STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146053	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Palos Park	12220 South Will Cook Road Palos Park, IL 60464

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F 0576 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure residents have reasonable access to and privacy in their use of communication methods. 46560 Based on interview and record review, the facility failed to ensure mail was delivered to residents on Saturdays for seven out of seven residents (R5, R11, R21, R40, R53, R76, R80) reviewed for residents' rights in a sample of 26. Findings include: On 05/16/2024 at 11:57 AM during resident council meeting, R5, R11, R21, R40, R53, R76 and R80 all stated that they do not receive mail on Saturdays and have to wait until Monday before it is given to them. On 05/16/2024 at 12:32 PM during interview with V44 (Life Enrichment/Activities), V44 stated that Saturday's mail is being put by the receptionist in her mailbox inside the administration office, which is a locked office. V44 also stated that activity aides do not have access to the administration office. V44 also stated that when she comes in on Mondays, she then distributes the mail to the activity aides to give to the residents. Review of facility's document entitled Contract Between Resident and Facility Attachment F: Statement of Resident Rights indicated: No resident should be deprived of any rights, benefits, or privileges guaranteed by law, the Constitution of the State of Illinois, or the Constitution of the United States solely on account of his or her status as a resident of the Community, nor shall a resident forfeit any of the following right: 22. The right to unimpeded, private, and uncensored communication by mail, phone calls, and with visitors, unless reasonably restricted by a physician to protect the resident or others from harm, harassment, or intimidation;

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 46560 Based on interview and record review, the facility failed to notify family of a resident's change of condition for one of three residents (R251) reviewed for notification of change in a sample of 26. Findings include: On 05/15/2024 at 8:37AM during interview with V39 (R251's family member), V39 stated that on 02/03/2023, R251 was sent to the hospital and V39 was not informed. On 05/16/2024 at 2:38PM during interview with V2 (Director of Nursing), V2 stated that it is expected for staff to notify the family of any change of condition of the residents' even in case of emergency. Review of R251's progress notes and assessments from 02/01/2023 to 02/05/2023 did not indicate any notification made to V39. Review of facility's policy entitled Change in Resident Condition reviewed on 1/10/2024 indicated the following: Policy: 3. The communication with the resident and their responsible party as well as the physician will be documented in the resident's medical record or other appropriate documents.

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. 41758 Based on interview and record review, the facility failed to ensure one resident identified as at risk for abuse was free from misappropriation of resident property by not providing a secure location for R86 to store his money. This affected one of three (R86) residents reviewed for misappropriation of funds. This failure resulted in R86 having four hundred dollars stolen while he was in the facility. This failure affected 1 of 3 reviewed for misappropriation of resident's funds in a total sample of 26. Findings Include: R86 was diagnosed with aphasia following a cerebral infraction. Minimal data set section C (Brief interview for mental status) dated 2/23/24 documents: memory/recall ability: resident (R86) was normally able to recall location of own room, staff names/faces and that they are in a nursing home/hospital swing bed. Cognitive skill for daily decision making documents: modified independence: some difficulty in new situation only. Section B (Hearing, Speech and Vision documents: Speech Clarity: unclear speech. Ability to express ideas and wants: sometimes understood: ability is limited to making concrete request. Ability to understand others: usually understands misses some part/intent of message but comprehends most conversation. Care plan dated 2/24/24 documents: R86 may be at risk for potential abuse related to physical and/or communication challenge as evidence by diagnosis of aphasia. On 5/15/24 at 9:41AM, R86 was assessed to be alert. R86 said four hundred dollars was stolen from his wallet. R86 said his wallet was in his room on the window seal. R86 said he does not have anywhere to secure or lock his personal items up. R86 said he saw a black, heavy, male staff member who worked on the second floor was in his room. R86 was unable to give a name and a complete description of the staff member. R86 said he was not able to purchase food, pay bills and was upset and angry. On 5/15/24 at 1:55PM, V20 (cna) said, R86 reported his money was stolen. V20 said R86 had money/bills on both sides of his wallet. R86 kept opening his wallet and showing his money before he reported it stolen. On 5/15/24 at 2:01PM, V1 (administrator) said a check request was submitted for R86 to be reimbursed for his loss. On 5/15/24 at 2:20PM, V27 (social service) said R86 reported he was missing four hundred dollars. R86 reported he had his money before lunch time in his room on the window seal. V27 said R86 reported conflicting information about who stole his money relating to the description of the person. R86 reported a caregiver stole his money. R86 is alert and oriented. R86 cannot speak clearly. V27 said she called R86's family who reported R86 had a large amount of money. V27 said she was unaware if residents had keys to their night stand. On 5/15/24 at 2:35PM, V1 said we don't provide anything for the residents to secure their personal items, we don't store resident's items in the business office. Resident's family can bring a lock box if they need to secure their personal items. (continued on next page)

