STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City View Multicare Center	5825 West Cermak Road Cicero, IL 60804

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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 - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, interview, and record review, the facility failed to serve lunch to residents in the dining room at the same time as other residents seated at the same tables. This affected four of four residents (R192, R195, R258, and R260) reviewed for dignified dining experience in a sample of 63. Findings include: On 6/4/25 at 12:30PM, lunch service started on 8th floor common dining room. Resident names were called and lunch trays were provided. At the completion of the tray line, R258, R260, R192, R195 all were not given lunch trays. R258 and R260 were present in the dining room and names were not called by staff. R258 and R260 lunch trays were found on cart by staff and given to the residents. On 6/4/25 at 1:14PM, R260 was served a lunch tray. On 6/4/25 at 1:16PM, R192 was served a lunch tray. R192 did not have a diet ticket. On 6/4/25 1:24PM, R258 was served his lunch tray. On 6/4/25 at 1:25PM, R195 was served a lunch tray. R195 did not have a diet ticket. Facility's dignity policy, undated, documents: Trays must be served in order at each individual table- residents should not be sitting at the table eating while tablemates wait for their food to be delivered to them.

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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain and document consent for participation in a pharmacy program, which included taking medication (descovy) for human immunodeficiency virus (HIV) pre exposure prophylaxis for four (R117, R129, R256, R258) of four residents reviewed for resident rights. Findings include: 1. R117 was admitted to the facility on [DATE], with diagnoses of hypertension, kidney disease, and schizoaffective disorder. R117's Brief Interview for Mental Status score, dated 5/14/25, documents a score of 15/15, which indicates cognitively intact. R117's physician orders, dated 5/28/25, documents Descovy Oral Tablet 200-25 MG. Give 1 tablet by mouth every day shift related to encounter for HIV pre-exposure prophylaxis. On 6/6/25, medication descovy was observed on medication cart with V10 (nurse). R117's medication administration record for June 2025 documents R117 received Descovy on 6/2/25, 6/3/25, and 6/4/25. On 6/5/25 at 4:15PM, R117, who was alert and oriented at time of interview, said he was familiar with his medications, and was not aware of taking descovy. R117 denied any information from the facility about the pharmacy program, or about taking medications to prevent sexual transmitted diseases. R117 said he did not agree to take that medication, and would not agree to take it. R117's medical record did not document any consent for participation in the program, consent for descovy, or education for descovy medication. Medical record did not have a plan of care or documentation about program. 2. R129 was admitted to the facility on [DATE], with diagnoses epileptic seizures related to external causes, altered mental status, schizoaffective disorder, bipolar, vascular dementia unspecified severity without behavioral disturbances. R129's Brief Interview for Mental Status score, dated 4/6/25, documents a score of 15 /15, which indicates cognitively intact. On 6/5/25 at 4:20PM, R129, who was alert and oriented at time of interview, said he was not taking any medications for sexual transmitted diseases. R129's physician orders, dated 5/28/25, documents Descovy Oral Tablet 200-25 MG. Give 1 tablet by mouth every day shift related to encounter for HIV pre-exposure prophylaxis. On 6/6/25, medication descovy observed on medication cart with V10 (nurse). R129's medication administration record for June 2025 documents R129 received Descovy on 6/2/25, 6/3/25, and 6/4/25. R129's medical record did not document any consent or education for descovy medication. Medical record did not have plan of care or documentation about program. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. R256 was admitted to the facility on [DATE], with diagnoses of major depressive disorder, type II diabetes, and hypertension. R256's Brief Interview for Mental Status score, dated 3/24/25, documents a score of 10 /15, which indicates moderate cognitive impairment. On 6/5/25 at 4:23PM, R256, who was alert to self, said he was not aware of what medications he takes, and unsure about any medications or education provided related to sexual transmitted diseases or HIV. R256's physician orders, dated 5/28/25, documents Descovy Oral Tablet 200-25 MG. Give 1 tablet by mouth every day shift related to encounter for HIV pre-exposure prophylaxis. On 6/6/25, medication descovy observed on medication cart with V10 (nurse). R256's medication administration record for June 2025 documents: R256 received Descovy on 6/1/25 6/2/25, 6/3/25, and 6/4/25. R256's medical record did not document any consent or education for descovy medication. Medical record did not have plan of care or documentation about program. 4. R258 was admitted to the facility on [DATE], with diagnoses of schizoaffective disorder, anxiety, cannabis use, and auditory hallucinations. R258's Brief Interview for Mental Status score, dated 5/23/25, documents a score of 15 /15, which indicates cognitively intact. R258's physician orders, dated 5/28/25, documents Descovy Oral Tablet 200-25 MG. Give 1 tablet by mouth every day shift related to encounter for HIV pre-exposure prophylaxis. On 6/6/25 medication descovy observed on medication cart with V10 (nurse). R258's medication administration record for June 2025 documents R258 received Descovy on 6/1/25, 6/2/25, 6/3/25, and 6/4/25. On 6/6/25 at 8:45AM, R258, who was alert and oriented at time of interview, said he was not aware he was taking any medication for HIV pre-exposure prophylaxis. R258 denied receiving any information related to the medication, and denied being sexual active at this time. R258 said he would not be interested in taking that medication. R258's medical record did not document any consent or education for descovy medication. Medical record did not have plan of care or documentation about program. On 6/6/25 12:10pm, V25(Certified Nurse Consultant) said residents at the facility are part of a community prevention for human immunodeficiency virus (HIV). Resident's charts are reviewed and those identified are asked if they would like to have testing for sexual transmitted disease and medication to prevent exposure. V25 said if resident agrees, they do not obtain a written consent for the medications. V25 said there is no documentation in the resident's medical record that documents they have consented to take the medication. There are no separate assessments that documents the identified risk factors for each resident. V25 said they are working on individualized plan of care for each resident receiving the medication. (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 6/6/25 at 9:53AM, V31(Medical Doctor) said he would expect the facility to obtain consent, provide education, and explain risk and benefits for the medication prior to administrating the medication. V31 said the medication is optional and up to the resident to consent if they would like to take the medication.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation, interview, and record review, this facility failed to ensure there was a call light cord attached to the call light switch on the wall for a dependent resident. This affected one of three residents R161 reviewed for call light accessibility in a sample of 63. Findings include: 06/03/25 11:40 AM, R161 was observed in bed. There was no call light cord attached to call light switch on wall. R161 stated she has to raise her bed up high and use her pillow to keep hitting the call light switch on wall behind R161's head of bed until it activates. R161 stated this has been going on for one month. On 6/3/25 at 12:45 PM, V34 (psychotherapist) stated today ,R161's BIMS (Brief Interview of Mental Status) score is 15 out of 15. V34 stated R161 has a good memory. On 6/3/25 at 11:55 AM, V3 (nurse) stated there is a binder kept at the nurse's station to document requests for maintenance. V3 held up the binder showing the last documented report to maintenance was June of 2024. V3 stated V3 called maintenance to notify of call light, but they must be busy because they have not come to fix R161's call light as of yet. On 6/3/25 at 12:20 PM, V19 (maintenance) stated he was informed today that R161's call light cord is missing. This facility's call light policy, dated 07/2011, notes check all call lights daily and report any defective call lights to the nurse immediately. If the call light is nonfunctional, give the resident another means to call for assistance. Be sure call lights are placed within the resident's reach at all times.