STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145866	A. Building B. Wing	05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hickory Vlg Nrsg & Rhb	9246 South Roberts Road Hickory Hills, IL 60457

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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 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 50036 Based on observation, interview and record review, the facility failed to have a five percent (5%) or lower medication error rate and failed to ensure staff followed proper infection prevention practices during medication administration. There were four medication errors out of 27 medication opportunities, resulting in a 14.81% medication error rate and affected 2 residents (R27 and R39) observed for medication pass. Findings include: On 5/14/24 at 8:08 am, V10 (Licensed Practical Nurse/LPN) was observed passing medications with the medication cart for south hall. Surveyor observed V10 prepare 3 pills total for R39 (Cholecalciferol 125 mg - 1 tablet, Cyanocobalamin 100 mcg tablet, and Norco 5/325 mg - 1 tablet) that was to be administered to R39. Upon review of the medication card, surveyor observed that it belongs to another resident. V10 was handing the medication cup with the 3 pills and water to R39. Once V10 was going to administer pills to R39, surveyor stopped V10 from administering Norco 5/325 mg and asked nurse to verify medication and resident name on that medication card. V10 then realized that medication card belonged to R65 and was not the correct medication. V10 took the Norco 5/325 mg pill with her bare hands and popped it back in the card it came out of, without correctly discarding the pill or securing the pill to card. V10 then pulled out the correct medication card and popped the correct pill (lorazepam 1 mg) into the cup and administered all three medications to R39. After V10 administered the medication to the R39 surveyor pointed out the error for the cyanocobalamin and asked V10 if she had the correct medication/dose in her cart. V10 looked in medication cart and did not have the correct medication in the cart. The following medication errors were identified: 1.) Inaccurate dose error: Cyanocobalamin 100 mcg given instead of Cyanocobalamin ER 1000 mcg. 2.) Inaccurate medication/dose error: Norco 5/325 mg was about to be given instead of Lorazepam 1 mg before surveyor stopped nurse from giving wrong medication. R39's Medication Administration Report documents cyanocobalamin tablet extended release 1000 mcg - 1 tab was signed off by V10 as given on 05/14/2024 for 9:00 am dose. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R39's Physician Order Report dated 4/15/2024 through 5/15/2024 shows order for cyanocobalamin tablet extended release; 1000 mcg; amt: 1; oral Once a Day; 09:00 AM DC date of 5/14/2024 (Awaiting DC Verification). This report also shows that R39 has an order for Lorazepam - Schedule IV tablet; 1 mg; amt: 1; oral Every 12 hours; 09:00 AM, 09:00 PM. R39 does not have an order for Norco 5/325 mg. R39's Brief Interview for Mental Status (BIMS) dated 04/11/2024 documents R39 with a score of 15 which indicates that R39 is cognitively intact. R39's face sheet documents, in part, R39's diagnoses including but not limited to: Anoxic brain damage, paranoid schizophrenia, schizoaffective disorder- bipolar type and anxiety. On 05/14/2024 at 8:31 am surveyor observed V10 (LPN) from the south hall medication cart start to prepare 6 pills total for R27 (Amlodipine 5 mg - 1 tablet, Atenolol 25 mg - 1 tablet, Cyanocobalamin 100 mcg tablet, Gemfibrozil 600 mg - 1 tablet, Glipizide 5 mg- 1 tablet and Metformin 850 mg - 1 tablet). V10 pulled 5 medication cards from the medication cart and one bottle from the top drawer of medication cart. The bottle was facility stock of cyanocobalamin 100 mcg. V10 pushed the tablet/pill from the 1st medication dispensing card plastic bubble which makes a pop sound audible to surveyor when the tablet exits out of the sealed lining at the back of the medication dispensing card. V10 then dispensed the pill from the 1st medication card with a pop sound audible to surveyor when the pill exits out of the medication card (bubble). V10 placed the medication card in a pile on top of the left side of the medication cart. V10 then picked up the Atenolol medication card and placed it over the pill cup, a popping sound was heard, but no pill observed dropping into the cup. Upon surveyor reconciling R27's medications that were ordered and scheduled for administration surveyor stopped V10 as she was handing medication cup to R27 and asked her to count the