

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Parkshore Estates Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 6125 South Kenwood Chicago, IL 60637	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067</p> <p>Based on observation, interview, and record review, the facility failed to perform timely incontinence checks and care for one resident (R2) in the sample of three residents reviewed for activities of daily living (ADL).</p> <p>Findings include:</p> <p>R2's Admission Record documents, diagnoses including dementia, pressure ulcer of sacral region stage 3, pressure ulcer of left heel stage 3, systolic (congestive) heart failure, anemia, essential hypertension, vitamin D deficiency, gastro-esophageal reflux disease, and atrial fibrillation.</p> <p>R2's Minimum Data Set (MDS), dated [DATE], documents, a Brief Interview for Mental Status (BIMS) score of 11 which indicates that R2 has moderate cognitive impairment. R2's Functional Abilities and Goals for Functional Limitation in Range of Motion for lower extremity is coded as impairment on both sides. R2's Toileting Hygiene for the ability to maintain personal hygiene after urinating or having a bowel movement is coded as 1: Dependent: Helper does all the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. R2's Mobility for bed mobility of rolling left and right defined as the ability to roll from lying on back to left and right side, and return to lying on back in the bed is also coded as 1: Dependent.</p> <p>R2's Care Plan (date initiated 5/1/24) documents, in part, a focus that R2 has self-care deficit and requires assistance with ADL's to maintain the highest possible level of functioning with interventions that R2 requiring extensive assistance with 2 person support for Bed Mobility (5/1/24), for toileting, that R2 is totally dependent on staff, and that R2 is non-ambulatory.</p> <p>On 10/7/24 at 11:31 am, R2 observed laying in bed with LAL (low air loss) mattress wearing a gown. R2 stated that R2 wears an incontinence brief and doesn't know when R2 has the urge to urinate. When asked if R2 gets R2's incontinence brief checked and changed every 2 hours by staff, R2 stated, No. This surveyor asked R2 for permission to request an incontinence check of R2's incontinence brief, and R2 agreed. R2 pulled the call light at 11:38 am which was answered at 11:41 am by V15 (Certified Nursing Assistant/CNA). This surveyor requested an incontinence check for R2 and was informed that R2's CNA (V10) is with another resident and will be here shortly.</p> <p>(continued on next page)</p>

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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/7/24 at 11:57 am, V10 (CNA) came to R2's room. V10 stated, I (V10) changed (incontinence brief) at 7:00 am. I changing and cleaning (R2) when starting at 7:00 am. V10 brings linens into R2's room, starts running warm water from the sink, and dons gloves. V10 lowers R2 head of bed and opened up R2's front of incontinence brief noted with yellow urine soaked in brief padding. V10 confirmed that R2 was incontinent when cleansing R2's pubic area, and V10 then said that the patch was coming off when wiping. After wiping R2's pubic area, V10 removed the cleansing towel and said to R2 you had a bowel movement. R2 stated, Oh, am I dirty? V10 next told R2 that V10 was going to turn R2 to the side while standing on the left side of the bed and wanting R2 to turn to the right side. R2 was asking if R2 can hold onto the privacy curtain next to the bed with no bed rail noted. V10 crossed R2's right leg over the left leg to try to turn R2 to the left side, and R2 said it hurt. V10 said that V10 will have to get another staff member to help with turning R2.</p> <p>On 10/7/24 at approximately 12:15 pm, V10 and V15 (CNA) observed cleaning R2's incontinence of yellow urine and brown, medium soft bowel movement. R2's right ischium bandage (patch) is off due to cleansing care. V15 is holding R2 rolled on left side of body with V10 removing the soiled incontinence brief with brown bowel movement noted on the plastic sides of the incontinence brief. V10 said that V10 will have to get the nurse to put on the new dressing and asked V15 to step out to get nurse. As V15 was getting ready to step out of R2's room, V5 (Wound Care Nurse, Licensed Practical Nurse, LPN) entered R2's room to perform R2's wound care treatment.</p> <p>On 10/9/24 at 1:51 pm, V2 (Director of Nursing, DON) stated that nursing staff perform rounds every 2 hours and as needed to assist with resident care needs. V2 stated that CNAs are to perform incontinence checks every 2 hours by physically checking the incontinence brief.