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on interview and record review, the facility failed to report an allegation of staff to resident abuse to the State Agency. This affected one (R170) of three residents reviewed for abuse policy and procedure. Findings include: On 6/5/25 at 9:30AM, the surveyor attempted to interview R170. R170 only said good morning, but would not answer any other questions. On 6/5/25 at 8:14 AM, V11, Registered Nurse/RN, said, The CNAs (Certified Nursing Assistants) told me (R170) was spitting and swearing at them. When I saw (R170), she was still agitated, and (R170) said the CNAs hit her. I asked the CNAs about it, and they said she does that, she make allegations about them. The next day, someone from administration called me to ask why I did not notify them, and I said it slipped my mind. V11 said he was aware the allegation needed to be reported to administration. On 6/5/25 at 9:13AM, V1, Administrator, said, These are all the abuse reportables for the facility. Upon review, the surveyor did not see a report for R170 dated 5/19/25. On 06/05/25 at 11:33 AM, V1 said, I did not report R170's) allegation. The facility Abuse Policy, dated 2/1/25, states the facility shall report alleged violations to the state agency and take necessary corrective actions depending on the results of the investigations. Ensure all alleged violations involving abuse are reported immediately but no later than 24 hours if the allegation does not involve serious bodily injury. Have evidence that all alleged violations are thoroughly investigated.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, facility staff failed to accurately code a Minimum Data Set (MDS) for residents. This affected three of three residents (R98, R46, R269) reviewed for accurate assessment in the total sample of 63. Findings include: 1. R98's MDS (Minimum Data Set) section N medications denote high risk drug class, An X is documented denoting anticoagulant (warfarin, heparin, or low-molecular weight heparin). Number 2. Indication noted X noted for indication for all medications in drug class. Review of R98's physician order sheet showed there are no orders for warfarin, heparin, or low-molecular weight heparin. On 6/5/25 at 8:00 AM, V26 (MDS coordinator) said she coded section N incorrectly, she plans to submit a modification. 2. R46's diagnosis include Chronic Kidney Disease, stage 4, Dependence on Renal Dialysis. On 06/03/25 at 11:12AM R46 said, I have dialysis, I go there. R46's care plan identifies Diagnosis of renal failure and potential for complications related to dialysis. On 06/04/25 at 11:55AM V6, Director of Nursing/DON, said, (R46) has dialysis on Monday, Wednesday, and Friday. On 06/04/25 at 2:31PM, V8, MDS Nurse, said, There is no reason (R46) is not marked dialysis on the MDS. It's a mistake. 3. R269's progress note, dated 4/11/25, documents: R269 remains out on pass, in care of brother. Minimal Data Set (MDS), dated [DATE], documents: Short-Term General Hospital (acute hospital, IPPS). On 6/6/25 at 11:33a AM, V8 (Minimal Data Set coordinator) said, The MDS should be coded accuracy. (R269) went out on pass, but his MDS was code as a hospitalization, which was inaccurate.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for a resident identified as a smoker. This affected one of three residents (R72) reviewed for smoking. Findings include: On 06/04/25 at 12:30 PM, V28, Smoking Monitor, said, (R72) comes to smoke. V28 showed R72's cigarettes. On 06/04/25 at 1:00 PM, R72 was on smoking patio, smoking. At 1:30PM, R72 said he enjoyed his smoking time this afternoon. On 6/5/24 at 11:15AM, V6, Director of Nursing, said she expects medications, diagnosis, dialysis care, health conditions, behaviors and refusals, and smoking to be care planned. The purpose of care planning is to set a guideline and provide interventions. R72's Smoking Assessment, dated 4/7/25, says R72 smokes. R72's name is not on the facility submitted smoking list of residents. R72's care plan does not identify him for smoking.

