STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146185	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Sisters of the Poor	2325 North Lakewood Avenue Chicago, IL 60614

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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 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** 45001 Based on interview and record review, the facility failed to clearly document the code status for one (R35) of 5 residents reviewed for advance directives in a total sample of 12. Findings include: Record review of R35's physician orders in the electronic medical record revealed R35 had three active advance directive orders, one order for full code dated [DATE], one order for CPR (cardiopulmonary resuscitation) dated [DATE] and one order for DNR (do not resuscitate) dated [DATE]. When reviewing R35's electronic record, writer clicked a hyper link reading (Advance Directives). The writer was taken to three documents, one being a IDPH Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form, dated [DATE], and designating Do Not Attempt Resuscitation/DNR. No form designating full code was observed. On [DATE] at 1:28 PM, V2 (Director of Nursing) stated there are two code status, DNR (do not resuscitate) or CPR (cardiopulmonary resuscitation)/full code. Writer showed V2 two active orders in R35's electronic record, one order for CPR and one order for DNR. V2 stated R35 has active orders for both CPR and DNR in R35's electronic record. There are two conflicting orders in the record. There should not be two conflicting orders in the record. In the event of a code, the nurse would locate the code status in the electronic record near the top of the page where the residents' picture is. V2 referenced/pointed to the top of R35's electronic record that read Code status: (Advance Directives (hyperlink)) CPR near R35's picture. V2 stated I don't know if this is accurate information at this time. I have to find out if R35 is CPR or DNR. At this time, we don't know. There is no document found in the electronic record to support CPR, only DNR. If the nurse looks at the top portion of the electronic chart it says CPR and the nurse will do CPR. The advance directive is the wishes of the resident of what they want to happen if they go into a code. At this time, I don't know what the residents or POA's (power of attorney) wishes are as far as code status. On [DATE] at 2:55 PM, V4 (Registered Nurse) stated if a resident is coding, I look at the electronic medical record at the top. The code status is dependent on the wants of the family. Therefore, staff have to follow the correct code status of what the family wants. That is contradictory if there is an order for CPR and an order for DNR. There should not be contradictory orders. I will not know which one to follow if there are contradictory orders. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 3:30 PM, V2 (Director of Nursing) presented writer with a IDPH Uniform Practitioner Order for Life-Sustaining Treatment (POLST) Form, dated [DATE], and designating CPR: Attempt cardiopulmonary resuscitation (CPR). V2 stated the form was found in the miscellaneous section of R35's electronic record and someone had placed it in the wrong place. Someone did not remove the DNR form and did not discontinue the DNR order. On [DATE] at 3:50 PM, V3 (Social Service Director/Admissions) stated currently R35 is a full code. CPR and DNR are not the same thing. CPR means they want to be resuscitated. DNR means do not resuscitate. There should only be one active order. Facility policy Advance Directives, ,d+[DATE], documents in part: It will ensure that resident's wishes will be respected in the event that illness or injury prevents them from communicating. Document on admission, that advance directives exist and place a copy of the advance directives in the resident medical record. As advance directives are completed or modified, a current copy is kept within the medical/nursing chart.

