STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145984	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden North Shore Rehab & Hcc	5050 West Touhy Avenue Skokie, IL 60077

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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 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 50036 Based on interview and record review, the facility failed to provide bed hold notification when transferring residents to a local hospital. This failure affected 5 residents (R1, R21, R29, R52, R64) reviewed for bed hold notification in a sample of 34. Findings include: R1 initially admitted on : 4-12-2024 with most recent readmission on 4-27-2024, with diagnoses that include but not limited to: pleural effusion, acute pulmonary edema, diabetes, and kidney transplant. R1 was transferred to a local hospital on 5-16-2024 per progress notes. Per record review no bed hold notification on record. R21 initially admitted on [DATE] with most recent readmission 5-6-24, with diagnoses that include but not limited to: Infection and inflammatory reaction due to internal right knee prosthesis, acute embolism and thrombosis of right calf muscular vein, and major depressive disorder. R21 was transferred to a local hospital on 5-3-24 per progress notes. Per record review, no bed hold notification on record. R52 initially admitted on [DATE] with most recent admission of 04/29/2024, with diagnoses that include but not limited to: wedge compression fracture of fourth thoracic vertebra, heart disease, parkinsonism, and depression. R52 was transferred to a local hospital on 4/26/2024 per progress notes. Per record review, no bed hold notification on record. R64 initially admitted on [DATE], with diagnoses that include but are not limited to: metabolic encephalopathy, sepsis, and non-traumatic chronic subdural hemorrhage. R64 was transferred to a local hospital on 4/26/2024 per progress notes. Per record review no bed hold notification on record. R29 initially admitted on [DATE], with diagnoses that include but are not limited to: primary lateral sclerosis, intracranial injury, monoplegia of upper limb, and severe protein calorie malnutrition. R29 was transferred to a local hospital on 4/7/24 and 05/22/24 per progress notes. Per record review no bed hold notifications on record. On 5-22-2024 at 1:45 PM, V2 (Director of Nursing/DON) stated, We did not give a bed hold policy to (R21). (continued on next page)

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor asked V2 to provide bed hold policy given to R1. During course of the survey, V2 unable to provide proof of bed hold policy given to R1. On 05/23/2024 at 2:00 PM, V2 (DON) stated, I cannot provide bed hold notifications for (R1), (R21), (R29), (R52), and (R64). I do not have them. Bed Hold/Ombudsman Notification Documentation Policy, dated 12/2018, states: Policy: 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 within 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. Procedure: 1. The Nurse will be responsible for opening the Bed Hold and Ombudsman Notifications Assessment for any resident being transferred to the hospital or going out on therapeutic leave. 2. The nurse will document that the bed hold notification was provided to the resident, and to the Resident Representative if present. 3. The Facility Designee will provide the Resident Representative the bed hold notification within 24 hours, if not previously given, and document completion in the Bed Hold and Ombudsman Notification Assessment. 4. The facility Designee will also document that the Ombudsman will be notified via the monthly transfer log in the Bed Hold and Ombudsman Notifications Assessment.