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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. Deficiencies at this level require more than one deficient practice statement. A. Based on interview and record review, the facility failed to conduct care plan meetings with residents and/or resident representatives quartely, and failed provide residents with an opportunity to participate in the development, review, and revision of their care plans. This failure affected six of seven residents (R9, R15, R149, R161, R211, and R255) reviewed for care planning in a sample of 63 Findings include: 06/04/25 at 09:17 AM, V22 (Social Service Coordinator) stated a care plan conference with resident and/or resident's family is held quarterly. V22 stated he has not spoken with R15's family as of yet. V22 stated the previous Social Worker for the third floor nursing unit was gone prior to his start date. V22 stated he was not aware of R15's family member's request to have R15 transferred to a facility closer to them. 06/05/25 at 11:45 AM, V24 (Social Services Director) stated care plan meetings are held quarterly and annually for all residents. V24 stated the MDS (Minimum Data Set) staff send out invites to the resident's representative, and notify them of upcoming care plan meeting. V24 stated Social Services is informed of the upcoming scheduled care plan meeting, and follows up with the resident's representative for attendance. V24 stated care plan meetings are documented in the resident's progress notes; the type of note should be selected accordingly, discharge or care plan meeting. V24 stated discharge planning is initiated upon admission to facility, and is updated/reviewed quarterly. V24 stated a discharge care plan should be developed for each resident. 1. R9's medical record does not note a care plan meeting including R9 and R9's POA (Power of Attorney) has occurred in the last twelve months. 2. On 6/3/25 at 1:45 PM, R15's family member stated the facility will not let R15 transfer to a facility closer to R15's family. R15's family member stated she asked the Social Worker to send referrals to other long term care facilities. R15 stated staff have not kept her updated on the outcomes of the referrals. R15's medical record notes in 2023, referrals were sent out to other long term care facilities. There is no documentation noting if R15 was accepted or rejected. There is no documentation noting R15's family member received updates on referrals. There is no discharge care plan found in R15's medical record. R15's medical record does not note a care plan meeting, including R15 and R15's family member, has occurred in the last twelve months. 3. R149's medical record notes one care plan meeting including R149 and R149's family member has occurred in the last twelve months. The meeting was held on 1/14/25. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	4. R161's medical record notes one care plan meeting, dated 2/10/25, has occurred in the last twelve months. R161 and R161's family were invited to attend; R161 refused and family did not participate. 5. R211's medical record notes two care plan meetings, dated 12/9/24 and 3/5/25, have occurred in the last twelve months. R211 attended these meetings. 6. R255's medical record does not note a care plan meeting including R255 and R255's family member has occurred in the last twelve months. The facility's care plan policy, undated, notes each resident will have a comprehensive assessment completed by the interdisciplinary team upon admission, quarterly, and an individualized care plan will be developed and updated as needed with quarterly assessments, re-admissions, and changes in condition. The MDS nurse will complete the care plan calendar for the upcoming month to have ample time to send out resident/family invites. The resident/family will be afforded an opportunity to change the meeting date or time or be offered the opportunity to attend via telephone conference if the facility scheduled time is not convenient. B. Based on observation, interview, and record review, the facility failed to develop a comprehensive care plan for a resident identified as a smoker. This affected one of three residents (R72) reviewed for smoking. Findings include: On 06/04/25 at 12:30 PM, V28, Smoking Monitor, said, (R72) comes to smoke. V28 showed R72's cigarettes. On 06/04/25 at 1:00 PM, R72 was on smoking patio, smoking. At 1:30PM, R72 said he enjoyed his smoking time this afternoon. On 6/5/24 at 11:15AM, V6, Director of Nursing, said she expects medications, diagnosis, dialysis care, health conditions, behaviors and refusals, and smoking to be care planned. The purpose of care planning is to set a guideline and provide interventions. R72's Smoking Assessment, dated 4/7/25, says R72 smokes. R72's name is not on the facility submitted smoking list of residents. R72's care plan does not identify him for smoking.