STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146167	A. Building B. Wing	10/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foster Health & Rehab Center	2840 West Foster Avenue Chicago, IL 60625

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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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. 46342 Based on observation, interview, and record review the facility failed to ensure the call light was within reach for one (R12) out of four residents reviewed in a total sample of 14 for call lights. Findings include: On 10/08/24 at 12:05 PM, R12 was observed lying in bed in R12's room. Call light was not visible. Call light was not within R12's reach. Observed yellow sign above R12's bed titled -Fall Precaution Checklist- which listed interventions including but not limited to call light at reach. R12 said, where is the call light? I don't see it. Observed pull string call light on R12's roommate side of the privacy curtain. Observed two strings attached with one long string which reached to R12's roommates bed and the other string was very short. This short string was not long enough to reach R12's side of the room. On 10/08/24 at 12:15 PM, V12 (Certified Nursing Assistant) stated the call lights should be within reach of the resident(s). V12 observed R12 lying in bed. Observed V12 trying to locate R12's call light. V12 went on the other side of R12's privacy curtain and observed the short string attached to the call light. V12 said, something happened to the string, it is too short. It won't reach him (R12). The string needs to be longer. V12 stated the call light should always be within reach of the resident for the resident's safety. V12 stated even if the resident can walk on their own the call light should be within their reach in case the resident falls and cannot get up. On 10/09/24 at 11:42 PM, observed R12 lying in bed in R12's room. Call light not visible. Call light not within R12's reach. R12 said, I cannot reach my call light. On 10/09/24 at 11:45 PM, V5 (Registered Nurse) observed R12's call light out of reach and stated, he cannot reach it and it needs to be made longer. Observed V5 looking for the call light string. V5 observed the very short string attached to the call light on the other side of R12's privacy curtain and noted the string is too short to reach R12. V5 stated the call light should be within reach of the resident so they can get the help they need and the potential problem if the call light is not within reach, the resident could fall. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/08/24 at 3:58 PM, V3 (Director of Nursing/Infection Preventionist) stated the call lights should be within easy reach of the resident so they can pull it when they are need of assistance. V3 stated all call lights should be within reach of the resident even if the resident is ambulatory. V3 stated if a call light is out of reach of a resident, then the resident could be in distress, or be having a life-threatening event or they could have fallen and they would not be able to alert the staff of the need for help. V3 stated this may make the resident feel as if no one cares for them. R12 has diagnoses which include but not limited to Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Alcohol Abuse, Gastro-Esophageal Reflux Disease, Unspecified Psychosis, Major Depressive Disorder, Conversional Disorder with Seizures or Convulsions. R12's MDS (Minimum Data Set) from 08/29/24 BIMS (Brief Interview for Mental Status) score is 06 out of 15 indicating severely impaired cognition and section G (Functional Status) documents in part R12 requires supervision/touch assistance with toileting hygiene and transfers. R12's Fall Risk Assessment completed 08/29/24 documents in part, score of 12 indicating high fall risk category. R12's care plan documents in part, R12 is at risk for falls related to gait/balance problems and diagnosis seizures and interventions include but not limited to be sure the resident's call light is within reach and encourage the resident to use it for assistance as needed. Facility provided policy titled, Call Light undated documents in part, the purpose is to respond to the resident's requests and needs in a timely and courteous manner and all residents shall have the nurse call light system available at all times and within easy accessibility to the resident at the bedside or other reasonable accessible location. Facility provided policy titled, Fall Prevention Policy dated 12/01/22 documents in part, to identify and establish plan of care of resident with increased risk of falling as identified by a fall assessment risk and please make sure the following is complete before leaving out: call light within reach.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on interviews and record reviews, the facility failed to accurately document advanced directives code status for 1 resident (R12) out of a four residents reviewed in a total sample of 14 residents for advance directives. Findings include: R12 was admitted to the facility on [DATE]. R12 has diagnosis which includes but not limited to Chronic Obstructive Pulmonary Disease, Hyperlipidemia, Alcohol Abuse, Gastro-Esophageal Reflux Disease, Unspecified Psychosis, Major Depressive Disorder, Conversional Disorder with Seizures or Convulsions. R12's MDS (Minimum Data Set) from [DATE] BIMS (Brief Interview for Mental Status) score is 06 out of 15 indicating severely impaired cognition On [DATE] at 3:00 PM, surveyor reviewed R12's IDPH (Illinois Department of Public Health) Uniform Practitioner Order For Life-Sustaining Treatment (POLST) Form signed by V10 (R12's Surrogate), dated [DATE] and documents in part Do Not Attempt Resuscitation/DNR and Selective Treatment: Primary goal of treating medical conditions with selective medical measures. On [DATE] at 3:05 PM, surveyor reviewed R12's Certification of Surrogate Decision-Making Form which documents in part the cause and nature of the qualifying condition Traumatic Brain Injury, Cognitive Impairment, and documents surrogate decision maker as V10 signed and dated [DATE]. On [DATE] at 3:10 PM, surveyor reviewed R12's Face Sheet which documented in part, Advance Directive FULL CODE. On [DATE] at 3:12 PM, surveyor reviewed R12's Order Summary Report which documents in part FULL CODE ordered [DATE]. On [DATE] at 3:15 PM, surveyor reviewed R12's care plans and could not locate care plan for advance directives and/or code status. On [DATE] at 3:28 PM, V10 (R12's Surrogate) stated via phone interview R12's wishes regarding advance directives is Do Not Resuscitate with Selective Treatment. V10 stated R12 does not want any heroic means to keep R12 alive, no CPR, but would consider use of antibiotics and hospitalization if recommended. V10 stated V10 keeps a copy of R12's POLST form at V10's home and stated R12's POLST form was revised and signed on [DATE]. V10 stated the POLST form was redone [DATE] when R12 was in the hospital and that prior to this R12 was full code. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 2:55 PM, V4 (Registered Nurse) stated a resident's code status is listed in the Electronic Health Record (EHR) in the Resident Profile and physician orders. V4 stated V4 is taking care of R12 today. V4 reviewed R12's EHR and stated R12 is a FULL CODE which would mean V4 would administer CPR (Cardiopulmonary Resuscitation) if indicated. On [DATE] at 4:00 PM, V3 (Director of Nursing/Infection Preventionist) stated the resident's wishes regarding code status on the POLST form should be followed as written per family/guardian preference and should also match the doctor's order in the EHR. V3 stated this is to make sure everyone is on the same page and there should be no conflicts. V3 stated this is important to make sure the resident preferences are being followed regarding code status. V3 stated it would be a problem if there is a discrepancy between the code status listed on the POLST form to that code status listed on the face sheet and physician order sheet because the potential is that the nurse could administer CPR when the resident's wishes is for DNR. On [DATE], 4:15 PM, V3 stated POLST forms for the residents who have them are kept in a book in the nursing station. Surveyor and V3 reviewed Advance Directives binder located at the nursing station and could not find a copy of R12's POLST form. V3 stated if R12 has a POLST form it should be kept in that binder, so the nurses have easy access to it and can cross check it with the information in R12's EHR. V3 stated the Advance Directive binder needed to be updated. Facility policy titled, Advance Directives dated [DATE] documents in part the purpose of this policy is to reflect residents wishes about receiving Cardiopulmonary Resuscitation (CPR) and life sustaining treatment such as medical interventions and artificial administration nutrition. It allows a resident, in consultation with their healthcare professional, to decide an (in) advance about CPR and other life sustaining decisions in the event the residents breathing and or heartbeat stop or they are at the end of life. At the time of admission residents will be interviewed regarding their code status and or preference and will be documented in their electronic health record. Facility policy titled, In-House DNR Policy undated, documents in part, it is the facility's policy to ensure that residents who DNR (Do Not Resuscitate) receive no resuscitation when found without vital signs.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. 44103 Based on interview and record reviews, the facility failed to complete the comprehensive Minimum Data Set (MDS) assessments using the CMS-specified Resident Assessment Instrument (RAI) process within the regulatory timeframes for 13 (R31, R11, R32, R4, R2, R35, R37, R5, R12, R19, R15, R24, R20) out of 26 residents reviewed for comprehensive resident assessments. Findings Include: On 10/09/24 at 2:27 PM, record reviews of the following Minimum Data Set (MDS) assessments revealed the following: 1. R31's Annual MDS assessment with assessment reference date (ARD) of 5/29/24, date signed assessment as complete on 7/15/24. 2. R11's Annual MDS assessment with ARD of 10/29/23, date signed assessment as complete on 12/3/23. 3. R32 Annual MDS assessment with ARD of 7/18/24, date signed assessment as complete on 9/19/24. 4. R4's Annual MDS assessment with ARD of 7/25/24, date signed assessment as complete on 9/19/24. 5. R2's Annual MDS assessment with ARD of 4/26/24, date signed assessment as complete on 7/1/24. 6. R35's Admission MDS assessment with ARD of 5/5/24, date signed assessment as complete on 7/18/24. 7. R37's Admission MDS assessment with ARD of 5/15/24, date signed assessment as complete on 7/21/24. 8. R5's Annual MDS assessment with ARD of 5/15/24, date signed assessment as complete on 7/2/24, and care areas completed on 7/10/24. 9. R12's Annual MDS assessment with ARD of 11/29/23, date signed assessment as complete on 1/25/24. 10. R19's Annual MDS assessment with ARD of 11/5/23, date signed assessment as complete on 12/24/23. 11. R15's Annual MDS assessment with ARD of 5/16/24, date signed assessment as complete on 7/2/24, and care areas completed on 7/10/24. 12. R24's Annual MDS assessment with ARD of 10/19/23, date signed assessment as complete on 11/16/23. 13. R20's Annual MDS assessment with ARD of 5/15/24, date signed assessment as complete on 7/11/24. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 10:14 AM, V17 (Licensed Practical Nurse MDS/Care Plan Coordinator) stated [V17] follows RAI guidelines including timeframe of every MDS assessment which are admission, annual, quarterly, and significant change. V17 stated that Admission MDS ARD is set within 14 days from admission and completed 14 days from the ARD. Example if resident is admitted today 10/10/24, ARD should be set within 10/10 to 10/23/24. Care Area Assessments (CAA) completed by the 14th day from admission. Transmission is within 14 days from the completion date. V17 stated that Annual MDS ARD is set every year and should be completed 14 days from the ARD. Chapter 2 of the RAI (October 2024) manual page 17 titled RAI OBRA-required Assessment Summary indicates that Admission MDS assessment's completion date is no later than the 14th calendar day of the resident's admission, and the Annual MDS assessment's completion date is no later than 14 days from the ARD.