</p> <p>Facility policy titled Guidelines for Incontinence Care and dated 9/21/23 documents, in part, Policy: It is the policy of the facility to ensure that residents receive as much assistance as needed for cleansing the perineum and buttocks after an incontinent episode or with routine daily care. Frequency depends on bladder diary results and/or routine minimal q (every) 2 hour checks as well as care planning.</p> <p>Facility undated policy titled Activities of Daily Living (Routine Care) documents, Policy: Residents are given routine daily care and HS (hour of sleep) care by a C.N.A. or a Nurse to promote hygiene, provide comfort and provide a homelike environment. ADL care is provided throughout the day, evening and night as care planned and/or as needed. ADL care is coordinated between the resident and the care givers with emphasis on resident preference as much as possible . ADL care of the resident includes: Assisting the resident in personal care such as bathing, showering, dressing, eating, hair care, oral care, nail care, appropriate skin care (as indicated and as per care plan).</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067</p> <p>Based on observation, interview, and record review, the facility failed to provide aseptic wound care treatments for pressure ulcer wounds; failed to ensure that a resident with pressure ulcers was repositioned timely; and failed to ensure that a resident's low air loss mattress setting for weight were at the appropriate weight which affect one resident (R2) in the sample of three residents reviewed for improper nursing care.</p> <p>Findings include:</p> <p>R2's Admission Record documents, diagnoses including dementia, pressure ulcer of sacral region stage 3, pressure ulcer of left heel stage 3, systolic (congestive) heart failure, anemia, essential hypertension, vitamin D deficiency, gastro-esophageal reflux disease, and atrial fibrillation.</p> <p>R2's Minimum Data Set (MDS), dated [DATE], documents, in part a Brief Interview for Mental Status (BIMS) score of 11 which indicates that R2 has moderate cognitive impairment. R2's Functional Abilities and Goals for Functional Limitation in Range of Motion for lower extremity is coded as impairment on both sides. R2's Mobility for bed mobility of rolling left and right defined as the ability to roll from lying on back to left and right side, and return to lying on back in the bed is also coded as 1: Dependent: Helper does all the effort. Resident does none of the effort to complete the activity. Or, the assistance of 2 or more helpers is required for the resident to complete the activity. R2's Skin Conditions documents, in part, that R2 is at risk of developing pressure ulcers and has one or more unhealed pressure ulcers. R2's unhealed pressure ulcers include one Stage 3, two Stage 4, and one deep tissue injury. R2's Skin and Ulcer Treatments include pressure reducing device for chair, pressure reducing device for bed, and pressure ulcer care.</p> <p>R2's Care Plan (date initiated 4/26/24) documents, in part, a focus that R2 has an alteration in skin integrity and is at risk for additional and/or worsening of skin integrity issues related to: Dementia, Anemia Weakness with interventions of low air mattress on bed (5/6/24), perform wound care treatments (4/26/24), and precautions for prevention of pressure ulcers like reposition resident frequently when in bed/chair/gerichair (4/26/24).</p> <p>R2's first facility weight, dated 4/29/24, is documented as 182 pounds. R2's most current weight, dated 10/9/24, is documented as 177.2 pounds.</p> <p>On 10/7/24 at 11:31 am, R2 observed laying in bed with a low air loss (LAL) mattress with the LAL pump hanging from the foot of the bed. R2's LAL mattress settings on the pump showed the weight setting on the dial past 400 pounds. When asked about R2's skin integrity, R2 stated, I (R2) have sores, and ache to my rear. R2 stated that R2's bandages are changed daily usually in the mornings. When asked about turning in bed, R2 stated, I (R2) need help to turn, and it's usually done with 2 staff members. When asked if CNAs are turning R2 to the side, then placing a pillow under your back to keep you propped to the side off of your sacral wound, R2 stated, No they are not. I wish I was. I got my sore on my rear. No extra pillows or wedges are observed in R2's room, open drawers or open closet.