STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146186	A. Building B. Wing	03/06/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Alden Estates Cts of Huntley	12140 Regency Parkway Huntley, IL 60142

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39543 Based on observation, interview, and record review the facility failed to ensure a video posted to a staff member's personal social media account did not include identifiable resident images and the facility failed to ensure residents at a dining table were served at approximately the same time. This failure applies to five residents R77, R24, R25, R62 and R120 reviewed for resident rights on the total sample list of 29. The findings include: 1. R77's Admission Record (Face Sheet) documents an admitted [DATE] with diagnoses including senile degeneration of the brain, anxiety, and depression. R77's 2/13/25 Quarterly Minimum Data Set (MDS) showed he had moderate cognitive impairment with a Brief Interview for Mental Status (BIMS) score of 9 out of 15. On 3/6/25 at 11:08 AM, V15 Memory Care Executive Director confirmed that V23 Memory Care Director posted a video of a code blue drill to his personal social media account. V15 stated that while the video was intended to feature V23, it also depicted R77. V15 confirmed the facility did not authorize the posting and that such posting to a personal social media account is not an approved use under the facility's consent policy. V15 expressed concern regarding resident dignity. On 3/6/25 at 11:27 AM, V1 Administrator stated she was aware of the incident with R77. V1 stated she did not view the video, she understood it depicted a resident. V1 said she did not believe it was V23's intent to show a resident in the video and it was an accident. V1 said, I don't think anyone should be scrolling through and see a family member in a social media post. V1 said posting a video to a staff member's personal social media account, which shows resident's, would not be respecting the resident's dignity. V1 said V23 should have been more careful. On 3/6/25 at 11:42 AM, V23 said he posted the video of the code blue drill to his personal social media account. V23 said he was notified by staff that they did not want to be in the video, so the video was deleted. V23 said the R77's face was not visible; however, the side profile of his face was visible in the video. V23 said he did not believe there was a policy stating he could not post videos of residents to her personal social media page. V23 said, twice, I would have to get the resident or family's permission and if I did get that permission, I could post it [a video with residents] to my own personal [social media video] page. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility's Social Media Policy (undated) showed, Employees may not use or disclose any resident identifiable information of any kind on any social media site. This includes photographs of residents. Even if an individual is not identified by name within the information you wish to use or disclose, if there is a reasonable basis to believe that the person could still be identified from that information, then its use or disclosure could constitute a violation of the Health Insurance Portability and Accountability Act. On 3/6/25 at 12:18 PM, stated the facility uses the Ombudsman program resident right pamphlet as their dignity policy. The State of Illinois Residents' Rights for People in Long-term Care Facilities showed, Your facility may not give information about you or your care to any unauthorized person(s) without your permission. R77's [The Facility's] Photo Consent, signed 3/10/2020, showed I give [the facility] consent to use my loved one's likeness to be used for Activity Photo Purposes and to be sent out via Family Newsletter. The consent does not show staff's personal social media pages as an accepted posting site. 20042 2. On 3/5/25 at 10:30 AM during the Resident Council Group Meeting they stated when sitting at their table for meals one person maybe served and then 45 minutes later another person at the table will get served. They stated they were all at the table at the same time when this happens. They stated their food should be served at the same time so they can eat together. On 3/6/25 at 11:19 AM, R24 was sitting in her wheelchair at the dining room table and was served her lunch. At 11:22 AM, R62 arrived at the dining room in her wheelchair and sat at the table with R24. At 11:26 AM, R25 came into the dining room in her wheelchair and sat at the table with R24 and R62. At 11:29 AM, R120 walked into the dining room and sat in a chair at the dining room table with R24 and R62. At 11:39 AM, R62 was served her drinks and lunch. At 11:41 AM, R25 was served her lunch and drinks. At 11:47 AM, R120 was served her drinks, her main meal of spaghetti and vegetables. R120 did not receive her mashed potatoes or dessert. R120 did not have any silverware. On 3/6/25 at 11:48 AM, V21 (Activity Aide) stated the first people into dining room get served first. Then it gets busy and sometimes it takes longer. It also takes longer if we don't have enough of the dishes for someone that orders something else. Today some dishes needed to go down to be cleaned. They didn't get cleaned from this morning; so there aren't enough dishes. R120 is waiting for her mashed potatoes and fruit because there aren't enough plates/bowls to serve it. This happens frequently. Sometimes one person at a table will get food and then 30 minutes later someone else will get their food. I have had people complain about it so I told V6 (Dietary Supervisor). It tends to happen more at dinner. