STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145963	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Orland Park	16450 South 97th Avenue Orland Park, IL 60467

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 44387 Based on observation, interview, and record review, the facility failed to have call lights within reach for dependent residents. This applies to 3 of 3 residents (R23, R55, and R155) reviewed for call lights in a sample of 36. The findings include: 1. On 10/1/24 at 11:07 AM, R55 was in bed watching TV. R55 said she could not find her call light; R55's call light was on the floor. R55 said she was able to use her call light if she could just find it. Surveyor informed V3 (Certified Nurse Aide/CNA) of the call light being on the floor. V3 said R55 was able to use the call light. R55's face sheet shows the diagnoses of functional quadriplegia and cognitive communication deficit. On 10/3/24 at 10:50 AM, V2 (Director of Nursing) said call lights should be with in resident's reach so they can use it when they need it. The facility's Call Light policy (9/20) states that call lights are placed within resident reach at all times. 41384 2. On 10/01/24 at 11:36 AM R155 was in his bed and his call light was under his bed out of his reach, at 11:37 AM V7 (Nurse) came in the room to assist R155 with his TV and then left the room and did not put the call light within R155 reach before leaving the room. At 12:25 PM R155 was in his bed and his call light was observed still under his bed out of his reach. At 01:20 PM R155 was in his bed and his call light was still on the floor under his bed out of his reach. On 10/02/24 at 08:33 AM R155 was in his bed and his call light was seen under his bed out of his reach. V6 (Nurse) was in R155's room at that time providing care for R155, and when V6 left the room, she did not put R155's call light within reach for R155. (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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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/03/24 at 09:52 AM R155 was in his bed and his call light was under his bed. V4 (Nurse) was called into the room, and she said that R155 is able to use his call light and he does use it but with it under the bed he is unable to reach it or use it. On 10/03/24 at 02:33 PM V1 (Administrator) said that the call light should be within reach so that the resident can alert staff when they need assistance. R155's 6/13/24 care plan showed that R155 is at risk for falls related to weakness, hemiplegia and hemiparesis, right sided, with interventions including keep frequently used items within reach in room and promote placement of call light within reach. 45906 3. On 10/1/24 at 4:15 PM, V16 (CNA/Certified Nurse Assistant) was observed assisting R23 from her wheelchair to her bed. V16 then left R23's room without making sure her call light was within reach. R23's call light was left on the floor. Surveyor asked R23 if she could reach her call light and R23 attempted to grab the cord but was unable to reach it. R23 said the CNA should have given me my call light before leaving the room. R23 said some of the CNAs leave the room without making sure she can reach her call light. R23 said it has happened before that she could not reach her call light and she had to yell out for help and still no staff came to assist her. R23's MDS (Minimum Data Set) dated 8/21/24 shows her cognition is intact and she requires staff assistance with toileting, bathing, dressing, personal hygiene, bed mobility, and transfers. R23's Care Plan initiated on 1/6/24 shows R23 is at risk for falls due to diagnoses of low back pain and weakness. Interventions include promote placement of call light within reach.

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44387 Based on interview and record review, the facility failed to provide resident and/or family/power of attorney written documentation of bed hold notification when residents were transferred to the hospital. The facility also failed to notify the ombudsman of the transfer. This applies to 3 of 5 residents (R105, R146 and R159) reviewed for discharge and hospitalization in a sample of 36. The findings include: 1. R105's After Visit Summary shows that R105 was admitted to the hospital from 8/25/24 to 8/28/24 and was treated for Elevated Troponin levels. R105's progress notes of 8/25/24 at 1:20 PM states that R105 was sent to the emergency room (ER) for swelling to bilateral ankle, daughter was at the facility, and was notified of the transfer. 2. R159's Hospital record shows that R159 was admitted to the hospital from 8/30/24 to 9/7/24 with diagnoses of sepsis due to unspecified organism. R159's progress notes of 8/30/24 at 4:40 PM shows that R159's abnormal lab was reported to the doctor, and the ordered for R159 to be transferred to the hospital for further evaluation. On 10/2/24 and 10/3/24, V1 (Administrator) said she does not have a bed hold assessment for R105, R146 and R159 and is not sure why it was not done by the nurses. On 10/3/24 at 10:51 AM, V2 (Director of Nursing/DON) said the nurse is to complete a discharge assessment when residents are transferred to the hospital. The nurse needs to give a copy of the bed hold/ombudsman form to the resident and/or family or send a copy with them to the hospital. The form informs them that there's a hold on their bed for 10 days. The facility's Bed Hold/Ombudsman Notification Documentation policy (12/2018) states the facility will be responsible for documenting that the bed hold policy was given to the resident at the time of transfer, and to the resident representative with 24 hours. The facility will also be responsible for documenting that the Ombudsman will be notified via the monthly transfer log for all hospital transfers and therapeutic leaves. 48526 3. R146's Discharge Instructions from the hospital dated 08/21/24 showed R146 was discharged from the hospital back to the facility on [DATE]. R146's discharge diagnoses included: fall, dislodged gastrostomy tube, severe dementia, seizure disorder, neurocognitive disorder, sinus tachycardia, hypertension, L4 vertebral fracture, and acetabulum fracture. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R146's progress note dated 08/19/24 showed R146 had an unwitnessed fall with a dislodged gastrostomy tube with minimal blood drainage. R146 was sent to hospital due to blood thinners.