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/7/24 at 11:57 am, V10 Certified Nursing Assistant (CNA) responded outside R2's room. Prior to entering room, this surveyor asked what care has V10 provided to R2 since the beginning of V10's day shift, and V10 stated, I (V10) changed (incontinence brief) at 7:00 am. I changing and cleaning (R2) when starting at 7:00 am. V10 brings linens into R2's room, starts running warm water from the sink, and dons gloves. V10 lowers R2 head of bed and opened up R2's front of incontinence brief noted with yellow urine soaked in brief padding. V10 confirmed that R2 was incontinent when cleansing R2's pubic area, and V10 then said that the patch was coming off when wiping. After wiping R2's pubic area, V10 removed the cleansing towel and said to R2 you had a bowel movement. R2 stated, Oh, am I dirty? V10 next told R2 that V10 was going to turn R2 to the side while standing on the left side of the bed and wanting R2 to turn to the right side. R2 was asking if R2 can hold onto the privacy curtain next to the bed with no bed rail noted. V10 crossed R2's right leg over the left leg to try to turn R2 to the left side, and R2 said it hurt. V10 said that V10 will have to get another staff member to help with turning R2.</p> <p>On 10/7/24 at approximately 12:15 pm, V10 and V15 (CNA) observed cleaning R2's incontinence of yellow urine and brown, medium soft bowel movement. R2's right ischium dressing (patch) is off due to cleansing care. V15 is holding R2 rolled on left side of body with V10 removing the soiled incontinence brief with brown bowel movement noted on the plastic sides of the incontinence brief. V10 said that V10 will have to get the nurse to put on the new dressing and asked V15 to step out to get nurse. As V15 was getting ready to step out of R2's room, V5 (Wound Care Nurse, WCN, Licensed Practical Nurse, LPN) entered R2's room.</p> <p>On 10/7/24 at 12:20 pm, V5 (WCN, LPN) walks into R2's room wearing an isolation gown and holding onto clean treatment supplies of dressings (in packages), Sodium Hypochlorite bottle (quarter strength), garbage bag and opened gauze pads. V5 places the wound care supplies on R2's bedside table without wiping the table. V5 opens up the garbage bag and wraps the open garbage bag over the end of the bedside table so the rest of the garbage bag is hanging down. To secure the garbage bag, V5 uses the Sodium Hypochlorite bottle by setting it in the top, inside portion of the bag, where the Sodium Hypochlorite bottle is on top of the table holding the garbage bag in place. R2's water bottle is in the middle of the bedside table. V5 sets the other dressing supplies on the bedside table.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/7/24 at 12:22 pm, V5 observed with clean gloves on and asks V10 to hold up R2's right leg. V5 removes R2's right lateral lower leg dressing and places it into the clear plastic garbage bag that is hanging from the bedside table. V5 then removes gloves and puts on new gloves with no hand hygiene performed. V5 lifts up the Sodium Hypochlorite bottle and holds onto the top of the garbage liner with one gloved hand and uses the other gloved hand to remove the cap of the Sodium Hypochlorite bottle. V5 pours Sodium Hypochlorite solution on top of several gauzes that V5 is holding with a gloved hand and places the Sodium Hypochlorite bottle back on the inside top of the garbage bag to secure it with the other gloved hand and caps it. V5 then cleans R2's right lateral right leg wound with the Sodium Hypochlorite-soaked gauzes and discards them into the garbage bag. V5 changes to new gloves with no hand hygiene. V5 opens up by peeling back edges the coverings for the calcium alginate and foam dressings and explains to R2 that this is alginate and a foam dressing, which V5 places alginate on wound then covers with foam dressing. V5 stated that this wound was skin grafted. V5 removes gloves and places on new gloves without performing hand hygiene. V5 has V10 then hold up R2's left leg, and R2 says, Be careful, that's my bad leg. R2's left heel dressing is wrapped with dressing, so V5 takes V5's gloved hand and moves isolation gown to the side, reaches in V5's scrubs (clothing) pocket and retrieves a pair of scissors. V5 then cuts R2's outer wrapping dressing, removes the dressing, and places it into the clear plastic garbage bag that is hanging from the bedside table. V10 then removes V10's gloves and puts on new gloves with no hand hygiene performed. V5 lifts up the Sodium Hypochlorite bottle and holds onto the top of the garbage liner with one gloved hand and uses the other gloved hand to remove the cap of the Sodium Hypochlorite bottle which falls onto the floor (at 12:27 pm). V5 pours Sodium Hypochlorite solution on top of several gauzes that V5 is holding with a gloved hand and places the open Sodium Hypochlorite bottle back on the inside top of the garbage bag to secure it. V5 next cleans R2's left heel wound with the Sodium Hypochlorite soaked gauze and discards them into the garbage bag. V5 changes to new gloves with no hand hygiene. Skin graft noted over base of R2's left heel wound. V5 stated that it's a stage 3. V5 opens up by peeling back edges the coverings for the calcium alginate and foam dressings, and V5 places alginate on the left heel wound then covers with foam dressing. V5 wrapped left foot with wrap dressing. V5 removes gloves without performing hand hygiene.