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 3/6/25 at 11:51 AM, R24, R25, R62 and R120 stated they should get served at the same time and did not like being served at different times. They stated they wanted to be able to eat their meals together. R120 continued to wait for silverware. R24 stated they did not have enough clean dishes to give R120 her food (mashed potatoes and dessert). At 11:53 AM, R120 stood up and walked to the middle of the dining room. V22 (Activity Aide) asked R120 if she was okay and if she needed anything. R120 replied that she needed silverware. At 12:03 PM, R24 called V22 over to the dining room table to remind V22 that R120 still had not received her mashed potatoes. At 12:05 PM, V22 brought R120 her mashed potatoes. R120 still did not receive her dessert. R120's meal ticket dated 3/6/25 for the lunch meal showed she was supposed to receive cookies as a dessert. At 12:11 PM, V22 was asked if R120 could get her dessert. V22 looked at R120's meal ticket and stated she is supposed to receive cookies for dessert. At 12:12 PM, V22 brought R120 her cookies. The meal ticket dated 3/6/25 for R120 showed she was supposed to receive spaghetti, vegetable, mashed potato, desert, water, gingerale and fruit. R120 never received any fruit. On 3/6/25 at 12:17 PM, V6 (Dietary Supervisor) stated meals times are 7:00 AM for breakfast, 11:00 AM for lunch, and 4:30 PM for dinner. V6 stated anyone that comes into the dining room first is served first V6 stated they start doing the room trays. They try to get through as quickly and accurately as possible. V6 stated there are standing orders on residents meal tickets. V6 stated they can flip the meal ticket over to the other side and circle what they want for meals. V6 stated staff will read the ticket and they serve the food according to what is on the ticket as long as it follows the residents dietary recommendations. V6 stated he was not aware of residents waiting for food unless they were residents that needed to be fed. V6 stated he was not aware of not having enough clean dishes to serve food to residents. V6 stated he was aware that residents seated at a table together wanted to be served together at the same time. The MDS (Minimum Data Set) dated 1/13/25 for R120 showed no cognitive impairment. The MDS dated [DATE] for R25 showed no cognitive impairment. The MDS dated [DATE] for R62 showed no cognitive impairment. The MDS dated [DATE] for R24 showed no cognitive impairment. The facility's Dining Room Meal Service policy (3/18) showed food will be served in a manner that is appealing to the senses. meals are delivered to the resident by the assigned staff for the dining room. The policy did not show all residents at a table would be served together. The Residents' Right for People in Long-term Care Facilities brochure by the Illinois Long Term Care Ombudsman Program (4/24) showed, you have the right to safety and good care. Your facility must provide services to keep your physical and mental health, and sense of satisfaction. Your facility must make reasonable arrangements to meet your needs and choices.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 41639 Based on observation, interview, and record review, the facility failed to follow professional standards of practice for the administration of oxygen for 1 of 5 residents (R38) reviewed for respiratory care in the sample of 29. The findings include: R38's electronic face sheet printed on 3/6/25 showed R38 has diagnoses including but not limited to acute respiratory failure with hypoxia, sepsis, chronic diastolic congestive heart failure, and dysphagia. R38's physician's orders dated 2/20/25 showed, Oxygen per nasal cannula at 2-4 liters per minute continuous. R38's care plan dated 12/30/24 showed, (R38) requires oxygen therapy .administer oxygen per physician's orders. On 3/4/25 at 9:53AM, V9 and V10 (Certified Nursing Assistants-CNA's) provided personal cares to R38. Upon completion of personal cares, V10 applied oxygen via nasal cannula at 4L to R38. V9 and V10 stated the CNAs are allowed to administer oxygen and it is not a physician's order. V10 stated the CNAs are able to look in their task list to see what liter flow the residents are supposed to be on. On 3/6/25 at 10:15AM, V7 (Registered Nurse) stated, (R38) is on continuous oxygen due to her congestive heart failure. The nurse's usually set and apply oxygen for the residents, but I think the CNA's can do it as well. Usually, they come and ask the nurses to verify the liter flow, but I don't see any reason why they can't do it. It's a simple procedure. On 3/6/25 at 11:41AM, V2 (Director of Nursing) stated, Oxygen is to be applied by the nurse's only because it's out of the CNA's scope of practice. The nurse is the only one who can ensure the oxygen is set at the correct liter flow according to physician's orders. The facility's policy titled, Oxygen therapy devices-nasal cannula dated 02/11 showed, 1. Verify physicians order .these guidelines are not meant to be excusive or exhaustive. Guidelines are meant to leave room for the exercise of professional judgement based on individual circumstances.