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Assure that each resident's assessment is updated at least once every 3 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on interview and record review, the facility failed to complete MDS (Minimum Data Set) assessments using CMS - specified Resident Assessment Instrument (RAI) process within the regulatory timeframes. This failure can potentially affect 13 (R1, R6, R9, R13, R17, R21, R23, R26, R27, R30, R33, R34, R38) out of 26 residents reviewed for resident assessment. The findings include: On 10/09/24 02:30 PM Surveyor reviewed the following MDS assessments and showed the following: 1. R1 Quarterly MDS dated [DATE] showed completion date on 9/27/24. 2. R6 Quarterly MDS dated [DATE] showed completion date on 9/19/24. 3. R9 Quarterly MDS dated [DATE] showed completion date on 9/26/24. 4. R13 Quarterly MDS dated [DATE] showed completion date on 9/26/24. 5. R17 Quarterly MDS dated [DATE] showed completion date on 9/19/24. 6. R21 Quarterly MDS dated [DATE] showed completion date on 9/26/24. 7. R23 Quarterly MDS dated [DATE] showed completion date on 9/30/24. 8. R26 Quarterly MDS dated [DATE] showed completion date on 9/27/24. 9. R27 Quarterly MDS dated [DATE] showed completion date on 9/19/24. 10. R30 Quarterly MDS dated [DATE] showed completion date on 9/19/24. 11. R33 Quarterly MDS dated [DATE] showed completion date on 9/26/24. 12. R34 Quarterly MDS dated [DATE] showed completion date on 9/30/24. 13. R38 Quarterly MDS dated [DATE] showed completion date on 9/30/24. (continued on next page)

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F 0638 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 10:14am V17 (MDS/Care Plan coordinator, LPN-Licensed Practical Nurse) stated she has been working in the facility for 2 years. MDS is an assessment to determine resident's ADL (activities of daily living), cognitive function, urinary / bowel function, current diagnosis, medication use, skilled therapy, and any falls. She said they follow RAI (Resident Assessment Instrument) guidelines including timeframe of every MDS assessment which are admission, annual, quarterly, and significant change. Quarterly ARD (Assessment Reference Date) is set every 91 days or prior from the last ARD. Completion date should be 14 days from the ARD. If not following the RAI guidelines required timeframe there would be problem with acceptance of the MDS assessment and it can potentially affect the care of the resident. Reviewed EHR (electronic health record) with V17 for the following residents: R6's Quarterly MDS ARD was on 7/24/24 and was completed on 9/19/24. V17 said R6's MDS assessment should have been completed 8/7/24. R38's Quarterly MDS ARD 8/21/24 was completed on 9/30/24. V17 sated R38's MDS assessment should have been completed 9/4/24. She said the MDS assessments have a late completion date. V17 stated she has been sick and maybe did not lock the assessment within the timeframe stated by RAI guideline. CMS'S (Centers for Medicare and Medicaid Services) RAI (Resident Assessment Instrument) Version 3.0 manual dated October 2024 page 2-17 documented in part: Quarterly (Non-Comprehensive) MDS Completion Date (Item Z0500B) No Later Than ARD + 14 calendar days.

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F 0642 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a qualified health professional conducts resident assessments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on interview and record review, the facility failed to ensure that each Minimum Data Set (MDS) assessment was certified as complete by a registered nurse (RN) for 7 (R6, R17, R23, R27, R30, R34, R38) out of 26 residents' assessments reviewed. The findings include: 1. R6 Quarterly MDS dated [DATE] showed completion date on 9/19/24 and signed by V17 (LPN/Licensed Practical Nurse). 2. R17 Quarterly MDS dated [DATE] showed completion date on 9/19/24 and signed by V17 (LPN). 3. R23 Quarterly MDS dated [DATE] showed completion date on 9/30/24 and signed by V17 (LPN). 4. R27 Quarterly MDS dated [DATE] showed completion date on 9/19/24 and signed by V17 (LPN). 5. R30 Quarterly MDS dated [DATE] showed completion date on 9/19/24 and signed by V17 (LPN). 6. R34 Quarterly MDS dated [DATE] showed completion date on 9/30/24 and signed by V17 (LPN). 7. R38 Quarterly MDS dated [DATE] showed completion date on 9/30/24 and signed by V17 (LPN). On 10/10/24 at 10:14am V17 (MDS/Care Plan coordinator, LPN-Licensed Practical Nurse) stated she has been working in the facility for 2 years. MDS is an assessment to determine resident's ADL (activities of daily living), cognitive function, urinary / bowel function, current diagnosis, medication use, skilled therapy, and any falls. She said they follow RAI (Resident Assessment Instrument) guidelines including timeframe of every MDS assessment which are admission, annual, quarterly, and significant change. State Operations Manual (SOM) dated 08-08-24 page 222 documented in part: Each resident's assessment will be coordinated by and certified as complete by a registered nurse, and all individuals who complete a portion of the assessment will sign and certify to the accuracy of the portion of the assessment he or she completed. 44103

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on interview and record review, the facility failed to follow their policies and procedures for the Preadmission Screening and Annual Resident Review (PASARR) process for 2 (R2, R8) residents reviewed for a Level 2 PASARR Screening for Mental Disability (MD) and Intellectual Disability (ID) in a total sample of 14. Findings Include: 1. R2's Minimum Data Set (MDS) dated [DATE] shows R2 is cognitively impaired. According to the Admission Record, R2 is [AGE] years old, R2 was admitted to the facility on [DATE] with a diagnosis of bipolar disorder. There is no documentation to show that R2 was referred to the appropriate state-designated authority for Level 2 PASARR evaluation and determination. On 10/09/24 at 3:10 PM, the surveyor asked V2 (Assistant Administrator) for a Level 2 PASARR screening for R2. V2 provided the surveyor with a Level 1 PASARR screening dated 4/20/15 for R2. V2 was unable to provide a Level 2 PASARR screening for R2. V2 stated that V2 has no Level 2 PASARR for R2. 47304 2. R8's admission record showed initial admitted on 7/1/2012 with diagnoses not limited to Malignant neoplasm of unspecified site of right female breast, Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes, Unspecified dementia, Essential (primary) hypertension, Other specified peripheral vascular diseases, Bipolar disorder, Anemia, Chronic kidney disease. MDS dated [DATE] showed R8's cognition was intact. On 10/09/24 at 10:56 AM No PASARR found in R8's health record. On 10/9/24 at 11:13am V2 (Assistant Administrator) stated when a resident is admitted to the facility, assessment pro becomes accessible. V2 stated he can't check the PASARR prior to admission. Social worker/discharge planner from the hospital is checking it (PASARR) prior to admission, the facility is not checking PASARR prior to admission. He (V2) said PASARR is done to determine if resident is eligible for nursing care or appropriate for placement. He (V2) stated R8's PASARR was not obtained. Facility unable to provide PASARR evaluation for R8. The facility policy titled, Preadmission Screen and Resident Review (PASRR) dated 12/2022 documents read in part: Prior to admission and upon any changes in status, residents will be screened for a known or suspected diagnosis of severe mental illness, developmental disability, or intellectual disability to ensure resident is appropriate for nursing facility services.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47304 Based on interview and record review, the facility failed to follow their policy to develop a comprehensive, person-centered care plan for each resident that includes measurable objectives and timetables to meet the resident's needs. This failure can potentially affect 5 (R1, R8, R27, R28, R39) of 5 residents reviewed for comprehensive care plan in the sample of 14. The findings include: R1's admission record showed initial admitted on 1/24/2022 with diagnoses not limited to Chronic obstructive pulmonary disease, Essential (primary) hypertension, Alzheimer's disease, Epilepsy, Gastro-esophageal reflux disease, Overactive bladder, Body mass index 19.9 or less, adult, Anemia in other chronic diseases classified elsewhere, Ventral hernia without obstruction or gangrene, Paranoid schizophrenia, Other specified arthritis multiple sites. MDS (Minimum Data Set) dated 8/10/24 showed R1's cognition was severely impaired. R1's POS (physician order sheet) dated 10/10/24 showed FULL CODE. No care plan found in R1's health record regarding code status. R8's admission record showed initial admitted on 7/1/2012 with diagnoses not limited to Malignant neoplasm of unspecified site of right female breast, Secondary and unspecified malignant neoplasm of axilla and upper limb lymph nodes, Unspecified dementia, Essential (primary) hypertension, Other specified peripheral vascular diseases, Bipolar disorder, Anemia, Chronic kidney disease. MDS dated [DATE] showed R8's cognition was intact. R8's POS (physician order sheet) dated 10/9/24 showed code status: DNR (Do Not Resuscitate). No care plan found in R8's health record regarding code status. R28's admission record showed initial admitted on 3/2/2023 with diagnoses not limited to Malignant neoplasm of pancreas, Type 2 diabetes mellitus without complications, Chronic obstructive pulmonary disease, Heart failure, Essential (primary) hypertension, Atherosclerotic heart disease of native coronary artery, Presence of cardiac pacemaker. MDS dated [DATE] showed R28's cognition was intact. R28's POS (physician order sheet) dated 10/9/24 showed FULL CODE. No care plan found in R28's health record regarding code status. R39's admission record showed initial admitted on 5/25/2024 with diagnoses not limited to Malignant neoplasm of unspecified site of right female breast, Anemia, Restlessness and agitation, Acute embolism and thrombosis of other specified deep vein of left lower extremity, Major depressive disorder, Other schizophrenia, Encounter for screening for unspecified developmental delay, Gastro-esophageal reflux disease without esophagitis. MDS dated ,d+[DATE]//24 showed R39's cognition was moderately impaired. (continued on next page)

