STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146094	A. Building B. Wing	01/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Eden Vista Burr Ridge	6801 Highgrove Boulevard Burr Ridge, IL 60521

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303 Based on interview and record review, the facility failed to give a resident a Skilled Nursing Facility Advanced Beneficiary Notice of Non-coverage (SNF-ABN) at the end of a resident's Medicare Part A stay. This applies to 1 of 3 residents (R225) reviewed for beneficiary notices in the sample of 12. The findings include: The facility's SNF (Skilled Nursing Facility) Beneficiary Notification Review for R225 showed R225's Medicare Part A Skilled Services started on October 10, 2024 and last covered day of Part A services was November 14, 2024. The documentation continued to show R225 was not given a SNF ABN form. The EMR (Electronic Medical Record) showed R225 was admitted to the facility on [DATE], and was discharged from the facility on November 19, 2024, to the local hospital. On January 28, 2025, at 12:18 PM, V18 (Social Services) said R225 did not receive a SNF ABN form because V18 did not know R225 was going to remain in the facility after his last covered day of Medicare Part A. On January 28, 2025, at 1:02 PM, V18 said a SNF ABN should be given to resident and/or their representative if the resident is staying in the skilled nursing unit as a private pay resident. V18 said the SNF ABN goes over the charges the resident will be responsible for paying if they chose to stay in the skilled unit. V18 continued to say the SNF ABN should be given two days before the last covered day so the resident and/or representative has time to appeal if they would like. The facility did not have documentation to show R225 received a SNF ABN form prior to his last covered day of Medicare Part A services.

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 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** 41855 Based on interview and record review, the facility failed to provide to the resident or resident's representative in writing the facility's bed hold policy when being transfer to the local hospital. This applies to 2 of 3 residents (R4 and R5) reviewed for hospitalization s in the sample of 12. The findings include: Facility provided their bed hold form titled, BEDHOLD AGREEMENT- TRANSFER NOTICE. The form showed the following information was required to be filled out: resident's name, date, the reason the resident being transferred to/for, why the transfer or discharge is necessary for the resident's welfare and the resident's needs, what was the bed hold decision, signature of facility representative, signature of resident/representative/responsible party who was given written notice of transfer, if needed phone confirmation, date, time, bed hold requested by, relationship to resident, confirmation received by facility representative signature. 1. R5's EMR (Electronic Medical Record) showed R5 was admitted to the facility on [DATE], with diagnoses that included combined systolic (congested) and diastolic (congested) heart failure, unspecified dementia, cognitive communication deficit, severe kidney failure stage 4, unspecified psychosis not due to a substance for known physiological condition, anxiety, and atrial fibrillation. R5's MDS (Minimum Data Set) dated January 16, 2025, showed R5 had severe cognitive impairment. R5's progress notes showed R5 was sent to the local hospital three times from August 2024 to present. There was no documentation to show the bedhold policy was discussed with R5 or her representative with any of these transfers. On August 21, 2024, R5 was sent to the local hospital for an evaluation after she was found on the floor in her room. R5 was admitted to the hospital and returned to the facility on [DATE]. R5 was sent to the local hospital on December 2, 2024 after she was found on the floor in her room with some confusion. R5 was admitted to the hospital and readmitted to the facility on [DATE]. Facility provided BEDHOLD AGREEMENT- TRANSFER NOTICE with the dates of August 27, 2024 and December 2, 2024. Both forms were left empty except for R5's signature, V18's (Social Services) signature, and a box checked I do not want a bed hold. R5 did not go to the hospital on August 27, 2024, R5 was sent to the local hospital on August 21, 2024. On December 24, 2024, R5 was sent to the local hospital for shortness of breath and fever. She was admitted to the hospital and was readmitted to the facility on [DATE]. There was no BEDHOLD AGREEMENT- TRANSFER NOTICE provided. (continued on next page)

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility provided a BEDHOLD AGREEMENT- TRANSFER NOTICE form for July 11, 2024. The form was left blank except for R5's signature, V18's (Social Services) signature, and a box checked I do not want a bed hold. The same was true for a BEDHOLD AGREEMENT- TRANSFER NOTICE provided for R5 and dated September 4, 2024. Review of progress notes showed R5 remained in the facility on those dates and was not transferred anywhere. On January 29, 2025, at 12:57 PM, V18 (Social Services) said when she is doing a new admission assessment, the bed hold policy is discussed with the resident and/or resident representative. V18 said at this time she will ask them if there is a time when the resident needs to be sent out to the hospital would they want us to issue a bedhold. V18 said most will decline. V18 said she understands that on admission she is asking them about possible future transfer but asks them anyway. V18 said once a resident is sent out to the hospital, she will call and ask again, but most say no. V18 said her conversation will be documented on the resident's progress notes. 