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on interview and record review the facility failed to ensure intravenous medications were administered by qualified staff. This applies to 1 of 1 resident (R165) reviewed for intravenous therapy in a sample of 36. Findings include: R165 admitted to the facility on [DATE] with diagnoses that includes orthopedic aftercare following surgical amputation, acute osteomyelitis right ankle and foot, type 2 diabetes and cellulitis of right lower limb. R165 current physician orders include Daptomycin 700 MG (Milligrams) a day until 10/09/2024 and Ceftriaxone 2GM (Grams) a day until 10/09/2024. On 10/03/24 at 05:14 PM, V13 LPN (Licensed Practical Nurse) stated she administered R165's IV (Intravenous) antibiotic at 9:30 AM. V13 stated she flushed the midline PICC (Peripherally Inserted Central Catheter) and changed the cap that morning. On 10/3/24 at 6:01 PM, V2 DON (Director of Nursing) stated only RNs (Registered Nurses) should be hanging IV's, disconnecting them or changing the dressing. The LPN should know they should not handle the IVs. Review of R165's MAR (Medication Administration Record) shows V13 administer daptomycin at 9 AM on 10/3/24. Further review the R165's MAR showed V40 LPN administered daptomycin September 5, 6, 11, 13, 14, and 15, 2024 and ceftriaxone on September 6,7,10,12, 14,15,16,19, and 20, 2024. V41 LPN administered daptomycin on September 28, 2024, and ceftriaxone on October 1, 2024. V43 LPN administered daptomycin on September 7, 8,12,17, and 20, 2024 and ceftriaxone on September 9,13,17, and 21, 2024. V42 LPN administered Daptomycin on September 30, 2024, October 1 and 2, 2024. The facility policy Central and Venous Access: Administration of Continuous or Intermittent Intravenous Fluids / Medications dated 01/2022 states administration of intravenous fluids through central venous access will be done, upon Physician's order, by a licensed nurse who has been trained in the procedure.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to provide care to residents dependent on staff for ADL's (Activities of Daily Living). This applies to 9 of 9 residents (R16, R73, R108, R25, R155, R82, R121, R159, and R161) reviewed for ADL's in a sample of 36. The findings include: 1. On October 1, 2024 at 12:17 PM, R16 said the facility staff skips washing her perianal area during incontinence care and used wipes to clean her during incontinence care. R16 said she believed their lack of use of water caused the diaper rash. At 12:23 PM, V29 (CNA/Certified Nurse Assistant) and V30 (CNA) came to R16's room to provide incontinence care for R16, as she had a bowel movement. When R16's incontinence brief was removed, R16 was turned to her right side, and V29 and V30 wiped R16's perianal area with wipes. R16 asked the CNAs to use water on her bottom because it felt like something was there, and V29 and V30 ignored R16's request and continued to use wipes on her bottom. V29 and V30 applied a barrier cream to her perianal area. V29 and V30 told R16 to turn from her side to her bottom after applying the new brief, and closed R16's brief without providing care to her perineal area or applying the cream to the perineal area or the folds. R16 said she felt like her skin was on fire on her bottom. R16 had reddened and inflamed skin from her lower back to the upper thigh areas, as well as her perineal area, and her folds. On October 3, 2024 at 4:03 PM, V34 (Wound Care Coordinator) provided a skin check and incontinence care for R16. V34 began to wipe R16's perianal area, and R16 asked V34 to use water on the area, as it would make her feel better. V34 ignored R16's request and continued to wipe her with the wipes. R16 said the area really hurt and V34 responded by saying Okay, I'm about to put the cream and R16 responded again saying water would really help and said the sores really hurt. V34 continued to put cream on the resident. When asked, V34 said the staff should be cleaning the entire perineal and perianal area, even if the resident only appeared to have a bowel movement. V34 then said the residents should be washed with water if it was their preference, and she does not know why she chose not to, and the wipes were readily available. V34 said the redness was probably related to prolonged exposure to urine and bowel. On October 3, 2024 at 4:52 PM, V29 (CNA) said if a resident was asking for water, the staff should have put water to clean the area. V29 said they should use water if she wanted so the burning sensation was gone. V29 also said they should provide perineal care even if the resident had a bowel movement. On October 3, 2024 at 3:48 PM, V2 (DON/Director of Nursing) said the staff should use water and soap for incontinence care, not just the wipes. V2 said if the resident said their skin was burning, they need to use a mild cleanser and water and be gentle. V2 said the staff should clean the entire perineal and perianal area, even if they only had a bowel movement because the stool could travel and irritate the skin everywhere. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R16 was admitted to the facility with diagnoses including heart failure, Chronic Obstructive Pulmonary disease, and Type 2 diabetes mellitus. R16's MDS (Minimum Data Set) dated July 9, 2024 showed R16 was cognitively intact. R16's MDS (Minimum Data Set) dated July 9, 2024 showed R16 was dependent on staff for toileting hygiene. The facility's Perineal Care policy dated September 2020 showed to Separate the labia. Clean downward from front to back with one stroke. Repeat until area is clean. Clean anal area. Clean from front to back. Equipment: Basin of warm water and soap or perineal washing solution. 48526 2. On 10/01/24 at 12:43 PM R73 was sitting at the dining room table in a high back wheelchair. R73 had an accumulation of chin hairs. On 10/03/24 at 10:45 AM R73 continued to have an accumulation of chin hairs. R73's Face Sheet showed R73 had diagnoses of Alzheimer's Disease, dementia, chronic kidney disease, senile degeneration of brain, major depressive disorder, and hypertension. R73's MDS dated [DATE] showed R73 required substantial/maximal assistance for personal hygiene. R73's ADL Functional Performance care plan showed an intervention: assist with personal hygiene as needed. 3. On 10/01/24 at 12:37 PM R108 was sitting at the dining room table in a high back wheelchair. R108's fingernails on both hands had a dark colored substance underneath. R108 stated she wanted her nails clean. On 10/03/24 at 11:00 AM R108 continued to have a dark colored substance underneath her fingernails on both hands. R108's Face Sheet showed R108 had diagnoses of senile degeneration of brain, dementia, polyarthritis, anxiety disorder, and hypertension. R108's MDS dated [DATE] showed R108 was dependent upon staff for personal hygiene. R108's ADL Self-Care Performance care plan showed interventions: assist with personal hygiene as needed. R108's Personal Grooming care plan showed interventions: assist resident with task as needed, provide supplies and necessary setup for grooming and hygiene tasks. On 10/03/24 at 10:30 AM V2 (Director of Nursing) stated female residents should not have facial hair above the lip or under the chin. Facial hairs should be plucked or shaved as needed. It is unsightly and a dignity issue for women to have facial hair. Women could be made fun of by other residents if they have facial hair. Residents fingernails should be clipped and always clean. Fingernails should he checked and cleaned on shower days and as needed. Infections can occur if residents have dirty fingernails, and they scratch themselves. CNA's (CNA/Certified Nursing Assistant) are responsible for fingernails and shaving. It is my expectation for the staff to check their residents for the appropriate ADL's when they come to work. 41384 4. On 10/01/24 at 12:13 PM R25's fingernails were observed long, about 1/2 inch over the top of the fingers, with a brown substance under the nails. R25 said that it been about a week since the staff provided nail care for him and that his nails grow fast. R25 said that he would like for staff to provide nail care for him. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25's 7/31/24 MDS (Minimum Data Set) section C showed that his cognition is intact and section GG showed that he needs supervision or touching assistance from staff for personal hygiene. R25's 8/6/24 care plan showed that he has potential for ADL (Activities of Daily Living) fluctuations with interventions including assist resident with ADLs as needed. On 10/03/24 at 02:53 PM V1 (Administrator) said that nail care should be provided as needed by the CNA (Certified Nurse's Assistant) for overall cleanliness. 5. On 10/01/24 at 11:32 AM R155 was observed with his right hand and fingernails with a brown substance under the nails and on the hand. R155's right hand nails were long and jagged about 1/2 inch long. On 10/02/24 at 08:33 AM, R155's the nails on his right hand were observed long and jagged. On 10/03/24 at 09:52 AM R155 was in his bed and his fingernails were observed long and with a brown substance under the nails and on the top of the fingers. V4 (Nurse) was in the room at the time and said that the brown substance under his nails and on his fingers should have been cleaned. R155's 7/17/24 MDS section GG showed that R155 is dependent on staff for personal hygiene. R155's 6/20/24 care plan showed R155 has an ADL functional performance deficit with interventions including assist with ADL tasks as needed. On 10/03/24 at 03:00 PM, V1 (Administrator) said that nail care, cutting, filing, and cleaning should be done as needed. 44387 6. On 10/1/24 at 11:27 AM, R159 was in bed resting. R159 had full black and gray beard and black dirty substance underneath his fingernails. R159 was non-interviewable. R159's Face Sheet shows the following diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting right dominant side, cerebral infarction, chronic respiratory failure with hypoxia, and tracheostomy. R159's Minimum Data Set (MDS) of 7/25/24 shows that his cognition is severely impaired and was dependent for all personal hygiene. R159's Care plan (initiated 7/30/24) shows that R159 has an ADL functional and performance deficit. 7. On 10/1/24 at 11:39 AM, R161 was in bed resting. R161 had several short white hairs on her chin. R161 said she would like the hair off her chin. On 10/2/24 at 11:10 AM, resident in bed resting, facial hair still noted on chin. R161's Face Sheet shows the following diagnoses nontraumatic subarachnoid hemorrhage, epilepsy, muscle weakness and tracheostomy. R161's MDS of 8/21/24 shows that R161's cognition is moderately impaired and needs partial/moderate assistance with personal hygiene. R161's care plan (initiated 8/16/24) shows that R161 has an ADL functional and performance deficit. 8. On 10/1/24 at 12:16 PM, R82 was in bed resting. R82 had several white hairs on her chin. On 10/2/24 at 11:04 AM, R82 was seated in high back wheelchair in TV room by dining station, still noted with facial hair, said she would like it off. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R82's Face Sheet shows the following diagnoses of hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, major depressive disorder, disorder of the brain and cognitive communication deficit. R82's MDS of cognition is intact and needs substantial/maximal assistance with personal hygiene. R82's Care plan (initiated 7/23/24) shows that R82 requires ADL assistance. 9. On 10/2/24 at 10:58 AM, R121 was in bed watching TV. R121 had full white beard; R121 said he does not like his full beard and would like it shaved off. R121's Face Sheet shows the following diagnoses of myopathy, depression, muscle weakness and depression. R121's MDS of 9/4/24 shows that R121's cognition is intact and need partial/moderate assistance with personal hygiene. R121's care plan (initiated 8/28/24) shows that R121 has an ADL functional performance deficit. The facility's Shaving the Resident policy (9/2020) states that to remove facial hair and improve the resident's appearance and morale. The facility's Nails Care policy (9/2020) states all resident will have clean, well trimmed nails.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to have a skin alteration worsening assessed by a physician? This applies to 1 of 1 resident (R16) reviewed for quality of care in a sample of 36. The findings include: On October 1, 2024 at 12:17 PM, R16 said she had a diaper rash. At 12:23 PM, V29 (CNA/Certified Nurse Assistant) and V30 (CNA) came to R16's room and provided incontinence care for R16, as she had a bowel movement. When R16's incontinence brief was removed, R16 had reddened and inflamed skin from her lower back to the upper thigh areas, as well as her perineal area, and her folds. V29 and V30 wiped R16's perianal area and applied a barrier cream to her perianal area but did not apply the cream to the perineal area or the folds. R16 said she felt like her skin was on fire on her bottom. On October 3, 2024 at 9:08 AM, V34 (Wound Care Coordinator) said R16 was not being seen for wound rounds. On October 3, 2024 at 4:02 PM, surveyor and V34 did a skin check for R16. V34 said R16 would benefit from vitamin A & D ointment and zinc. V34 said the CNAs should be alerting the staff nurse to evaluate the rash. V34 continued to examine R16's bottom, and R16 said she had a bump on her gluteal fold, which was visible. V34 said the bump was blanchable. R16 said the whole area really hurt and said the sores really hurt her. V34 said the area was incontinence related and it was possible the areas were burning, and boils were present because of the moisture. V34 said she would be notifying the floor nurse to contact the doctor to evaluate the treatment. V34 said if R16 was getting an ointment and her skin was not improving, they should notify the doctor so they could try something else. V34 said it was possible to make the MASD (Moisture Associated Skin Damage) area better, and it was not acceptable for the floor staff to say the area had remained the same and to not do anything. V34 said by notifying the doctor, they could determine whether the treatment needed to be changed. On October 3, 2024 at 4:33 PM, V21 (LPN/Licensed Practical Nurse) said he had taken care of R16 for a long time, and she had come to the unit with the redness on her bottom. V21 said he did not know the last time the skin was evaluated by a physician and had not notified any doctor of the skin alteration. V21 said the area had not gotten any better but had also not gotten any worse. V21 looked at the progress notes and was unable to find any notes regarding the last time the wound was evaluated. V21 said he spoke to the doctor about her medication noncompliance and about drawing labs. V21 said the doctor was aware of the rash as she had ordered the creams during that conversation. On October 3, 2024 at 4:48 PM, V34 said the facility staff should still notify the doctor about the skin alteration even if the resident was not following the interventions, and if they did not want to change the treatment, they would need to document no change. On October 4, 2024 at 10:02 AM, V44 (Wound Care Physician) said he was not consulted to see R16. V44 said he did not see any messages from the floor staff or wound care coordinator regarding R16. V44 said MASD was usually managed by the primary care provided or Nurse Practitioner, but if it did not get better, he would typically be consulted after two to three weeks. V44 said if the rash was fungal, he would be consulted to evaluate the skin. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R16 was admitted to the facility with diagnoses including heart failure, Chronic Obstructive Pulmonary disease, and Type 2 diabetes mellitus. R16's MDS (Minimum Data Set) dated July 9, 2024 showed R16 was cognitively intact. R16's POS (Physician Order Sheet) dated October 3, 2024 at 4:12 PM, showed an order for Calmoseptine External Ointment ordered on August 28, 2024 with instructions to apply topically every shift as needed for skin condition and a second order to apply to buttocks and perineum topically every shift. R16 also had orders for Miconazole Nitrate ordered on July 2, 2024 Apply to bilateral thighs one time a day for skin condition, as well as Zinc Oxide Ointment 20% ordered on August 13, 2024 with instructions to apply to bilateral buttocks topically as needed for skin condition, as well as a second order to apply to bilateral buttocks topically every night shift for skin condition. R16's POS provided by the facility on October 4, 2024, showed discontinued orders for the Calmoseptine External Ointment, originally ordered on August 28, 2024, discontinued Nystatin powder, ordered on July 2, 2024, and discontinued Zinc Oxide Ointment 20%, ordered on August 13, 2024. R16's POS showed new orders for Fluconazole Oral Tablet 100 MG (Milligrams) ordered on October 3, 2024 for seven days. The POS also showed a new order dated October 3, 2024 for Miconazole Nitrate Topical Apply to buttocks topically every morning and at bedtime for Skin Condition. R16's Care Plans were reviewed, and there were no care plans in place for R16's skin condition. R16's care plan dated July 11, 2024 showed R16 had the potential for alteration in skin integrity. R16's bowel and bladder care plan dated July 12, 2024 showed to Monitor for excoriation near peri area. Notify nurse for any changes. R16's Progress Note dated August 13, 2024 showed Shearing Skin alteration with Bruise noted to Right Buttock as described above with Skin intact, shearing skin alteration with bruise noted to left buttock. Wound MD (Medical Doctor) notified, treatment orders issued and received. On August 16, 2024, a progress note written showed Spoke with [R16] and encouraged her to get up for meals today to help her bottom that burning like a fire. No other progress notes regarding R16's skin was noted after August 16, 2024. R16's Braden Scale assessment dated [DATE] showed R16 was at moderate risk for skin alterations. The facility's Prevention and Treatment of Pressure Injury and other Skin Alterations policy dated March 2, 2021 showed Implement preventative measures and appropriate treatment modalities for pressure injuries and/or other skin alterations through individualized resident care plan. Non-Pressure skin alterations ie: skin tears, abrasions, surgical wounds, MASD, lesions and rashes, will be documented weekly on a Skin Progress Note. Develop a Care Plan for either actual or potential alteration in skin integrity and change as needed. Revise Care Plan approaches as needed based on resident's response and outcomes.

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Alden Estates of Orland Park	16450 South 97th Avenue Orland Park, IL 60467

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45906 Based on interview and record review, the facility failed to offer restorative services to a resident as recommended per the admission restorative nursing assessment. This applies to 1 resident (R152) reviewed for restorative services in a sample of 36. The findings include: R152's Face Sheet shows he was admitted to the facility on [DATE]. On 10/1/24 at 12:27 PM, R152 said he had been in the facility for about 4 months and he was not too happy because he had just found out that he was supposed to be getting rehab services, but he had not received any therapy services at all since his admission. R152's Functional Abilities and Goals Admission assessment dated [DATE] documented by V7 (Restorative Registered Nurse) shows R152 had no impairment to his upper and lower extremities, was completely dependent on staff for toileting hygiene and had a discharge goal to improve to only require substantial assistance with toileting hygiene, and was completely dependent on staff during bed mobility/rolling left and right in bed and had a discharge goal to improve to only require substantial assistance to roll left and right in bed. R152's Restorative Nursing assessment dated [DATE] completed by V7 (Restorative RN) shows R152 had a decrease in muscle strength and recommended PROM/AROM (Passive Range of Motion/Active Range of Motion) and Bed Mobility/Walking programs. R152's MDS (Minimum Data Set) dated 8/26/24 shows he received 0 days of PROM, AROM, or bed mobility in the previous 7 calendar days. On 10/3/24 at 4:37 PM, V7 (Restorative RN) said she assessed R152 for restorative therapy but he was not currently on any restorative programs. V7 said R152 came in under public aide so she knew he did not receive any physical therapy services. V7 said she last assessed R152 for restorative therapy on 8/26/24 and her priority programs for him were range of motion and bed mobility. V7 said she gave R152 different options for restorative therapy, but R152 didn't want to participate on a regular basis because he is really alert so I didn't go through with any programs. V7 said there was no documentation to show R152 refused restorative therapy services because he is alert so she didn't think to document his refusal. R152's Care Plan initiated on 6/4/24 shows he has an ADL Functional Performance Deficit and presents with weakness, impaired gait, and mobility. The goal shows resident will improve current level of functioning in ADLs. R152's Care Plan does not show any documentation of restorative therapies being offered or refused. R152's EHR (Electronic Health Record) task section does not show any tab referencing restorative therapy programs ever being ordered, offered, or refused. (continued on next page)

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Restorative Nursing Program dated 3/10/22 states, Policy: It is the policy of this facility that a resident is given the appropriate treatment and services to enable residents to maintain or improve his or her abilities and to promote the resident's ability to adapt and adjust to living as independently and safety as possible. Increased independence fosters self-esteem and promotes quality of life for residents . All residents will be assessed on admission, as change of condition warrants, and quarterly thereafter, for participation in the Restorative Nursing Program (RNP). An individualized program will be developed based on the resident's needs as appropriate. The program(s) will be reflected on the interdisciplinary care plan and consistently carried out by staff . Procedure: .9. Program goals will be documented in the POC task section, Restorative, nursing, therapy, and/or any other trained personnel will document the resident's participation .