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F 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/16/24 at 11:06AM, V34 (cna) said, the day before R86 reported his money missing, R86 came to the nursing station and could not explain himself. V34 said she asked R86 to go get his communication folder. R86 requested that staff call his family because he wanted to go home. V34 said she informed R86 she could not help him get home. R86 became upset and pulled out his wallet. V34 said R86 had two wads of cash/bills on both sides of his wallet. V34 said she did not count R86's cash but it looked like he had been saving his trust fund. R86 had a lot of cash/bills that filled his wallet. V34 said, R86 reported he had money and could go home. V34 said she was not working the day R86 reported his money being stolen. Witness statement dated 4/30/24 documents: Where was his wallet when he believed someone took his money. Resident (R86) stated, laying on the edge of the stomp next to the radiator and when he went to the dining room to eat breakfast he came back and his money was gone. Spoke with R86's family, who reported they took R86 to the bank a week ago and he withdrew $600.00. Concern/Compliment Form dated 5/1/24 documents: Patient (R86) has concerns regarding missing $400.00. Check Request dated 5/6/2024 documents: check amount $400.00 (four hundred dollars) Payee: R86. Check dated 5/16/24 documents: Check #100025 payable to R86 for four hundred dollars. Abuse policy 10/2022 documents: The facility affirms the right of our residents to be free from abuse, neglect exploitation, misappropriation of property, deprivation of goods and mistreatment of residents. Misappropriation of resident property means the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belonging or money without the resident's consent.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to follow their abuse policy by not immediately reporting a bruise of unknown origin to the immediate supervisor or the administrator. This affected one of three (R17) reviewed for injury of unknow origin in a total sample of 26. Findings include: R17 was admitted to the facility on [DATE] with a diagnosis of hypertension, depressive disorder, hemiplegia and respiratory failure. R17's progress note dated 4/19/24 documents by V25(Nurse): Patient sister reported to me that her sister had a bruise on her hand and states it was caused by a staff member. Patient interviewed and skin assessment completed, noted a bruise to her right hand. Patient states that while being changed by staff, staff member dug her long fingernails into patient while turning her. When patient said that hurts the staff member said I'll show you what hurts and squeezed her hand causing a bruise. She was unable to tell me the days or the staff member who did it. Administration notified immediately. On 5/15/24 at 1:20pm, V25(nurse) said she was made aware of incident by family and was unaware of any injury/bruising to R27 prior to 4/19/24. V25 said she was aware of incident on 4/16/24 but there was no bruising noted on R27 at that time or did R27 report any concern with staff. Facility reported incident dated 4/19/24 with incident date of 4/18/24 documents under description: Facility staff were interviewed. Staff member stated a few days prior R27 was combative during care, but not aware of any injury at that time. Facility abuse investigation witness statements dated 4/19/24 from V19 (CNA) documents: Patient in room on Wednesday (4/17/24) said ouch when I was getting her dressed and changed in bed. I asked her what happened and she didn't respond to me. Her hand was lightly discolored. V31(CNA) statement documents: V31 worked with R27 on 4/18/24 for the first time in s few months. I noticed she had a bruise on her hand. V31 asked R27 what happened, and she stated she couldn't remember. On 5/16/24 at 11:29AM, V19 (CNA) confirmed her statement from the investigation. V19 said she did not report bruise because she was not sure if it might of have been from a blood draw and R27 would not answer her about the bruise when asked. V19 said she would normally report any changes in resident skin to the nurses immediately. On 5/16/24 at 10:01Am, V31 (CNA) said R17 can be aggressive and hit staff at times. V31 said R17 has hit her in the past. V31 said she was assisting V36(CNA) with getting R17 up for breakfast on 4/16/24. V31 said R17 became combative, we put her back to bed and told nurse. V31 said she already had a bruise on her hand on day of incident and nurse aware. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility abuse policy and prevention program dated 10/22 documents under internal reporting requirements and identification of allegations: Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, exploitation, mistreatment or misappropriation of residents property they observe, hear about or suspect to the administrator immediately, to an immediate supervisor who must then immediately report it to the administrator or compliance officer. The nursing staff is responsible for reporting the appearance of suspicious bruises. Lacerations or other abnormalities of unknown origin as soon as it is discovered.