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41639 Based on observation, interview, and record review, the facility failed to obtain daily weights for a resident (R38) with congestive heart failure, failed to assess and perform dressing changes for a resident with a surgical wound (R242), failed to provide skin care for a resident with reddened skin (R86). These failures apply to 3 of 4 residents reviewed for quality of care in the sample of 29. The findings include: 1. R38's electronic face sheet printed on 3/6/25 showed R38 has diagnoses including but not limited to acute respiratory failure with hypoxia, sepsis, chronic diastolic congestive heart failure, and dysphagia. R38's physician's orders dated 2/21/25 showed, Daily weight notify physician if patient gains more than 5lbs (pounds) in a week. R38's care plan dated 2/21/25 showed, (R38) has a diagnosis of CHF (Congestive heart failure), has potential for impaired gas exchange, edema, and respiratory distress .(R38) utilizes diuretic to manage edema and is therefore with a potential for dehydration .monitor for fluid excess (weight gain, elevated blood pressure .monitor weight as ordered . R38's progress notes dated 12/28/24 showed, admitted to facility from local hospital due to CHF exacerbation, BLE (bilateral lower extremity) swelling .on fluid restriction . R38's weight log showed R38's weight was not obtained on 2/27/25. R38's weight on 2/28/25 was 164.2lbs which was a 5.4lb weight gain within 48 hours. Additionally, R38's weight was not obtained on 2/23/25 or 3/2/25 as ordered by R38's physician. On 3/6/25 at 10:15AM, V7 (Registered Nurse) stated, (R38) has congestive heart failure and she has orders for daily weights to be performed and we should notify her physician if she gains more than 5lbs in a week. If daily weights are not done, she could go into fluid overload and experience CHF exacerbation. The weights are a starting point for us so if there is an increase in weight, we would do further assessments on her to ensure she is not in exacerbation. On 3/6/25 at 11:41AM, V2 (Director of Nursing) stated, The CNA's (Certified Nursing Assistants) and nurse's work together to obtain the weights. Either staff member can enter the weights but for a CHF resident, the nurse will have to enter it on the medication administration record because it is a physician's order. As managers we make sure the weights are getting done. It is important to obtain weights on a resident with CHF to ensure they are not going into fluid overload or becoming dehydrated. On 3/6/25 at 12:13PM, V4 (R38's physician) stated, If a resident has an acute decompensation, then we would need the daily weights to determine their fluid status and to ensure they do not become dehydrated or overloaded with fluid. I would prefer they would do it as ordered but it's not a huge jump for her when they missed a day. I would like them to obtain consistent weights to determine their trend. If you lose the consistency, then you can't see the trend. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled, Weights dated 09/2020 showed, Residents will be weighed to establish baseline weights and identify trends of weight loss or weigh gain. 34491 2. R242's Admission Record, printed by the facility on 3/6/25, showed she had diagnoses including, but not limited to, displaced intertrochanteric fracture of right femur with subsequent encounter for closed fracture with routine healing (right hip fracture and surgical procedure to repair), anxiety disorder, muscle weakness, presence of left artificial knee joint, primary osteoarthritis, and glaucoma. The Admission Record showed no diagnosis of dementia, Alzheimer's disease, or other cognitive dysfunction. On 3/4/25 at 9:40 AM, R242 was sitting up in bed. R242 was alert and oriented. R242 said she had been at the facility for five days. R242 said the dressing to her right hip has not been changed since she was admitted to the facility. R242 said the dressing should have been changed. At 12:14 PM V14 (Certified Nursing Assistant/CNA) assisted R242 with rolling onto her left side and pulling down her pants so an observation of her right hip dressings could be observed. R242's right hip had two areas with white dressings. A large (transparent) dressing covered the entire surgical area. R242 said that is the bandage that was put on in the hospital. V14 agreed and said that is the same dressing R242 was admitted