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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 0684 Level of Harm - 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** 44570 Based on observation, interview, and record review, the facility failed to accurately identify a change in condition and immediately notify the physician regarding a resident (R29) who demonstrated signs of respiratory distress from [DATE] until [DATE]. This failure affected one (R29) of one resident who was emergently transferred to a local hospital due to a change of condition on [DATE] at 12:36PM, and resulted in R29 expiring at the hospital at 3:50PM. Findings include: R29 is [AGE] years old and admitted to the facility on [DATE]. R29 had diagnoses that included lateral sclerosis, intracranial injury with loss of consciousness, anarthria (loss of speech), and pressure ulcers. On [DATE] at 11:21AM, R29 was observed in bed, with continuous gastric tube running, unresponsive to verbal stimuli, and noted with shallow audible respirations. R29 was breathing with mouth open and had a nasal cannula applied with humidity at 2L (liters). An indwelling catheter was observed thick cloudy bloody tinged sediment. At 12:28PM, a CNA (Certified Nursing Assistant) was observed going into R29's room, to call the roommate of R29 to lunch, and did not check on R29. At 12:37PM, CNA was noted to come back to the room to serve lunch to the roommate and did not check on R29, who was in the same position. At 12:52, another CNA went into the room and did not render care for or check R29. At 1:24PM, V11, RN (Registered Nurse), came into the room and removed the completed gastric feeding. V11 came into the hallway to ask the unit manager for assistance to change position of R29. At 2:47PM, Surveyor asked V11 about R29's breathing. V11 said, The CNA's are responsible for taking vitals which are usually daily or per shift. V11 stated V11 had not personally taken vitals for R29 during the shift and was unsure of when they were last taken. V11 also said R29 is a mouth breather, and the current state was baseline. V11 went on to say, when they first cared for R29 closer to admission, V11 sent R29 out to the hospital for the same concern, but R29 was sent back the same day. V11 took the oxygen saturation and pulse upon request, with results of 99% oxygen and pulse 94 bpm (beats per minute). On [DATE] at 9:22AM, R29 presented in bed, unresponsive to verbal stimuli and on 2L continuous nasal cannula. R29 was turned on the left side had a visual bounding pulse to the right neck. Respirations were shallow, audible, and visibly distinguished counted at 42 breaths per minute using a stopwatch. The indwelling catheter was clean. V11 was the nurse on duty, and said R29's condition had been unchanged since the previous day. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE] at 12:18PM, V11 was observed on the unit and said the previous night shift nurse endorsed this morning that R29 had a fever overnight, which was treated with acetaminophen. V2 said they took the temperature of R29 with no additional vital signs, documented as 97.8F, and called V8 PA (Physician's Assistant) to receive orders. V11 was asked by the Surveyor to obtain a manual set of vitals for R29. R29 presented in bed, with shallow, audible respirations and forced work of chest and abdominal breathing. Vital signs obtained were as follows: Oxygen: 92% on 2L of oxygen via nasal cannula, Temperature: 103.3F Pulse: 156bpm Respirations: 40 and Blood Pressure ,d+[DATE]. V11 said R29 did not demonstrate this state of breathing when assessed earlier this morning, but pointed to a simple oxygen face mask that they brought into the room just in case. V11 applied the oxygen mask from the bedside and said it would be better for R29 to receive oxygen through the mouth due to the way she was breathing. V11 then said they would call the doctor for further orders. Fire Department report, dated [DATE]: paramedics were dispatched to the facility at 12:35PM and arrived at the bedside of R29 at 12:38PM. R29 was assessed to be unconscious, non-verbal, and without any eye movement. Vital signs taken: Blood Pressure: ,d+[DATE]; Pulse 162 beats per minute; Respirations (shallow) 40 breaths per minute; SpO2 (oxygen): 93% on a non-rebreather mask. R29 was transported to the hospital at 1:05PM. Hospital emergency room report, dated [DATE], stated when R26 arrived to the hospital, emergency room diagnoses included: Sepsis, Hypernatremia, Dehydration and Pneumonia of right lower lobe due to infectious organism. There were no nursing notes documented for R29 from [DATE] until [DATE]. Progress Note written for [DATE] 12:25PM: Public Health Surveyor came up to the floor and asked this writer about resident's condition. This writer notified surveyor that new orders were received from (V8, Physician Assistant/PA) to do stat cbc/cmp/chest x-ray and ua/cs. The surveyor wants to see the resident and wants this writer to check resident's current vitals. Resident was seen in bed breathing heavily and warm to touch at this time. T-103.3 P-150 R-40 BP-,d+[DATE] SAT-92% with 02 at 2liters/nc. Resident was switch to medium concentration 02 (oxygen) mask at this time due to (shortness of breath). This writer notified the surveyor that MD will be called to get order to send out resident to the hospital for evaluation. PA was notified of resident's condition and agreed to send resident to the hospital via 911 for evaluation. 