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to effectively monitor/supervise a resident with known history of wandering into other residents' rooms. This affected one of three residents (R255) reviewed for monitoring/supervision in a sample of 63. Findings include: 06/03/25 at 11:00 AM, R255 was observed entering R211's room and taking a pair of blue sweat pants from R211's belongings. R255 exited R211's room, and brought clothing item into her room and put with her belongings. R255 then entered R71's room and took an orange tee shirt from R71's drawer and put it on over her clothing. There were no staff monitoring R255. On 06/03/25 at 11:15 AM, R71 stated, (R255) does this all the time; coming in her room and taking her belongings. On 06/05/25 at 11:15 AM V6, Director of Nursing/DON stated the resident's care plan is expected to contain information on medications, health conditions, behaviors, and refusal of care. V6 stated R255 has a behavior of wandering into other residents' rooms. V6 was informed staff developed a hoarding care plan related to R255 entering other residents' rooms in search of items to hoard. V6 stated R255 should have a care plan for wandering behavior. V6 stated staff are expected to monitor residents with wandering behavior. V6 stated these residents should be encouraged to stay in dining room during day and participate in activities. R255's hoarding care plan, dated 3/3/25, notes this symptom is manifested by: R255 entering another person's room in search of items to hoard. Interventions identified: become familiar with the R255's patterns and whereabouts on the nursing unit. If rummaging/hoarding behavior is observed, request R255's help in another area. Provide a task or assignment for the resident to complete; check the R255's room on a frequent basis (e.g., weekly, monthly) to remove hoarded items that might pose a health or safety risk; and encourage participation in exercise programs and movement activities to help dissipate excess energy.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to serve double portions for one resident (R260) who was identified with a significant weight loss of 7.5 % in three months. This affected one of seven (R260) reviewed for significant unplanned weight loss This failure resulted in the R260 losing an additional unplanned five pounds in a month, and a total of 12.5% in six months. Findings include: R260 was admitted to the facility on [DATE], with diagnoses of major depression disorder, schizophrenia, autistic, anxiety, delusional disorder, and paranoid disorder. R260's weights: 5/5/25- 156.6 pounds 4/5/25 157.2 pounds 3/4/25- 161 pounds 2/5/25 168 pounds 1/28/25- 168.4 pounds 1/21/25- 169.8 pounds 1/14/25-170.4 pounds 1/5/25- 172.6 12/30/24- 172 pounds. R260's mini nutritional assessment, dated 4/7/25, documents malnourished. R260's progress note, dated 4/15/25, documents: NUTRITION: RD (Registered Dietician) WEIGHT REVIEW Value: 157.2 Vital Date: 2025-04-05; -7.5% change [8.9% , 15.4]; BMI: 21.3 within normal limits (wnl); Diet: General Regular thin liquids; SKIN: No reported open areas. Review: Weight loss trend reflecting significant changes x 90 days. No reported edema. Records of amount eaten showing by mouth intake 76-100% of most meals. Plan/Recommendation: Add to diet: Double portions all meals. Staff supervision at meals, monitor intake, weights, labs, skin. Reassess as needed. R260's diet tickets reviewed for 6/3/25 and 6/4/25 did not document double portions. On 6/4/25 at 1:14 PM, R260 was served a lunch tray without double portions. On 6/5/25 at 1:46PM, R260's weight taken on standing scale; R260 weighed 151.4 pounds. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/5/25 at 12:40PM, V5 (Dietician) said, (R260) was assessed in April due to a significant weight loss of 7. 5 % in 3 months. Double portions were added to all meals to add extra calories. I communicate changes or recommendations to the Director of Nursing, who will put the orders in the electronic charting system. V5 was asked how you ensure recommendations are being followed. V5 said she checks the resident's chart. V5 said they will only check weekly weights for residents with a weight loss of 5 % in one month. V5 said they will not usually put in other interventions because R260 was eating at all meals with no concerns. V5 said there were no other interventions in place. V5 said she would expect her recommendations to be followed. On 6/5/25 at 1:53PM, V14(Dietary Manager) said residents receiving double portions