with. R242's March 2025 TAR (Treatment Administration Record) showed an order to change R242's right hip dressing 3 days after surgery, daily, on day shift. V8 signed off as having done the dressing change to R242's right hip on 3/1/25 and 3/2/25 on the day shift. On 3/5/25 at 8:49 AM, R242 said one of the nurses changed the dressing to her right hip yesterday and did an assessment. R242 said it was the first time it was done since her admission. On 3/5/25 at 4:27 PM, V8 (Registered Nurse-RN) said she was R242's nurse on 3/1/25 and 3/2/25. V8 said she changed the dressing to R242's right hip on 3/1/25 and 3/2/25. V8 was asked what the treatment was to R242's right hip. V8 said she thinks it was a large island dressing. V8 described the dressing as a large white dressing with softer material in the middle and adhesive around the edges. V8 was asked if she did an assessment of R242's surgical wound and documented the assessment. V8 said she assessed R242's surgical wound but did not document an assessment of the wound site. V8 was asked what the surgical site looked like. V8 said she charts by exception and did not see anything concerning that she would need to notify R242's doctor for. V8 said she did not know if she was the first one to remove the dressing from the hospital, and did not know if there was a documented full assessment of the wound site prior to her changing the dressing on 3/1/25. V8 said she did not measure the surgical site. V8 was asked if sutures or staples were used to hold the surgical incision together. V8 said she did not recall, but thinks it was staples. On 3/5/25 at 1:29 PM, V11 (Wound Nurse/RN) said initially the admitting nurse does the initial assessment. They go through the resident's AVS (after visit summary from the hospital) and do a reconciliation with the resident's physician. At 1:33 PM, V11 said if any changes were made to the wound treatments, it would either be documented in the initial assessment, or in the resident's progress notes. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/6/25 at 9:08 AM, V8 entered R242's room carrying supplies for her right hip dressing change. V8 had a large white bordered dressing with adhesive edges. R242 had three incisions to her right hip/upper-thigh area from the hip surgery. Staples were used to hold the surgical incisions together. V8 cleaned the areas, then went to apply the dressing. V8 was asked if that was the same type of dressings she used when she did the dressing changes on 3/1/25 and 3/2/25. V8 replied yes. The large white dressing did not cover all three incisions. V8 had to fold over the end of the dressing and go out of the room to get another dressing. V8 returned to R242's room and placed another partial dressing that she had cut over the bottom incision. On 3/6/25 at 9:59 AM, V11 (Wound Nurse) said treatment supplies are kept in the treatment carts. V11 said she was not sure if the facility had any large tegaderm or large transparent dressings. V11 said the facility usually does not get them for stock supplies. V11 identified V24 (Unit Manager/CNA) as the staff responsible for ordering house-stock supplies. V11 said wound assessments are initially done when the patient first arrives. Skin checks are part of the initial assessment. V11 said We do not normally document surgical wounds. V11 said she did an assessment of R242's surgical wound on 3/4/25 (the day the annual survey was initiated). V11 said the information from R242's after visit summary from the local hospital showed her dressing was to remain in place for three days after surgery. V11 said typically there should be an assessment completed and documented the first time the dressing is removed. V11 was asked what day R242's surgery was done. V11 said she would have to look to see when her surgery was done. V11 said if R242's surgery was done on 2/25/25, then the first dressing change should have probably been done on 2/28/25. On 3/6/25 between 10:12 AM-10:30 AM, this surveyor reviewed the treatment carts and medication rooms on the second and third floors with V11. No large tegaderm or transparent dressing were found. V11 said the only large transparent dressings she is aware of are in sealed wound vac kits. V11 said none of the nurses have requested a large transparent dressing from her. V11 said R242's treatment order does not call for a large transparent dressing. During that same period (at 10:16 AM) a review of the facility's central supply room was conducted with V24 (Unit Manager/CNA). V24 said she orders supplies such as bandages, tape, syringes, etc. V24 said the only supplies she cannot order are for IVs (intravenous lines). V24 said the only bandages they have for surgical hip wounds are bordered gauze w/adhesive border. V24 showed this surveyor the dressings. they were the same dressings that V8 placed on R242's right hip during the previously observed dressing change. V24 said she keeps track of the supplies in the central supply room and the facility had not had any large transparent dressings recently. At 10:30 AM, V11 (Wound Nurse) said