43389 2. R4's Resident Information sheet showed her to be a [AGE] year old female admitted to the facility on [DATE]. R4's progress notes dated January 11, 2025 showed that R4 was sent out to the hospital at approximately 11:10 PM related to symptoms of congestion and a chest x-ray showing atelectasis, pneumonia, or edema. Review of R4's Bed Hold Agreement in the resident's Electronic medical record showed it was uploaded on January 2, 2025. This form was not signed by V18 (Social Services) and there were no dates on the form. This same form was then presented to the surveyor on January 29 2025, now with a handwritten date of January 11, 2025 and electronically signed by V18, but otherwise empty of detail like what hospital the resident was discharged to. On January 29, 2025 at 12:51 PM and 1:10 PM, V18 stated that the Bed Hold Agreement form for R4 that was in the computer was uploaded on January 2, 2025. V18 stated she had R4's representative party sign the Bed Hold Agreement on admission. V18 stated she then signed and put the date that R4 was discharged on that form. V18 also stated this is what she does for all residents. V18 stated she does not speak to the resident, family, or resident representative, nor does she give them a copy of the Bed Hold Agreement form at the time of discharge. The facility's Admission, Readmission, Bed Hold, and Transfer/Discharge policy dated October 12, 2021 showed the following: Bed Hold: At the time of transfer of a resident for hospitalization or therapeutic leave, the facility will provide to the resident and the resident representative written notice which specifies the duration of the bed-hold, during which the resident is permitted to return and resume residence in the facility, the reserve bed payment policy in the state plan, and the facility policies regarding bed-hold periods. The facility's admission packet, Attachment I, Notice of Bed-hold information showed the following: Federal Law requires Nursing homes to give written notices to Residents and/or Responsible party at the time of the resident transfer to a hospital or overnight Leave of Absence.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35267 Based on observation, interview and record review, the facility failed to ensure a resident with significant weight loss was reviewed by a dietitian upon readmission to the facility from the hospital, failed to provide nutritional interventions to assist in preventing weight loss, and failed to obtain weekly weights as ordered by the physician. This applies to 1 of 1 residents (R3) in the sample of 12. The findings include: Face sheet, dated January 28, 2025, shows R3's diagnoses included pneumonitis due to inhalation of food and vomit, methicillin resistant staphylococcus aureus infection, osteomyelitis, severe protein-calorie malnutrition, acute respiratory failure with hypoxia, hemiplegia and hemiparesis following cerebral infarction, dysphagia, muscle wasting and atrophy, sepsis, iron deficiency anemia, vitamin D deficiency, major depression, epilepsy, chronic kidney disease, and hypoglycemia. Nutrition note, dated November 20, 2024, shows R3 had a history of significant weight loss and was receiving nutrition supplements 120 milliliters twice daily. On January 27, 2025, at 11:15 AM during initial tour, R3 appeared very thin. Weights and Vitals Summary, dated 12/1/24 to 1/30/25, shows the following weights were obtained by the facility for R3: December 6, 2024 - 126.6 pounds December 7, 2924 - 126.5 pounds December 22, 2024 - 125.5 pounds December 29, 2024 - 126.6 pounds January 5, 2025 - 127.4 pounds January 27, 2025 109 pounds - 14% weight loss MAR (Medication Administration Record), dated January 1-29, 2025, shows R3 had a physician order for weekly weights one time a day every Sunday ordered on December 25, 2024, and discontinued January 27, 2025. Review of the December 2024 MAR shows R3's weight was obtained on December 29, 2024. Review of the January 2025 MAR shows R3's weight was only obtained on January 5, 2025. No weights were obtained between January 5-26, 2025 as ordered by the physician. MAR, dated December 1-31, 2024, shows R3 had a physician order for a nutritional supplement 120 milliliters twice daily ordered on September 17, 2024, and discontinued on December 10, 2024, when R3 was transferred to the hospital. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's clinical record shows R3 was admitted to the hospital on December 9, 2024, with a diagnosis of pneumonia and returned to the facility on [DATE]. The clinical record shows R3 was again admitted to the hospital on December 23, 2024, with a diagnosis of hypoglycemia and returned to the facility on [DATE]. The clinical record showed R3's nutritional supplements were not reordered upon either readmission to the facility and R3 was not reviewed by the facility dietitian until January 27, 2025. On January 28, 2025, at 2:16 PM, V6 (Licensed Practical Nurse) stated R3 required staff to feed him for approximately a month and also had difficulty swallowing. V6 stated sometimes R3 would eat and sometimes he would not. Progress note, dated January 16, 2025, shows R3 was identified by the clinical director to