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident's assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666 Based on review of records and interview the facility failed to follow resident assessment instrument (RAI) related to discharge assessment within the required timeframe after discharge for one (R39) out of four residents for a total sample of 12 residents. This failure resulted failure of completion and/or submission that causes errors on report. Findings include: R39 was initially admitted on [DATE] and was discharged on [DATE]. Per R39's record there was no discharge assessment done after [DATE]. Per record latest assessment of R39 was done on [DATE]. No other assessment was done after [DATE]. On [DATE] at 1:07 PM, V11 (MDS (Minimum Data Set) coordinator/Registered Nurse) states that she has worked for the facility for over [AGE] years as the MDS coordinator. This surveyor asked V11 when she completes the MDS discharge assessment. V11 states that it depends, in several cases, the residents first came from the community as Medicare A and B, and they discharged back to the community. We have 14 days to complete the assessment. V11 states that R39 was in the facility for a couple of months and then she was sent to the hospital. She died in the hospital. V11 states at this point we don't do anything. V11 states that R39's chart is closed, and she cannot open the MDS assessment. State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities dated [DATE], documents in part 483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: i. Admission assessment. ii. Annual assessment updates. iii. Significant change in status assessments. iv. Quarterly review assessments. v. A subset of items upon a resident's transfer, reentry, discharge, and death. vi. Background (face-sheet) information if there is no admission assessment.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45000 Based on interview and record review, the facility failed to refer four (R1, R23, R30, R35) out of twelve residents with newly evident or possible serious mental illness to the appropriate state-designated authority for review. Findings include: On 03/06/2025, at 3:50 PM, V3 (Social Services Director) states all residents require a level I PASARR to determine if the nursing home is the correct setting for the resident to live in. V3 states she is responsible for making sure Level 1 Pre-Admission Screening and Resident Review (PASARR) are in the residents' records. V3 states she is responsible for all PASARR screenings in the facility. V3 states when the new screening agency requirements were implemented approximately 2 years ago, V3 states she entered the residents' information into the new system. V3 states she is responsible for putting in demographics such as the residents' social security number, their diagnoses, their date of birth, and their name. V3 states she is not sure if she entered residents' diagnoses into the new system. V3 states she remembers ensuring that residents' names were on the screening agency census report and is not aware that the facility should be updating the residents' PASARR information as needed to ensure accuracy of diagnoses. V3 states if a resident has a diagnosis of a severe mental illness, then the diagnosis should be entered into the screening agency system for the resident. V3 states the information she enters the screening agency website will determine rather or not a PASARR level II is generated for the resident. V3 states if resident information is entered incorrectly, then there is a possibility that an incorrect PASARR screening could be generated for the resident. V3 states now that she is aware, she will update all the residents' information in the PASARR screening system to ensure an accurate PASARR screening is completed for the residents. 1.) R1s' Face sheet documents that R1 is a [AGE] year-old female admitted to the facility on [DATE], with diagnoses not limited to: major depressive disorder, generalized anxiety, and bipolar disorder. Record review documents that R1 has an initial OBRA Level I Pre-Admission Screening and Resident Review/PASARR dated 03/25/2002. There is no documentation to show that R1 was screened for a Level II PASARR. 2.) R30s' Face sheet documents that R30 is a [AGE] year-old female admitted to the facility on [DATE] with diagnoses not limited to: major depressive disorder, anxiety disorder, psychotic disturbance, and unspecified psychosis. Record review documents that R30 has an initial OBRA Level I Pre-Admission Screening and Resident Review/PASARR dated 11/12/2020. There is no documentation to show that R30 was screened for a Level II PASARR. Facility policy dated 08/31/2024, titled Request for Criminal History Record and Screenings documents in part, Procedure: The Social Service department will initiate a PASRR screening through . its designee responsible for the screening required. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	49666 3.) R23's Face sheet documents that R23 was admitted to the facility on [DATE]. R23 has a diagnosis of bipolar disorder, current episode manic severe with psychotic features with onset date 11/11/2020. Record reviewed documents that R23 has an initial Level 1 Pre-Admission Screening and Resident Review/PASARR dated 05/18/2017, documents in part based upon all information and data available to me for this person there is a reasonable basis for suspecting DD (developmental disability), or MI (mental illness) and the noted response is no. There is no documentation to show that R23 was screened for a Level 2 PASARR. On 03/06/25, 4:11 PM, V3 (Social Service Director/Admissions) states that the diagnosis of bipolar disorder, current episode manic severe with psychotic features is a mental illness. V3 states I don't think I updated the diagnosis in maximus or assessment pro. V3 continues to state I wasn't here in 2020. 