it is important to assess wounds as soon as possible, so we can monitor progression, or identify any issues such as dehiscence (a surgical complication where a wound partially or completely separates along the incision line) or signs of infection. On 3/6/25 at 1:05 PM, V2 (Director of Nursing/DON) said the dressing changes should be completed as ordered. R242's 2/27/25 after visit summary from a local hospital showed Keep dressing in place for 3 days after surgery, after which you may remove and subsequently cover with clean, dry dressings and change as needed. R242's hospital documents, provided by the facility on 3/6/25, showed her hip surgery was performed on 2/25/25. The operative report from R242's surgical procedure was filed by the surgeon at 10:31 AM on 2/25/25. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R242's March 2025 Treatment Administration Record (TAR) showed an order dated 2/27/25 to change R242's dressing on her right hip 3 days after surgery, every day shift. The TAR showed V8 signed off as having done the dressing change on 3/1/25 and 3/2/25. The TAR showed no dressing change was signed off as being completed on 3/3/25. R242's February 2025 TAR showed no dressing change was signed off as being completed on 2/28/25. R242's progress notes were reviewed from 2/27/25-present. The only full assessment of R242's surgical wound was done on 3/4/25 at 1:04 PM (after the start of the annual survey) by V11 (Wound Nurse). The progress note showed Resident's surgical dressing changed. Site is well-approximated. Three incision sites, staples present. Nine staples to proximal incision approximately 5 x 0 x 0. Three staples to next incision approximately 3 x 0 x 0, and three staples to distal incision approximately 3 x 0 x 0. Site is free of signs of infection. No drainage, bleeding, redness, or warmth noted. R242's notes showed no new order to change the date of the dressing change to 3/1/25. R242's Initial Nursing assessment dated [DATE] showed Wound/Skin Condition: Unable to see due to dressing covered. The facility's 3/4/2021 policy and procedure titled Wound Care (Surgical) showed 6. Inspect wound for appearance, drainage, and integrity. Any sutures, staples and how many used .12. Follow MD (Doctor's) orders and apply new dressing .13. Daily evaluate resident for complaints of increasing pain, site for redness, changes in drainage amount, increase in temperature, swelling or induration (an inflammatory process that can make the skin feel firmer or thicker than normal), Report to Surgeon or Physician for further management if applicable. 20042 3. On 3/4/25 at 9:15 AM, V16 CNA (Certified Nursing Assistant) and V17 CNA were at R86's bedside to provide incontinence care. R86 had a wet incontinence brief. V16 opened R86's incontinence brief and his scrotum was reddened. V16 used disposable wipes to clean R86's groin, penis and scrotum. When V16 was wiping R86's scrotum he complained of pain and hissed. R86 stated it was cold and painful. At 9:25 AM, V18 RN (Registered Nurse) came into R86's room, applied a zinc ointment to R86's buttocks but not to his reddened scrotum and then left the room. V17 asked V16 if the nurse was going to apply the ointment to R86's scrotum. V16 did not reply. V16 and V17 put a clean incontinence brief on R86, changes his bed, changes his gown, repositioned him to a sitting position, and covered him. The Progress Notes for R86 dated 3/4/25 did not show any documentation of redness to his scrotum or any treatments applied. The Physician Orders dated 3/5/25 for R86 showed Zinc Oxide Ointment 20%; Apply to buttocks topically every shift for skin condition (use house stock) and apply to buttocks topically as needed for skin condition (use house stock) with an order date of 3/14/24. Nystatin powder 100000 unit/GM, apply to groin topically as needed for skin conditions. Cleanse area with normal saline prior to application. On 3/5/25 at 1:58 PM, V19 CNA (Certified Nursing Assistant/Unit Manager) stated if a resident has redness to their skin it is to be reported to the nurse immediately. The nurse will come in and depending on what the nurse think needs to be done they will put a cream on maybe zinc or whatever the wound nurse thinks is best to apply on resident. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/5/25 at 2:06 PM, V2 DON (Director of Nursing) stated if a CNA saw that the resident had a reddened scrotum they would notify the nurse to make sure she is aware. The nurse assess what's going on and would see if there are any orders for that. V2 stated he was not sure what happened or why the nurse did not apply cream or anything for R86's reddened scrotum. V2 stated he would go and check R86's scrotum. On 3/5/25 at 2:14 PM, V2 stated he went and looked at R86's scrotum and it was red but not that red. R86 stated he was fine and it only hurts with cleaning. V2 stated he would do some education on it. The Face Sheet dated 3/5/25 for R86 showed diagnoses including type 2 diabetes mellitus, chronic kidney disease, malignant neoplasm of the prostate, and unspecified