have poor appetite and signs of dehydration. The note shows R3's physician ordered three liters of intravenous fluids. No referral to the dietitian was identified. MAR, dated January 2025, shows R3's nutritional supplement was reordered on January 20, 2025. Nutrition note, dated January 27, 2025, shows R3's weight was obtained and R3 weighed 109 pounds. The facility dietitian documented R3 experienced a significant weight loss which was confirmed by reweighing the resident. The note shows R3's usual body weight was 125-135 pounds and his meal intake varied between 25-75% at meals. On January 19, 2025 at 10:29 AM, V23 (Dietitian) stated on approximately January 20, 2025, the facility Director of Nursing informed V23 that R3 was not eating well so V23 reordered R3's nutrition supplements. R3 stated she believed R3's supplements were not reinstated when he returned from the hospital in December 2024. V23 stated she had not seen R3 at the facility since her November 2024 nutrition note, was not notified regarding R3's December 2024 hospitalization s and readmissions to the facility. At 11:45 AM, V23 stated, It would have been resumed had I seen him on admission. On January 29, 2025, V9 (Food Service Manager) stated normally a nurse would email the dietitian and let them know if they should see a resident if needed. On January 29, 2025, at 11:12 PM, V19 (Physician) stated R3's nutritional supplement not being reinstated upon readmission from the hospital may have contributed to some of R3's weight loss he experienced during the month of January 2025. V19 stated she defers to the dietitian for resident supplements because they should be performing a readmission assessment and periodically doing an assessment of facility residents. V19 stated she expected if nurses notice some changes in appetite or condition, they should refer a resident to the dietitian.

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43389 Based on observation, interview, and record review, the facility failed to verify the placement and patency of a resident's gastrostomy tube (G-tube) before administering medication through it. This applies to 1 of 1 residents (R176) reviewed for gastrostomy tubes in the sample of 12. The Findings Include: R176' Resident Information sheet showed an [AGE] year old male admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Dysphagia following Cerebral Infarction, Encounter for attention to Gastrostomy, and Type 2 Diabetes Mellitus. On January 28, 2025, at 8:36 AM, during medication administration observation, V6 (Nurse) entered R176 room with medications she had prepared outside of the room. V6 then removed the covers from over R176, lifted up his shirt. V6 picked up the end of R176's G-tube (where the catheter accesses were located), looked at it in her hand, and said, it look's okay. V6 then grabbed one of the prepared cups that contained crushed medication and water put it in a large syringe and started injecting it into the resident's G-tube. Before injecting the medication into R176's G-tube catheter, V6 did not aspirate (pull back on the plunger of the syringe) to see if there was any residual gastrointestinal fluid, nor did she flush the catheter. On January 29, 2025, at 4:13 PM, V3 (Regional Nurse Consultant) stated that before using a resident's G-tube, she expects the staff to check for proper placement and patency of the G-tube by checking for residuals and flushing the G-tube. The facility's Tube Feeding: Administering Medications Policy dated September 8, 2023, showed the procedure includes: 7) prepare ordered medication, 8) unclamp tube, 9) Verify placement of feeding tube: Verifying Placement of feeding Tube policy, 10) Insert syringe (without plunger) and flush tube with 30 milliliters of water or as ordered. The facility's Verifying Placement of Feeding Tube policy showed the following: Gastric aspirate will be visually inspected prior to initiation of feeding. Aspirate will be observed for changes in volume and appearance.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41855 Based on interview and record review, the facility failed to identify resident specific behaviors to monitor the effectiveness of psychotropic medications. This applies to 3 of 5 residents (R3, R5, and R75) reviewed for unnecessary psychotropic medications in the sample of 12. The findings include: Review of R3, R5, and R75's Documentation Survey Report, dated January 1, 2025 to January 29, 2025 showed all three residents were being monitored for the same behaviors. These included: 1. grabbing, 2. pinching, 3. scratching, 4. hitting/punching, 5. kicking, 6. pushing, 7. spitting, 8. biting, 9. sexually inappropriate, 10. verbal threatening, 11. screaming at others, 12. cursing at others, 13. hitting self, 14. scratching self, 15. pacing, 16. public sexual acts, 17. disrobing in public, 18. rummaging, 19. throwing/smearing food, 20. throwing/swearing bodily waste, 21, screaming/yelling out, 22. disruptive sounds, 23. attention seeking, 24. refusing care, 25. exit seeking, 26. wandering, 27. no behaviors observed. On January 29, 2025 at 9:53 AM, V18 (Social Services) stated the nurses let her know if the residents express comments or feelings related to depression. V18 stated she completes the mood assessment and then visits residents on the weekend to check in to see if they have any further symptoms of depression. V18 stated she was not aware of any facility assessments to identify specific resident behaviors to assess the effectiveness of psychotropic medications. V18 stated she was not aware of any ongoing, daily monitoring of resident-specific behaviors to monitor the effectiveness of resident psychotropic medications. V18 stated resident information regarding their psychotropic medications was located in their care plans. 