45001 4.) According to R35's face sheet provided by facility, R35 has diagnoses that include but are not limited to anxiety disorder, schizoaffective disorder, benign prostatic hyperplasia. R35's initial admitted is 9/15/2022. Facility provided R35's Notice of PASRR Level 1 Screen Outcome, review date 9/2/2022 that read in part: PASRR Level 1 Determination: Refer for Level II Onsite, Suspected or confirmed PASRR Condition(s): (MH) Mental Health Disability and (ID) Intellectual Disability. Reviewed Interagency Certification of Screening Results, dated 9/12/2022. Document has no indication that it is a PASARR level 2. Facility is not able to provide a Notice of PASARR level 2 Screen Outcome for R35. On 3/6/25 at 3:50 PM, V3 (Social Service Director/Admissions) stated I've been doing PASARR (pre-admission screening and resident review) since it first started, approximately two years ago. I have to make sure I go into Maximus to see if the resident needs a PASARR level 2. I put in residents' demographics, chart information, mental illnesses into the Maximus system. I've never had an incorrect PASARR. The purpose of PASARR is to make sure the resident is nursing home appropriate. If the nursing home is the correct setting. The system asks for medical chart and medications. I don't remember if it asks for diagnoses. I am the only one that inputs information. Residents that have SMI (severe mental illness) should be referred for a PASARR level 2. They are referred through Maximus. All the information I put in (demographics, chart info, medications taken) lets Maximus know if to come out for a PASARR level 2. According to R35's PASARR level 1 outcome, R35 had a mental disability and they had to come out and see R35. Residents get a PASARR level 1 first. Dependent on what I input, determines if the resident requires a PASARR level 2. Personally, I feel bipolar, and major depressive disorder are not a SMI. Psychosis and schizophrenia are SMI. I have to go by the screening agency.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45001 Based on observation, interview and record review, the facility failed to adhere to nursing standards of practice by preparing/pre-cupping medications and documenting in advance of administration for four (R5, R15, R19, R20) of 5 residents reviewed for medications in a total sample of 12. Findings include: On [DATE] at 8:50 AM, reviewed second floor medication room with V5 (Registered Nurse) observed: - three medication cups with medications in them and a name printed on the cup - one medication cup with crushed medications and apple sauce in it and a name printed on the cup 1.) R5's physician order summary provided by facility reads in part: diltiazem HCL oral tablet 120mg three times a day for hypertension, hydralazine HCL oral tablet 25 mg three times a day for hypertension, Lasix oral tablet 20mg in the morning for hypertension, losartan potassium oral tablet 100mg one time a day for hypertension, metoprolol tartrate oral tablet 50mg two times a day for hypertension. 2.) R15's physician order summary provided by facility reads in part: lisinopril oral tablet 40mg in the morning for hypertension. R15's Medication Administration Audit Report provided by facility indicates R15's morning medications on [DATE] were administered at 8:04 AM and documented at 8:06 AM by V5 (Registered Nurse) 3.) R19's physician order summary provided by facility reads in part: amlodipine besylate oral tablet 2.5mg one time a day for hypertension, carvedilol oral tablet 6.25mg two times a day for hypertension. R19's Medication Administration Audit Report provided by facility indicates R19's morning medications were administered at 7:34 AM and 7:35 AM. This was documented at 7:35 AM by V5 (Registered Nurse) 4.) R20's physician order summary provided by facility reads in part: amlodipine besylate oral tablet 5mg one time a day for hypertension, hydrochlorothiazide oral tablet 6.25mg in the morning for hypertension, losartan potassium oral tablet 100mg in the morning for hypertension. On [DATE] at 9:04 AM, V5 (Registered Nurse) stated medications are not supposed to be prepared/pre-cupped early. Writer asked V5 to identify the residents named on the cups and identify each tablet and/or capsule in the medication cups. V5 verbalized the four resident names written on the cups. V5 stated V5 cannot tell what medications are in the cups. V5 stated the four residents whose names are on the cups had not received their medications. V5 stated V5 had already documented in the electronic medical record that R15 and R19 whose names were written on two of the cups, received their medications even though they had not. V5 stated you have to make sure the resident takes the medication before documenting it. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 1:28 PM, V2 (Director of Nursing) stated on the second floor, some residents go to the medication room and for some residents the nurse goes to their room. When the resident is in front of the nurse, the nurse opens the residents' chart, looks at what medication they are taking, confirms the right medication, right dose, right time, and right resident, all the rights of medication administration. At that time, the nurse takes the medications from the bingo cards or the bottles. The nurse checks that the medication is not expired as well. No nurse is supposed to pre-pour the medications. That's nursing 101. That's room/risk for medication error. Nurses should not be pre-pouring medications. The medications are clicked/signed out on the MAR (medication administration record) as soon as it is administered to the resident. The nurse should make sure the resident took the medication before documenting/signing that they took it. It should not be sign-out until the medication is given to the resident and is swallowed. It should not be signed out prior to. What if the resident refused the medications, it was entered into the system incorrectly. On [DATE] at 2:55 PM, V4 (Registered Nurse) stated we are not supposed to pre-cup medications before administration. You can make a mistake and the resident may refuse. Pertaining to blood pressure medication, the blood pressure may be too low to give the medication and now you don't know which pill the blood pressure pill is to pull out. Some pills look alike. According to bulletin, Pre-pouring Medications: A Risky Approach, from the Institute for Safe Medication Practices Canada, found at https://ismpcanada.ca/bulletin/pre-pouring-medications-a-risky-approach/, Pre-pouring is a behavior that puts patients at risk and is not recommended for the following reasons: often involves removal of the medication from packaging that identifies the medication and/or the intended recipient.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45001 Based on observation, interview and record review, the facility failed to ensure expired medications were not available to administer to residents. This failure has the potential to affect all residents that receive medications from the first-floor medication cart and the second-floor medication room. Findings include: On 3/4/25 at 10:00 AM, reviewed first floor medication cart with V4 (Registered Nurse) observed: - geri-lanta antacid/antigas with expiration date 02/25 - calcium 600mg with expiration date 02/25 - folic acid 400mcg with expiration date 02/25 - centrum silver with expiration date 02/24 On 3/5/25 at 8:50 AM, reviewed second floor medication room with V5 (Registered Nurse) observed: - vitamin C 500mg with best by date 02/25 - five bottles of Glucerna with expiration date [DATE] On 3/4/25 at 10:26 AM, V4 (Registered Nurse) stated there should not be expired medications in the medication cart or medication room. It is believed that expired medications have lost their potency. The expired medication will not be effective, it will not do what it is supposed to do and that will not help the resident. The resident will not get the maximal effect. On 3/5/25 at 9:04 AM, V5 (Registered Nurse) stated there should not be expired medications and meal supplements in the medication cart or medication room. If expired medications were given to the residents, it could be harmful, cause a stomachache or some adverse reaction. On 3/6/25 at 1:28 PM, V2 (Director of Nursing) stated there should not be expired medications in the medication carts or in the medication rooms. There should not be expired supplements in the medication carts or medication rooms. There should not be expired medications because it may be a hazard to the residents, there may be side effects. The medication may not be as effective as it is supposed to be. There is a reason there is an expiration date and it should be followed. Facility policy Medication Storage and Administration, 8/2022, reads in part: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner. No expired or discontinued medications shall be stored with stock, house, routine, or PRN medications that are readily available for administration.

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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** 45000 Based on observation, interview, and record review, the facility failed to follow proper sanitation and food storage practices as evidenced by a.) food not properly labeled, b.) food not properly stored, c.) equipment used for food preparation not properly sanitized, and d.) dishwasher temperatures not reaching at least 160 degrees Fahrenheit during the wash cycle. These deficient practices have the potential to affect all 43 residents receiving food prepared in the facility kitchen. Findings include: On [DATE] at 9:39 AM during initial kitchen tour with V7 (Dietary Manager), the following food items were found in the dairy walk-in cooler: 1. 1 package of opened cream cheese wrapped in clear plastic wrap, no open date, no expiration date or use by date labeled on cream cheese. The following food items were found in the prep walk-in cooler: 1. 7 containers of pureed fruit cups individually wrapped in clear plastic wrap, no preparation date, or use by date labeled on fruit cups. 2. 1 round sheet cake labeled with an expiration date of [DATE]. 3. 1 box of lettuce and tomatoes with a use by date of [DATE]. The following food items were found in the bread walk-in cooler: 1. 2 packages of six grain bread with an expiration date of [DATE]. Upon entering the vegetable cooler with V7, surveyor smells a strong, foul, rotten, odor. V7 makes surveyor aware that V7 smells the foul odor also. The following food items were found in the vegetable walk-in cooler: 1. Multiple packages of radishes with a receive date of [DATE]. 2. Multiple packages of shredded carrots that are mushy and slimy, with a receive date of [DATE]. 3. 3 clear packages of spinach that is wilted and discolored and has a dark and light green color, with a receive date of [DATE]. 