911 was called and took over care. Resident son was called and notified of residents' condition and agreed with the transfer. Resident was switch to non-rebreather oxygen mask before (leaving the facility) and 02 was increased to 5 liters. Progress note written at 6:36PM noted: Received a call from Hospital informing this (nurse on duty) that patient expired at 15:50. DON made aware. MD notified. Endorsed. On [DATE] at 12:54PM, V11 said, prior to the observation at the bedside with the surveyor, V11 didn't recognize R29 was in any distress and that the breathing prior to the observation was normal. V11 applied the simple oxygen mask in that moment due to R29 being a mouth breather, and the mask will provide higher amount of oxygen delivered than a nasal cannula. V11 said just before the paramedics arrived, R29 was placed on a non-rebreather mask that provides even more oxygen support than the simple face mask and nasal cannula. V11 did not think it was needed prior to that time. V11 said they did not take vitals because there were no orders to take vital signs during their shift. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On [DATE], at 10:50AM, V8, PA (Physician's Assistant), said nursing staff this morning informed V8 about an increased temperature that was taken during the night shift. V8 gave orders to the nurse to complete a STAT (rapid) chest-Xray, urinalysis with culture and blood lab values. Based on previous assessments, V8 would expect for R29's respirations to be between ,d+[DATE] breaths per minute as normal, and they rely on the nurses to accurately assess all vital signs as they should be reported when abnormal and they are reviewed during rounds. V8 said they, or the attending physician, is usually available during the day and some weekends on-call, and when they are not available, the facility uses a telehealth service for immediate resident needs or concerns. V8 said if the respiratory rate was outside of the baseline parameters, they would want to know the oxygenation level which would lead a path to determine if R29 was stable, and they would expect the nursing staff to notify them right away because R29 is high risk of urinary tract infections and aspiration pneumonia. On [DATE] at 11:12AM, V2, DON (Director of Nursing), said normal respirations are between 12 to 20 breaths per minute, however normal is determined by the resident's baseline. V2 said vital signs are normally taken with a machine, which is operated by nursing staff, and is automatically uploaded into the chart. The [electronic health record] determines the baseline considering previous results and alerts the nurse of abnormalities as noted by change of color. V2 said vital signs are expected at least once daily (once every 24 hours), or more frequently as ordered by the physician. The nurses, however, do not need a physician's order to obtain vital signs outside of those parameters if the resident is presenting with any change of condition. On [DATE] at 1:23PM, V10, Medical Director, said they were not alerted by staff that R29 was having a physical decline, and the staff will predominately contact V8, PA, for relaying labs or change of condition. V10 said, If it was noted (R29) was exhibiting increased respirations, the assessment should be relayed to the doctor or the PA that something was abnormal. This would prompt the provider to ask more questions to determine a big picture and proceed with monitoring or treatment. V10 said if they were notified the respirations were elevated on [DATE], they would have likely done something about it, such as give orders, but could not say exactly without knowing the immediate circumstance. V10 said they were not notified by staff of R29's transfer to the hospital or that R29 expired. V10 said they were notified the morning of [DATE], after logging into the hospital electronic health record. Facility Policy Vital Signs- Temperature, Pulse and Respirations, revised ,d+[DATE], states: If temperature is unusually high or low, check with another thermometer. If results are consistent, notify nurse and physician as appropriate. Change of Condition policy- revised ,d+[DATE] states; Purpose: to ensure that the resident's physician/physician on call/NP (nurse practitioner) and responsible party is kept informed regarding the resident's change in condition. Policy: The attending physician or physician on call/NP and responsible party will be notified with changes in a resident's condition. Procedure: 1. Attending physician or physician on call/NP and responsible party will be notified of all changes I condition. 2. Follow framework for reporting changes in vital signs or laboratory values based on AMDA Guidelines.3. Follow suggested guidelines for reporting clinical problems based on AMDA Guidelines. 4. Document time of call, physician or nurse practitioner or other person spoken to; reason for call and result or orders received. 5. Place call to responsible party to notify them of the resident's change in condition. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Facility presented printed training module, dated 2011 for vital signs; Vital Signs (report why vial signs were taken). This document indicated respirations greater than 28 and a temperature of over 100.5F should be reported immediately. Oxygen Therapy Devices- revised ,d+[DATE] states; Policy: Oxygen delivered by simple mask, will be used to prevent or reverse hypoxia and improve tissue oxygenation. Procedure: 6. Set the flow rate, as ordered. Liter flows should be adjusted between 5 to 8 liters per minute.