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41384 Based on observation, interview, and record review, the facility failed to provide a safe supervised environment. This applies to 3 of 4 residents (R221, R222, & R142) reviewed for free of accidents, hazards, supervision and devices in a sample of 36. The findings include: 1. On 10/01/24 at 01:30 PM, R221 was observed in his wheelchair by the nursing station without his shoes or eyeglasses on, and the socks he had on were not non-skid socks. R221 was observed trying to get up from his wheelchair and appeared confused and had difficulty understanding staff's request when asked to see the bottom of his feet. V37 (Nurse) said he is to have non-skid socks on. V38 CNA (Certified Nurse's Assistant) said that she was the staff that assisted him with dressing that morning and she observed him taking his shoes off, but she did not put non-skid socks on him after seeing him taking off his shoes. V38 said that she should have put the non-skid socks on R221 because he is a fall risk. R221 electronic health record showed that he was admitted on [DATE] with diagnoses including metabolic encephalopathy, and Parkinson's with dyskinesia. R221's 09/28/2024 care plan showed that he is a risk for falls with a goal to be free from injury related to falls and interventions including assure resident is wearing glasses. On 10/03/24 at 03:13 PM, V1 (Administrator) said that R221 should have had non-skid footwear on for safety. 2. On 10/01/24 at 11:19 AM R222 was in his bed with his bedrails up and on the right side of his bed, touching the mattress, was the over the bedside table, longways, and on the left side of the bed was 1 room chair pushed up against the mattress and next to the chair was R222's wheelchair pushed up to the mattress on an angle touching the mattress and the chair, leaving an approximate 1 and 1/2 foot by 2 foot triangular area open. Under the window was a mat setting up against the wall. R222 said that staff put the chairs and table against his mattress in case he fell . R222 said that when he gets up, he gets dizzy. R222 was asked how he would get out of the bed with all of the items around his bed and he said he would step in the hole, referring to the 1 and 1/2 by 2 foot triangular open area. R222's 9/25/24 care plan showed that he is at risk for falls related to cognitive deficits, functional deficits, poor balance, poor safety awareness, and unsteady gait. The interventions included floor mats to left side of his bed while in bed. R222's MDS (minimum data set) showed that R222 has long, and short term memory problems and his cognitive skills are severely impaired. On 10/03/24 at 03:18 PM V1 (Administrator) said that nothing should be cluttering the area in the resident's room and the mat should have been on the floor next to R222's bed as his care plan showed for his safety. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Management of Falls policy dated 08/2020 showed that the facility will assess hazards and risks, develop a plan of care to address hazards and risks, implement appropriate resident interventions, and revise the residents plan of care in order to minimize the risk for falls incidents and or injuries to the resident. 46003 3. R142 admitted to the facility on [DATE] with diagnosis that includes failure to thrive, congestive heart failure, dementia, kidney disease and glaucoma. R142 MDS (Minimum Data Set) dated 9/20/24 shows BIMS (Brief Interview for Mental Status Score of 10) indicating moderate cognitive impairment. On 10/01/24 at 12:23 PM, R142 had a can of disinfectant spray in the bed with her. R142 stated she has the spray for the stink. On 10/03/24 at 11:40 AM, R142 had two 12.5 oz (Ounce) cans of disinfectant spray in reach on her overbed table. R142 stated she needed them to kill the stank. The facility policy Chemical Storage / Usage and SDS dated 1/23 states all chemicals will be always kept inaccessible to residents. Chemicals will be stored in locked carts, cabinets or rooms. During use, chemicals will be under constant supervision of staff.

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F 0694 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide for the safe, appropriate administration of IV fluids for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review the facility failed to change a soiled PICC midline PICC (Peripherally Inserted Central Catheter) as needed. This applies to 1 of 1 resident (R165) reviewed for intravenous therapy in a sample of 36. Findings include: R165 admitted to the facility on [DATE] with diagnoses that includes orthopedic aftercare following surgical amputation, acute osteomyelitis right ankle and foot, type 2 diabetes and cellulitis of right lower limb. R165 current physician orders include IV (Intravenous) Midline: transparent sterile dressing change weekly and PRN (as needed). Check IV site every eight hours for unusual redness, drainage and skin irritation, site pain etcetera and document condition. On 10/01/24 at 01:43 PM, R165's showed the surveyor his left upper arm PICC line. The PICC insertion was covered by a gauze and transparent dressing dated 9/29. On 10/03/24 at 11:48 AM, R165 showed the surveyor his PICC line. The gauze under the transparent dressing had bloody drainage on it and was dated 9/29. On 10/03/24 at 05:12 PM, R165 showed the surveyor his PICC line. The gauze under the transparent dressing had bloody drainage on it and was dated 9/29. On 10/03/24 at 05:14 PM, V13 LPN (Licensed Practical Nurse) stated she did not know when his PICC line dressing was changed. V13 stated the PICC dressing is changed weekly on night shift and as needed if it is soiled, lifting or shows signs things that can cause infection like drainage. On 10/03/24 at 02:46 PM, V2 DON (Director of Nursing) stated PICC line dressings are changed once per week on Sunday unless they get dirty or have blood on it or anything that may cause infection. The gauze being in place does not change the frequency of the PICC line dressing change unless it is soiled or has blood on it. The facility provided IV (Intravenous) Care Reference Guide dated 11/21/2021 states, dressing change site covered with gauze not visible: change dressing daily. The facility provided policy Central Venous Access Catheter Device: Dressing Change dated 01/2022 states dressing changes are done one time per week and PRN (as needed).