</p> <p>On 10/7/24 at 12:31 pm, V5 moves the bedside table to get past the table by touching sides of the table and does not perform hand hygiene. V5 dons new gloves. V5, V10 and V15 reposition R2 to the left side which shows no dressing/bandage to R2's right ischium wound.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/7/24 at 12:33 pm, V5 removes R2's sacrum dressing (separate wound from the right ischium wound). When asked about the staging of R2's sacral wound, V5 stated, Stage 3, both (sacrum and right ischium) are stage 3. V5 rolls up R2's soiled incontinence pad under R2's left hip, and then V5 changes gloves with no hand hygiene performed. V5 lifts up the open Sodium Hypochlorite bottle and holds onto the top of the garbage liner with one gloved hand and uses the other gloved hand to pour the Sodium Hypochlorite solution on top of several gauzes that V5 is holding with one gloved hand. V5 next places the open Sodium Hypochlorite bottle back on the inside top of the garbage bag to secure it with the other gloved hand. V5 separates the soaked gauzes then cleanses the sacral wound with some soaked Sodium Hypochlorite gauze, discards them in the garbage bag, and then with the same gloved hand, V5 uses the other soaked Sodium Hypochlorite gauzes to cleanse the right ischium wound and discards them into the garbage bag. V5 changes to new gloves with no hand hygiene. V5 next opens up by peeling back edges the coverings for the calcium alginate and a large heart foam dressing. V5 places the alginate on sacrum wound then covers with the heart foam dressing. V5 changes gloves with no hand hygiene. V5 then opens up by peeling back edges the coverings for the calcium alginate and square foam dressing. V5 places calcium alginate on right ischium wound then covers with foam dressing. V5 changes gloves with no hand hygiene. V5 stated that V5 will be stepping out and V15 and V10 can finish the ADL (activities of daily living) care for R2.</p> <p>On 10/9/24 at 9:57 am, V5 observed in R2's room performing R2's wound care treatment. At this time, R2's LAL mattress setting on the same weight setting of greater than 400 pounds.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 10/9/24 at 10:09 am, V5 (WCN, LPN) stated that V5 is the only wound care nurse in the facility, works 5 days a week and that staff nurses will perform the wound care treatments on the days that V5 is not working. V5 stated that R2 is being offloaded from size to side with pillows. V5 stated that R2 originally had a wedge to prop R2's body to the side for repositioning; however, R2 said that it was too much. V5 stated that staff are using pillows to keep R2 repositioned every 2 hours. When informed that this surveyor did not see any extra pillows in R2's room or on bed on 10/7/24, V5 acknowledged that there were no extra pillows being used with R2, and V5 asked V10 (CNA) to obtain some pillows for repositioning after this surveyor's observation on 10/7/24. When asked about R2's LAL mattress settings, V5 stated that V5 is responsible for checking the LAL mattress settings and functionality of the LAL mattresses. V5 stated, The right setting is according to (R2's) weight and that R2's weight fluctuates. V5 stated, In my opinion, some days (R2) looks smaller, and I come back and (R2) looks more swollen. V5 stated that V5 looks at the resident's weight in (electric health record system) and will change to what the weight is at that time. This surveyor informed V5 that on 10/7/24 and 10/9/24, this surveyor observed R2's weight setting on the LAL mattress pump as over 400 pounds. When asked if R2's current weight is over 400 pounds, V5 stated, No, not over 400. (R2's) current weight, I have not had a chance to look today. V5 stated that the LAL mattress' purpose is to prevent more pressure ulcers from forming; to keep blood circulation; more offloading of pressure points so it's not a hard service. V5 stated that the LAL mattress is filled with the amount of air that correlates to the weight of the resident on the LAL pump dial setting. When asked about R2's wound care treatments, V5 stated that all of R2's four pressure ulcer wounds (sacrum, right ischium, left heel and right