would be documented on the resident's meal ticket. V14 confirmed R260 dietary ticket did not document double portions. On 6/6/25 at 9:24AM, V5 said R260 had significant weight loss, and would not be considered insidious weight loss. V5 was asked if the lack of double portions would have contributed to R260 weight loss. V5 said she would not be able to determine if that was accurate statement. Facility policy titled weight, revised 9/23, documents the clinical nutrition practitioner will identify significant and insidious weight loss. Significant weight change is defined as: 2 % change in one week, 5% change in one month, 7.5 % change in three months, 10 % change in 6 months. Insidious weight loss or gain defined as a gradual, unintended, progressive weight loss or gain over time. Residents with significant and insidious weight changes will be assessed to determine the reason for significant weight change.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145850	A. Building B. Wing	06/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
City View Multicare Center	5825 West Cermak Road Cicero, IL 60804

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on interview and record review, the facility failed to post Nurse Staffing Data available for residents and visitors. This failure has the potential to affect all 267 residents in the facility. Findings include: According to the CMS 671 form, dated 06/03/25, there are 267 residents in the facility. On 06/03/25 at 1:28 PM, surveyor went to the front desk looking for staff data sheet. None seen. V7, Security Director, said I'll ask. I don't see one, let me ask. On 06/03/25 at 1:43 PM, V7 presented the Nursing Staffing Data Sheet, dated 6/3/26, and said, It should be in the case, but it wasn't this morning. On 06/04/25 at 9:39 AM, posting, dated 6/1/25, in the case. On 6/5/25 at 10:35AM, posting, dated 6/1/25, in the case.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. Based on interview and record review, the facility failed to ensure the resident was free from unnecessary medications and with a diagnosis for the use of an anticoagulant. This affected one of one resident (R120) reviewed for unnecessary medications in the total sample of 63. Findings include: R120's face sheet shows diagnoses of unspecified dementia, bipolar disorder, schizoaffective disorder, zoster without complications, hyperlipidemia, tinea unguium, unspecified psychosis, dementia in other disease, screening for malignant neoplasm of prostate, fracture of orbital floor 5/8/2023), history of COVID 19, contact with and suspected exposure to COVID19, and acute kidney failure. On 6/3/25 and 6/4/25, R120 was alert; speech was not clear when attempt to interview about his medication. R120 was ambulating independently, transferring from bed independently, and transferring from surface to surface independently. R120's physician order sheet documents orders for heparin Heparin Sodium (Porcine) Injection Solution 5000 UNIT/ML(milliliter), Inject 1 milliliter subcutaneously every eight hours for VTE (Venous Thromboembolism) prophylaxis, order date 1/20/2025. R120's medication administration record for June 2025 documents R120 received heparin 5000 units 12 times in June 2025. On 6/5/25 at 1:58 PM, V27 (Medical Doctor) said R120 was taking heparin because he was on it in the hospital, and it thins the blood to prevent clots. V27 said when the resident is non ambulatory, it puts them at risk for blood clots. R120's medical diagnoses were reviewed with V27 as listed on the face sheet. V27 restated R120 was on heparin while in the hospital, and the plan is to place R120 on coumadin. Review of R120's medical diagnoses shows no documented diagnosis of VTE (venous thromboembolism). Review of the MDS (Minimum Data Set) section I for diagnoses shows no diagnosis of VTE. On 6/6/25 at 9:28 AM, V1 (Administrator) confirmed there are no current diagnosis for R120's use of heparin injections. V1 said she will have the medical provider evaluate R120 to determine if the heparin is needed. On 6/6/25 at 2:05 PM, V1 presented a document stating R120 was seen by the NP (Nurse Practitioner). Review of the document, V1 was informed there is not a diagnosis for the use of heparin.