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review the facility failed to provide oxygen supplementation as ordered by the physician. This applies to 1 of 2 residents (R42) reviewed for oxygen therapy. Findings include: R42 admitted to the facility on [DATE] with diagnosis that includes encounter for palliative care, adult failure to thrive, chronic obstructive pulmonary disease, hypertension, anxiety and dependence on supplemental oxygen. R42's Physician orders include oxygen 4 liters per minute per nasal cannula continuous. On 10/01/24 at 11:32 AM, was in bed with a nasal cannula connected to an oxygen compressor set to 0 Liters. R42 tongue was blue, and her respirations were shallow. On 10/01/24 11:47 AM, V6 RN (Registered Nurse) assigned to R42 stated she did not turn the oxygen supply off and did not know who did. V6 stated R42 physician order is for 4L (liters) per minute to be administered. On 10/03/24 at 11:35 AM, R42 had nasal cannula connected to an oxygen compressor set to 4L. R42's tongue was pink and was breathing regular. On 10/03/24 at 02:46 PM, V2 DON (Director of Nursing) stated potential problems with residents not receiving the prescribed oxygen administered is they can become short of breath, have changes in their blood gasses or develop respiratory distress. A tongue that has turned blue means there is a lack of oxygen. The nurse should make sure the oxygen is running at the correct rate. If the nursing assistant notice it is off or there is a change, they should notify the nurse. The facility policy Oxygen Concentrator dated 9/2020 states residents will be administered oxygen via concentrator upon Physician's order by an RN, LPN (Licensed Practical Nurse), or RT (Respiratory Therapist). Certified Nurse Assistants / Hab aids may adjust or reapply the nasal cannula or mask only.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed to have an accurate Record of Receipt for a controlled medication. This applies to 1 of 1 resident (R324) reviewed for Record of Receipt for controlled medications. The findings include: On 10/03/24, at 10:00 AM, During the observation of the third floor (split) medication cart, a handwritten note on white copy paper was in the Controlled Drug Receipt/Record/Disposition Form book. The handwritten note contained R324's name and directions as followed: take 5 mg (0.25mL) by mouth or sublingual every hour as needed for pain, shortness of breath. May titrate in 5 mg (0.25 mL) increments up to. The handwritten note did not contain the medication's name, quantity on hand, quantity received, or licensed nurses signatures. R324 had a box of Morphine Sulfate 30 mL in the locked box on the medication cart. On 10/03/24 10:07 AM V2 (Director of Nursing) stated R324 did not have the appropriate narcotic count sheet. The medication name of Morphine Sulfate should have been on the handwritten sheet. Whenever a nurse does not receive a narcotic sheet for whatever reason, they need to create one for the resident with the resident's name, date dispensed, name of drug, dosage, route, directions for use, amount received, room for signatures, the amount given, and amount left. If medication narcotic sheets do not contain the name of the medication, the wrong medication can be given, also too much or too little can be given. A resident can stop breathing from Morphine, they could have an overdose, or go into a coma. We do a narcotic count at the beginning of each shift. I do not know why no one caught this error. My expectation is that licensed nurses create the appropriate sheet and honor the five rights of medication administration. R324 was admitted to the facility on [DATE] with the following diagnoses: encounter for palliative care, vascular dementia, atherosclerotic heart disease, atrial fibrillation, and hypertension per the Face Sheet. R324 had an active order for Morphine Sulfate (Concentrate) Solution 20 mg/mL with directions: 0.25 mL mucous membrane every two hours as needed for moderate pain. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Controlled Drug Documentation Policy dated 06/22 showed: A. Purpose- To maintain control and prevent loss and/or diversion of controlled substances. B. Prerequisites: 2. Individual proof-of-use receipt/record/disposition form for each controlled medications. 3. Controlled Substance Shift Count form (997-027). C. Procedure: 1. For each controlled substance dispensed individually, pharmacy supplies a pink proof-of-use form (Controlled-Drug Receipt/Record/Disposition Form), pre-printed with resident and medication information. A. The nurse receiving the medication delivery will indicate on the quantity received and sign/date the accompanying proof-of-use form. 2. Controlled substances must be counted and verified every shift, usually at shift change, by two licensed nurses. Balances are documented on the Shift Count form and must be signed by both nurses performing the count. Any discrepancy between the number of controlled drugs on hand and the sheet's balance must be brought to the attention of the Director of Nursing immediately, following the facility's policy.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48526 Based on observation, interview, and record review, the facility failed properly store mediations and remove expired medications from stock. This applies to 5 of 5 residents (R115, R121, R138, R148, R165) reviewed for medication storage. The findings include: 1. On 10/03/24 at 9:30 AM During the observation of the first floor (split) medication cart, R115 oral and Proctosol-HC 2.5 % rectal medications were stored together in the drawer. The rectal medication was not bagged or separated from the oral medications. On 10/03/24 at 11:41 AM V10 (Assistant Director of Nursing) stated rectal medications should not be stored with oral medications. Two routes should not be mixed. There could be an infection control issues with the rectal medication mixed with the oral medication. On 10/03/24 at 12:08 PM V4 (Registered Nurse) stated R115 has an active as needed order for Proctosol rectally. Rectal medications should not be stored with oral medications. That is an infection control issue. Rectal medications should be stored in the treatment cart. R115 was admitted to the facility on [DATE] with the following diagnoses: metabolic encephalopathy, altered mental status, hypertension, muscle weakness, and osteoporosis per the Face Sheet. R115 had an active order for Anusol-HC External Cream 2.5% apply to rectal area topically every 12 hours as needed for hemorrhoids per the physician's orders. 2. On 10/03/24 at 9:05 AM During observation of the first floor medication room with V10, R165 had a bag of Daptomycin 700 mg in normal saline 100 mL, intravenous antibiotic, stored in the refrigerator. The bag of Daptomycin was stored with other bags of the same medication. The expiration date for the one bag of Daptomycin was 10/01/24. On 10/03/24 at 11:41 AM V10 stated R165 was still receiving Daptomycin intravenous for osteomyelitis to the right ankle and foot. V10 said R165 was admitted on [DATE] with orders for the medication. The medication stop date is 10/09/24. V10 said I do not know why the medication was not discarded. We send expired medications back to the pharmacy. V10 stated intravenous antibiotics get mixed and are only good for so long. The medications come with an expiration date and is not effective after a certain time. I expect the nurses to send all expired medications back to the pharmacy. R165 was admitted to the facility on [DATE] with the following diagnoses: osteomyelitis of right ankle and foot, acquired absence of right toes, diabetes, morbid obesity, and hypertension. R165 had an active order for Daptomycin-Sodium Chloride Intravenous Solution 700-0.9 mg/100 mL daily until 10/09/24. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Storage/Labeling/Packaging of Medications Policy dated 01/2022 showed: A. Purpose: To store medications and biologicals under proper conditions of temperature, light, and security. B. Policy: 1. Resident specific medications are placed in a locked cabinet or cart that is affixed to a wall, in close proximity to a nursing station, or in a locked, well-illuminated room accessible only to licensed nursing personnel, licensed pharmacy personnel, or staff members lawfully authorized to administer medications. 8. All medications for external use are kept in a separate section from internal use medications. 41384 3. On 10/01/24 at 12:05 PM, R138 was observed in her room and on her over the bedside table there was a medication cup with 4 pieces of nicotine gum 4 milligrams in the cup. R138 said, I can have it. I am not smoking. I do 4 pieces a day probably every 2 to 3 hours. I have a piece in the morning and a piece after my meals, maybe it is 4 or 5, I don't know. R138's 11/7/2023 Physician order showed Nicorette Mouth/Throat Gum 4mg. Give 1 gum by mouth every 4 hours as needed for smoking cessation, unsupervised self-administration. On 10/03/24 at 02:45 PM V1 (Administrator) said that the pieces of 4mg nicotine gum are medications, and they should be safely stored. 4. On 10/01/24 at 01:22 PM, V39 (R148's Daughter-in-law) picked up a 2oz tube of Zinc Oxide 20 % off R148's bedside table and said that the staff put the medication there so the staff and herself can apply it to R148's buttocks after they provide incontinence care for him. R148's 4/12/24 physician order showed, apply to sacrum topically every shift for MASD (moisture associated skin damage), cleanse with NS (normal saline), apply zinc oxide to site and cover with foam dressing. R148's 4/12/24 physician order showed, apply to sacrum as needed for MASD (moisture associated skin damage), cleanse with NS (normal saline), apply zinc oxide to site and cover with foam dressing. R148's 4/8/24 care plan showed R148 has a potential for alteration in skin integrity with interventions including treatment as ordered. On 10/03/24 at 02:36 PM, V1 (Administrator) said that the zinc oxide 20% is for the nurse to give and it should be locked and stored in the medication cart. 44387 5. On 10/1/24 at 12:05 PM, there was a bottle of Nystatin Powder 100, 000 units per gram on the shelve in R121's room. On 10/2/24 at 10:58 AM, the Nystatin powder still in R121's room; R121 said he uses the Nystatin powder. R121's Physician Order shows an order for Nystatin External Powder 100, 000 unit/gram apply to groin and abdominal folds topically two times a day for skin condition. R121 does not have an order for the medication to be stored in resident room. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/3/24 at 10:48 AM V2 (Director of Nursing/DON) said residents needs to have an order to have medications at the bedside, medications should be secured, residents needs to be alert and oriented and understand the reason why they are on the medications. They need to be aware of medications residents are taking to ensure that there are no adverse effects with medications being provided by the facility.

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	145963	A. Building B. Wing	10/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates of Orland Park	16450 South 97th Avenue Orland Park, IL 60467

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46003 Based on observation, interview and record review the facility failed to maintain the kitchen facility in a manner to prevent foodborne illness. This applies to 152 residents in the facility receiving dietary services. Findings include: On [DATE] 11:15 AM V1 Administrator confirmed 152 residents were being served from dietary services on [DATE]. 1. On [DATE] at 10:45 AM, the walk-in cooler contained: Shredded yellow and white cheese in a bag without a label or date. Fifteen clear bags identified by V9 Kitchen Supervisor as liquid eggs stored above cooked pureed and mechanical processed food items. Six silver metal pans identified by V9 as pureed bread without a label or dates. Six silver metal pans identified by V9 as pureed eggs without a label or dates. Six silver metal pans identified by V9 as pureed sausage without a label or dates. Three silver metal pans identified by V9 as mechanical ground sausage without a label or dates. V9 identified four large metal containers without identifying labels as pureed sausage, pureed eggs, mechanical ground sausage and two with pureed bread. Pureed beef with an expiration date of ,d+[DATE]. Mechanical sausage with an expiration date of [DATE]. Open packaged hot dog with an expiration date ,d+[DATE]. A clear facility container with Jalapeno dated [DATE]. V9 stated he was not sure when they expire. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On [DATE] at 03:35 PM, V9 Kitchen Supervisor stated it is important to have both an open on and use by date on food items to know when to throw them away. It is not good for residents to eat expired food. The thawing eggs should have been stored under the cooked prepared food items for safety. V9 stated he uses an app on his phone to tell him how long food items are good for from the day of purchase, but the app does not tell him how long food items are good for after they are opened. V9 sated food should be dated and labeled when it is transferred from its original container. We should know what the ingredients are for residents with allergies. Food expires in either 3 or 7 days after opening or preparation. V9 could not verbalize what food items expire in 3 or 7 days or how staff should know which food items expire in 3 or 7 days. The facility policy Food Storage dated ,d+[DATE] states food taken from the original container will be labeled by common name. Raw foods will be stored below cooked ready to eat foods. The facility did not provide a policy regarding how foods should be dated once opened or the expiration date. 2. On [DATE] at 10:13 AM, the dry storage contained: Six dented 6lb (pound) 9 oz (ounce)cans of sliced pears. Two dented 6lb 10oz cans of fruit cocktail. One dented 7lb can of chocolate pudding Three dented 6lb 10oz cans of tomato sauce. On [DATE] at 12:34 PM, V15 Corporate Executive [NAME] stated dented cans should be separated to make sure they are not served to the residents. Food items should be labeled with its contents, opened on and use by dates. We should assure residents aren't served foods they are allergic to, there is no cross contamination, and we know how long foods are good to use. On [DATE] at 03:35 PM, V9 Kitchen Supervisor stated We should not use dented cans because the metal can mix with the food item and the resident can ingest it. Also, residents may get sick if they eat food from dented cans, they teach us this. The facility policy Dented Cans dated ,d+[DATE] states canned foods with swelled top or bottom, leakage, flawed seals rust or dents will be rejected. Compromised cans will be stored on a shelf marked do not use. 3. On [DATE] at 10:34 AM, the walk-in freezer contained: Four packages of five count deep dish pie crust without any dates. Pastries identified by V9 as apple Danish. The 10-count package did not have an identifying label and was dated only ,d+[DATE]. Pastries identified by V9 as cinnamon Danish. Eight Danish remained in the open package. The package did not have an identifying label and was only dated ,d+[DATE] (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	An 8 count of waffles without a label, open on or use by date. An open package identified by V9 as chicken tenders without a label, open on or use by date. On [DATE] at 04:06 PM, V36 [NAME] was observed entering the freezer. V9 was requested to translate for V36 non-English speaking. V36 was asked questions regarding how to store, label and date food items. V36 looked confused and was unable to answer surveyor questions. 