| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145804 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Oak Trace | 250 Village Drive<br>Downers Grove, IL 60516 |

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide privacy covers for residents requiring the use of urinary catheter bags. This applies to 2 out of 3 residents (R10 and R60) reviewed for privacy in a sample of 20.<br><br>Findings include:<br><br>1. R10's EMR (Electronic Medical Record) said R10 required an indwelling urinary catheter for acute urinary retention related to malignant neoplasm of the bladder. R10's MDS (Minimum Data Set) dated 12/17/2024 said R10 was dependent on the facility staff for her toileting hygiene needs.<br><br>On 1/14/2025 at 11:00 AM, R10 was in the dining room for lunch with other residents and visitors. R10's urinary catheter bag was attached to the bottom of her high-back wheelchair. R10 did not have a privacy covering her urinary catheter bag. R10's urinary catheter bag was exposed with dark-red urine.<br><br>On 1/15/2025 at 8:55 AM, R10 was in the dining room for breakfast with other residents and visitors. R10 did not have a privacy covering her urinary catheter bag. R10's urinary catheter bag was again exposed with dark-red urine.<br><br>2. R60's EMR said R60 required the use of a suprapubic urinary catheter for obstructive uropathy related to benign prostatic hyperplasia. R60's MDS dated [DATE] said R60 was dependent on the facility staff for his toileting hygiene needs.<br><br>On 1/15/2025 at 8:40 AM, V23 (Certified Nurse Assistant/CNA) transported and placed R60 in the dining room for breakfast with other residents and visitors. R60's urinary catheter bag was attached to the bottom of his recliner wheelchair. R60 did not have a privacy covering her urinary catheter bag. R60's urinary catheter bag was exposed with amber urine.<br><br>On 1/16/2025 at 10:45 AM, V2 (Assistant Director of Nursing/ADON) said she expected staff to provide privacy bags for residents requiring the use of urinary catheter bags for their dignity.<br><br>The facility's policy titled Resident Rights dated 10/10/2024, said (Facility) philosophy of care is founded upon its commitment to promote and protect the rights of each resident .To be treated with consideration, courtesy, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for all personal needs. |

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 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow resident to participate in the development and implementation of his or her person-centered plan of care.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to facilitate resident rights to participate in the development of person centered care-plan and the right to request revisions to the care-plan. This applies to 1 of 20 residents reviewed for resident rights in a sample of 20.<br><br>Findings include:<br><br>R35's face-sheet showed, he is a [AGE] year old male admitted to the facility on [DATE] with diagnoses to include unspecified fall with left sub-trochanteric fracture, chronic obstructive pulmonary disease, dementia and hypertensive heart disease. R35's MDS (Minimum Data Set) dated 12/4/24 showed, R35 had cognitive impairment and was dependent for ADLs (activities of daily life). Progress notes dated 1/16/25 at 1:59 PM showed R35 lost about 10.1 lbs. in one month (12/16/24 to 1/15/25), which was -6.7% = Severe weight loss.<br><br>Weight log:<br><br>1/16/2025<br><br>142.3 Lbs.<br><br>1/7/2025<br><br>144.7 Lbs.<br><br>1/2/2025<br><br>144.7 Lbs.<br><br>1/1/2025<br><br>145.6 Lbs.<br><br>12/16/2024<br><br>152.4 Lbs.<br><br>Skilled Nursing Evaluation dated 12/3/24 showed, cardiovascular - no edema issues.<br><br>Mini Nutritional assessment dated [DATE] showed a score of 6.0 (0-7 = malnourished).<br><br>On 1/14/25 at 9:15 AM, R35 was napping on his bed. He woke up and asked for V19 (R35's daughter). R35 stated, he is doing alright. He was alert and was able to state that V19 is his daughter. R35 stated that at the moment he was comfortable and not in any pain. Appearance-wise, he looked thin and frail.<br><br>On 1/15/25 at 9:40 AM, V19 (R35's daughter) stated, she thinks R35 looked skinnier, and he is<br><br>(continued on next page) |