protein-calorie malnutrition. The MDS (Minimum Data Set) dated 2/21/25 for R86 showed he is dependent for toileting hygiene and shower/bathing. The Care Plan dated 2/27/25 showed, R86 has the potential for alteration in skin integrity related to need for assistance with care, impaired mobility, and contributing medical diagnosis of type 2 diabetes mellitus, chronic kidney disease, asthma, and long term use of aspirin. R86 is noncompliant with turning and repositioning and poor nutritional intake. R86 prefers to stay in bed. Barrier cream to areas exposed to moisture/incontinence. Inspect skin daily with care. The facility's Prevention and Treatment of Pressure Injury and other Skin Alterations policy (3/2/21) showed non-pressure skin alterations i.e.: skin tears, abrasions, surgical wounds, moisture associated skin dermatitis, lesions and rashes, will be documented weekly on a skin progress note: if you are using electronic health record or on TAR (Treatment Administration Records) if using paper chart. Develop a care plan for either actual or potential alteration in skin integrity and change as needed. At least daily, staff should remain alert for potential changes in the skin condition during resident care. Moisture barrier may be applied as needed. Revise care plan approaches as needed based on resident's response and outcomes.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20042 Based on observation, interview, and record review the facility failed to ensure R74's indwelling urinary drainage bag was maintained in a manner to prevent contamination and kept below the level of the bladder for 1 of 2 residents (R74) reviewed for catheters in the sample of 29. The findings include: On 3/4/25 at 10:10 AM, R74 was sitting in a motorized wheelchair in her room. R74's catheter tubing was visible an had cloudy, yellow urine present with sediment. R74 had a dignity cover on her drainage bag that covered the top half of the drainage bag. The lower half of the drainage bag was visible and laying on her [NAME] rest behind her feet. R74 stated the drainage bag slips out the bottom all of the time. Discussed the drainage bag laying on her foot rests and R74 stated no one ever told her that it should not be there or explained anything related to infection control. R74 stated she wished there was a way to keep the drainage bag completely covered. R74 stated the drainage bag was on her foot rest because she doesn't like to keep it attached to the arm of her wheelchair because her catheter doesn't drain like it should. R74 stated the drainage bag is attached to the armrest of her wheelchair when she goes to meals. On 3/4/25 at 11:38 AM, R74 was sitting in her motorized wheelchair in the dining room. The catheter drainage bag was attached to the armrest of her wheelchair and was not below the level of the bladder. The Progress Notes for the Month of February 2025 through 3/5/25 did not show any education given to the resident related to her indwelling urinary catheter and infection control such as keeping the bag off the foot rests and floor or to keep the bag below the level of the bladder. The Face Sheet dated 3/5/35 for R74 showed diagnoses including acute kidney failure, methicillin resistant staphylococcus aureus, cellulitis of right lower limb, type 2 diabetes mellitus, muscle weakness, abnormalities of extremities and gait, chronic venous hypertension, anemia, chronic kidney disease, peripheral vascular disease, hypertension, and congestive heart failure. The Physician Orders dated 3/5/25 for R74 showed, may use indwelling urinary catheter size 16, size 10 balloon due to urine retention per urologist; indwelling urinary catheter care daily and as needed; may change catheter bag as required due to sediment, staining, or contamination. The MDS (Minimum Data Set) dated 1/13/25 for R74 showed no cognitive impairment; dependence for toileting hygiene and lower body dressing; and substantial/maximal assistance needed for upper body dressing. The Care Plan dated 1/19/25 for R74 showed, R74 requires the use of an indwelling catheter. Catheter care per orders. Keep drainage bag covered to promote privacy. The care plan did not show any intervention related to keeping the drainage bag below the level of the bladder and to keep the drainage bag off the floor/foot rests. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Indwelling Catheter Policy (9/2020) showed, Place drainage bag below the level of the resident's bladder to facilitate drainage and minimize stasis of urine. A sterile, continuously closed drainage system will be maintained for indwelling and suprapubic catheter systems.