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34071 Based on observation, interview, and record review, the facility failed to assess pain and administer pain medications as ordered for one (R43) of one resident reviewed for pain in the sample of 34. This failure resulted in R43 experiencing severe pain to both shoulders and knees, becoming so anxious R43 was unable to perform daily activities. Findings include: R43 is an [AGE] year old, female, admitted in the facility on 03/10/23, with diagnoses of Bilateral Primary Osteoarthritis of Knee and Restless Legs Syndrome. R43's MDS (Minimum Data Set), dated 04/18/24, documented R43 has BIMS (Brief Interview for Mental Status) score of 10 which means moderate impairment in cognition. Her MDS also recorded: Section J - Pain Management: receives scheduled pain medication regimen. R43's POS (Physician Order Sheet) documented the following: 03/14/23 - Acetaminophen tablet 500 mg (milligrams) give two tablets by mouth every 6 hours as needed for pain management 03/14/23 - Acetaminophen tablet 500 mg give two tablets by mouth two times a day for pain management 03/10/23 - Comfort-Focused Treatment: Maximizing comfort: Relieve pain and suffering through the use of medication, oxygen, suctioning and manual treatment of airway obstruction. 04/05/24 - Tramadol HCl (Hydrochloride) oral tablet 25 mg give one tablet by mouth in the morning for pain management R43's care plan documented in part but not limited to the following: Alteration in comfort due to arthritis, bilateral knees and shoulders (date initiated 03/10/23) Intervention: Administer pain strategies according to MAR (medication administration record)/TAR (treatment administration record); Assess pain every shift; Complete pain assessment; Monitor for non-verbal indicators of pain daily with tasks and activities; Observe resident for effectiveness of pain relief. MAR (Medication Administration Record) dated 05/18/24 recorded: Pain evaluation every shift - Days: pain level was charted as 0. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 05/20/24 11:20 AM, R43 was observed in her room. She was sitting in the wheelchair by the foot of the bed. She was observed listening to music. Her bedside table was placed in front of her. There were reading materials and spiritual books on top of the bedside table. R43 was alert, oriented, able to verbalize needs and concerns. R43 stated she loves listening to music and reading prayer books. She was asked if she has concerns related to care in the facility. R43 stated, I have a concern regarding my medications last Saturday (05/18/24). I did not receive my medications in the morning on time. I had this severe pain, like 10 as the worst pain, in my shoulders and knees. The nurse who was on duty gave my medications including pain pills late in the morning. I always take it early in the morning. I have arthritis, and that time, my shoulders hurt like I cannot breathe anymore. I felt suffocated, and my knees were in so much in pain that my legs were so restless. I told (V5, Certified Nurse Aide, CNA) about the pain. She told me that she will tell the nurse. The nurse was not my regular nurse, that was the first time I saw her. She gave all my medications at 11:00 AM. I was so sick with pain, they should have never assigned somebody here who does not know the residents. On 05/21/24 at 10:29 AM, V5 was asked regarding R43 and incident last 05/18/24. V5 replied, I am the regular CNA of (R43). That incident was last Saturday, 05/18/24. She usually gets her medications around breakfast between 7:30 AM to 8AM, including pain medications. Around 10:00 AM she pressed her call light. I went to her room, she said she had not received all her medications. She was in a lot of pain, complaining of pain on her shoulder and knees. I told the nurse, she was an agency nurse, don't remember her name, about (R43's) medications and pain. The nurse said she (R43) got all her medications and those are all the medications she saw in the system. (R43) kept on saying she was in pain. She usually goes to the dining room every day, but that Saturday, she did not because of pain. She said she did not receive all her medications. The agency nurse went to her room and saw her but she did not call the physician. She