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Foster Health & Rehab Center	2840 West Foster Avenue Chicago, IL 60625

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R39's POS (physician order sheet) dated 10/9/24 showed FULL CODE. POS showed active order of Alprazolam (antianxiety medication) and Haldol (antipsychotic medication). No care plan found in R39's health record regarding code status, use of anti-anxiety and anti-psychotic medication. On 10/10/24 at 10:14am V17 (MDS-Minimum Data Set/Care Plan coordinator, LPN-Licensed Practical Nurse) was interviewed and stated the following: (V17) has been working in the facility for 2 years. Care plans (CP) are done or developed for every resident and should be individualized according to resident's needs/problem. A care plan is important so staff know what kind of care or treatment the resident needs. If there is no care plan, staff might not know how much care the resident's needs. Care plans are completed by the interdisciplinary team. Seizure diagnosis needs to be care planned. Residents on psychotropic medication, a CP should be done by category of psychotropic medications (separate care plan for antidepressant, antipsychotic, antianxiety, hypnotic medication) because each medication has different side effects and should have different interventions. Advance directives should be care planned. Staff need to know the code status of the resident. A CP includes interventions on how to care for the residents. EHR (electronic health records) were reviewed with V17. V17 was unable to locate a plan for advance directive for R1, R8, R28 and R39. No care plan found for antipsychotic or antianxiety medication use for R39. Facility's policy for care plan, comprehensive person-centered (undated) documented in part: A comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident. The interdisciplinary team (IDT), in conjunction with the resident and his / her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. 44103 On 10/09/24 at 9:09 AM, R27 stated R27 has not received Levetiracetam medication for four days now. R27 stated R27 is taking it for seizures. At 11:00 AM, Surveyor requested for R27's care plan for anticonvulsant medication use. At 11:59 AM, V3 (Director of Nursing) stated R27 has no care plan addressing the anticonvulsant medication use for seizures. R27's face sheet documents in part a medical diagnosis of Anoxic Brain Damage and Cerebral Infarction. R27's physician orders document in part: Levetiracetam Solution 100 MG/ML to give 1 ML by mouth two times a day for seizure activity.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 44103 Based on observations, interviews, and record reviews, the facility failed to follow their policy and procedure to ensure emergency supplies in the crash cart were securely locked at all times when not in used. This failure has the potential to affect 19 ambulatory residents residing in the facility (R12, R32, R33, R6, R22, R17, R19, R4, R35, R9, R39, R30, R37, R27, R28, R31, R13, R20, R10). Findings Include: On 10/08/24 at 9:47AM, observed emergency crash cart parked in the hallway easily accessible to anyone walking by the front lobby and the nurses' station. The emergency crash cart was not locked and some of the items found inside were intravenous (IV) line kits, multiple sizes needles, oxygen tubing, and four 1 Liter IV fluid bags. On 10/08/24 at 10:28 AM, V4 (Registered Nurse) and V5 (Registered Nurse) stated the night shift nurse checks the emergency crash cart. V4 stated that the cart is supposed to be locked. V4 and V5 stated they do not know how long the cart has been unlocked. Both denied unlocking it. Both stated any resident can potentially access what's inside if it's not locked and it would be a safety issue if a resident was to access the needles. On 10/08/24 at 10:45 AM, V3 (Director of Nursing) stated that the emergency crash cart is supposed to be locked when not in use, but the facility has no lock for it. V3 stated, V2 (Assistant Administrator) is in the process of ordering a new one. When I came in August it did not have a lock. We put a temporary lock, but it did not work. The IV fluids, needles, gowns, blood glucose machine, and oxygen tubing are inside the crash cart. I check it when I'm here. The nurses should be checking it every shift. We don't have a lock for it. The residents do not touch it. If a resident walks by it and opens it, then that would be a potential safety hazard. They could get the needles out of the cart, and they can open up the IV fluids and take it to their room. Out of 38 residents from the facility's residents' roster dated 10/08/24, restorative provided a list of residents who are ambulatory, and it revealed a total of 19 residents. The facility's Crash Cart policy and procedure (no date) documents in part: The crash cart will be locked at all times to ensure that all supplies are available during the course of a medical emergency. The crash cart will be checked daily to ensure that the crash cart lock is intact. If the lock is not intact the nurse will verify that all supplies are present in the crash cart and then relock the cart. Any time that the crash cart is used for a medical emergency, the crash cart will be restocked and relocked as soon as possible.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49486 Based on observation, interview, and record review, the facility failed to perform monthly medication regimen review (MRR) for 4 (R8, R28, R35, and R39) residents reviewed for psychotropics in a sample of 14. Findings Include: R35 was admitted to the facility on [DATE] with diagnoses not limited to Bipolar disorder, Major depressive disorder, Metabolic Encephalopathy, Long term use (current) of anticoagulants, and Anoxic brain damage. R35's MDS shows R35 is moderately cognitively impaired. On 10/10/24 at 10:04 AM, V3 (Director of Nursing/DON) stated that Medication Regimen Review (MRR) should be done monthly by the pharmacist, but V3 does not have any MRR done for R35 or any residents in this facility. V3 stated that it is important for the pharmacist to perform monthly MRR to evaluate the effectiveness, adverse reaction, and the safety of the medication to R35 or any residents. Surveyor requested for the MRR policy from V1, and V3 multiple times on 10/9/24 and 10/10/24 but the facility could not provide the policy. R35's Minimum Data Set (MDS) dated [DATE] shows R35 is moderately cognitively impaired. R35's Physician Order Sheet (POS) with active orders as of 10/10/24 shows an order for Fluoxetine HCL oral tablet 10 mg (milligrams) by mouth one time a day related to depressive disorder. R35's Medication Administration Records (MAR) dated 09/24 to 10/24 shows R35 is currently on Fluoxetine HCL oral tablet 10 mg daily for depressive disorder, and Valproic Acid oral solution 25ml (milliliters) via peg tube every 12 hours related to major depressive and bipolar disorder. Reviewed the only R35's Pharmacist's Medication Review (MRR) dated 71/24 and 7/10/24. The facility's policy titled: Psychotropic Drug Program dated 6/2000 documents read in part: All residents on psychotropic drugs will be evaluated upon admission for medication review. 47304 On 10/10/24 at 9:51 AM Surveyor reviewed R39's physician order sheet (POS) and showed order including but not limited to: ALPRAZolam Oral Tablet 0.25 MG (Alprazolam) Give 1 tablet by mouth every 12 hours as needed for anxiety for 14 Days. Haloperidol Tablet 5 MG Give 1 tablet by mouth two times a day. TraZODone HCl Tablet 150 MG Give 1 tablet by mouth at bedtime for insomnia At bedtime. Medication review regimen (MRR) not found in R39's electronic health record. At 11:20 AM Surveyor reviewed R8's physician order sheet (POS) and showed order not limited to: ALPRAZolam Tablet 0.25 MG Give 1 tablet by mouth two times a day Sertraline HCl Tablet 100 MGGive 200 mg by mouth at bedtime. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Medication review regimen (MRR) not found in R8's electronic health record. At 1:29 PM Surveyor reviewed R28's physician order sheet (POS) and showed order including but not limited to: PARoxetine HCl Oral Tablet 10 MG (Paroxetine HCl) Give 1 tablet by mouth at bedtime for Generalized Anxiety Disorder. (Give with 40mg for a total dose of 50 mg). PARoxetine HCl Oral Tablet 40 MG (Paroxetine HCl) Give 1 tablet by mouth at bedtime for Generalized Anxiety Disorder. (Give with 10mg for a total dose of 5mg). Medication review regimen (MRR) not found in R28's electronic health record. On 10/10/24 at 11:52am V3 (Director of Nursing / DON) said she started working in the facility in August 2024. V3 stated a MRR should be done at least monthly by pharmacy, looking for effectiveness, side effects, compatibility with some other medications. V3 stated a MRR is a wholistic review of resident medications and evaluation if medication is needed for safety of medication administration. Several attempts were made to request MRR of R8, R28 and R39, facility was not able to provide.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. 44103 Based on observations, interviews, and record reviews, the facility failed to maintain a medication error rate of less than 5% for 3 (R6, R22, R27) of 11 residents reviewed for medication administration. There was a total of 28 opportunities with 4 errors observed, which resulted in a medication error rate of 14.29%. Findings Include: On 10/08/24 at 11:31 AM, Surveyor observed V4 (Registered Nurse) checked R6's blood glucose. R6's blood glucose reading was 218. V4 stated, based on R6's insulin sliding scale order, R6 will be getting 1 unit of Fiasp insulin injection. At 11:59 AM, V4 was about to prepare R6's insulin injection, but V4 was unable to find R6's Fiasp insulin medication in the medication cart or the convenience box. V4 stated R6 will not be receiving the ordered insulin injection since it's not available. R6's physician orders show R6 to receive 1 unit of Fiasp Injection (Insulin Aspart) for blood glucose reading of 181-220 (ordered on 8/08/24). R6's progress notes written by V4 dated 10/08/24 at 12:52 PM documents in part, Fiasp Injection Solution 100 UNIT/ML(milliliters) (Insulin Aspart) not administered, awaiting pharmacy delivery later today. On 10/09/24 at 8:55, V8 (Registered Nurse) was obsereved preparing R22's morning medications. V8 prepared Metoprolol 100 mg, Amlodipine 5 mg (milligrams), Benztropine 2 mg, Haloperidol 10 mg, Lorazepam 0.5 mg, Losartan Potassium 50 mg, and Multivitamin 1 tablet for R221. At 9:00 AM, R22 took the oral pills. At 9:02 AM, V8 stated [V8] completed R22's medication pass and continued to R27's room. R22's 10/09/24 Medication Administration Record (MAR) documents in part a 9:00 AM dose for Flonase Nasal 1 spray in both nostrils. V8 did not administer it during 10/09/24 medication administration observations. On 10/09/24 at 9:07 AM, V8 prepared R27's morning medications. Surveyor observed V8 preparing Aspirin 81 mg, Seroquel 25 mg, Metoprolol 12.5 mg, and Buspirone 5mg for R27. V8 stated R27's Levetiracetam solution (anticonvulsant medication) is not available and R27 will not be receiving it. At 9:09 AM, R27 took the oral pills and was notified by V8 that R27 will miss a dose of R27's Levetiracetam solution. R27's 10/09/24 MAR documents in part 9:00 AM dose for Levetiracetam Solution 100 MG/ML to give 1 ML by mouth for seizure activity, Aspirin 325 mg 1 tablet, Seroquel 25mg, Metoprolol 12.5 mg, and Buspirone 5 mg. R27 did not receive the ordered dose of Levetiracetam and only received Aspirin 81 mg (ordered Aspirin 325 mg). On 10/09/24 at 11:59 PM, interviewed V3 (Director of Nursing) and stated that for medication administration, the nurses should be following the 6 Rs right resident, right route, right medication, right time, right dose, and right for education. V2 stated nurses are supposed to be following physician orders when administering medications to the residents. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's Quality Assurance in Medication Administration policy (no date) documents in part: The medications must be administered in accordance with the written orders of the physician. Therefore, medication administration record (M.A.R.) must be used while passing the medications. The medication must be given in correct strength, route, and dosage form and at correct time.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 44103 Based on observations, interviews, and record reviews, the facility failed to ensure that two residents (R6, R27) were free of any significant medication errors out of eleven residents reviewed for medication administration. Findings include: On 10/08/24 at 11:31 AM, Surveyor observed V4 (Registered Nurse) checking R6's blood glucose. R6's blood glucose reading was 218. V4 stated, based on R6's insulin sliding scale order, R6 will be getting 1 unit of Fiasp insulin injection. At 11:59 AM, V4 was about to prepare R6's insulin injection, but V4 was unable to find R6's Fiasp insulin medication in the medication cart or the convenience box. V4 stated R6 will not be receiving the ordered insulin injection since it's not available and V4 will follow up with pharmacy. R6's face sheet documents in part a medical diagnosis of Type 2 Diabetes Mellitus Without Complications. R6's physician orders show R6 to receive 1 unit of Fiasp Injection (Insulin Aspart) for blood glucose reading of 181-220 (ordered on 8/08/24). R6's care plan documents in part, R6 has Diabetes Mellitus with one intervention that includes, Diabetes medication as ordered by doctor. R6's progress notes written by V4 dated 10/08/24 at 12:52 PM documents in part, Fiasp Injection Solution 100 UNIT/ML (milliliters) (Insulin Aspart) not administered, awaiting pharmacy delivery later today. On 10/09/24 at 9:07 AM, V8 (Registered Nurse) prepared R27's morning medications. Surveyor observed V8 prepare Aspirin, Seroquel, Metoprolol, and Buspirone for R27. V8 stated R27's Levetiracetam solution (anticonvulsant medication) is not available and R27 will not be receiving it. V8 stated V8 will follow up with pharmacy. At 9:09 AM, interviewed R27 and stated R27 has not received R27's Levetiracetam medication for four days now. R27 stated R27 is taking it for seizures. R27's face sheet documents in part a medical diagnosis of Anoxic Brain Damage and Cerebral Infarction. R27's 10/09/24 Medication Administration Record (MAR) documents in part a 9:00 AM dose for Levetiracetam Solution 100 MG/ML (milligrams/milliliters) to give 1 ML by mouth two times a day for seizure activity. V8 did not administer it during 10/09/24 observations and was not signed off on the MAR as given. R27's progress notes written by V8 dated 10/09/24 at 11:48 AM documents in part, LevETIRAcetam Solution 100 MG/ML Give 1 ml by mouth two times a day for seizure activity medication on order. A follow-up call was placed over to the pharmacy staff. On 10/09/24 at 11:59 PM, V3 (Director of Nursing) stated that nurses are to administer residents' medications according to physician's orders. V2 stated if medications are not administered as ordered, there could be adverse reactions. V2 stated nurses must call the physician and follow up with the pharmacy. V2 stated insulins, anticonvulsants, cardiac medications are high alert medications. V2 further stated that if residents miss their anticonvulsant medication, the resident could possibly have seizure activity and if a resident misses their insulin, there could be an adverse reaction such as hyperglycemia. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility's Quality Assurance in Medication Administration policy (no date) documents in part: The medications must be administered in accordance with the written orders of the physician. Therefore, medication administration record (M.A.R.) must be used while passing the medications. The medication must be given in correct strength, route, and dosage form and at correct time.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 44103 Based on observation, interview, and record review, the facility failed to properly date opened multi-dose inhalers for 4 residents (R2, R23, R28, R31) and to dispose a house stock medication after the expiration date from one out of one cart reviewed for medication storage and labeling. Findings include: On 10/08/24 at 9:28 AM, the facility's medication cart was inspected with V5 (Registered Nurse). There was a bottle of house stock Famotidine 10 mg (milligrams) medication with expiration date of 9/24 labeled on the bottle. There were also R23's Breo inhaler without the opened date on the label; R28's Incruse inhaler without the opened date on the label and shows to discard 6 weeks after opening; R31's Advair inhaler without the opened date on the label and shows to discard 30 days after opening; and R2's Fluticasone Furoate inhaler without the opened date on the label and shows to discard 42 days after opening. On 10/09/24 at 11:59 PM, V3 (Director of Nursing) stated all inhalers should be labeled with the date it was opened, and discard based on the label. V3 stated over-the-counter medications are supposed to be discarded on the expiration date and are not to be given or be stored in the medication cart over the expiration date. V3 stated all medications should be discarded by the expiration date. R2's physician orders document in part: Fluticasone Furoate Aerosol Powder Breath Activated 1 puff inhale orally every 24 hours as needed. R23's physician orders document in part: Breo Inhalation Aerosol Powder Breath Activated 1 puff inhale orally one time a day. R28's physician orders document in part: Incruse Ellipta Inhalation Aerosol Powder Breath Activated 1 puff inhale orally one time a day. R31's physician orders document in part: Advair Diskus Aerosol Powder Breath Activated 2 puff inhale orally two times a day. The facility's ID1: STORAGE OF MEDICATIONS policy (revised 11/22) documents in part: Expiration Dating (Beyond-use dating) C. Certain medications or package types, such as IV solutions, multiple dose injectable vials, ophthalmics, nitroglycerin tablets, inhalants, blood glucose testing solutions and strips, once opened, require an expirations date shorter than the manufacturer's expiration date to insure medication purity and potency. G. All expired medications will be removed from the active supply and destroyed in the facility, regardless of amount remaining. The medication will be destroyed in the usual manner.