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F 0689 Level of Harm - 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** 41758 Based on interview and record review, the facility failed to supervise one resident while sitting in the dining room unattended who was identified as a high fall risk and has a diagnosis of Dementia, syncope, and a history of falls. This failure resulted in R401 having an unwitnessed fall from her wheelchair sustaining a left hip fracture. The facility also failed to utilize a leg rest during a transport for a wheelchair bound resident. This failure resulted in R61 having a fall from the wheelchair sustaining a right forehead hematoma. These failures affected two of three residents reviewed for falls in a total sample of 26. Findings Include: R401 was diagnosed with Dementia, Syncope and Collapse. Minimal data set Section GG (functional abilities and goals) dated 3/31/24 documents: R401 required partial/moderate assistance for sit to stand (the ability to come to a standing position from sitting in a chair. Helper lifts, holds or support trunk or limbs but provides less than half the effort). Comprehensive restorative assessment dated [DATE] documents: History of falls in the past 1-6 months, S/P Fall and/or Fracture in past 6 months. Fall Risk Scoring: Add up the numbers of the responses above twenty-two. Fall risk scoring: ten or above: high fall risk. On 5/14/24 at 1:01PM, V4 (restorative nurse) said R401 had an unwitnessed fall. V22 (CNA) saw R401 on the floor. No staff was in the dining room when R401 fell . Staff should have been in the dining room monitoring R401. On 5/15/ 24 at 12:51PM, V22 (cna) said she saw R401 on the floor after a resident mentioned R401 had fallen. V22 said R401 used a rollator walker to assist with ambulation. V22 said she saw R401's walker unlocked after the fall. V22 said at the time of R401's fall no staff was in the dining room. Staff was moving residents from the dining room to the television room. V22 said no staff was monitoring R401 when R401 fell . Nursing note dated 03/31/24 documents: V47 (nurse) was called to the dining room by a CNA at 1:15pm stating resident fell on the floor and was laying on her left side. Fall was unwitnessed. R401 observed laying on the floor on her left side. When asked what occurred R401 stated in broken English, stood up, lost balance. R401 complained and was rubbing area of left hip/leg stating it hurts. R401 was assisted onto her rollator walker with staff assist. POA was called to try to translate R401's pain and what occurred. R401 with Dementia diagnosis. M.D called and order was obtained to send to emergency room (ER) for evaluation. POA (power of attorney) requested call 911. 911 called, Paramedics arrived and transferred R401 to a stretcher and departed facility at 1:50 PM to Hospital per POA request for evaluation. Care Plan Initiated on 03/28/2024 documents: R401 is at high or increased risk for falls, R401 is at risk for injury from falls related to diagnosis of Dementia, Syncope, decreased physical mobility, generalized weakness, and history of falls. R401 is positive for recent and frequent falls at home. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Hospital record dated 03/31/24 documents: Patient (R401) presented to emergency department via emergency medical service after fall out of wheelchair. R401 complained of left hip pain. Positive external rotation and shortening. X-ray dated 03/31/24 documents: Left Femur (hip) Findings: Comminuted intertrochanteric fracture of the proximal LEFT femur with displacement of the lesser trochanter fragment and medial angulation of the distal femur shaft. Fall prevention and management policy dated 1/2024 documents: The facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all fall is not possible, the facility will identify and evaluate those resident at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible. R61 was diagnosed with Dementia, Alzheimer's disease and Anxiety. Minimal data set section GG (functional abilities and goals) dated 01/05/24 documents: manual wheelchair. R61 required supervision or touching assistance (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident complete activity. Assistance may be provided throughout the activity or intermittently. R61's care plan dated 3/12/24 documents: actual fall. Slid to front of wheelchair and slid out of chair. Intervention: staff to encourage R61 to sit back in wheelchair, assist to reposition as indicated. On 5/14/24 at 1:01PM, V4 (restorative nurse) said, R61 was being transported in her wheelchair without leg rests. R61 was holding her feet up off the ground. R61 dropped her feet at some point. R61 had on anti-skid foot wear. R61's foot gripped on the floor leading to a fall forward out of the wheelchair. Residents who use wheelchairs for mobility should not be pushed without leg rests. Leg rests were available at the time of R61's fall. On 5/14/23 at 3:37PM, V13 (cna) said, R61 was in a wheelchair. R61 asked him to push her to the dining room. V13 said, R61 did