was in severe pain, so I gave her a hot pack; she said it helped. On 05/21/24 at 10:45 AM, V6 (Registered Nurse, RN) was interviewed regarding R43. V6 stated, She has Tramadol, scheduled in the morning between 8 AM and 9 AM. She knows her medications, she will verbalize if she is in pain. Observation made on 05/20/24 and 05/21/24 at 11:45 AM showed R43 eats lunch in the main dining room. On 05/21/24 at 1:43 AM, V7 was asked regarding incident on 05/18/24 with R43. V7 verbalized, I worked in the facility last 05/18/24, 7 AM to 3 PM shift. That was my first time working on the second floor. For (R43), I remember her, she got all her 9 AM medications. She did not complain to me but to CNA (V5) that she needs pain medicine. I don't remember her pain medications. I went to see her and asked if she has pain and that she has pain medications which are due for me to give that time. She said she was not in pain. I passed a few medications, and I was in the hallway when I got busy with a family member, the new resident and the roommate who was screaming at the time. I got off track, and I also called therapy. I went back to (R43) and asked if she has any pain, she said her shoulders hurt and it was 3. I gave her medications. She said the medications were late. But it was only 45 minutes late; the medications should be given at 9 AM and I gave all her medications around 9:45 AM. She said her pain level was 3. I did assess her after I gave the medications, she said she was not in pain anymore. (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	On 05/22/24 at 11:05 AM, V9 (Staffing Coordinator) was asked on who was the nurse assigned to care for R43. V9 stated it was V7 (Agency Licensed Practical Nurse, LPN) and worked from 7:00 AM to 3:00 PM shift. On 05/23/24 at 10:40 AM, R43 was observed in her room, sitting in her wheelchair. She was observed listening to music. Her bedside table was placed in front of her. There were reading materials and spiritual books, religious items and television remote controls on top of the bedside table. R43 was pleasant, not in any form of distress. R43 was asked regarding typical day activities. R43 verbalized, I get up around 6:30 AM to 7:30 AM for the morning care like change my clothes and change my brief. I go to the bathroom, wash face, hands, and brush teeth. At 7:30 AM, I go to the dining room for breakfast. I eat in the dining room. During breakfast, the medications are prepared, and I will take them, including pain pills right after breakfast. After breakfast, I will go back to my room and will listen to music, read prayer books, pray, watch TV, and water my plants every other day. I go back to bed by 7-8 PM. But that Saturday (05/18/24), when I went to the dining room to eat breakfast, my medications were not there. I finished breakfast and still no medications. It was 9 AM and my shoulders are painful. My legs were so restless, I was very anxious because of the pain. I felt like I am so suffocated and strangled in the neck. My medications were given at 11 AM. That day, I ate lunch inside my room because I was still in pain. On 05/22/24 at 10:42 AM, V8 (Physician Assistant) was asked regarding R43 and pain management. V8 stated, Been taking care of her (R43) since her admission to facility. She is a very nice resident, friendly. She is here for assistance, ADLs (activities of daily living) due to arthritis in shoulders and knees that is managed. She is alert, oriented to time, place and person, able to verbalize needs and concerns. She is on pain medications; she has a scheduled Tramadol and Acetaminophen in the morning. If she has pain, she will vocalize it to the nurse. If its scheduled pain medication, it should be given at the time it is scheduled. If a resident complained of pain, nurse should be informed, nurse will assess the resident and will give medications as ordered and if there is still pain - they have to notify physician or nurse practitioner. On 05/22/24 at 11:33 AM, V2 (Director of Nursing) stated, Each medication is specific, we have 9 AM, 1 PM for day shift. Each medication is according to the doctor's order. If a resident has a medication, including pain pill for 9 AM, the medication can be given as early as 8 AM until 10 AM. (R4 is a longterm care patient