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 46342 Based on observation, interview, and record review the facility failed to provide and follow menus and recipes to ensure menu variety for three (R2, R5, R15) out of three residents reviewed for pureed menus in a final sample of 14. Findings Include: On 10/08/24 at 10:20 AM, V14 (AM Cook) stated there are no recipes in the kitchen to follow for pureed diet consistencies. V13 (Dietary Manager) stated the kitchen does not follow any production or spreadsheets and that the cooks know how to prepare and what to serve different diets because they have been working here a long time. On 10/08/24 at 12:55 PM, observed regular diets receiving Hawaiian Chicken with pineapple, white rice, broccoli, and fruit cocktail. Residents on pureed diets appeared to receive pureed white meat, mashed potatoes, pureed green vegetable and pureed canned fruit. On 10/09/24 at 11:15 AM, observed V14 prepare pureed food for lunch. V14 stated residents on a regular and mechanical soft diet are receiving spaghetti with meatballs in tomato sauce, mixed vegetables, cornbread, and chocolate water cookies. V14 stated residents on a pureed diet are receiving pureed meatballs in tomato sauce, mashed potatoes, pureed mixed vegetables and applesauce. V14 stated V14 does not puree the spaghetti for the pureed diets because the pureed spaghetti is ick so that is why V14 is serving mashed potatoes to the pureed diets. V14 stated V14 does not puree rice either and that yesterday when the regular and mechanical soft diet received rice the pureed diets all received mashed potatoes. V14 stated the pureed diets are also not receiving pureed cornbread today, only the regular and mechanical soft diets are getting cornbread. On 10/09/24 at 12:20 PM, V15 (PM Cook) stated V15 is the cook that made dinner for the residents on 10/08/24. V15 stated residents on regular diets received chili dogs, tater tots, and applesauce and the residents on pureed diets received mashed potatoes, pureed string beans, pureed chicken patty and applesauce. V15 stated V15 always gives residents on pureed diets mashed potatoes at every meal. V15 stated V15 does not puree tater tots, or potato wedges, Au Gratin potatoes, rice, or spaghetti. V15 stated on evening meals when the regular and mechanical soft diets are receiving cold sandwiches for dinner V15 does not give the pureed diets pureed a cold sandwich, V15 substitutes a hot meal (pureed meat, pureed hot vegetable and mashed potatoes). (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/09/24 at 12:38 PM, V13 stated residents on pureed diets should receive the same food that the regular diets receive only in pureed form when possible. V13 stated the kitchen does not puree corn, beans, rice, raw vegetables, or processed meats. V13 stated there are no recipes for pureed foods available in the kitchen for the cooks to follow. V13 stated last night on 10/08/24 the regular and mechanical soft diets received chili dogs, tater tots and applesauce for the dinner meal. V13 stated the residents on pureed diets get whatever the kitchen has available which is usually leftovers from two days ago assuming they did not have that already to eat. V13 stated the cooks do not have anything to follow like a spreadsheet or production sheet but the cooks know the pureed diets need a starch, a vegetable and protein and a dessert so it is up to the cook to determine what they want to serve the pureed diets for a particular meal based on food availability. V13 stated residents on pureed diets get mashed potatoes at every lunch and dinner every day. V13 said, they must get tired of receiving the same thing every day. I don't know why it is like that here. That is just the way it has always been done here. V13 stated applesauce was given to the pureed diets today, not pureed cookies and the pureed diets received applesauce last night for their dessert at dinner so the pureed diets received applesauce 2 days in a row which is not varied menu. V13 stated the cornbread was not pureed because it probably doesn't puree up well. On 10/09/24 at lunch meal observed regular diets receiving spaghetti with meatballs in tomato sauce, cornbread, mixed vegetables, and sandwich wafer cookies. Residents on pureed diets received pureed meatballs, mashed potatoes, pureed mixed vegetables and applesauce. Pureed diets did not receive pureed cornbread, pureed cookies, or pureed spaghetti. On 10/10/24 at 11:52 AM, V6 (Registered Dietitian) stated the menus have been created to ensure nutritionally adequacy and the menus should be followed to make sure the residents receive a variety of different foods. V6 stated residents should not receive the same foods over and over so they do not get bored getting the same items. V6 stated the cooks should be following the menus and recipes, and it is not okay for the cook to make substitutions on their own they would need to be approved by V6. V6 stated the potential problems if the kitchen staff are not following a menu and recipe is that the residents may not be getting enough calories, protein, or micronutrients and this could also cause problems with menu variety. V6 stated when the cooks are preparing pureed foods, they should be following a recipe. V6 stated basically you can puree any regular item as long as it reaches a pureed consistency (no lumps, or pieces or participles). V6 stated residents receiving a purred diet should receive same food as regular just in pureed form assuming the item can be safely pureed. V6 stated items such as rice, spaghetti, tater tots, hotdogs, cornbread can all be pureed with the right preparation which is why it is important for the cooks to follow recipes. Residents on pureed diets should not receive mashed potatoes with lunch and dinner every day or applesauce back-to-back for dessert because they should have a more variety of foods in their meals. R2 has diagnosis which includes but not limited to Parkinson's Disease, Type 2 Diabetes Mellitus, Bipolar Disorder, Schizoaffective Disorder, Major Depressive Disorder, Hypertension, Gastrostomy Status, Dysphagia, Dementia, Cerebral Infarct Due To Unspecified Occlusion Or Stenosis Of Unspecified Cerebral Artery. R2's Order Summary Report printed 10/09/24 documents in part, pureed diet texture, thin consistency order date 08/16/22. R2's MDS (Minimum Data Set) dated 08/07/24 BIMS (Brief Interview for Mental Status) was 5 out of 15 indicating severe cognitive impairment and R2 requires mechanically altered, therapeutic diet. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foster Health & Rehab Center	2840 West Foster Avenue Chicago, IL 60625

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R5 has diagnosis not limited to Dementia, Parkinson's Disease, Cerebral Infarction Due To Unspecified Occlusion Or Stenosis Of Unspecified Cerebral Artery, Dysphasia Following Cerebral Infarction, Bell's Palsy, Moderate Intellectual Disabilities, Schizoaffective Disorder, Malignant Neoplasm Of:, Morbid Severe Obesity Due To Excess Calories. R5's Order Summary Report printed on 10/09/24 documents in part, pureed texture, nectar consistency ordered 05/19/22. R5's MDS (Minimum Data Set) dated 09/07/24 BIMS (Brief Interview for Mental Status) was not able to be assessed and R5 requires mechanically altered, therapeutic diet. R15 has diagnosis not limited to Cerebral Palsy, Acute Respiratory Failure, Dysphasia, Reduced Mobility, Moderate Protein Calorie Malnutrition, Repeated Falls, Muscle Wasting Atrophy, Difficulty In Walking, Encounter For Attention To Gastrostomy, Major Depressive Disorder, Anxiety Disorder, Pain. R15's Order Summary Report printed on 10/09/24 documents in part, pureed texture, thin consistency order date 09/04/24. R15's MDS (Minimum Data Set) dated 08/16/24 BIMS (Brief Interview for Mental Status) was not able to be assessed and R15 requires mechanically altered, therapeutic diet. Kitchen policy titled, Standardized Recipes dated 10/02/23 documents in part, standardized recipes for menu items will be used to help ensure consistent quality, portion size and cost control. Recipes are standardized for the facility and will accompany the menu, all recipes will be followed as written. Kitchen policy titled, Cycle Menu dated 09/26/23 documents in part, the facility will follow a cycle menu planned at least 4 weeks in advance. Menus are planned using established national guidelines to assure the menu meets nutritional needs.