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| F 0553<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | weaker than how he was when he was admitted to the facility, about six weeks ago. V19 stated, she thinks that he does not always get fed when she is not there.<br><br>On 1/15/25 at 10:36 AM, V19 stated, she had been asking the facility for a care-plan meeting and they haven't scheduled one yet.<br><br>On 1/15/25 at 3:24 PM, V16 (Social Services Aide) stated, there was no IDT (Inter Disciplinary Team) meeting held for R35 for initial care-plan nor for the change of condition of losing weight.<br><br>On 1/15/25 at 3:08 PM, V2 (interim DON-Director of Nursing) stated, for the short term residents, the initial IDT meeting is conducted within three days of admission to generate the initial care-plan. V2 (interim DON) stated, R35 was considered as a short term care resident. The IDT is repeated, and care-plan revised if there is a change in resident's condition, family requesting a meeting or if there are changes in discharge planning. V2 stated, there was no IDT meeting conducted for R35 to address the decline in the body weight of R35. V2 stated, losing about 10 lbs. in one month is a change of condition. V2 stated, the team members talk to V19 (R35's daughter) individually, but facility did not hold an IDT meeting for R35 and V19.<br><br>Facility policy on Care Planning - Interdisciplinary Team (IDT) dated 2/3/2019 showed, facility's IDT is responsible for the development of an individualized comprehensive care plan for each resident. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide residents and their representatives a written notification of the facility's bed hold policy when transferred to the hospital. This applies to 4 out of 4 (R307, R58, R77, R6) residents reviewed for hospitalization in a sample of 20.<br><br>Findings include:<br><br>1. R6's EMR (Electronic Medical Record) said she was her own responsible party, and her family member was her emergency contact/POA (Power of Attorney). R6's EMR said she required an emergency transfer to the hospital on 1/11/2025 and was currently admitted for a urinary tract infection.<br><br>R6's late entry Progress Note dated 1/11/2025 said R6 was noted with change in her mentation, weakness, tremors, flushed face, and low blood pressure. The note continued to say R6 was transferred to the hospital and her POA was notified.<br><br>The facility does not have documentation to show R6 and her representative were provided written notification of the facility's bed hold policy at the time of her hospital transfer.<br><br>2. R307's EMR said he was his own responsible party, and his spouse was his emergency contact. R307's EMR said he required an emergency transfer to the hospital on [DATE] and was admitted for low hemoglobin.<br><br>R307's Progress Note dated 12/30/2024 said R307 had critical lab results requiring hospitalization. The note continued to say R307's spouse was notified.<br><br>The facility does not have documentation to show R307 and his spouse were provided written notification of the facility's bed hold policy at the time of his hospital transfer.<br><br>3. R58's EMR said she was her own responsible party, and her family member was her emergency contact. R58's EMR said she required an emergency transfer to the hospital on 1/13/2025 and was currently admitted for an evaluation for acute change in health and abnormal lab results.<br><br>R58's Progress Note dated 1/13/2025 said R58 was noted with low oxygen saturations, unrelieved left leg pain, anxiety, and pallor. The note continued to say R58 was transferred to the hospital and her emergency contact was notified.<br><br>The facility does not have documentation to show R58 and her representative were provided written notification of the facility's bed hold policy at the time of her hospital transfer.<br><br>4. R77's EMR said she was her own responsible party, and her family member was her emergency contact. R77's EMR said she required an emergency transfer to the hospital on 1/08/2025 and was currently admitted for a GI (Gastrointestinal) problem needing a surgical procedure.<br><br>R77's Progress Note dated 1/08/2025 said R77 was noted with low oxygen saturations and nausea with an episode of emesis. R77 was transferred to the hospital and her emergency contact was notified.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The facility does not have documentation to show R77 and her representative were provided written notification of the facility's bed hold policy at the time of her hospital transfer.