4. On [DATE] at 11:15 AM, under the kitchen counter a 5.5 L (Liter) clear container containing white powder identified by V9 Kitchen Supervisor as thickener. The container did not have a label identifying contents, open on or use by dates. A squirt bottle containing thick yellow liquid identified by V9 as butter alternative did not have a label identifying its contents opened on or use by dates. On [DATE] at 04:15 PM, V12 Dietary Supervisor stated cooked or opened food items expire in either 3 or 7 days. The facility does not have a chart or policy to reference for the kitchen staff to refer to on which food items expire in 3 or 7 days. V12 stated V9 or himself go through the refrigerator and throw out expired food items. 5. On [DATE] at 11:06 AM, V9 tested the sanitization level in the three-compartment sink and two red buckets in use. V9 stated they should test between 200 and 300 ppm (Parts Per Million) On [DATE] at 04:54 PM, the facility provided the sanitization log for the three-compartment sink for July and [DATE] and a sanitization log for the sanitization bucket dated [DATE]. V1 Administrator stated the facility only uses one log for testing the three-compartment sink because the red sanitization buckets are filled from the three-compartment sink and do not require a separate log. V1 stated V9 should only use the log for the three-compartment sink. On [DATE] at 04:57 PM, V9 stated only the three-compartment sink sanitization level is tested and the red sanitization buckets are filled that sink. V9 stated he did not know how the sanitization level was different for the two sanitization buckets. On [DATE] at 12:34 PM, V15 Corporate Executive [NAME] stated the red sanitization buckets are filled from the three-compartment sink, but there should still be separate logs for the sanitization buckets and the three-compartment sink. If the sanitization buckets had two different readings it may be because the solution settled in the sink and needed to be stirred or it had sat for too long. On [DATE] at 04:10 PM, V14 Dietary Aide stated he does the three-compartment sink documentation of sanitization level on one log. There is one sanitization log that covers the three-compartment sink and the red sanitization bucket. The facility policy Sanitization Bucket / Spray dated ,d+[DATE] states test the solution with the chemical test strip to ensure the proper ppm has been met. Record the results of the sanitizing solution on the appropriate log each time the bucket and or spray bottle is prepared. The facility policy Operation of the Three Compartment sink dated ,d+[DATE] states test the sanitizing solution with a test strip. Record the ppm in log.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46409 Based on observation, interview, and record review, the facility failed to follow infection control practices during blood glucose monitoring and dining service. This applies to 5 of 5 residents (R16, R5, R98, R133, R221) reviewed for infection control in a sample of 36. The findings include: 1. On October 1, 2024 at 11:57 AM, V45 (LPN/Licensed Practical Nurse) went from R29's room and performed a blood glucose test on R29. V45 left R29's room after getting the blood glucose results and returned to her nurse cart. V45 inputted R29's blood glucose level into the computer, then grabbed her supplies again and went to R16's room. V45 did not clean the glucometer before testing R16's blood glucose level. On October 3, 2024 at 2:15 PM, V19 (LPN) said she would wipe down the blood glucose monitor after each resident as it was a precaution for infection control. On October 3, 2024 at 2:34 PM, V21 (LPN) said he would wipe down the glucometer between residents with the wipes. V21 said the wipes container also told them how long they should let the glucometer dry for. V21 said the staff should not go from one room to the next with the same glucometer as that could cause cross contamination. On October 3, 2024 at 3:48 PM, V2 (DON/Director of Nursing) said the staff were supposed to clean the glucometer after each resident using the instructions on the container of wipes. V2 said the container told you how long the glucometer also needed to dry for. V2 said this was done for infection control, because there was blood involved, and it could be on the glucometer. R16 was admitted to the facility with diagnoses including heart failure, Chronic Obstructive Pulmonary disease, and Type 2 diabetes mellitus. R16's MDS (Minimum Data Set) dated July 9, 2024 showed R16 was cognitively intact. R16's MDS (Minimum Data Set) dated July 9, 2024 showed R16 was dependent on staff for toileting hygiene. The facility's Assure Platinum Blood Glucose Monitoring policy dated August 2024 showed After each use clean/disinfect outside of the meter with disinfectant wipes. 41384 (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2-6 On 10/01/24 at 12:27 PM during lunch service in the dining room, V5 CNA (Certified Nurse's Assistant) was observed touching R221's plate of food that he was eating from and picked up the empty glass that R221 had drank from, using both her left and right hands. V5 refilled R221's glass with thickened water that she got off a cart that contained fluids for all the residents. V5 said that the carton of thickened water was for everyone. After filling R221's glass, V5 returned the carton of thickened water to the cart and went to the serving window and picked up R5's tray without cleaning her hands first. V5 put R5's plate in front of her and then went back to the window and picked up R133's tray and served R133 her plates again with her dirty ungloved hands. Then V5 went back to the window again and picked up R98's tray and served R98 her food. V5 went back to the window and picked up R28's tray brought the tray to R28's table. V5 placed the food on the table, opened up R28's napkin, setup his utensils, and cut up the food on his plate. V5 did all of this still with her dirty ungloved hands. R221's EHR (Electronic Health Record) showed he was admitted to the facility on [DATE] with diagnoses including urinary tract infection, Proteus Mirabilis (bacterial infection), & pseudomonas (bacterial infection). R5's EHR showed she was admitted to the facility on [DATE]. R133's EHR showed she was admitted to the facility on [DATE]. R98's EHR showed she was admitted to the facility on [DATE]. R28's EHR showed that he was admitted to the facility on [DATE]. On 10/03/24 at 02:18 PM, V1 (Administrator) said that V5 should have cleaned her hands after touching the first resident's cup and plate and before touching the thickener. V1 said that V5 should have cleaned her hands before moving or touching residents' plates or before setting up their utensils for infection control. The facility's Hand Washing and hand Hygiene policy dated 6/4/2020 showed that appropriate hand hygiene is essential in preventing the spread of infectious organisms in health care settings. The guidelines show hand hygiene must be performed after touching body fluids and contaminated items including but not limited to items or surfaces that may be contaminated with body fluids, after caring for residents, and between contact with different residents.