here. She requires assistance with ADLS, alert, oriented. She has scheduled pain medications. If a resident is in pain, the nurse needs to assess for location, a numeric pain scale associated with, any relieving factors, administer pain medications as ordered. Reassess after giving pain medication, and if not relieved, we would need to contact the physician. If she (R43) was given medications at 11 AM, that is not acceptable. Medications should be given on time, within specified time frame, as ordered. Facility's policy titled Medication Administration: General Guidelines, dated 03/2021, stated the following: A. Policy: To ensure that medications are administered safely as prescribed. D. Procedure: (continued on next page)

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F 0697 Level of Harm - Actual harm Residents Affected - Few	6. If the physician's medication order cannot be followed, the physician should be notified, depending upon the situation. 8. Medications are administered within one (1) hour of prescribed time. Unless otherwise specified by the physician, routine medications are administered according to established medication administration schedule. Facility's policy titled Pain Management Evaluation, dated 09/2020, documented the following: Purpose: Our mission is to facilitate resident independence, promote resident comfort and preserve resident dignity. Procedure: 4. During the pain evaluation, determine the most workable pain rating for the resident. The following scales are available: a. The numeric rating scale (NRS): 1-3 (mild), 4-6 (mod), 7-10 (severe) b. PAINAD scale 1-3 (mild), 4-6 (mod), 7-10 (severe) 5. Pain will be evaluated each shift.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50036 Based on observation, interview, and record review, the facility failed to: ensure food items were labeled and dated per facility policy, failed to ensure plastic bins are clean, failed to ensure foods are not expired, failed to ensure items are air dried before stacking the dishes, and failed to ensure no dented cans were in the dry storage area. This applies to 65 residents that receive oral nutrition and food prepared in the facility kitchen. Findings include: On [DATE] at 9:54 AM, tour was done with V3 (Executive chef), and the following observations were observed: Walk in refrigerator: *Mozzarella cheese that was opened and did not have an open date labeled on the package. V3 stated, It was opened today, but they must have forgot to label it. He stated he did not open the package and it should have been labeled. *Package of parmesan cheese that was opened and did not have an open date labeled on package. V3 did not know when that was opened, and it should have been dated. V3 stated the use by date is 7 days after package is opened or the food is prepared. *A tray of individual cups of something was in the refrigerator with caps, but none were dated or labeled. V3 stated they were syrups and sauces from a previous event, and should have been labeled and dated. *Tray of uncooked substance was not labeled what it was, but did have date of ,d+[DATE]. V3 stated those were meatballs and should have been labeled. When asked if the year should be on the package date, V3 stated it should. *Opened block of unknown substance, dated [DATE], was not labeled and was stored above cheeses. V3 stated it was deli ham and should have been labeled. *Open bread potato rolls were not dated. V3 stated they should have been dated. Freezer; *A frozen substance was not labeled. V3 stated it was canoli cream. *Tray of unknown substance was not labeled. V3 stated they are Matzo balls for soup. *Tray of unknown substance stated by V3 to be Breadsticks, dated ,d+[DATE] were not labeled. *Tray of unknown substance stated by V3 as Salmon, dated [DATE] was not labeled. Dry storage room: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145984	A. Building B. Wing	05/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden North Shore Rehab & Hcc	5050 West Touhy Avenue Skokie, IL 60077