pills in the medication administration cup she was about to give to R27. V10 stated, she had 5 pills in the medication cup. V10 was asked by surveyor how many medications R27 should be getting she stated 6. Upon verification of what pills were in the medication cup and which one was missing it was discovered that there were supposed to be 2 small round pills. The one in the med cup was the one with markings U on one side and 5 on the other side which was the Amlodipine 5 mg. It was deducted that the atenolol 25 mg tablet with markings of 21 on one side and D on the other side was not in the medication cup. When V10 looked at that medication card she noticed that the pill was popped out but was stuck in the bubble pack and did not fall into the medication cup. After V10 administered medication to R27, the surveyor pointed out the dosage on the bottle of cyanocobalamin to V10. V10 looked at the order and asked surveyor if she should have given 5 tablets. Surveyor told V10 that she could not tell her what to do. V10 did not administer any other medication to R27. The following medication errors were identified: 3.) Inaccurate dose error: Cyanocobalamin 100 mcg given instead of Cyanocobalamin 500 mcg. 4.) Omission error: V10 would have omitted giving the Atenolol 25 mg pill if surveyor did not stop V10 from giving only the 5 pills in the medication cup. R27's Medication Administration Report documents cyanocobalamin tablet 500 mcg - 1 tab was signed off by V10 as given on 05/14/2024 for 9:00 am dose. R27's Physician Order Report dated 4/15/2024 through 5/15/2024 shows order for cyanocobalamin (vitamin B-12) tablet; 500 mcg; amt: 1 tablet; oral Once a Day; 09:00 AM. This report also shows that R27 has an order for atenolol tablet; 25 mg; amt: 1 tab; oral (DX: Essential (primary) hypertension) Every day; 09:00 AM (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R27's Brief Interview for Mental Status (BIMS) dated 03/21/2024 documents R27 with a score of 14 which indicates that R27 is cognitively intact. R27's face sheet documents, in part, R27's diagnoses including but not limited to: Type 2 diabetes mellitus, major depressive disorder, essential (primary) hypertension, and hyper lipidemia. On 05/14/2024 at 8:08 AM V10 was observed administering medications to 5 residents (R2, R17, R27, R39, R66). During this observation V10 did not wash hands or use alcohol-based hand rub one time between all 5 residents. On 05/15/24 at 2:12 PM Interview with V2 Director of Nursing (DON), V2 stated medication administration should go according to policy and procedure using 5 rights, infection control and all of them other things. A nurse should not walk away from the medication cart if it is unlocked. All nurses should wash hands or use alcohol-based hand rub between residents and use soap and water if hands become visibly soiled. When a med error does occur nurse should report immediately and call doctor and follow doctors' orders. Ongoing education is done twice yearly called a skills fair which includes med administration, hand hygiene, not leaving the cart unlocked when not present, and all other nursing and certified nursing assistant's competency skills. On 05/14/24 at 10:53 AM Phone interview with V12 Pharmacist consultant for facility pharmacy states the tablet(s) given to R39 should have been extended release not just the regular house stock bottle it was given from and the correct dosage that was ordered. On 05/15/2024 at 3:42 PM Interview with V2 DON. V10 did not report any med errors to me she reported giving R39 cyanocobalamin 100 mcg instead of cyanocobalamin extended release 1000 mcg to the front office. That is the only medication error she reported. Medication Administration Policy with an effective date of March 2014 and an Updated date of March 2022 states: 1. Drugs will be administered in accordance with orders of licensed medical practitioners of the State in which the facility operates. 7. No medication may be returned to its original container once removed from that container. 8. Medications errors, drug side effects and adverse drug reactions, including overdoses or poisoning, will be immediately reported to the attending physician. Director of Nursing and pharmacist. The error or clinical symptoms will be documented in the clinical record and on the facility designated form. LPN Job description provided on 05/15/2024 by V1 at 2:12 pm states: Duties/Responsibilities/Function 6. Dispense medications as ordered by attending physician in accordance with facility policies. 23. Ensure compliance with infection control standards. Immediately correct/address identified instances of non-compliance.