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. 44103 Based on observations, interviews, and record reviews, the facility failed to provide therapeutic diets as prescribed by the physician for 5 (R1, R5, R10, R15, R25) out of 5 residents reviewed in a total sample of 14. Findings Include: On 10/08/24 at 12:02 PM, R10's physician orders document a diet order of NCS (No Concentrated Sweets) diet, Pureed texture, Thin consistency (ordered on 4/28/24). R10's last Dietary Notes dated on 6/28/24 at 9:14 AM written by V18 (Former Dietitian) revealed R10's Diet: NCS, pureed texture, thin liquids. R10's face sheet documented in part medical diagnoses of Unspecified Dementia and Neurocognitive Disorder with Lewy Bodies. On 10/08/24 at 1:12 PM R10 was eating lunch in the dining room. R10 received chunks of chicken and pineapples, rice (no sauce), broccoli, canned mixed fruits, thin juice and water. R10's meal ticket shows STD-mechsoft. On 10/09/24 at 1:43 PM, interviewed V13 (Dietary Manager) and stated, I get the diet order from the nurses they give me a pink slip with the diet order, name, room number and the type of diet. The type of diet should be ordered by the physician. They give me a pink slip every time there is a new admission and re-admission. The diet order should reflect on the diet card. Currently I have [R10] as a mechanical soft. [R10] was a pureed. [R10] was hospitalized came back as pureed. A lot of those changes are verbal. The nurses told me that [R10] was mechanical I don't remember when. I don't remember if they give me a pink slip. The facility's DIET ORDERS policy (revised 11/1/23) reads in part: Upon resident admission or diet change, the nurse will verify the diet order with the physician. The diet is recorded in the medical record. The diet is communicated to the food and nutrition department on a Diet slip. Pureed Diet: General diet with texture adjusted so that foods are blended smooth in consistency, like pudding or mashed potatoes, for those with chewing and/or swallowing problems. 46342 R25 has diagnosis not limited to Type 2 Diabetes Mellitus, Severe Morbid Obesity Due To Excess Calories, Hypertension, Hyperlipidemia, Acute Kidney Failure, Heart Failure, Atherosclerotic Heart Disease, Anemia, Glaucoma. R25's Medication Review Report printed on 10/09/24 documents in part, renal dialysis diet order date 02/16/24. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R25's MDS (Minimum Data Set) dated 08/01/24 BIMS (Brief Interview for Mental Status) score 15/15 indicating intact cognition and R25 requires therapeutic diet. R25's nutrition care plan documents in part, the resident is on a therapeutic diet. At risk for potential alteration in nutritional status. R25's copied meal card list diet as renal diet. On 10/09/24 at 12:40 PM, R25 was observed sitting in the dining room eating lunch meal. R25's meal ticket read Renal Diet. R25 received meatballs served in tomato sauce over spaghetti, mixed vegetables (potatoes, carrots/green beans), and corn bread. R25 consumed 100% of the meal. On 10/09/24 at 3:22 PM, V15 (PM Cook) stated R25 used to be on a renal diet but R25 is done with R25's treatments so R25 is not on that special diet anymore. V15 stated right now R25 is not on any dietary restrictions. V15 stated R25's diet card says renal diet, but it says that because it hasn't been changed yet to regular diet which is what the kitchen is giving R25. V15 stated the kitchen staff used to follow a list posted in the kitchen which listed the foods R25 could and could not be served but the list has been removed now because R25 is not on any diet restrictions anymore. V15 stated a renal diet is not allowed fish, or salt but V15 is not sure of what else the renal diet is not allowed. On 10/09/24 at 3:30 PM, V13 (Dietary Manager) stated R25 is on a regular diet with no dietary restrictions. V13 stated R25's meal ticket lists renal diet but the renal diet was discontinued when R25 stopped dialysis and the kitchen just never changed R25's meal ticket. V13 stated when R25 was on a renal diet, there was a list posted which said what foods R25 was allowed and what R25 was not allowed to eat so the kitchen staff would know what R25 could and could not have. V13 stated verbally one of the nurses told V13 that R25's renal diet was discontinued but V13 does not remember the name of the nurse or when this happened. V13 stated V13 pulled the list that used to be posted in the kitchen so the kitchen staff does not restrict R25's diet, but V13 did not update R25's meal ticket to reflect the change to regular diet but everyone in the kitchen knows R25 is no longer on that diet anymore. R5 has diagnosis not limited to Dementia, Parkinson's Disease, Cerebral Infarction Due To Unspecified Occlusion Or Stenosis Of Unspecified Cerebral Artery, Dysphasia Following Cerebral Infarction, Bell's Palsy, Moderate Intellectual Disabilities, Schizoaffective Disorder, Malignant Neoplasm Of:, Morbid Severe Obesity Due To Excess Calories. R5's Order Summary Report printed on 10/09/24 documents in part, pureed texture, nectar consistency ordered 05/19/22. R5's MDS (Minimum Data Set) dated 09/07/24 BIMS (Brief Interview for Mental Status) was not able to be assessed and R5 requires mechanically altered, therapeutic diet. R5's copied meal card list diet as pureed. It does not list R5 should receive nectar thickened liquids. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R15 has diagnosis not limited to Cerebral Palsy, Acute Respiratory Failure, Dysphasia, Reduced Mobility, Moderate Protein Calorie Malnutrition, Repeated Falls, Muscle Wasting Atrophy, Difficulty In Walking, Encounter For Attention To Gastrostomy, Major Depressive Disorder, Anxiety Disorder, Pain. R15's Order Summary Report printed on 10/09/24 documents in part, pureed texture, thin consistency order date 09/04/24. R15's MDS (Minimum Data Set) dated 08/16/24 BIMS (Brief Interview for Mental Status) was not able to be assessed and R15 requires mechanically altered, therapeutic diet. R15's copied meal card list diet as pureed. On 10/10/24 at 8:10 AM, observed R5 sitting in the unit dining room eating breakfast meal. R5's meal ticket read pureed diet. Observed R5 drinking a thin orange flavored liquid from a Styrofoam cup. R5 consumed 100% orange flavored drink. On 10/10/24 at 8:12 AM, observed R15 sitting in the unit dining room being fed by V20 (Restorative Certified Nursing Assistant). R15's meal ticket read pureed diet. Observed R15 drinking thickened water from a Styrofoam cup. R15 consumed 100% thickened water. On 10/10/24 at 8:15 AM, V10 (Certified Nursing Assistant) stated R5 is on a pureed diet with thin liquids. V10 stated R5 is not given thickened liquids, the staff gives R5 thin liquids. V10 stated R15's liquids have to be thickened to nectar consistency using a powder. On 10/10/24 at 11:15 AM, V20 (Restorative Certified Nursing Assistant) stated V20 fed R15 breakfast this morning and R15 consumed 100% water thickened to nectar consistency. V20 stated V20 knows R15 should get thickened liquids because it was communicated to V20 verbally by the other staff. V20 stated it does not say that R15 requires thickened liquids on R15's meal card. On 10/10/24 at 11:25 AM, V13 (Dietary Manager) stated R15 requires nectar thickened liquids, R5 does not. V13 stated R5 receives thin liquids. V13 stated it is the nursing staff's responsibility to let V13 know about any changes to resident's diet orders. V13 stated V13 was not aware that R5 has an order for nectar thick liquids and R15 has an order for thin liquids. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/10/24 at 12:08 PM, V6 (Registered Dietitian) stated diet orders are physician generated and should be followed as ordered. V6 stated each resident has a meal ticket which list the diet order including therapeutic restrictions, food/liquid consistency, and any special requests such as likes/dislikes or food allergies. V6 stated it is dietary departments responsibility to make sure the diet orders in the electronic health record (EHR) match the diet orders listed on the resident's meal tickets including their diet consistency, liquid consistency, and therapeutic diet order. It is important for the meal tickets to be correct because this tells the kitchen and nursing staff what food/liquids to serve the resident. V6 stated if there is a discrepancy, there is the potential for the resident to receive the wrong diet. V6 stated if a resident has a doctor order for a pureed diet but receives mechanical soft a resident could choke. V6 stated if a resident on nectar thick liquids receives thin this could cause aspiration and lead to pneumonia. V6 stated if a resident is receiving thickened liquids but they have an order for thin liquids there is no medical risk, but it could create a palatability issue. V6 stated if a resident does not need to be on thickened liquids, they should not receive it. V6 stated residents on a renal diet should not have been given spaghetti with meatballs in a tomato sauce because tomatoes are high in potassium and if you have impaired kidney function then the ability to metabolize potassium is decreased which can cause potassium to build up. V6 stated even though R25 is no longer receiving dialysis V6 would not take R25 off the renal diet unless the doctor ordered to liberalize the diet. V6 stated R25 should have received spaghetti with plain meatballs, not in any tomato sauce. Facility policy titled Tray Pass Policy dated 10/2020 documents in part, ensure trays have proper meal ticket; appropriate resident name and appropriate diet. 47304 R1's admission record showed initial admitted on 1/24/2022 with diagnoses not limited to Chronic obstructive pulmonary disease, Essential (primary) hypertension, Alzheimer's disease, Epilepsy, Gastro-esophageal reflux disease, Overactive bladder, Body mass index 19.9 or less, adult, Anemia in other chronic diseases classified elsewhere, Ventral hernia without obstruction or gangrene, Paranoid schizophrenia, Other specified arthritis multiple sites. MDS (Minimum Data Set) dated 8/10/24 showed R1's cognition was severely impaired. On 10/8/24 at 12:50pm Observed R1 lying in bed, alert and verbally responsive with confusion. Lunch tray was provided with pureed food consistency. R1 can feed self post tray set up. On 10/9/24 at 1:04pm R1 resting in bed, lunch tray was served with pureed food consistency. At 1:46PM V13 (Dietary Manager) has been working in the facility for more than 3 years. V13 stated diets should be served according to doctor's order. He (V13) said if a diet order is not followed it could potentially harm the resident. V13 stated R1 is on a Pureed diet. R1's physician order was reviewed with V13 and order showed Mechanical soft. He (V13) said facility is not following diet order of R1 as prescribed by physician. On 10/10/24 at 11:52am V3 (DON) said she started working in the facility in August 2024. V3 stated diet should always be followed according to doctor's order for safety of the resident. (continued on next page)

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F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R1's POS (physician order sheet) dated 10/10/24 showed: Mechanical Soft texture, thin consistency. Order date 1/31/22. Care plan dated 03/07/2022 documented in part: R1 unable to consume regular consistency foods and requires a mechanically altered diet. Provide diet as ordered.