1. R5 was admitted to the facility on [DATE], with diagnoses that included unspecified psychosis not due to a known substance or physiological condition, anxiety, and unspecified dementia with behaviors, and suicidal ideations. R5's MDS (Minimum Data Set) dated January 16, 2025, showed R5 had severe cognitive impairment. R5's care plan identified depression as a condition for R5 and the goal was for R5 to remain free of signs symptoms of distress, symptoms of depression, anxiety, or sad mood. Interventions included to discuss with resident, family, and caregivers any concerns fears, or issues, regarding health. R5 uses antidepressant medications and interventions included administer medications as ordered by physician, monitor/document side effects and effectiveness. R5 also had potential for behavior symptoms (Psycho-active adaptation and/or psychotropic medication use) related to unspecified dementia, unspecified severity, with behavioral disturbances, suicidal ideations. The goal is to have fewer episodes of TARGET BEHAVIORS by the review date. Interventions included anticipate and meet my needs, consult psychiatry for recommendations, monitor behavior episodes and attempt to determine underlying cause, consider location, time of day, persons involved, and situation. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5's psych note dated September 11, 2024, showed, R5 has multiple psychiatric complexities and would benefit from continued management with monitoring of mood and behavior, Will titrate medication based on current symptom progression. R5's psych note dated October 17, 2024, showed to continue current treatment. Administer antipsychotic medication as ordered by physician, monitor for side effects and effectiveness. Monitor target behaviors, number of behaviors and document episodes. Consent for Lexapro (Antidepressant) and Seroquel (Antipsychotic) was signed and dated January 25, 2025. R5's behavior monitoring was reviewed from January 1, 2025 to January 28, 2025. Target behaviors were not identified and behavior monitoring was vague and not resident specific. During this time period, there were 14 shifts where no behavior monitoring was completed. 35267 2. MAR, dated January 2025, shows R75's diagnoses included depression. MAR, dated January 2025, shows R75 had a physician order, initiated January 18, 2025, for escitalopram oxalate daily for depression. Review of R75's clinical record shows no assessment which determined R75's specific behaviors indicative of R75 experiencing depression. Care plan, revised January 14, 2025, shows R75 has an actual/potential psychosocial well-being problem r/t (related to). R75's interventions show no resident-specific behaviors identified to monitor R75's depression or the effectiveness of his anti-depression medication. On January 29, 2025 at 10:07 AM, V18 stated no resident-specific behaviors were identified to monitor for the effectiveness of R75's newly-prescribed antidepressant medication. 3. Face sheet, dated January 28, 2025, shows R3's diagnoses included depression. MAR (Medication Administration Record) shows R3 had a physician's order for mirtazapine daily for depression. Review of R3's clinical record shows no assessment to determine R3's specific behaviors indicative of R3 experiencing depression. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of R3's care plan, revised 4/4/24, shows, I exhibit Behavior Symptoms (Psycho-social adaptation and/or Psychotropic Medication use) related to 10/24/22 [R3] is refusing skin interventions of protective boots. Interventions include, Monitor behavior episodes and attempt to determine underlying cause. Consider location, time of day, persons involved, and situations. Document behavior and potential causes. R3's care plan, revised 8/25/24, shows The resident has depression due to the passing of his son. Interventions include, Monitor/document/report PRN (As Needed) any s/sx (signs/symptoms) of depression, including: hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing negative statements, repetitive anxious or health-related complaints, tearfulness. R3's care plan, revised 6/20/24, shows The resident has potential psychosocial well-being problem r/t (related to) depression diagnosis. R3's care plan, initiated 3/26/24, shows, Resident uses antidepressant medication r/t depression. Review of R3's behavior tracking records, Documentation Survey Report January 2025, shows none of the signs/symptoms which are listed to be monitored include the symptoms/behaviors indicated in R3's care plan. Facility Policy/Procedure Psychotropic Medication, revised 9/6/24, shows 1. An assessment must be conducted to identify specific behaviors/symptoms, potential causative factors and recommendations for managing identified behaviors. 2. The medical record documentation must reflect the specific behaviors/symptoms and the resident's response to non-pharmacological interventions to manage the behaviors/symptoms.