lateral lower leg) had skin grafts recently placed on the wounds by V21 (Wound Physician). V5 stated that R2's four wounds are ordered for daily cleansing of Sodium Hypochlorite solution, applying calcium alginate, and to cover with foam dressing. When asked V5 about the process of performing wound care treatments, V5 stated that V5 washes hands prior to the wound care treatment and don gloves. V5 stated, I take off the dirty bandage, take off gloves, and put on new gloves and clean the wound. V5 stated that V5 will next get new gloves and explain to the resident what treatment V5 is using, place on the treatment and bandage, change gloves and do the next wound to do the same process for all wounds. When asked if changing gloves is the same as cleaning V5's hands (hand hygiene), V5 stated, Well, I feel like it. I just change gloves. When asked if changing gloves when going in between clean and dirty wounds/surfaces replaces hand hygiene, V5 stated, I am not sure how to answer it. I stay as clean as possible. I change gloves a lot. I don't know if it's okay to have sanitizer on hands. I am not sure if that's okay to bring it (sanitizer bottle) in the resident's room for wound care treatments. When asked the purpose of hand hygiene, V5 stated to prevent spread of infection.</p> <p>In R2's Weekly Wound Evaluations, all dated 10/3/24, V5 documents, in part, the following: R2's left heel pressure injury (stage 3: full thickness tissue loss and subcutaneous fat may be visible but bone, tendon or muscle are not exposed), sacrum (stage 3), right ischium (stage 3) and right lateral leg (stage 3) have current treatments of skin grafting, Sodium Hypochlorite solution for cleansing, calcium alginate, and nonadherent foam dressing ordered on 10/3/24 by V21, and the current preventative interventions are pressure redistribution mattress and specific turning/repositioning program.</p> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility policy dated 10/9/23 and titled Guidelines for Prevention/Treatment of Pressure Injuries documents, Purpose: It is the intent of the facility to recognize the following information and to act on it in such a way as to practice evidence-based recommendations for the prevention/treatment of pressure injuries to the residents who reside in the facility. Objectives: In accordance with Federal Regulations-and based on resident assessment, the facility will ensure: 1. A resident receives care, consistent with professional standards of practice; to prevent pressure ulcers . 2. A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing . Terms and Definitions: Pressure ulcers/injuries-are also called decubitus ulcers, bed sores or pressure sores . A pressure injury is localized damage to the skin and/or underlying soft tissue, usually over a bony prominence or related to a medical or other device . Areas more vulnerable include heels, sacrum, ischial tuberosities, spine, parts of the body where pressure and sheer are exerted in the course of a resident's activities of daily living . 4. Positioning and Mobilization-Immobility can play a large role in the causing pressure injuries . Tissue closest to the bone may be the first tissue to undergo changes related to pressure . Turn and reposition resident who are 'at risk' for pressure injury often unless contraindicated. At least every 2 hours in recommended . Treatment of Pressure Injuries: It is imperative that each existing PU/PI (Pressure Ulcer/Pressure Injury) whether identified on admission or readmission or after admission or readmission have the factors that influence its development defined. This will allow appropriate interventions to be put into place to guard against further development of more areas or worsening of current area(s) . Infection Concerns Related to Pressure Injuries: Pressure injuries may progress or may be associated with complications-such as infections . Dressings and Treatments Related to Pressure Injuries: . Evidence-based practice suggests that PU/PI dressing protocols may use clean technique . Clean technique (also known as non-sterile technique) requires proper hand-hygiene and proper glove use. A clean field, using clean instruments and prevention of direct contamination of materials and supplies is also required.</p> <p>Facility policy dated 5/20/23 and titled Guidelines for Preventative Skin Care documents, in part, Guideline: It is the intent of the facility to provide residents with preventative skin care through care careful washing, rinsing and drying of their skin, to keep them clean, comfortable, well-groomed and free from pressure sores . Procedure: . 4. Residents identified as being at high risk for potential breakdown shall be turned and repositioned frequently to prevent redness that does not fade or blanche. 5. Air mattresses/gel mattresses may be used for those residents identified as being high risk for potential skin breakdown. 6. Positioning pillows and/or specialty devices may be used between two skin surfaces or to slightly elevate bony prominences/pressure areas off of the mattress. 'Offloading' must be provided as indicated to provide pressure relief . 17. Follow/implement care plan intervention as per each resident's person-centered care plan related to skin.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145938	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/10/2024