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, interview, and record review, the facility failed to provide the lunch meal served from the steam table at a temperature of at least 125 degrees Fahrenheit. This failure affected the 10 of 10 (R51, R79, R176, R186,R192,R195, R222, R256,R258, R260) residents on the eighth floor nursing unit. Findings include: According to the current resident census there are 10 resident residing on the eight floor nursing unit. (R51, R79, R176, R186,R192,R195, R222, R256,R258, R260) On 6/4/25 at 12:30 PM, the lunch meal was observed on the eighth floor nursing unit. V23 (Dietary staff) was noted obtaining the following temperatures: regular diet: chuckwagon beef stroganoff at120 degrees, noodles were at 110 degrees, buttered cabbage at 120 degrees, hamburgers at 90 degrees. Mechanical soft diet: chuckwagon beef stroganoff at 110 degrees. After V23 checked the temperatures, V23 began serving the meal. V23 did not bring the food to the appropriate temperature prior to serving. 06/04/25 02:21 PM, V14 (Dietary Director) stated the food temperatures should be 125 degrees prior to serving meal from steam table. This facility's food temperature resident policy, revised 04/2022, notes hot foods will be held at a minimum of 135 degrees Fahrenheit during tray assembly. Food temperature being held in the steam table will be documented by the food service manager or designee. Food that do not meet the above criteria for hot foods will be quickly brought to the appropriate temperature. Hot foods will be served to the resident at a temperature palatable and acceptable to the resident, general practice should not be less than 125 degrees Fahrenheit.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to check a resident's food allergy prior to meal service. This affected one of one residents (R192) reviewed for food allergies. Findings include: R192 was admitted to the facility on [DATE], with diagnoses of type II diabetes, asthma, and multiple sclerosis. Under allergies documents mushrooms. On 6/4/25 at 1:16PM, R192 was served a plate of beef stroganoff at lunch. R192 observed mushrooms in the sauce, and informed staff he was allergic to mushrooms. R192s diet ticket for 6/5/25 documents lunch chuck wagon beef stroganoff, with no allergy listed. Facility recipe for chuck wagon beef stroganoff, dated 6/4/25, documents: 10.5 pounds of fresh mushrooms On 6/5/25 at 1:53PM, V14(Dietary Manager) confirmed R192's diet ticket did not indicate documented food allergy. V14 said any food allergy would be documented on the dietary ticket to alert staff of any concerns. Facility diet orders policy, dated 9/2023, documents: food allergies and intolerances will not be liberalized.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to maintain separation between clean and soiled equipment, and failed to ensure staff and residents were not sharing drinks to prevent cross-contamination. This failure affected three residents (R68, R161, and R178) out of four reviewed for infection control in a sample of 63. Findings include: 1. R161's MDS (Minimum Data Set), dated 5/5/25, notes R161 is dependent on staff for toileting. R161 is frequently incontinent of bowel and bladder. On 6/3/25 at 10:50 AM, V18, CNA (Certified Nurse Aide), was observed providing incontinence care for R161. V18 donned gloves, provided bowel incontinence care, and with the same gloves, inserted four right fingers into a large multi-use container of petroleum jelly and scooped up some petroleum jelly and applied the petroleum jelly to R161's buttocks, then replaced lid on jar. Upon exiting room, V18 placed the jar in the clean linen cart with briefs and clean linen. On 6/5/25 at 12:45 PM, V35, CNA (Certified Nurse Aide) stated a barrier cream is applied to resident's buttocks after each incontinence episode. On 6/5/25 at 12:50 PM, V36 (Nurse) stated the CNAs should apply petroleum jelly to the resident's buttocks after each incontinence episode. On 6/3/25 at 3:45 PM, V6, DON (Director of Nursing), stated the petroleum jelly container is not to be used for multiple residents to prevent cross-contamination. 2. On 6/3/25 at 3:30 PM, V21, CNA, was observed sitting in the dining room supervising residents. V21 was observed drinking a large red slushee drink. The 30 ounce cup was half full. R68 was sitting at the same table with V21, with a styrofoam cup containing red slushee drink. R178 was sitting at a table across from V21, with a styrofoam cup containing red slushee drink. V21 shared her drink with R68 and R178. On 6/3/25 at 3:35 PM, V10, LPN (Licensed Practical Nurse), stated staff are not supposed to share their drinks with residents. On 6/3/25 at 3:45 PM, V6, DON (Director of Nursing), stated staff are not permitted to eat or drink while on duty. V6 stated this is completely inappropriate. On 6/6/25 at 9:30 AM, V25 (Chief Nursing Officer) stated preventing cross-contamination is the standard of care. This facility's infection prevention policy, dated 7/19/18, notes standard precautions for all residents is used to prevent the spread of infection within the facility. All resident body fluids, excretions, and secretions will be considered potentially infectious.