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 35267 Based on interview and record review, the facility failed to provide the minimum required servings of fruits/vegetables and grains/breads on their planned menus as per facility policy. This applies to 15 of 15 residents (R1, R3, R7, R10, R11, R14, R15, R16, R18, R20, R127, R128, R129, R130, R176) reviewed for menu planning. The findings include: Facility Diet Type Report, dated January 29, 2025, shows R1, R3, R7, R10, R11, R14, R15, R16, R18, R20, R127, R128, R129, R130, R176 had physician orders for Regular and/or No Added Salt diets. Review of facility Regular/NAS (No Added Salt) menu, dated Week 3 Sunday through Week 3 Saturday, shows the facility failed to provide at least 5 fruits/vegetables planned on the daily menus 4 of 7 days (Sunday, Tuesday, Friday, and Saturday). The menu shows the facility failed to provide at least 6 servings of grains/breads on 2 of 7 days (Monday and Saturday). Review of facility Regular/NAS (No Added Salt) menu, dated Week 1 Sunday through Week 1 Saturday, shows the facility failed to provide at least 5 fruits/vegetables planned on the daily menus 4 of 7 days (Tuesday, Wednesday, Friday and Saturday). The menu shows the facility failed to provide at least 6 servings of grains/breads on 5 of 7 days reviewed (Sunday, Wednesday, Thursday, Friday and Saturday). Review of facility Regular/NAS (No Added Salt) menus, dated Week 2 Sunday through Week 2 Saturday, shows the facility failed to provide at least 5 fruits/vegetables planned on the daily menus 3 of 7 days (Tuesday, Thursday and Saturday),. The menu shows the facility failed to provide at least 6 servings of grains/breads on 3 of 7 days reviewed (Sunday, Tuesday, Friday). Review of facility Regular/NAS (No Added Salt) menus, dated Week 4 Sunday through Week 4 Saturday, shows the facility failed to provide at least 5 fruits/vegetables planned on the daily menus 1 day (Saturday). The menu shows the facility failed to provide at least 6 servings of grains/breads on 5 of 7 days reviewed (Monday, Tuesday, Thursday, Friday, and Saturday). On January 29, 2025 at 1:57 PM, V9 (Food Service Manager) stated the menus were reviewed by the corporate dietitian. V9 reviewed the menus and was unable to identify any of the missing servings of fruits/vegetables or grains/breads on the menus. Facility Menu Planning Guide, dated November 2023, shows the Regular/No Added Salt menus are designed to include foods in amounts that will meet or exceed the Dietary Reference Intakes (DRIs) for older adults. The following components are included daily: . Vegetables and Fruit: 5 or more servings, Grains: 6 or more servings.

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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. 35267 Based on observation, interview and record review, the facility failed to clean and sanitize kitchen equipment, failed to label/date potentially hazadardous stored food, failed to store cooked meat to prevent cross contamination, and failed to perform hand hygiene per facility policy. This applies to all 22 residents residing in the facility. The findings include: Facility Long-Term Care Facility Application for Medicare and Medicaid, dated January 27, 2025, shows the facility census was 22 residents. On January 27, 2025, at 9:38 AM, during initial tour of the kitchen with V9 (Food Service Manager), the area behind/between large cooking equipment had a large amount of food splatters and food build up as well as dust with loose particles located behind and slightly above a pan of margarine melting on the flat top. The equipment hoses/cords and the back panels of equipment were covered in large amounts of dust and food splatter. On January 27, 2025, at 9:38 AM, during initial tour of the kitchen with V9, there was a package of four hot dogs (identified by V9) in the walk in cooler stored on a full sheet pan without a label/date and loosely packaged stored above packages of raw Swiss steak. V9 stated he was unsure when the hot dogs were opened or when they should be discarded because they were not labeled or dated. The raw Swiss steak blood leaked from the packaging and there was blood pooling in the bottom of the sheet pan. Below the sheet pan of raw Swiss steak were packages of fully cooked bratwurst. V9 stated the bratwurst was already cooked. V9 removed the pan of cooked bratwursts from below the raw Swiss steak pan and placed it above the Swiss steak pan on the cart. V9 stated the staff know when to discard food in the cooler by the time it is kept in the cooler but they would be unable to determine when it should be discarded unless the food is dated. Food delivery invoice, number 114326, shows the bratwurst purchased by the facility was delivered fully cooked. On January 27, 2025, at 12:30 PM, V11 (Food Service Worker) served food and coffee to a resident, removed her gloves and placed clean gloves on her hands without washing her hands. V11 then served food on to a resident tray which was served to the resident. With the same gloves she placed a raw lemon wedge on a different resident tray and then retrieved a wipe cloth from the counter and wiped the counter using the same gloves. V11 then placed the wipe cloth back on the counter and using the same gloves served food items on to a resident tray. Facility policy Basics for Handling Food Safety, undated, shows Don't cross cross-contaminate. Keep raw meat, poultry, fish and their juices away from other food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility Dishwashing Procedure, undated, shows, .9. Before any dish machine operator moves from soiled dishes to clean dishes, one of the following