated, alert with confusion. Observed with IV fluids D5 0.45% NACL infusing on right arm at 40cc/hr. Requested V5 (Registered Nurse / RN) to R30's room, V5 donned gloves and access IV site by removing kerlix wrap to check IV dressing. V5 did not wear gown. No EBP signage posted on room entrance, no PPE supplies available nearby or by the hallway. She said IV fluid was started 3-4 days ago for hydration. At 11:58 am, V7 (Certified Nursing Assistant / CNA) stated has been working in the facility for [AGE] years and regularly assigned on 4th floor. Stated she is working with R30. She said R30 is incontinent of bowel and bladder, requires total assistance with transfer, bed mobility and toileting hygiene. V7 said incontinence care was done earlier and wore gloves. Stated did not wear gown because R30 is not on isolation. At 2:49 pm, Interview with V2 (Director of Nursing / DON) said resident who has foley cath, wounds, G-tube, colonized MDROs, with peripheral line, PICC line, central line, dialysis access site should be placed under Enhanced Barrier Precautions (EBP) and signage should be posted by resident's door so everyone would be alerted when going inside the room. V2 said staff should be wearing proper PPE (Personal Protective Equipment) such as gown, gloves when providing high care activities such as accessing IV site, providing incontinence care, ADL (activities of daily living) care. Wearing proper PPE is for staff and resident protection to prevent cross contamination. PPE supplies should be available at least 2 rooms apart. On 9/5/24 at 11:35 am, V3 (Infection Preventionist / IP nurse) said has been working in the facility for a year. Residents who have indwelling medical devices such as IV access site, central line and dialysis access site, wounds should be placed under EBP. Signage kept in front of the door; PPE supplies keep in bins shared in between every 2 -3 resident's rooms. She said EBP signage is posted so staff is aware that resident is on EBP in that room and instructions of PPE requirements, when to put it on. High contact activities / care such as changing bed, linens, incontinence care and IV dressing. Staff should be wearing proper PPE such as gloves and gown and mask if needed. V3 said if staff is not wearing proper PPE, could potentially Introducing possible infection to the residents. Protection for staff and residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	MDS (minimum data set) dated 6/3/24 showed R30's cognition was severely impaired. She needed substantial / maximal assistance with eating, oral and personal hygiene, shower / bathe self, upper body dressing, Dependent with toileting hygiene and lower body dressing. MDS showed R30 was incontinent of bowel and bladder. R30's POS (physician order sheet) showed active order not limited to: Dextrose - NaCl solution 5-0.45% (Dextrose - Sodium Chloride) use 40ml/hr intravenously every shift for hydration for 3 days. Order date 8/31/24. Facility's policy for Enhanced Barrier Precaution dated 7/26/24 documented in part: EBP involves the use of gowns and gloves to reduce transmission of resistant organisms during high contact resident care activities for residents known to be colonized or infected with MDROs as well as residents with wounds and / or indwelling medical devices. The EBP requires the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of XDROs to staff hands and clothing. Examples of high contact resident care activities requiring gown and gloves use among resident s that trigger EBP use include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care use. 39779 On 09/03/24 at 09:17 AM, V13 (Registered Nurse) entered R153's room with signage posted Enhanced Barrier Precautions with the blood pressure monitor obtaining a blood pressure reading of 114/71 pulse 74. V13 exited R153's room without performing hand hygiene and began preparing R153 medications. On 09/03/24 at 09:24 AM, V13 (Registered Nurse) entered R153's room and administered R153 medications. On 09/03/24 at 09:31 AM, V13 (Registered Nurse) entered R114's room with signage posted Enhanced Barrier Precautions and assisted R114 with dressing. V13 exited R114's room without performing hand hygiene and began preparing R114 medications. V13 reentered R114's room to administer R114's medications. On 09/03/24 at 09:37 AM, V13 (Registered Nurse) returned to the medication cart to document in the computer without performing hand hygiene. V13 then put on gloves and began cleaning the blood pressure monitor. On 09/03/24 at 09:39 AM, surveyor asked V13 (Registered Nurse) what she should have done after obtaining R153's blood pressure, before preparing R153 medication, after assisting R114 with dressing, before preparing R114's medications and before applying gloves to clean the blood pressure monitor. V13 responded, hand sanitizing. I used gloves, but it is for infection control. On 09/03/24 at 09:46 AM, V12 (Registered Nurse) proceeded down the hallway and pushed R53 in her wheelchair to her room. V12 returned to the medication cart and began preparing R53's medications without performing hand hygiene. On 09/03/24 at 09:50 AM, V12 (Registered Nurse) entered R53's room and administered R53's medication. V12 retrieved the medication cup, placed R53's call light closer to her, returned to the medication cart, and discarded the medication cup. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/03/24 at 09:54 AM, V12 (Registered Nurse) entered R99's room with signage posted indicating Enhanced Barrier Precautions with the blood pressure monitor obtaining a blood pressure reading of 133/65 pulse 75. On 09/03/24 at 10:01 AM, V12 (Registered Nurse) returned to the medication cart without performing hand hygiene then began preparing R99's medications. V12 reentered R99's room and administered R99's medications. V12 then exited R99's room without performing hand hygiene, retrieved a pair of gloves then reentered R99's room and repositioned R101 in the bed. On 09/03/24 at 10:05 AM, surveyor asked V12 (Registered Nurse) what she should have done after pushing R53 in the wheelchair and before preparing R53 medications. V12 responded, Hand hygiene, wash or do something to prevent any cross infection. When asked should hand hygiene be done before applying gloves, V12 responded, technically if my hands are clean, I would not do it. When asked after administering medication and touching the medication cup that the resident took the medication cup would her hands be considered unclean. V12 responded, yes, they would be contaminated. When asked are gloves used as a substitution for hand hygiene. V12 responded, gloves are not used as a substitute for hand hygiene. Hand hygiene should be done before the gloves are applied. On 09/05/24 at 12:06 PM, V2 (Director of Nursing) stated when staff is passing medications at the beginning and completion of the task, hand washing or hand hygiene with the sanitizer should be done. After touching the wheelchair, the nurse hands were contaminated, and she should have done hand washing or sanitizing before preparing the medication. After touching the blood pressure monitor, the nurse should have washed her hands before preparing the medication. That is standard precautions for infection control. The nurse should have washed her hands before applying the gloves and repositioning R101. Gloves are not used as a substitution for hand hygiene. Always hand washing then gloves. Before and after resident contact hand hygiene should be performed. Policy: Titled Medication Pass revised 08/16/24 document in part: Policy Statement: It is the policy of the facility to adhere to all Federal and State regulations with medication pass procedures. 7. PO (by mouth) meds: a. Follow hand hygiene procedure before and after each resident. Titled Hand Hygiene revised 07/30/24 document in part; Policy Statement: Hand hygiene is important in controlling infections. Hand Hygiene consists of either hand washing or the use of alcohol gel. The facility will comply with the CDC (Centers for Disease Control and Prevention) Guidelines in regard to hand hygiene. Procedures 1. Hand Hygiene using alcohol-based hand rub recommended during the following situations: a. Before and after direct resident contact. i. after removing gloves including during wound dressing change. 46342 On 09/03/24 at 11:03 AM, observed tube feeding pole at R64's bedside with no tube feeding hung or infusing. There was no Enhanced Barrier Precaution (EBP) signage posted outside R64's room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 09/03/24 at 11:11 AM, V13 (Registered Nurse) stated residents on Enhanced Barrier Precaution include those who have any indwelling catheter for urinary, feeding tube, central line or open wounds. V13 stated Enhanced Barrier Precaution signage is posted outside the resident's room to give a visual alert to staff and visitors so they know to do hand hygiene before and after entering the room or wear personal protective equipment (PPE) when administering care. V13 stated R64 has a gastrostomy tube and R64's tube feeding is administered at night. On 09/03/24 at 12:19 PM, V13 looked in R64's electronic health record (EHR) and stated R64 has a physician order for Enhanced Barrier Precaution dated 09/02/24. V13 observed that there was no Enhanced Barrier Precaution sign outside R64's room and stated V13 does not know why there is no Enhanced Barrier Precaution sign outside R64's door. V13 stated R64 should have an Enhanced Barrier Precaution sign posted outside R64's room because R64 has a gastrostomy tube. On 09/03/24 at 12:21 PM, observed V13 posting Enhanced Barrier Precaution sign outside R64's room on R64's door. V13 stated, V13 called the Infection Preventionist Nurse who told V13 to post the EBP sign outside R64's room. On 09/05/24 at 9:40 AM, V2 (Director of Nursing) stated if a resident has a feeding tube there should be Enhanced Barrier Precaution signage outside the resident's door to tell the staff what type of PPE to wear and when to where it. V2 stated the potential problem if there is no EBP signage on the resident's door is the staff may not know to wear PPE when providing care which would be an infection control concern because of the potential for cross contamination. On 09/05/24 at 10:22 AM, V3 (Infection Preventionist Nurse) stated V3 is the one who reviews all new admissions to see if they require contact isolation. If a resident has an indwelling catheter or open wound(s) they are placed on Enhanced Barrier Precautions. V3 stated V3 is responsible for putting up the Enhanced Barrier Precaution sign outside the resident's room. V3 stated the purpose of putting up the Enhanced Barrier Precaution sign is to notify the staff what PPE they have to wear when providing direct care to the resident and alert visitors to do hand hygiene before/after entering the room. V3 stated the potential problem if the Enhanced Barrier Precaution sign is not posted outside the resident's room who required EBP is that the staff would not know to put on PPE for high contact care activities and therefore there would be an increased risk of the resident getting an infection from the staff. V3 stated V3 put in an order into R64's EHR on 09/02/24 for Enhanced Barrier Precaution when V3 found out R64 was receiving tube feedings. V3 stated R64 should have had an Enhanced Barrier Precaution sign posted outside R64's room because R64 has a feeding tube. V3 stated, it was an oversight. R64's diagnosis included but not limited to Hemiplegia and Hemiparesis Following Cerebrovascular Disease Affecting Right Dominant Side, Dysphasia, Aphasia, Encounter for Attention to Gastrostomy, Difficulty in Walking, Abnormalities of Gait Mobility, Cognitive Communication Deficit, Muscle Wasting and Atrophy, Need For Assistance With Personal Care, Type 2 Diabetes Mellitus, Long Term Use Of Insulin, Encephalopathy, Malignant Neoplasm Of Unspecified Part Of Unspecified Bronchus Or Lung, Cerebral Infarction, Depression, Asthma, Chronic Pain, Gastroesophageal Reflux Disease Without Esophagitis, Osteoarthritis Left Knee, Spinal Stenosis, Intervertebral Disc Degeneration, Hyperlipidemia, Hypertension, Hypertensive Heart Disease With Heart Failure, Radiculopathy. (continued on next page)

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