NAME OF PROVIDER OR SUPPLIER Parkshore Estates Nursing & Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 6125 South Kenwood Chicago, IL 60637	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Facility undated policy titled Infection Control: Hand Hygiene Guideline documents, in part, . III. Procedure: a. When hands are visibly soiled, exposure to spore forming organism has been suspected or proven . hands should be washed with a non-microbial or anti-microbial soap. i. Wet hands with warm water. ii. Applied generous amount of soap to hands and run hands together vigorously for at least 20 seconds, keeping in mind to cover surfaces of the hands and fingers. iii. Interlace fingers and rub palms and back of hands in a circular motion at least 5 times each. Keep the fingertips down to facilitate removal of microorganisms. iv. Rinse hands with warm water while keeping hands down and elbows up then dry thoroughly with a disposable towel. v. Use towel to turn off faucet and exit the area. vi. The duration of the entire procedure should be approximately 40-60 seconds, per evidenced based practice. b. When criteria above have not been met it is appropriate to use a waterless alcohol-based agent. i. Apply product to the palm of one hand and rub hands together. ii. Cover all surfaces of hands and fingers. iii. Continue to rub until dry, remembering to no fan your hands. iv. Allow hands to completely dry prior to applying gloves or interacting with a resident.</p> <p>Facility provided Operator's Manual for R2's LAL mattress, dated 3/28/19, documents, in part, for product functions, Patient weight settings are available along the knob perimeter as a guide, and the mattress control unit comes with an air cell mattress that provides low air loss.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40067</p> <p>Based on observation, interview, and record review, the facility failed to maintain hot foods on the service steam table for meal tray assembly at 135 degrees Fahrenheit or higher and failed to serve hot foods to the residents at a temperature not less than 125 degrees F which affected R5 and has the potential to affect 60 residents residing on the floor utilizing the steam table.</p> <p>Findings include:</p> <p>On 10/7/24 at 1:35 pm, R5 stated, I (R5) eat in my room. When I get my food, it's cold. When asked if a CNA (Certified Nursing Assistant) then heats up R5's cold food from the meal tray, R5 stated, Yes, but they should not have to do that. They are not supposed to be serving food that's cold when it should be hot.</p> <p>R5's Order Summary Report documents, in part, R5's diet order of renal with dialysis diet indicating regular texture food, thin liquid consistency, no added salt and no concentrated sweets.</p> <p>R5's Minimum Data Set (MDS) dated [DATE] documents, in part, a Brief Interview of Mental Status (BIMS) score of 14 which indicates that R5 is cognitively intact.</p> <p>On 10/8/24 at 11:45 am, the steam table and empty meal trays on an uncovered portable cart were brought from the facility kitchen to the 2nd floor dining room. The steam table hot food items observed covered with plastic wrap and metal covers, and the electrical plug is observed wrapped up towards the bottom of the steam table.</p> <p>On 10/8/24 at 11:54 am, V13 (Dietary Aide) dons gloves and begins removing the metal lids and plastic wraps from the hot food items on the steam table. V13 did not plug in the steam table's cord into the electrical wall socket behind the steam table in the 2nd floor dining room. V13 performs temperatures of each hot food item by placing the tip of the food thermometer (analog dial) in the center of the hot foods in each tray, waiting 15 seconds, and then reading the food thermometer. This surveyor observed the food temperature readings as follows:</p> <p>Mashed Potatoes: 140 degrees F</p> <p>Broccoli: 170 degrees F</p> <p>Pureed Broccoli: 120 degrees F</p> <p>Sliced Turkey: 95 degrees F</p> <p>Pureed Turkey: 120 degrees F</p> <p>On 10/8/24 at 12:08 pm, V13 observed starting to prepare lunch meal plates as the CNA staff call out for diet meals from residents' meal tickets on the trays. CNA staff were observed serving residents sitting in the dining room first to eat their lunches.