must occur: a. Hands shall be washed using proper hand washing procedures. B. If using gloves, soiled gloves shall be removed, hands shall be washed using proper hand washing procedures and clean, unused gloves must be put on Facility policy/procedure, revised 5/8/24, shows, .4. Dietary employees will adhere to the facility hand washing policy. Hand washing is required: a. Before preparing food or putting on gloves g. After engaging in any activities that might contaminate the hands, such as taking out garbage, handling soiled utensils or equipment or handling cleaning chemicals. h. Directly before touching ready-to-eat food or food-contact surfaces 9. Single use gloves may be used as necessary to prevent bare hand contact with ready-to-eat food or to cover an open sore. Gloves shall be changed when switching tasks, when gloves become soiled or torn or when 4 hours has elapsed. Facility policy/procedure Sanitation and Cleaning Schedule, reviewed 8/15/23, shows, The Dietary Department shall be responsible for maintaining sanitary conditions in the kitchen, all storage and dining areas, including all equipment located and/or utilized in these areas Storage .2. All raw meat must be stored on the bottom rack of the refrigerator for thawing. 3. All refrigerated and prepared food must be covered, labeled and dated with a use-by date that is a maximum of 7 days from date of preparation. Label must include the name of the food and the date by which it should be used Equipment 1. All equipment must be cleaned and sanitized with approved sanitizer after each use.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45303 Based on observation, interview, and record review, the facility failed to follow their Water Management Plan for Legionella. The facility also failed to perform hand hygiene during provisions of care, failed to follow the EBP (Enhanced Barrier Precautions) policy, and clean medical equipment between resident use. This applies to all 22 residents residing in the facility. The findings include: 1. The facility's Long-Term Care Facility Application for Medicare and Medicaid dated January 27, 2025, showed the facility census was 22 residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Water Management Pan dated November 7, 2024, showed Purpose: The purpose of this Water Management Plan (WMP) is to establish the minimum legionellosis risk management requirements by illustrating the procedures for minimizing the risk of Legionnaires' disease within the building water systems of one facility . Control Measures: Cold Water Systems, Risk Factor: Eyewash Station, Control Measure: Plumbed units are to be activated weekly to flush the line and verify operations; at least a three minute flush is recommended . Frequency: Weekly, Monitoring: Execute the control measure based on the stated frequency and the type of eyewash station present as indicated in the control measure . Control Measures: Hot Water Systems, Risk Factor: Water Heater, Control Measure: Check flow and return temperatures at hot water heater. Location: Boiler Room. Frequency: Monthly or as required or recommended by AHJ (Authority Having Jurisdiction) or your water treatment professional. Monitoring: Supply temperature should be checked at the outlet of the Hot Water Heater and should not be lower than 140 degrees Fahrenheit. The return temperature should also be checked monthly and should not be lower than 122 degrees Fahrenheit. Control Limits (Lower): 122 degrees Fahrenheit, Control Limits (Upper): 140 degrees Fahrenheit, Corrective Actions: If unable to maintain desired temperatures; the Program Team shall consider alternate methods to conform with compliance to reduce risk of legionella. NOTE: State and local regulations limit the temperature set-points of water heaters due to scald protection. This places most facilities out of control limits set by the scientific community. Accordingly, the only way to confirm legionella is under control is to test specifically for legionella. [Water Safety Company] suggests performing at a minimum two (biannual) tests per year, with four (quarterly) being more ideal. By doing so, the Program Team responsible has documented evidence that the hazard of legionella is under control . Control Measures: Hot and Cold Water Systems, Risk Factor: Check for Residual (Free) Disinfectant (Chlorine) Levels, Control Measure: Measure and record Residual (Free) Disinfectant (Chlorine) levels on the incoming city water supply as well as a representative most distal location within the facility. NOTE: A Free and Total Chlorine test kit that reads at least zero to six PPM (Parts per Million) as 'Cl' should be utilized to complete this test. Location: At any or multiple locations throughout the building. Frequency: Weekly, Monitoring: Use a chlorine test kit to measure the residual (free) disinfectant (chlorine) levels on the incoming city water supply as well as representative most distal location within the facility and record the results. Control Limits (Lower): 0.5 PPM, Control Limits (Upper): 3.0 PPM not to exceed 4.0 PPM, Corrective Actions: If disinfectant (chlorine) levels exceed 4.0 PPM (Parts per Million) on the upper level, please notify your municipal water supplier. If no chlorine levels are detected, please speak to your water supplier to see if they can increase the disinfectant levels. NOTE: [Water Safety Company] recommends a minimum of 0.5 PPM of Free Chlorine. Contact [Water Safety Company] with questions or concerns. If the free residual chlorine is less that 0.5 PPM, then it is recommended that special medical-grade 0.2-micron inline filters be installed for the ice machines . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On January 29, 2025, at 10:44 AM, V12 (Maintenance Director) said the facility has two eye wash stations which are plumbed in. V12 continued to say every week, V12 turns the eye wash stations on to ensure they work and then V12 turns the eye wash station off. V12 demonstrated his check of the eye wash station in the soiled linen room. V12 turned the lever and activated the eye wash station, water flowed from the eye wash spouts for one to two seconds, V12 immediately turned the faucet off to the eye wash station. V12 said that is how he does his weekly check of the eye wash stations. V12 said he checks the temperatures on the hot water tank and hot water return weekly. V12 said the temperatures on the hot water tank are 120 degrees Fahrenheit and the return is 110 degrees Fahrenheit. V12 said he does not perform weekly chlorine testing of the water. V12 continued to say he does not have any chlorine testing kits. V12 said he has the test kit to collect samples for legionella testing but has not sent them to the laboratory. V12 continued to say the last test result for the facility's legionella testing is from August 2023. V12 said he does not have any test results for legionella since May 2023. The facility's Weekly Boiler and Tanks Water Temp Log showed the facility's Domestic Boiler and Return temperatures from September 2, 2024, to January 27, 2025, were 120 degrees Fahrenheit at the boiler and 110 degrees Fahrenheit at the hot water return. These readings are outside of the control limits per the facility's Water Management Plan. The facility does not have documentation to show biannual testing for legionella was completed in 2023 or 2024. The facility does not have documentation to show chlorine testing of the facility's water was being performed weekly. On January 29, 2025, at 11:37 AM, V1 (Administrator) and V3 (Regional Director of Clinical Operations) said V12 should be following the facility's Water Management Plan for legionella including performing control measures and legionella testing. V3 said V12 should be flushing the eye wash stations for at least three minutes. 43389 2. R176's Resident Information sheet showed an [AGE] year old male admitted to the facility on [DATE] with diagnoses that included Hemiplegia and Hemiparesis following Cerebral Infarction affecting left non-dominant side, Dysphagia following Cerebral Infarction, Encounter for attention to Gastrostomy, and Type 2 Diabetes Mellitus. R176's Physician order dated January 15, 2025 showed the following: Resident is on Enhanced Barrier Precautions due to Gastrostomy tube (G-tube). Personal Protective Equipment (PPE) is to be worn during high contact activities. R176's G-Tube Care plan dated January 23, 2025, showed an intervention of Enhanced Barrier Precautions. On January 28, 2025, between 8:36 AM and 9:34 AM during medication administration observation with V6 (Licensed Practical Nurse), observed the following: (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	V6 took a rolling blood pressure cuff out of R12's room that she had just used on him and did not perform hand hygiene, nor did she sanitize the blood pressure cuff. V6 took the blood pressure cuff to R176's room. R176 has an Enhanced Barrier Precautions (EBP) sign on the outside of his door and Personal Protective Equipment in a bin outside the door. The EBP sign says stop: Everyone Must: Clean their hands including before entering and when leaving the room. Providers and staff must also wear gloves and gown for High Contact Resident Care Activities that include device care or use of feeding tubes. V6 entered R176 room and did not perform hand hygiene on the way into the room nor did she put on a gown. After taking the R176's blood pressure, V6 left the room and went to her medication cart outside of the room and started getting R176's medication ready. V6 did not perform hand hygiene when exiting the room. V6 then crushed all 6 of R176's medications separately and put them in separate medication cups. After crushing each medication, V6 picked up the garbage can lid to threw away the plastic sleeve she crushed the medication in. V6 then crushed another medication and repeated for all 6 medications. V6 then said she was going to get warm water from R176's restroom. V6 went into R176's room grabbed and open the restroom door and then came out 5 seconds later with a cup of water. V6 exited R176's the room with the water and applied gloves without performing hand hygiene. V6 then brought the medication into R176 room. R176 then asked for a cloth to wash his hands. V6 gave him a dry cloth and R176 asked if she can wet it. V6 with her gloves on grabbed the restroom door with her right hand, disposable cloth in the left hand and went into the restroom. V6 emerged from the R176's restroom [ROOM NUMBER]-5 seconds later with gloves still on and handed R176 the wet cloth. V6 then removed the covers from over R176 and lifted up his shirt. V6 turned and poured water into each cup and started one by one injecting the medication into R176 G-tube. After injecting each medication, and with the same gloves on. V6 grabbed the restroom door and went into the restroom, came out of the restroom [ROOM NUMBER] seconds later with water and then flushed 30 ml of that