not have any leg/foot rest on her wheelchair. R61 usually self-propel. V13 said he pushed R61 and her right foot got stuck on the floor. V13 said R61 fell forward onto the floor landing on the right side of her body. V13 said at the time of the incident, R61 reported she hurt her right side and her back. R61 laid on the floor until the emergency medical technicians arrived. Nursing note dated 03/19/24 documents: around 0745 CNA observed assisting resident (R61) to the dining room. Nurse observed resident (R61) leaning forward in the wheelchair and fell to the floor. R61 left in position, during assessment, R61 was observed with a small lump to the right side of her forehead. R61 complained on right arm pain. R61 was observed with swelling to right lower leg without shortening of extremity. 911 called. Fall event dated 03/19/24 predisposing physiological factors documents: gait imbalance, impaired memory, decrease vision or hearing; predisposing situation factors: using wheelchair and leaning. V13's witness statement dated: 03/19/24 documents: during breakfast resident (R61) asked CNA (V13) if he can push her to the dining room. While pushing R61 her foot got stuck to the floor causing R61 to fall forward. In-service dated 03/19/24 topic of education: propelling residents without foot rest. Please report to nursing when residents ask for assistance propelling. Resident may need to be evaluated for the need of leg rest. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	R61's kardex dated 3/19/24 documents: safety: staff education to only propel wheelchairs with footrest on them. Facility reportable incident dated 3/20/24 documents: Patient name: R61, describe incident/accident: while being assisted to dining area resident fell forward from the wheelchair. She (R61) complained of pain to her right arm and leg. Hospital record dated 3/19/24 documents: She (R61) leaned forward and fell out of her wheelchair. R61 has hematoma to right forehead. Fall prevention and management policy dated 1/2024 documents: The facility is committed to maximizing each resident's physical, mental and psychosocial well-being. While preventing all fall is not possible, the facility will identify and evaluate those resident at risk for falls, plan for preventive strategies, and facilitate as safe an environment as possible.

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F 0776 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39340 Based on interview and record review, the facility failed to have a system to track requests for diagnostics services to ensure timely x-ray services are provided to residents. This failure resulted in R5 being transported to the hospital after waiting over 30 hours for x-ray service and being diagnosed with multiple rib fractures for one of one reviewed for diagnostic services in a total sample of 26. Findings include: R5 was admitted to the facility on [DATE] with a diagnosis of syncope, unsteadiness on feet, orthostatic hypotension, restless leg syndrome, unspecified dementia and anxiety disorder. R5's Minimum Data Set, dated dated dated [DATE] documents brief interview for mental status is 12/15 which indicates cognitively intact. On 5/14/24 at 3:10 PM, R5 who was alert and oriented to self, place and time at time of interview said he was in his room, was putting on a jacket when he lost his balance and fell backwards hitting his left side on the heating/air conditioning wall unit and windowsill. The next day he was having pain and told staff. R5 said he was having pain in his left side 9/10. R5 pain was worse with movement and it hurt when breathing in. R5 facility reportable dated 4/6/24 documents: R5 informed nurse on duty that he fell two days ago, but did not report it, but now has pain in his left arm and left side. R5 was noted with a scrape to left side of his back. Nurse on duty notified doctor and received order for chest x-ray. Power of attorney made request for resident to go to emergency room . R5 returned on 4/8/24 with multiple rib fractures. R5's progress notes dated 4/6/24 at 12:32PM documents: Resident informed writer that he fell 2 days ago while putting on his shirt. Resident states that he didn't think it was a big deal, so he didn't tell anyone but now he is experiencing pain from his left shoulder to his abdomen. Upon assessment writer noted a scrape to left side of back. MD made aware. MD ordered chest x-ray. R5's progress notes dated 4/7/24 at 11:57AM documents: Resident alert verbally responsive. Breathing even unlabored. Denies pain and discomfort at this time. Resident and daughter inquired about estimated time of arrival of X-ray service. Writer placed call to x-ray company, informed that technician is en route. Resident and family made aware of estimated time of arrival status. Will continue plan of care. R5's progress notes dated 4/7/24 at 21:00PM documents: Per report AM nurse contacted x-ray company with estimated time of arrival and the company claimed they were en route. Resident's family concerned with timeliness of x-ray technician. Writer called x-ray services again and was unable to reach anyone. Per family's request resident sent out to local hospital. (continued on next page)