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 40718 Based on observations, interviews, and record reviews the facility failed follow their policy and procedures to ensure food was prepared under sanitary conditions by not ensuring the kitchen was maintained in a clean and sanitary manner, not performing hand hygiene when necessary, not ensuring the kitchen environment was maintained in a manner to prevent contamination, and not ensuring food preparation equipment was dried properly in between uses to prevent food-borne illnesses. This failure affects all 66 residents receiving food from the facility. Findings include: On 05/13/24 at 10:25 AM during kitchen tour surveyor observed the ice machine stained with residue on the inside wall, and rust along the border of the door, and frames of door, and buildup of a black substance on the upper corner of the interior of the ice machine between the lid and ice compartment. Observed V13 (Dietary Manager) remove all the residue and buildup on all these areas of the ice machine with a cloth. V13 stated, the ice machine is cleaned every six months, and all the kitchen staff are responsible for daily cleaning of the ice machine and kitchen appliances. Observed seven 3lb bags of yellow squash stored in the kitchen freezer with heavy buildup of ice on the packaged squash with no labeling. V13 stated the bags of squash should be labeled and will be thrown away because they are freezer burned and no good. V13 was unable to state for certain how long the yellow squash had been stored in the freezer. Observed dust and dirt particles on the kitchen knife holder with 3 knives stored in the holder. V13 stated the holder should not have dust or dirt particles on it. Observed a large bag of snicker doodle cookies stored in the freezer with heavy buildup of ice inside the bag and a hole in the bag. V13 stated, the bag of snicker doodle cookies was approximately 3lbs and he would be throwing it away because of the hole in the bag. Observed the creases inside the folds of the entire lid of the deep freezer where the cookies and meal shakes were stored with a heavy buildup of a black substance. V13 stated, he will clean the deep freezer lid today and he wouldn't want the buildup of the black substance to be present within the deep freezer lid because it could tear us apart. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 05/14/24 from 10:07 AM - 11:30 AM During the kitchen tour observed the floor tile underneath the three-compartment sink cracked and with heavy buildup. Observed the water temp booster next to three compartment sink underneath the handwashing sink with a heavy presence of rust, buildup, and residue, and with holes in walls around piping underneath both sinks. Observed a garbage bin for paper goods next to the stove covered with dust and residue. Observed the floor underneath a crate with a grease bucket sitting on top of it, with heavy buildup of oil, dust, food particles, and residue. Observed the floor underneath the steam table with cracked tiles, and heavy buildup. Observed the overflow drain near the steam table with heavy buildup inside the perimeter. Observed the spray hose attachment to dishwashing machine with a heavy presence of dust and rust. V13 (Dietary Manager) stated, the sprayer is used to prerinse dishes that go in the machine and should be clean. Observed buildup and two small holes along the wall directly next to the dishwashing machine scraping table. Observed spatter and dust on the walls and ceiling surrounding the dishwashing machine area. Observed the walls underneath the dish machine with cracked paint and heavy buildup. Observed the chlorine bottle tube connecting the chlorine to the dishwasher with a heavy presence of a dark and dusty substance. Observed several dish racks and eight utensil holders, some with clean utensils in them, heavily stained. V13 stated, the dish racks and utensil holders are old and need to be replaced. V13 and V15 (Cook) agreed that the staining of the dish racks and utensil holders makes it difficult to determine if they are clean. Observed the side of the ice machine with a heavy amount of dust, and the floor underneath the ice machine with cracked tile, and a heavy buildup of dust and residue. Observed the open window sill directly next to two dish racks with partially covered clean dishes with buildup and dust. Observed outlets directly next to and over the food prep table with heavy buildup. Observed V13 remove some of the buildup on the outlets with a cloth to confirm it can be removed. V13 stated, the outlets should be clean each