<br><br>On 1/15/2025 at 2:00 PM, V2 (Assistant Director of Nursing/DON) said nurses do not provide residents with written documentation of the facility's bed hold policy. V2 said at times nurses verbally inform residents and their families of the bed hold policy at the time of their transfer and enter a progress note. V2 said she reviewed R6, R307, R58, and R77's EMRs and was unable to locate written notifications of the bed hold policy for their recent hospitalizations.<br><br>On 1/16/2025 at 9:15 AM, V1 (Administrator) said all residents are required to receive a written notification of the facility's bed hold policy at the time of admission and when having a leave from the facility including hospitalizations. V1 said the facility's Bed Hold Policy form should be explained as indicated in the form to ensure they understand billing for holding their bed during their leave. V1 said the forms are to be uploaded to the residents' EMRs once completed.<br><br>The facility's Bed Hold Policy form undated, said This community will notify, and/or representatives of the bed hold policy guidelines, as follows: Upon admission to the Community, At the time of transfer to hospital or other type of leave, At the time of non-covered therapeutic leave. |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide appropriate pressure ulcer care and prevent new ulcers from developing.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to implement measures to prevent the further deterioration of a pressure ulcer. The applies to 1 of 4 residents R91 reviewed for pressure ulcers in the sample of 20.<br><br>Findings include:<br><br>R91 readmitted to the facility from a hospital stay on 12/12/24 with diagnoses that includes wedge compression fracture, dysphagia, acute respiratory failure, weakness, type 2 diabetes, gout, anemia and chronic kidney disease. R91's MDS (Minimum Data Set) dated 12/19/24 indicates he is cognitively intact. MDS indicates R91 is dependent on staff for his Activities of Daily Living, toileting and transferring between the wheelchair and bed. The MDS section M documents skin / ulcer treatments pressure reducing device for chair, pressure reducing device for bed, nutrition or hydration intervention to manage skin problems, pressure ulcer / injury care, application of non-surgical dressings and application of ointments / medications.<br><br>On 01/16/25 at 11:07 AM, R91 was sitting up in his wheelchair and stated he had been up since the morning. R91 stated he had not been back to bed, transferred or repositioned since he was gotten out of bed. R91 stated he received his air mattress the prior week. R91 stated his pain was much worse before he received the air mattress.<br><br>V32 Family Member of R91 stated he had been sitting up in the wheelchair when she arrived at 8:30 am. R91 stated he returned to the facility with wound and was disappointed he was not provided with the air mattress at that time.<br><br>On 01/16/25 at 11:39 AM, V34 COTA (Certified Occupational Therapy Assistant) took R91 to the therapy room.<br><br>On 01/16/25 at 11:54 AM, V34 with another therapy worker assisted R91 to stand with a walker.<br><br>On 01/16/25 at 12:02 PM, V26 CNA (Certified Nursing Assistant) assigned to R91 stated she assisted him up to the wheelchair at 7:30 am. V26 stated R91 had not been back to bed, toileted or repositioned since she got him out of bed.<br><br>On 01/16/25 at 12:08 PM, V27 RN assigned to R91 stated intervention include to reposition him every two hours, make sure his dressing is changed as ordered, document and notify physician of any changes to his wound. V27 stated CNAs are responsible to reposition and transfer residents. The wound may worsen and get bigger if he is not repositioned. It increases his risk of infection. Sitting in one position for too long decreases the blood circulation to his skin.<br><br>On 01/16/25 at 02:35 PM, V2 DON (Interim Director of Nursing) stated R91 was upgraded to the air mattress because his wound was deteriorating. V2 stated, He should be off loaded as frequently as possible. We encourage him to reposition himself. Staff should reposition him every 2-3 hours. If he was up at 7:30 am the CNA should be assisting him to reposition by 9:30 am. Extended periods of time could cause him to develop further ulcerations and deterioration of his current wound. Even if he did not require incontinence care, the CNA should still assist him with offloading and examine his skin. 7:30 am to 11:54 is too long a time period without being repositioned.