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 10/8/24 at 12:27 pm, V7 (CNA) observed placing residents' meal tickets on the stacked empty blue trays on the uncovered meal cart for the residents who will be served their lunch meals in their respective rooms.</p> <p>On 10/8/24 at 12:29 pm, V13 plates the lunch meal, hands the plate to V7 who places a cover over the plate (no hot plate under the plate), and V7 puts the covered plate on the empty tray.</p> <p>On 10/8/24 at 12:38 pm, V7 (CNA) stated that there were 6 empty trays left to be prepared before the meal cart will leave the dining room for resident room service. This surveyor then requested from V13 a test tray to be prepared for the meal cart for temperature testing after the last resident meal tray is served to residents eating in their rooms.</p> <p>On 10/8/24 at 12:40 pm, V6 (CNA) and V7 (CNA) push the lunch meal trays on the cart and the covered drink cups on a separate cart to the hallway on the 2nd floor to start passing resident meal trays into residents eating in their rooms.</p> <p>On 10/8/24 at 12:52 pm, the last resident meal tray was served from the cart by staff. V14 (Dietary Director) and surveyor are next to meal tray cart, and V14 moves the test tray up to a higher shelf and removes the cover lid off the regular diet meal. V14 performed temperatures using a digital food thermometer to obtain observed readings (after 15 seconds) of 89.4 degrees F for the sliced turkey, 116.2 degrees F for the broccoli, and 125.9 degrees for the mashed potatoes. When asked what temperature the hot foods should be upon service to the resident, V14 stated, At least 130 to 135 (degrees F) and that foods should be served at a temperature that is palatable to the resident. V14 stated that normally V14 obtains readings of 125 to 135 degrees for hot foods. When asked what temperature the hot foods should be when being held on the steam table for plate service, V14 stated, Over 135 degrees (F). When asked if the hot foods on the steam table have temperature readings of less than 135 degrees, what should the dietary staff do, and V14 stated, Reheat to the proper temperature. When asked if the hot foods are served at the below the proper temperatures and residents consume these food items, what could possibly occur, and V14 stated that residents could experience food borne illness. V14 stated that water is electrically heated in the wells of the steam table to create steam which helps keep the hot food items hot. V14 stated that dietary staff should plug it (steam table) in to maintain heat retention.</p> <p>On 10/8/24 at 2:24 pm, when asked is V14 expecting the first resident served on the 2nd floor to have the same temperature of hot food as the last resident served on the floor, V14 stated, That's not my decision. We have to follow the policy.</p> <p>Facility Census dated 10/7/24 documents, in part, that 60 residents reside on the 2nd floor in the facility.</p> <p>Facility policy titled Food Temperature Resident Service and dated April 2017 documents, in part, Policy: The facility will ensure foods are served in an attractive and at temperature that is palatable and acceptable to the resident. Procedure: 1. Hot foods will be held at a minimum of 135F during tray assembly . 2. 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 and cold foods will be quickly brought to the appropriate temperature . 4. Hot foods will be served to the resident at a temperature palatable and acceptable to the resident, general practice not be less than 125F.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Facility policy titled Food Temperatures and dated April 2017 documents, in part, Policy: The facility will ensure foods are served in an attractive and palatable manner. Food temperatures will meet appropriate criteria for clocking in service to prevent the risk of food borne illness. Procedure: 1. Hot foods will be held at a minimum of 135F during tray assembly . 3. A food temperature log will be kept for each meal and each food item. The Food Service Manager or designee is responsible for documenting the food temperatures. Any food/s that do not meet the above criteria for hot and cold foods will be quickly brought to the appropriate temperature. 4. To maintain food temperature during meal service follow best practice guidelines. a. Use warmed plates and / or pallet systems when serving hot foods.</p>