4. 1 box of whole cucumbers with a white and green furry substance growing on the cucumbers. 5. 1 box of multiple heads of lettuce wrapped in clear plastic that is wet and discolored with a dark green color, with a receive date of [DATE]. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	6. Multiple bags of red seedless grapes with a white and green furry substance growing on the grapes. 7. 1 box of multiple bulbs of garlic and multiple ginger roots with a green furry substance growing on the garlic and ginger. 8. 1 box of multiple heads of cauliflower wrapped in clear plastic that is wet and discolored with a black color, with a receive date of [DATE]. On [DATE] at 10:26 AM the following items were found in the dry storage area: 1.Multiple boxes of food items sitting on the floor. At 10:28 AM, dry, bulk storage containers labeled oatmeal, flour, and sugar observed without a date on the bulk storage containers. On [DATE] at 10:30 AM, V7 states all opened food items stored in the walk-in coolers should have an open date, use by date, or expiration date labeled on the food items. V7 states the facility recently had a delivery, which is why the boxes/food items were left sitting on the floor. V7 states food items stored in the dry storage room should be stored on a shelf at least 6 inches off of the floor. V7 states the dry, bulk containers should be labeled with a use by date on them. V7 states all expired food items found in the walk-in coolers should not be stored in the walk-in coolers available and intended for resident use. V7 states produce items should be discarded after at least 14 days after the receive date. V7 states the green and white furry substance growing on the food items appear to be mold. V7 states molded food items are inedible and should be discarded immediately. V7 states if residents consume expired or molded food items, the residents could acquire a food borne illness and become sick due to bacteria. On [DATE] at 10:35 AM, during tour of the dish washing area with V7 (Dietary Manager), surveyor requested V9 (Dishwasher) to test the temperature of the cleaning cycle with V7 present. V9 places a testing strip on a blue plastic bowl and put it inside the dishwasher and ran the cycle. As the dishwasher cycle ran, the wash temperature gauge was observed at 140 degrees Fahrenheit, and the rinse temperature gauge was observed at 185 degrees Fahrenheit. Once the dishwasher cycle completed, the testing strip remained white in color and did not turn black in color. V7 states if the dishwasher reaches the correct temperature, then the testing strip will turn black in color to indicate that the dishware has been sanitized properly. V7 states the dishwasher is a high temperature dishwasher and the dishwasher temperature should reach at least 160 degrees Fahrenheit. V9 then places another testing strip on the blue plastic bowl and ran the dishwasher cycle again. The second testing strip does not turn black and remained white color. V7 is made aware that both test strips did not turn black and remained white in color. V7 states she is not sure why the test strips are not turning black in color because the facility recently received the new dishwasher approximately , d+[DATE] months ago. On [DATE] at 10:44 AM, V9 tests the dishwasher temperature two more times, and a fourth testing strip does not turn black, indicating the correct dishwasher temperatures were not reached. V9 and V7 states the test strips are not turning black because the test strips are not being placed on metal dishware prior to running and testing the dishwasher. V7 states if the correct temperatures are not reached for the dishwasher, then dishware will not be sanitized properly, and residents could potentially get food poisoning. (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 11:03 AM, V9 (Dishwasher), V7 (Dietary Manager), and surveyor located next to the three-compartment sink inside of the kitchen. V9 states the facility uses quaternary solution to sanitize dishes washed in the three-compartment sink. V9 observed testing the quaternary solution in the designated sanitize compartment of the three-compartment sink. V9 observed using test strips to test the quaternary solution. V9 observed immersing the test strip in the solution for approximately 5 seconds and test strip turns blue in color. V9 places the test strip next to the test strip package to compare the colors. V9 states the blue color does not show on the package. V9 observed immersing another test strip in the solution for approximately 3 seconds and test strip remains yellow in color. Surveyor asks V9 what the correct ppm is reading for the test strip he immersed in the quaternary solution. V9 states the test strip reading is 200 ppm and matches the green color on the package. Surveyor asks V9 how long he should immerse the test strip in the solution in the sanitize compartment of the sink. V9 states he usually does not keep count of how long he immerses the test strip. V9 states he does not believe he immersed the test strip long enough in the sanitize solution in the three-compartment sink. On [DATE] at 11:18 AM, surveyor located in the kitchen and requested V10 (Dishwasher) to test the temperature of the cleaning cycle with V7 present. V10 places a testing strip on a white glass bowl and put it inside the dishwasher and ran the cycle. As the dishwasher cycle ran, the wash temperature gauge was observed at 140 degrees Fahrenheit, and the rinse temperature gauge was observed at 190 degrees Fahrenheit. Once the dishwasher cycle