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 01/16/25 at 03:03 PM, V33 wound nurse stated R91's admitted back to the facility on [DATE] with a stage 3 sacral wound. V33 stated on 12/17/24 R91's sacral wound was 1.1cm x 0.8cm with depth of 0.8 cm. On 12/27/24 the sacral wound was 4.1 cm x 1.9cm with 0.1 depth. V33 stated, (R91's) mobility may have decreased as well as his nutritional status. He also has the contributing factor of long dialysis times on his wound healing. As a nurse it is recommended to reposition residents every two hours. Two hours is an important marker because extended periods in one position could contribute to pressure injuries. When he returned, he had a regular mattress which is not the same as a pressure relieving mattress. The air mattress assisted him with off-loading but repositioning by staff is still required. Staff should be going to him to reposition him not waiting for him to call for repositioning. He should receive assistance to reposition even if he is sitting in the chair. The admitting nurse does not measure wounds they document its presence and describe it. The wound nurse measures wounds. Anyone one on the floor can order an air mattress based on the mobility and skin condition of the resident. I verbally requested floor nurse to order the air mattress on 12/31/24.<br><br>R91's current care plan includes pressure wound on the sacrum related to decreased functional mobility, incontinence and comorbidities such as chronic kidney disease, hemodialysis and diabetes mellitus was initiated on 1/7/25. The goal set resident's pressure ulcer will show signs of healing and remain free from infection by / through next review date. Interventions include administer treatments as ordered , educate the resident / family / caregivers as to the cause of skin breakdown including transfer / positioning requirements, importance of taking care during ambulating / mobility , good nutrition and frequent repositioning, follow facility policies / protocols for the prevention / treatment of skin breakdown, pressure relieving device on chair / chair off load heals, teach resident / family the importance of changing positions for prevention of pressure ulcers, encourage small frequent position changes.<br><br>Wound evaluation documentation provided by the facility was completed by V33 Wound Nurse. on 12/17/24. The stage 3 sacral pressure wound measured 0.68cm2 x 1.14 cm x 0.81cm (Centimeter). V33 documented the wound as present on admission. Treatment documented as foam dressing, mobility aid provided, moisture barrier and nutritional / dietary supplementation. No other documentation of a sacral wound was provided by the facility prior to 12/17/24 documentation.<br><br>Wound documentation by V33 on 12/27/24 stage 3 sacral pressure wound measured 6.11cm2 x 4.14 cm x1.86 cm. Treatment documented as foam dressing, mobility aid provided, moisture barrier and nutritional / dietary supplementation.<br><br>Wound documentation by V33 on 1/7/25 unstageable sacral pressure wound measured 5.27cm2 x 4.62 cm x 2.37 cm. Treatment documented as cleanse with normal saline, enzymatic debridement (collagenase), calcium alginate dressing, foam, mattress with pump, mobility aid, moisture barrier and nutrition / dietary supplement.<br><br>V35 wound doctor initial wound evaluation dated 1/9/25 documents a full thickness unstageable sacrum wound. Measuring 3.8cm x 3.8cm x 0.2 cm (centimeter). Plan of care recommendation off load wound reposition per facility protocol, upgrade offloading chair cushion and recommended upgrading dialysis chair dietician consult.<br><br>Current Physician orders includes pressure relieving mattress order date 1/9/25.<br><br>No documentation of repositioning of R91 was provided by the facility.<br><br>(continued on next page) |