water into the R176's G-tube. V6 adjusted resident, gave juice, opened and placed straw in juice all with the same gloves on. V6 took off gloves and put on new ones on without performing hand hygiene, then cut up R176's pancakes. V6 removed her gloves and left the room without using hand sanitizer or performing hand hygiene. At no point did V6 put on an isolation gown while passing medication to R176 who was on Enhanced Barrier Precautions. V6 went to her cart and pulled it to R20's room. V6 pulled the blood pressure cuff with her that she used on R12 and R176 which was still not sanitized. V6 then opened the garbage can connected to her medication cart and threw something away with her right hand. V6 grabbed the blood pressure cuff she used on R12 and R176 (which was still not sanitized) and took R20's blood pressure. V6 left the room without performing hand hygiene, prepared and grabbed the medications and went into R20's room and administered 9 oral medications. V6 then went back out to her cart, got R20's inhaler put gloves on without performing hand hygiene and administered R20's inhaler. V6 then prepared and administered a stool softener and placed a pain patch on R20 back and still had not performed any hand hygiene yet. V6 then removed her gloves left the room and took her medication cart to R16's room and started preparing 4 medication for R16. V6 then poured R16 a cup of water. V6 then went to clean utility room down the hall with R16's medication in one of her hands and opened the door with the other and got a box of gloves while holding door open with her left foot. V6 went back to R16's room and put on new gloves. V6 still had not performed hand hygiene yet. V6 then took the same blood pressure cuff she had used on R12, R176, and R20 (without sanitizing the cuff in between residents) and checked R16's blood pressure. V6 then retrieved R16's water and put a straw in the water while touching the straw with the gloved hands. V6 took off gloves did not perform, put on new gloves adjusted R16 in the bed with gloves on and gave her the medication. V6 then removed the gloves and for the first time since the medication observation started, V6 performed hand hygiene with hand sanitizer that was hanging in the hallway outside the room. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On January 28, 2025, at 9:34 AM, V6 stated that when providing care and passing medication via G-tube to R176 who is on EBP isolation, she should have performed hand hygiene. V6 stated she should have used hand sanitizer or perform hand hygiene when going in and out of all rooms and when going from clean to dirty. V6 stated she should have performed hand hygiene after removing gloves. V6 stated she should have sanitized the blood pressure cuff in between residents. On January 29, 2025, at 4:13 PM, V3 (Regional Nurse Consultant) stated that before donning gloves or utilizing a resident's G-tube, staff should perform hand hygiene. V3 stated that before providing care to a resident on Enhanced Barrier Precautions, the nurse should perform hand hygiene, and don gloves and a gown. V3 stated, after performing care or using a resident's G-tube, staff should remove their gown and gloves before leaving the room, and perform hand hygiene. V3 stated soap and water should be used and hands washed for 20-30 seconds and dried. V3 stated hand sanitizer is acceptable to use unless hands or gloves are soiled. V3 stated the reason for preforming hand hygiene before and after resident care and before and after using a resident's g-tube is to prevent the spread of infection. The facility's Hand Hygiene policy dated May 8, 2024, showed the following: Purpose to provide guidelines to staff for proper and appropriate hand washing and hygiene techniques that will aid in the prevention of transmission of infections. Procedure 2. The use of gloves does not replace hand hygiene. 3. Hand hygiene is always the final step after removing and disposing of personal protective equipment (PPE). Washing Hands with Soap and Water 1. Staff will perform hand hygiene by washing hands for at least twenty (20) seconds with antimicrobial or non-antimicrobial soap and water should be performed under the following conditions: b. before applying gloves and after removing gloves or other PPE. h. After using a restroom. Using Alcohol-Based Hand Gel: 1. If hands are not visibly soiled, use and alcohol-based hand rub for the following situations: b. Before entering and leaving an isolation room, c. Before preparing or handling medications, d. before applying gloves and after removing gloves or other PPE. g. After providing direct care, i. After using a restroom. m. after contact with inanimate objects (e.g., medical equipment) in the immediate vicinity of the resident. The facility's Isolation precautions Policy dated May 8, 2024, showed the following EBP: 1. Expands the use of PPE beyond situations in which exposure to blood and body fluids is anticipated, refers to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of MDROs to staff hands and clothing. The facility's Cleaning and Disinfection of Resident Care Equipment policy dated May 8, 2024, showed the following: Procedure: 1. Reusable equipment will be cleaned and disinfected after used of one resident and before use of another resident. The facility's Personal Protective Equipment policy dated June 14, 2024, showed the following: Procedure: PPE will be worn for residents requiring Enhanced Barrier Precautions.