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	*Light corn syrup received [DATE] with use by [DATE] was still on shelf in dry storage area. *Honey opened ,d+[DATE] did not have use by date. *Oats with a best before date of [DATE] still on shelf. *White wheat flour with a best if used by [DATE] still on shelf. *Dented can of cherry pie filling - 7 lb can, and dented can of refried beans - 7 lb can, comingled with other cans on shelf. *Pasta opened with no date on bag. *Orzo pasta opened with no date on container. *Bin of navy beans dated [DATE] with a use by date sticker of [DATE]. *Green peas dated [DATE] with a use by sticker [DATE]. *Barley dated [DATE] with no use by date. *Container of Almonds with a date of [DATE] no use by date. V3 stated V3 will get with his manager and give surveyor a paper showing recommended use by dates for Almonds. *A tin container wrapped with saran wrap was not labeled or dated. V3 stated it has powder sugar in it, but could not provide dates or when it was prepared. Kitchen area in front of manager office: *5 bins labelled flour, sugar, panko bread crumbs, oatmeal and cake flour all had the tops of the bins dirty and had debris and dust on top of them. Season cart: *Open bottle of vanilla extract was not dated when it was opened. Upon touring the dish drying area, there were three large pans stacked on top of each other on drying table. Upon surveyor asking V3 to unstack pans to see the inside, water ran out of each pan that was stacked on top of the other and pans insides were visibly wet. On left side of wash, rinse, sanitize sinks there was a red bucket with liquid in it. Surveyor asked V3 to test liquid. Liquid tested at 0ppm. V3 stated bucket is used for sanitizer, but we just dumped it out a little while ago and put soap and water in it. V3 was asked what the red buckets are supposed to have in them. V3 stated it should always have sanitizer in it. When asked what the green buckets were for, V3 stated they are for soap and water. Freezer and Refrigerator logs were checked, and discrepancy noted on [DATE] PM shift; no recording of temperature on log. (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 9:55 AM, V4 (Kitchen manager) stated all days on temperature logs should be filled in for every shift. If missed, she in-services her staff. Regarding food labeling and dating, V4 stated all items should have a received dated and a used by date, as well as a label of what food the item is. V4 also stated when items are opened, the open date should be on the item, and the open date +7 days should be the discard date. Open date is day 1. V4 stated trays of food should be labeled with date and food type when put in refrigerator or freezer. V4 also stated there should not be any expired foods in the refrigerator, freezer, or dry storage. Regarding the large bins for flour, etc. V4 stated they should be clean inside and outside. They are cleaned weekly when they are refilled with shipments, but the tops should be cleaned if they are dirty. On [DATE], documentation provided by V4 from USDA (United States Department of Agriculture) with recommended consumption times for almonds. V4 states 4 months is the date they would go by, as it was in the dry storage room. Dented Can Policy, dated ,d+[DATE], states: Procedure: 1. Canned foods with swelled top or bottom, leakage, flawed seals, rust or dents will be rejected. 2. Compromised cans will be stored on a shelf marked -do not use. Cleaning and Storing of Dishware's Policy, dated ,d+[DATE], states: Procedure: 1. Dishware's will be properly washed, rinsed, sanitized, and air-dried. Labeling & Dating Policy, dated ,d+[DATE], states: Procedure 1. Ready-to-eat time/temperature for safety (TCS) food that is held for less than 24 hours may be labeled with the common name, date and time it is placed in the refrigerator. 2. On premise preparation of ready-to-eat TCS item that is to be held for longer than 24 hours in the refrigerator will be marked to indicate which date or day the food must be consumed or discarded. 3. Commercially processed TCS that is to be held for longer than 24 hours in the refrigerator will be marked to indicate which date or day the food must be consumed or discarded. The day or date marked by the food service establishment may not exceed the manufacturer's use by date. 7. All food products that have Pre-printed by manufacturer date labels on on them will be discarded by that noted date printed on the product. 9. Spices containers will be dated when opened.