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| F 0686<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The facility policy Prevention of Pressure Ulcers / Injuries dated 2/18/22 states assess the resident on admission for existing pressure ulcer / injury risk factors. Conduct a comprehensive skin assessment upon admission including skin integrity any evidence of existing or developing pressure ulcers or injuries areas of impaired circulation due to pressure from positioning or medical devices. Every two hours as tolerated, reposition residents who are reclining and dependent on staff for repositioning. Reposition more frequently as needed, based on the condition of the skin and tolerance, the resident's comfort, the resident's mobility, the support surface in use and the resident's stated preferences. |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.<br><br>4. On 1/15/25 at 10:56 AM, observed V17 (CNA-Certified Nursing Assistant) lowering R18 by herself onto the wheelchair via mechanical lift. V17 was operating the machine and at the same time trying to hold R18 on the sling and managed to maneuver R18 to the chair by herself. V13 (RN-Registered Nurse) was standing at the door of the room watching the procedure.<br><br>On 1/15/25 at 11:00 AM, V13 stated, she was watching only. V13 (RN) stated, mechanical lift transfer must be done by two staff and not just one person for safety reasons - one person handles the machine, and the other person supports the resident.<br><br>On 1/15/25 at 11:10 AM, V17 (CNA) stated, she transferred the resident from bed to wheelchair by herself. V17 agreed that for safety reason, it should be always two people to transfer a resident via mechanical lift.<br><br>Based on observation, interview, and record review, the facility failed to safely transfer, position, implement fall interventions, and secure a mattress cover for residents (R9, R18, R48, R60) at risk for accidents. This applies to 4 out of 4 residents (R9, R18, R48, R60) reviewed for accidents in a sample of 20.<br><br>Findings include:<br><br>1. R48's Care Plan dated 1/15/2025 said he was a high risk for falls related to safety awareness deficiency, anti-anxiety medication use, debilitating cardio-respiratory conditions, and cognitive deficit. The Care Plan had a goal for R48 not to sustain a serious injury. The Care Plan had active interventions to Anticipate and meet the resident's needs .The resident needs prompt response to all requests for assistance initiated on 12/18/2024.<br><br>R48's Care Plan said he needed assistance with his ADLs (Activities of Daily Living) including transfers and mobility. The Care Plan showed, [R48] has fluctuation in physical abilities and it was recommended he use a total-mechanical lift device and be assisted with his mobility.<br><br>On 1/14/2025 at 11:00 AM, R48 was in the dining room sitting on his high-back bariatric wheelchair not properly positioned. R48 was slouched in his chair not in an upright sitting position and had a total-mechanical lift sling underneath him. R48 appeared uncomfortable, he was trying to adjust himself but was unable. At 12:10 PM R48 was in the same position in his wheelchair being assisted with lunch by his family member. R48 started to cough and said his bottom was hurting. Then V31 (Hospice Aide) came to visit R48 and said he did not appear comfortable. V31 said he was sliding off his wheelchair and not properly positioned. V31 requested assistance from the facility staff to assist her with properly positioning R48 in his wheelchair.<br><br>On 1/15/2025 at 8:55 AM, R48 was in his room yelling in a standing position while being assisted with a sit-to-stand lift by V22 (Certified Nurse Assistant/CNA) and V21 (Restorative Aide/RA). R48 had a high black bariatric wheelchair and another wheelchair in his room. V21 said they were assisting R48 into his wheelchair because he was sliding. They continued to use the sit-to-stand lift to bring R48 into a sitting position on his high-back wheelchair, while they placed and adjusted a total-mechanical sling underneath him.<br><br>(continued on next page) |

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| F 0689<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 1/16/2025 at 3:00 PM, V21 (RA) said R48 required the use of a total-mechanical lift device for transfers. V21 said that on 1/15/2025 they used the sit-to-stand lift device to lift R48 in a standing position to adjust his total-mechanical lift sling underneath. V21 said that with other residents who require assistance with positioning and depend on the use of a total-mechanical lift, she would have asked for assistance to roll the resident in the wheelchair to place the sling underneath. V21 said she used her judgment on using the sit-to-stand device with R48. V21 said R48 was now using a new geriatric recliner wheelchair.