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 38488 Based on observation, interview, and record review the facility failed to ensure food preparation was completed in a manner to prevent cross contamination. This applies to 15 of 15 residents (R4, R14, R79, R119, R36, R61, R5, R97, R52, R449, R3, R107, R82, R70, R240) reviewed for cross contamination in the sample of 29. The findings include: On 3/6/25 at 1:00 PM, the facility provided a list of residents on a pureed diet which included R4, R14, R79, R119, R36, R61, R5, R97, R52, R449, R3, R107, R82, R70, and R240. On 3/4/25 at 10:40 AM, V5 (Executive Chef) was preparing the pureed foods for service. V5 placed a glove on his right hand and scooped servings of meatballs into a container to take to the blender. V5 took the container of meatballs to the blender and used his gloved hand to scoop the meatballs into the blender. V5 removed the glove from his right hand. No hand hygiene was completed. V5 completed the puree process pushing the buttons on the blender, touching the containers, the lid to the blender, and the handles of the utensils. V5 then scooped the servings of pureed meatballs into separate containers for the steam table. V5 went to the other side of the counter and removed a magnetic folding thermometer off the vent hood. V5 used his bare hands to open the thermometer (touching the thermometer probe) and placed the probe directly into the pureed meatballs without wiping the probe. V5 touched his uniform to remove a marker from his pocket and label the pureed meatballs. V5 started pureeing the noodles, touching the utensils and the containers, pulling at his uniform and touching his mask. Once completed, V5 went across to the other side of the counter and took another thermometer off the vent hood. Again, V5 used his bare hands to open the folding thermometer, touching the probe and not wiping the probe with alcohol prior to checking the temperature of the pureed noodles. V5 again touched his uniform to remove a marker from his pocket and label the pureed noodles. V5 proceeded to puree the vegetables in the same manner. No hand hygiene was performed during the duration of the puree process or temping of the pureed foods. On 3/6/25 at 11:06 AM, V6 (Dietary Supervisor) said handwashing or hand hygiene should be done in between tasks, anytime they are going from one task to another and all thermometers should be wiped with alcohol prior to introducing them into food products to prevent cross contamination. The facility's policy and procedure with review date of 3/18 showed, Handwashing . To reduce the risk of food borne illness through cross contamination . The facility's policy and procedure with review date of 7/2018 showed, Taking Temperatures of Food . Purpose: To reduce the risk of food borne illness from undercooking or improper holding . After taking the temperature of any food, sanitize the probe to reduce the risk of cross contamination.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 34491 Based on observation, interview and record review, the facility failed to perform a dressing change for a resident with a surgical incision in a manner to prevent cross-contamination, and failed to ensure enhanced barrier precaution (EBP) signage was on or near the doorway to a resident's room for a resident with an IV (intravenous) midline for to two of two residents (R242 and R130) reviewed for infection control in the sample of 29. The findings include: 1. R242's Admission Record, printed by the facility on 3/6/25, showed she had diagnoses including, but not limited to, displaced intertrochanteric fracture of right femur with subsequent encounter for closed fracture with routine healing (right hip fracture and surgical procedure to repair), anxiety disorder, muscle weakness, presence of left artificial knee joint, primary osteoarthritis, and glaucoma. The Admission Record showed no diagnosis of dementia, Alzheimer's disease, or other cognitive dysfunction. R242's initial Nursing assessment dated [DATE] showed she was alert and oriented to person, place and time with no confusion. On 3/6/25 at 9:08 AM, V8 (Registered Nurse-RN) performed a dressing change to the surgical wound on R242's right hip. V8 applied saline to all 3 wounds and then used the same gauze, and the same section of gauze to dab the lower incision, then the middle incision, then the upper incision. V8 used the same gauze, same section of gauze to go back and dab the middle and lower incisions, and then back up to dab the middle and upper incisions again. V8 did not use a different gauze for each site, and did not change gloves, or perform hand hygiene between incisions. On 3/6/25 at 9:59 AM, V11 (Wound Nurse) said whenever you do a dressing change, the wound should be cleaned with normal saline or soap and water. You clean one incision site then discard the gauze. V11 said a clean gauze should be used for each incision to prevent infection and cross-contamination. R242's March 2025 Treatment Administration Record, showed an order dated 2/27/25 to change the dressing on R130's right hip three days after surgery, daily on day shift. The facility's 3/4/2021 policy and procedure titled Wound Care (Surgical) showed sterile dressing and sterile technique should be used for fresh post op-patients. Often the original dressing applied in the operating room is left in place for the first 48 hours .Thereafter 1. Utilize clean/aseptic technique .3. Undress and expose only one area at a time. 4. Change dressings in order from clean to dirty. 