completed, the testing strip remained white in color and did not turn black in color. V10 states he usually tests the dishwasher temperature using a metal piece of dishware and the strip turns black in color. V10 then places a test strip on a metal bowl and put it inside the dishwasher and ran the cycle. As the dishwasher cycle ran, the wash temperature gauge was observed at 140 degrees Fahrenheit, and the rinse temperature gauge was observed at 190 degrees Fahrenheit. Once the dishwasher cycle completed, the testing strip remained white in color and did not turn black in color. On [DATE] at 11:40 AM, surveyor observes V8 (Cook) preparing and cooking food in the kitchen without a hair net on his head. V7 (Dietary Manager) is made aware and states anyone located in the kitchen should have on a hair net because it is a requirement. Facility policy dated 2017, titled Dishwashing Machine Operation documents in part, Paper thermometers are used to determine correct rinse temperature of the dishwashing machine. Facility policy undated, titled, Manual Sanitizing in Three-Compartment Sink documents in part, In determining the correct concentration of the sanitizing solution and the length of immersion time, manufacturer's instructions are followed. Facility policy dated 2017 titled, Refrigerated Food documents in part, Foods are labeled with the date received and if not opened, are discarded by the manufacturer's expiration date. If opened, the cold food item is labeled with the date opened and the date by which to discard or use by. Facility policy undated, titled, Labeling and dating foods documents in part, Packaged or containerized bulk food may be removed from the original package and stored in an ingredient bin labeled with the common name of the food, the date the item was opened and the date by which the item should be discarded or used by. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146185	A. Building B. Wing	03/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Little Sisters of the Poor	2325 North Lakewood Avenue Chicago, IL 60614

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility policy dated [DATE] titled, Hair Restraints documents in part, Hairnets will be worn at all times in the kitchen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49666 Based on interview and record review, the facility failed to have an appropriate policy and procedure to ensure residents are offered a pneumococcal immunization. The facility also failed to offer and provide pneumococcal vaccination for 5 residents (R6, R23, R31, R32 and R40) out of 5 in a sample of 12. Findings include: On 03/06/2025 at 9:29 AM, V2 (Director of Nursing) states that she is the infection preventionist nurse and manages residents' immunization records. V2 states that she keeps the resident's immunization record in their electronic medical record (EMR) under immunization tab and she also uploads the consents in their EMR. V2 reports that every year they do the flu and Covid-19 vaccines. Right now, they are working on getting the Pneumococcal vaccine clinic set up. V2 states that when there is a new admission, their immunization record is checked and if they need a recommended vaccine, the facility offers it. V2 states that it is documented in the resident EMR if the resident refuses. V2 states that the pneumococcal vaccine is good enough up until 5 years. V2 states that they must have a certain amount of number of residents who are interested in the Pneumococcal vaccine. V2 states that the resident council that just happened on Monday. V2 spoke about it with the residents, and many were interested. V2 states that they are waiting to pick a date when the clinic will come to administer the pneumococcal vaccines. R31's pneumococcal vaccine (Prevnar 13) dated 08/12/2015. There is no documentation noted that R31 was offered a pneumococcal vaccine since then. R32 received pneumococcal vaccine (Prevnar 13) on 1/13/2022. There is no documentation noted that R32 was offered a pneumococcal vaccine since then. R23 received pneumococcal vaccine (Prevnar 13) on 10/08/2019. There is no documentation noted that R23 was offered a pneumococcal vaccine since then. R40 does not have pneumococcal vaccine on record and no documentation noted that R40 was offered a pneumococcal vaccine. R6 refused the influenza and Covid-19 but there is no documentation that R6 refused or was offered pneumococcal vaccine. Facility document dated 08/2017, titled vaccine, pneumococcal documents in part the pneumovax is made available to all residents of the home. It will be administered to all residents who wish it unless there is a history of it already being given within five (5) years and if resident was <[AGE] years of age at the time of vaccination, or if medically contraindicated. Purpose to protect residents from pneumococcal infection. Centers for Disease Control and Prevention website documents in part Adult Immunization Schedule by Age [AGE] years or older who have: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Not previously received a dose of PCV13, PCV15, PCV20, or PCV21 or whose previous vaccination history is unknown: 1 dose PCV15 or 1 dose PCV20 or 1 dose PCV21. If PCV15 is used, administer 1 dose PPSV23 at least 1 year after the PCV15 dose (may use minimum interval of 8 weeks for adults with an immunocompromising condition, * cochlear implant, or cerebrospinal fluid leak). Previously received only PCV7: follow the recommendation above. Previously received only PCV13: 1 dose PCV20 or 1 dose PCV21 at least 1 year after the last PCV13 dose.