time the food prep area is cleaned. Observed multiple slices of bread left on the floor underneath the food prep and storage table near the cooler. Observed a soap dispenser over the dishwashing machine area with heavy dust buildup. Observed multiple pipes on the ceiling and other areas of the kitchen with heavy presence of dust. Observed a hanging dish rack with multiple clean dishes hanging from it with dust on various parts of the rack. In response to surveyor asking if the kitchen should be kept clean, V13 stated, the building is old, and there is no ventilation in the kitchen and pointed out that there is only one vent in the kitchen over the stove. V13 stated, the kitchen needs a lot of attention. V13 stated, the lack of ventilation in the kitchen means the kitchen requires more attention with cleaning. V13 stated, if the kitchen is not kept clean the residents are at risk for salmonella and agreed they are also at risk for food contamination. V13 stated all dietary staff are responsible for maintaining the cleanliness of the kitchen and the daily cleaning requirements. Observed steam table with ready to serve food with heavy buildup of food particles along the crevice of the table. Observed V14 (Dietary Aide) drop the lid to a water pitcher, pick it up and place it in a rack to be run through the dishwasher, then continue to fill water pitchers without performing any hand hygiene. V14 stated, she didn't wash her hands because she did not touch the floor and only touched the top of the water pitcher lid. V14 stated, the water pitchers would be used to serve the residents during dining. Observed V15 (Cook) wash the industrial food processor base and lid in the dishwashing machine. Observed V15 then make peach puree in the food processor without allowing the food processor base and lid to completely air dry. V15 confirmed that the food processor equipment had not fully air dried when she used it to make the peach puree. On 05/16/24 at 10:06 AM V1 (Administrator) stated, per V13 (Dietary Manger) holes should be sealed for pest control to avoid any possible entry and the food processor has to be air dried in between uses after being sent through the dishwasher for infection control. V1 stated, per V13 paper towels or any sort of towel are prohibited for use to dry any equipment because of cross contamination. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Dietary Infection Control Policy received/reviewed 05/15/2024 states: The purpose of the policy is To ensure that the dietary department practices and procedures ensure safe, sanitary food operation to prevent food borne illness. The policy states The dietary department will meet accepted standards of safety and sanitation of food, equipment, and cleaning supplies. The Dietary Department: Will be maintained in a clean and sanitary manner to prevent foodborne illness. Food is labeled and dated to allow for rotation of supplies. Food equipment: are thoroughly cleaned as required between food preparations. Food preparation procedures include: Discarding food that becomes contaminated. Dietary waste is kept away from food preparation area. Dietary department is cleaned on a regular schedule. The facility's Weekly Cleaning Assignments received/reviewed 05/15/2024 states: Clean bottom of walls; Clean ice machine; Clean windowsills in dietary; Wash steam table inside and out; Everything in Freezer should be labeled and in order. The facility's Handwashing Policy received/reviewed 05/15/2024 states: Food and nutrition service employees will practice safe food handling to prevent foodborne illness. Food and nutrition services employees will thoroughly wash their hands with soap and water at the following times: after touching anything unsanitary (dirty dishes).

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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 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 40718 Based on interviews and record reviews, the facility failed to designate an infection preventionist who had completed specialized training in infection prevention and control. Findings include: On 05/15/24 at 3:58 PM V3 (Assistant Director of Nursing/ IP - Infection Preventionist) stated, she has been the IP for the facility for approximately four years. The CDC (Centers for Disease Control) Nursing Home Infection Preventionist Training Course Certificate received/reviewed 05/15/2024 documents V3 (Assistant Director of Nursing/Infection Preventionist) was awarded certification on 05/15/2024. The facility did not provide a policy for infection preventionist qualifications requested on 05/16/2024.