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F 0776 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	On 5/14/24 at 3:46PM, V12 (Nurse) was assigned to R5 on day he reported fall. V12 said she called the doctor who ordered an x-ray. X-ray called in and requisition completed. X-ray usually comes within 24 hours. They said they would be there the next day. V12 said she put in report but was not assigned to R5 after that day. On 5/15/24 at 12:03pm, V2(DON), said x-rays should be completed within 24 hours. If x-ray is not completed the doctor should be notified and any further orders followed. On 5/15/24 at 1257PM, V26 (Xray tech) said they received an x-ray order for R5 on 4/6/24 at 2:44PM and staff said the x-ray was to be done on 4/7/24. V26 said there was no other documentation from the facility that they called for follow up about x-ray. Technician arrived at 9:40PM on 4/7/24 but resident was already at the hospital. On 5/16/24 at 10:15AM , V32 (MD) I would expect an x-ray to be completed within 24 hours or be notified if not completed within 24 hours. I would not necessarily send the resident to hospital for pain because it's not an emergency and rib fractures are hard to see on x-rays. There really isn't much treatment. There can be pain with movement or breathing but I would not prescribe narcotics for pain. The x-ray is more of a legality, to show that fracture occurred at that time. On 5/17/24 at 10:12AM, V2(DON) said they track diagnostics services by when staff enter the order into electronic medical record under orders. Staff communicate through report when waiting for an x-ray to be conducted. Requested physician order and communication for R5's x-ray and no documentation received. R5's physician order sheets for April did not document any order for a chest xray. R5's hospital record dated 4/7/24 documents R5 arrived in emergency room at 21:54. At 22:36 Pain score of 8. Under history: R5 with mild dementia present to emergency room for evaluation of left sided back and shoulder pain. Patient states that approximately 2 days ago, he was reaching for his jacket in the middle of the night, when he slipped and fell off the bed possibly striking a shelf near his bed. Patient was able to get himself up, and nursing noticed the injuries and recommended a chest x-ray that is yet to be done. Patient states that he has been noticing increasing pain with movement on the left side and standing and finally called 911 and was brought to the emergency room . Patient denies any headache, neck pain, low back pain, chest pain, shortness of breath, cough, fevers or chills, bowel or bladder changes. Patient feels some fullness along the left upper quadrant extending from his injury in the left lower thoracic area. Patient is unaware of the pain medicine they have been given at the nursing home but states it has been only mildly helping him. Under Xray results documents: Acute left lateral seventh and eighth rib fractures. X-ray services facility in-service packet undated documents under ordering procedure: All non stat orders are performed same day, unless requested to be done another day. If the results cannot be provided same day as the procedure, you will receive them early the next day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146053	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Aliya of Palos Park	12220 South Will Cook Road Palos Park, IL 60464

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	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 34069 Based on observation, interview, and record review the facility failed to follow Sanitizing Guidelines and Manufacturer's Instructions by not sanitizing a knife and cutting board for 1 minute. This failure has the capacity to affect 104 residents receiving an oral diet at the facility. Findings include: On 5-15-24 at 10:15 AM, surveyor and V11 (Regional Dietary Manager) observed V10 (Cook) sanitize a knife and cutting board by submerging them in the sanitizer in the 3-compartment sink for 1 second. On 5-15-24 at 11:05 AM, V10 (Cook) said cooking items should be sanitized for 1 minute. On 5-15-24 at 10:16 AM, V11 (Regional Dietary Manager) said items should be sanitized for 1 minute in the sanitizer. On 5-15-24 at 11:10 AM, V21 (Dietary Manager) said when using the 3-compartment sink, items should be sanitized for 1 minute. V21 said the manufacturer's guideline says items should be sanitized for at least 60 seconds. V21 said the items are sanitized for 60 seconds to ensure they are properly sanitized and cleaned. Sanitizing Guide documents: Wash, Rinse, and Sanitize equipment and utensils in warm 75 degrees water with sanitizer for one minute. Sanitizer contact time is important. Manufacturer's instructions documents: 4. Sanitize by immersing articles with a use-solution of 1-2 ounces of this product per 4 gallons of water (200-400 ppm active quaternary) for at least 60 seconds.