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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** 46342 Based on observation, interview, and record review, the facility failed to ensure food items were properly labeled, dated, and stored, failed to properly rotate food using First In, First Out (FIFO) guidelines, and failed to ensure kitchen staff were wearing appropriate hair coverings. These failures have the potential to affect all 38 residents receiving food prepared in the facility's kitchen. Findings include: On [DATE] at 9:38 AM, V13 (Dietary Manger) stated perishable items should be dated with the date it was prepared, a use by date and used within three days. V13 stated the kitchen staff follows the manufacturer label if there is a use by or best by dates printed on the product. V13 stated for shelf- items which need to be refrigerated after being opened such as salad dressing, mayonnaise, and sauces get labeled with a delivery date, an open date and a use by date which is within 30 days of the item being opened. V13 stated it is important for food items to be labeled and dated with opened and use by dates to prevent food-borne illness which could harm the residents. On [DATE] at 9:40 AM, observed the following items in the Walk-In Refrigerator: 1.) Opened 30-Fluid Ounce glass bottle Barbeque Marinade 50% full with manufacturer best by date [DATE] printed on the side of the bottle. No opened date labeled on the item. V13 stated the Marinade sauce was used on chicken served to the residents last week for a cookout. V13 viewed the best by date of [DATE] printed on the side of the bottle and said, I would still use this for residents because the vinegar inside it would kill any bacteria in the marinate. 2.) Opened 1-gallon Golden Italian Dressing labeled with an open date of [DATE]. Item was not labeled with a use by date. 3.) Opened 1-gallon Honey Mustard Dressing labeled with an open date [DATE]. Item was not labeled with a use by date. 4.) Opened 1-gallon Soy Sauce dated with an open date [DATE]. Item was not labeled with a use by date. 5.) Opened 1-gallon Mayonnaise dated with an open date [DATE]. Item was not labeled with a use by date. 6.) Opened 1-gallon Pickle Chips labeled with an open date [DATE]. Item was not labeled with a use by date. 7.) Opened 64-ounce plastic container Mayonnaise. Not labeled with an opened date. On [DATE] at 9:50 AM, V13 stated those items in the Reach-In Refrigerator not labeled are used so frequently that labeling them with a use by date is not necessary because V13 said, we go through the items quickly. (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, when touring the dry storage room, V13 stated all items must be labeled with a delivery date and the items are organized according to First In, First Out (FIFO). V13 stated FIFO means the newest or most recently delivered item is stored in the back and the oldest item is stored in the front. V13 stated this is important to rotate the food items so that the older items are used first. On [DATE] at 9:58 AM, observed the following items in the dry storage room: 1.) #10 can Dark Red Kidney Beans - not labeled with delivery date. V13 stated V13 knows when that was delivered but the delivery date should be written on the can. 2.) #10 can Diced Beets - not labeled with delivery date. V13 stated the delivery date should be written on the can. 3.) 5 of 6 - #10 cans Cut Waxed Beans labeled with delivery date [DATE] and 1 of 6 #10 can Cut Waxed Beans labeled with delivery date [DATE]. The can dated [DATE] was in the very back behind the cans dated [DATE]. V13 stated the can dated [DATE] should be in the front so it is used before the other cans dated [DATE]. 4.) Separate bins filled with Breadcrumbs, Farina, Parboiled Rice, Oatmeal, Flour, Sugar. None of the bins were labeled with the item name, open or use by dates. V13 stated since there are no labels on the bin items you cannot tell when they were opened and the potential problem with that is the kitchen could be using items over the expiration date without realizing it. On [DATE] at 10:06 AM, V13 stated spices are good for two years. Observed in the cook's prep station near the stove the following spices: 1.) Opened 10-ounce bottle titled Poultry Seasoning labeled with delivery date [DATE]. Not labeled with an open or use by date. There was no manufacturer's best by date printed on the bottle. 2.) Opened 8-ounce bottle titled Ground Sage labeled with delivery date [DATE]. Not labeled with an open or use by date. There was no manufacturer's best by date printed on the bottle. On [DATE] at 10:29 AM, observed V15 (PM Cook) in the kitchen organizing meal tickets. V15 had a mustache and beard which was not covered with a beard protector or any type of covering. V15 stated V15 is not wearing a beard protector over V15's beard right now because V15 is doing the meal tickets and emptying the garbage. V15 stated V15 only wears the beard protector when V15 is dealing with food, not necessarily every time V15 enters the kitchen. On [DATE] at 3:20 PM, observed V15 in the kitchen walking around food prep area in front of the oven with uncovered food on the stove. V15 stated V15 is preparing the food for the dinner meal tonight. V15 had a mustache and beard which was not covered with a beard protector or any type of covering. (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 3:30 PM, V13 stated hair and beard restraints should be put on before crossing the threshold into the kitchen regardless of whether or not someone is handling food. V13 stated the kitchen is currently out of beard protectors and in the meantime, the kitchen is using the white hairnets in place of the beard protectors. V13 stated any facial hair needs to be covered regardless of the length. V13 stated the purpose of wearing hair coverings including beard protectors is to prevent hair from falling into the food because this would contaminate the food. V13 stated V15 is the only staff down in the kitchen right now and is the cook on duty so V15 is working with food and should have a beard protector or white hairnet over V15's beard. On [DATE] at 11:45 AM, V6 (Registered Dietitian) stated labeling and dating are important so the kitchen staff is aware of when a food item is expired so it is not served to the residents. V6 stated serving food after the best by or used by date to the residents could potentially cause an overgrowth in bacteria which could lead to food borne illness. V6 stated food items should have a receive date (delivery date), and then once opened labeled with an opened and a use by date or expiration date. V6 stated if the items are not labeled with an open or use by date the staff won't know when the items are no longer any good and when they should be discarded. Facility provided document titled, Diet Type Report dated [DATE] listing residents with their diet orders. There are no residents who are NPO (receiving nothing by mouth). V3 and V13 stated none of the residents living at the facility are NPO. Facility provided policy titled Employee Health & Personal Hygiene dated [DATE] which documents in part, hair restraints will be worn at all times. Beards should be well-trimmed and covered with an appropriate hair restraint. Facility provided V15's signed job description dated [DATE] which documents in part, hair covering must be worn while cooking or food handling. Any facial hair (beards) must be covered while in the kitchen. Facility provided policy titled, Date Marking and Labeling dated [DATE] which documents in part, 1.) All foods that are stored will be properly dated and labeled to ensure food safety. 2.) Date marking is an identification system that helps identify the name of the food, when the food was prepared and when it is to be discarded 3.) When to date mark: the food requires refrigeration, a commercially prepared food item is opened, when potentially hazardous (PHF/TCS) food are stored, when purchased, ready-to-eat foods are removed from their original packaging/container. 4.) When to discard refrigerated items that are opened must be discarded or used in 7 days, the item has expired according to the manufacturer's expiration date. Facility provided policy titled First In First Out (FIFO) dated [DATE] which documents in part the facility will follow safe food handling and storage practices and newly arrived food stock items will be placed at the back of the shelf and the older food items to the front of the shelf. The old stock items will be used first.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foster Health & Rehab Center	2840 West Foster Avenue Chicago, IL 60625