5. After performing hand hygiene, with clean gloves, remove dressings one layer at a time, observing appearance and drainage on dressing. 6. Inspect wound for appearance, drainage, and integrity. Any sutures or staples and how many were used . 9. Perform hand hygiene. 10. Cleanse area following doctor's orders. 11. Perform hand hygiene. 12. Follow doctor's orders and apply new dressing. 13. Perform hand hygiene. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. R130's Admission Record, printed by the facility on 3/6/25, showed she had diagnoses including, but not limited to, chronic obstructive pulmonary disease, acute and chronic respiratory failure with hypercapnia (occurs when the body cannot remove excess carbon dioxide from the bloodstream, causing it to build up), and hypoxia (a condition in which the body or a region of the body is deprived of adequate oxygen supply at the tissue level), bronchiectasis (a disease in which there is permanent enlargement of parts of the airways of the lung-symptoms can include a chronic cough with mucus production, shortness of breath, coughing up blood, and chest pain), severe protein-calorie malnutrition, essential (primary) hypertension, atherosclerotic heart disease, atrial fibrillation, atrial flutter, emphysema, and dependence on supplemental oxygen. R130's Order Summary Report, printed by the facility on 3/6/25, showed she had an IV (intravenous) midline. The report showed an active order dated 2/27/25 for EBP for device care or use of midline. The report also showed an order for Piperacillin Sod-Tazobactam So Solution Reconstituted 4-0.5 GM. Use 4.5 gram intravenously every 6 hours for pneumonia for 4 Days start 3/5/25. end date 3/9/25. R130's 2/15/25 facility assessment showed she was cognitively intact. On 3/4/25 at 9:19 AM, R130 was in her room sitting up in bed receiving a nebulizer treatment. An IV pole was positioned next to R130's bed. No signage showing R130 was on enhanced barrier precautions was posted on or near R130's doorway. At 10:40 AM, when surveyor left the second floor, there was still no EBP signage on R130's doorway. At 12:17 PM, when surveyor went back up to the second floor to watch V12 (Licensed Practical Nurse-LPN) remove the completed antibiotic medication that had been administered through R130's IV midline, signage was now posted on R130's doorway showing she was on EBP precautions. At 12:27 PM, V12 performed hand hygiene and put on the appropriate PPE (personal protective equipment). V12 removed the tubing for the empty antibiotic bag. Prior to exiting R130's room, V12 removed the gown and gloves and was looking around R130's room and bathroom for an isolation bin to dispose of the PPE. After V12 exited the room, R130 said the nurse's usually do not wear a gown when they are doing anything with her IV. R130 said they wear a face mask and gloves. On 3/5/25 at 8:43 AM, there was no sign showing R130 was on EBP on or near her doorway again. At 9:15 AM, the signage was back up on R130's doorway. V1 (Administrator) was asked what would qualify a resident to be on enhanced barrier precautions. V1 said a resident is placed on EBP precautions if they have a catheter, an IV, a draining wound that cannot be contained. V3 (Infection Preventionist/Assistant Director of Nursing) walked up and added if a resident has recurrent ESBL and cannot be contained, or a chronic wound they would also be placed on EBP precautions. V3 was informed that there was no signage on R130's doorway in the morning the previous day, then around noon signage was observed on R130's doorway, and again that morning (3/5/25) there was no signage on R130's doorway when this surveyor arrived on the second floor. V3 said R130 changed rooms yesterday and the census had not been updated. V3 said she removed the sign, then did an audit that morning (3/5/25) and put the signage back up. On 3/5/25 at 9:25 AM, V13 (Registered Nurse-RN) confirmed that the EBP signage was not on R130's door when she started her shift at 7:00 AM that morning (3/5/25). V13 said V3 put the sign on R130's door around 9:00 AM. On 3/6/25 at 8:55 AM, V3 (Infection Preventionist/ADON) said R130 was on EBP precautions due to having a midline IV. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's 12/2024 policy and procedure titled Enhanced Barrier Precautions showed Enhanced Barrier Precautions (EBP) are an infection control intervention designed to reduce transmission of multidrug-resistant organisms (MDROs) in nursing homes. As well as to prevent multidrug-resistant organism acquisition of those with an increased risk of acquiring MDROs including residents with a chronic wound or an indwelling medical device .1. EBP involves gown and gloves use during high-contact resident care activities for residents known to be infected or colonized with MDROs when contact precautions do not otherwise apply. As well as residents with a chronic wound and/or indwelling medical device. The policy showed Residents that have indwelling medical devices, regardless of MDRO status, will be on EBP.