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 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Have a policy regarding use and storage of foods brought to residents by family and other visitors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46342 Based on observation, interview, and record review the facility failed to label and date food items in resident personal refrigerators and failed to discard unlabeled/undated spoiled foods in resident personal refrigerators. This has the potential to effect one resident (R29) out of four residents reviewed for personal food storage in a total sample of 14. Findings include: On [DATE] at 11:25 AM, observed personal refrigerator in R29's room next to R29's bed. R29 gave surveyor permission to look inside R29's refrigerator. R29 said, I cannot reach inside the refrigerator, so I don't know what's in there. R29 stated R29 likes to buy himself food from outside the facility. Observed the following items inside R29's refrigerator: 1.) Opened one-pound plastic container of Turkey Bologna 50% full, not labeled or dated with an open or use by date. The turkey bologna had a sour, off-putting smell to it. 2.) Opened plastic container of hotdogs with two hot dogs left in the package. The plastic wrapping was covered in black to dark gray spots and the two hotdogs were discolored with a green tint to them. The container was not labeled or dated with an open or use by date. 3.) Opened 32-ounce container of Almond Milk 80% full, not labeled or dated with an open or use by date. The container had manufacturer guidelines printed as follows refrigeration not needed before opening, once opened refrigerate ,d+[DATE] days. On [DATE] at 11:35 AM, R29 stated R29 did not realize the hotdogs and turkey bologna were still in R29's refrigerator. R29 stated R29 buys food but cannot open or reach items because R29 does not have enough hand strength. R29 stated no one ever told R29 that the food inside R29's refrigerator should be labeled and dated. R29 said, see? I keep markers on the side on my refrigerator which can be used to label my food. R29 stated R29 did not know the almond milk should be discarded once it is opened after 10 days. R29 said, thank you for telling me that. On [DATE] at 11:46 AM, V13 (Dietary Manager) stated V13 is responsible for checking the resident's personal refrigerators daily to check the temperatures inside the refrigerators and to look for any old or expired foods. V13 stated the items inside should be dated but it is not V13's responsibility to date them. V13 stated the food items inside should be dated because otherwise staff have no way of knowing how long an item has been inside the refrigerator or when to throw away the item so residents do not eat the spoiled food which could potentially make the residents sick. V13 opened the package of hot dogs and stated V13 does not know what the black spots are or why the hotdogs are greenish in color. V13 acknowledged the bad smell of the turkey bologna. R29 asked V13 to throw out the hotdogs and turkey bologna. R29 stated R29 had opened the almond milk ,d+[DATE] days so R29 did not want to throw it out but stated someone could write an open date on the container. (continued on next page)

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F 0813 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 12:20 PM, V6 (Registered Dietitian) stated food items inside resident's personal refrigerators should be labeled and dated so the staff/resident knows when item needs to be thrown out. V6 stated it is important that residents do not consume expired items because that could potentially make them sick. R29's diagnosis which includes but not limited to Cachexia, Unspecified Severe Protein-Calorie Malnutrition, Anemia, Type II Diabetes Mellitus, Orthostatic Hypertension, Weakness, Adult Failure to Thrive, Abnormal Weight loss, Neuromuscular Dysfunction of Bladder, Retention of Urine, Fatty Liver. R29's Order Summary Report dated [DATE] documents in part general diet, regular texture dated [DATE]. R29's MDS (Minimum Data Set) dated [DATE] BIMS (Brief Interview for Mental Status) was 15 out of 15 indicating intact cognition. Facility provided policy titled, Food Policy From Outside Sources undated documents in part, food and beverages brought in from the outside will be labeled and dated with the resident's name, room number and the date the items was brought into the facility for consumption/storage, they will be appropriately labeled and dated when accepted for storage and discarded after 48 hours and staff will be responsible for checking resident personal refrigerator daily for proper labeling, temperature recording.

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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. 49486 Based on observation, interview and record review, the facility failed to handle linen in a manner to prevent cross contamination, failed to conduct an annual review of its infection control policy and procedures, failed to post Enhanced Barrier Precautions (EBP) signage outside 2 residents (R21, R38) rooms with active wounds, and failed to have measures to prevent the growth of Legionella and other opportunistic waterborne pathogens in building water systems. These failures could potentially affect all 38 residents residing in the facility. Findings Include: R21's Treatment Administration Record (TAR) dated 9/1/24 to 9/30/24 shows R21 has venous wound of the left lateral leg with daily treatment. Progress note dated 10/10/24 documents in part: R21 on ABT Doxycycline 100mg PO bid x 10 days wound infection on the left leg. R38's TAR dated 10/1/24 to 10/31/24 shows R38 has treatment to lower legs every shift for skin infection. On 10/08/24 10:48 AM, R21 is obserevd lying in bed with left leg wound. No signage of EPB on R21's door. On 10/08/24 10:46 AM, R38 is observed in bed with skin peeling on both legs. No enhanced barrier precaution (EBP) signage on R38's door. On 10/08/24 at 10:50 AM, V4 (Registered Nurse/RN) stated that Enhanced Barrier Precautions (EBP) signage should be posted outside the door of any resident with wounds, Feeding tube, Foley Catheter, and central line. V4 stated it is important to have EBP signage to ensure that staff are wearing the necessary Personal Protective Equipment (PPE) required before providing care for R21 and R38. 10/08/24 at 12:13 PM, surveyor V3 (Director of Nursing/Infection Preventionist) observed R21 and R38's door without the EBP signage. V3 stated that R21, and R38 have wounds, there should be a EBP signage by the door to alert staff to know the type of PPE to wear before providing care to R21, and R38. V3 stated that not having the signage by R21, and R38's door, is a potential for transmission of infection. On 10/08/24 at 12:08 PM, surveyor reviewed the water management area with V16 (maintenance Director). Surveyor asked V16 for measures in place to prevent the growth of Legionella. V16 stated V16 is not sure, and V16 could not provide any documentation. V16 stated V16 will ask V1. On 10/09/24 at 1:01 PM, V1(Administrator) stated that Legionella is checked yearly, and V1 has not checked for Legionella this year. V1 stated that the last time the water was checked for Legionella was 1/11/23 which is over one year. V1 stated that V1 will call the company to come over later. V1 stated that failure to perform an annual check for Legionella, is a potential for waterborne infection. V1 stated that the infection control policy is reviewed or revised yearly, but V1 provided surveyor undated infection policy. V1 stated that the date should have been November 2023, but it was an oversight. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 10/08/24 at 12:53 PM, the laundry room was obsereved with V7 (Laundry/Housekeeping Aide). Surveyor observed V7 pick up the dirty mop from the laundry room without wearing a pair of gloves, and V7 used the same dirty hand to pick up clean resident gowns from the folding table. V7 stated that V7 is sorry because, V7 forgot to sanitize V7's hand before picking up the clean gowns from the folding table. Surveyor asked V7 if the clean gowns are now contaminated and should be rewashed. V7 responded yes. On 10/08/24 at 12:58 PM, the chute was observed with V7, surveyor observed V7 walking in the hallway with a dirty pair of gloves. Surveyor asked V7 if the dirty gloves can result in spreading of bacteria. V7 responded Yes. On 10/09/24 at 1:10 PM, V3 stated that it is the expectation of V3 that staff will wear a pair of gloves to pick up a dirty mop and perform hand hygiene before handling clean gowns or clean linen. V3 stated that the potential problem of handling clean gowns with a dirty hand may result in spreading of bacteria. V3 stated that, no staff should be wearing gloves when walking in the hallway to prevent the spread of infection. The facility policy titled Hand Hygiene dated 12/17/19 documents read in part: Hand hygiene is the single most efficient means of preventing the spread of infection. The facility policy titled Linen Handling dated November 2023 documents read in part: Wash hands after handling soiled linen and before handling clean linen. The facility policy titled Enhanced Barrier Precautions (EBP) dated 3/21/24 documents read in part: Clear signage will be posted on the door or wall outside of the resident room indicating the type of precautions, required Personal Protective Equipment (PPE). The facility policy undated, titled Infection Control and Procedure. A copy of EBP documents read in part: Wear gloves and a gown for wound care, any skin opening requiring a dressing.