<br><br>On 1/16/2025 at 3:15 PM, V2 (Assistant Director of Nursing/ADON) said she expects the nursing staff to follow resident's transfers and use the identified transfer equipment as indicated for safety. V2 said total-mechanical lift transfers required 2-staff members to be actively assisting and be within arms-length during the transfer. V2 said residents in wheelchairs should be properly positioned in an upright position, not slouched to prevent an injury.<br><br>The facility's policy titled Safe Resident Handling/Transfers dated 10/01/2024, showed, It is the policy of this facility to ensure that residents are handled and transferred safely to prevent or minimize risks for injury and provide and promote a safe, secure and comfortable experience for the resident.<br><br>2. R60's Care Plan dated 1/15/2025 stated he was at risk for falls and had a goal to be free of injuries. The Care Plan had an active intervention to add floor mat to bed side due to bed exiting behavior initiated on 3/18/2024.<br><br>On 1/14/2025 at 10:33 AM, R60 was in bed sleeping. R60 did not have a floor mat in place on the floor. R60's thick blue floor mat was folded up against his bathroom wall.<br><br>On 1/16/2025 at 11:00 AM, V2 (DON) said R60 had a history of falling from bed. V2 said R60 had multiple fall prevention interventions including the use of a thick floor mat to the side he favored when in bed. V2 said she expected fall prevention interventions to be followed to ensure residents were provided with a safe environment.<br><br>3. R9's Care Plan dated 1/15/2025 stated R9 was at risk for falls and had a goal to be free from falls. The Care Plan had an active intervention to ensure staff maintain her in the center of the bed while resting initiated on 11/12/2024. R9's EMR said she required the use of pressure pressure-reducing device for her bed for her skin management.<br><br>On 1/15/2025 at 4:00 PM, R9 was in bed on top of a foam egg crate mattress topper that was covered with a thin sheet. The foam mattress topper was on top of her air-loss mattress that had a plastic covering. The foam topper was not secured. R9's daughter was present and said R9's physician had recommended she use the foam mattress topper to help her with her skin. R9's daughter said she had asked the facility about the use of the foam mattress topper, and they approved its use.<br><br>On 1/16/2025 at 1:40 PM, V2 said the facility did allow for mattress overlay covers but were required to be assessed individually before using them. V2 said she expected staff to follow up to ensure they were properly placed. V2 said she assessed R9's mattress and foam topper. V2 said she removed the topper for R9's safety because it was not secured properly, and she could have slid off. V2 said the facility did not have a policy about the use of mattress covers. |

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|---|---|---|---|
| | 145804 | A. Building<br>B. Wing | 01/17/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| Oak Trace | 250 Village Drive<br>Downers Grove, IL 60516 |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | Provide enough food/fluids to maintain a resident's health.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure resident maintained acceptable nutritional status. Facility failed to provide adequate interventions to prevent further decline in resident's body weight. This failure resulted in R35 experiencing unplanned weight loss. This applies to 1 of 20 residents reviewed for nutrition and hydration in a sample of 20.<br><br>Findings include:<br><br>R35's face-sheet showed R35 is a [AGE] year old male admitted to the facility on [DATE] with diagnoses to include unspecified fall with left sub-trochanteric fracture, chronic obstructive pulmonary disease, dementia and hypertensive heart disease.<br><br>R35's MDS (Minimum Data Set) dated 12/4/24 showed, R35 had cognitive impairment and was dependent for ADLs (activities of daily life).<br><br>Progress notes dated 1/16/25 at 1:59 PM showed R35 lost about 10.1 lbs. in one month (12/16/24 to 1/15/25), which is -6.7% = Severe weight loss.<br><br>Weight log:<br><br>1/16/2025<br><br>142.3 Lbs.<br><br>1/7/2025 144.7 Lbs.<br><br>1/2/2025<br><br>144.7 Lbs.<br><br>1/1/2025<br><br>145.6 Lbs.<br><br>12/16/2024 152.4 Lbs.<br><br>Progress notes dated 1/10/25 at 1:32 PM showed, facility offered ONS (oral nutritional supplement) of Ensure Plant-based to meet estimated needs, snacks in between meals and smoothies.<br><br>R35's Physician orders for January 2025 did not include magic cup.<br><br>Skilled Nursing Evaluation dated 12/3/24 showed, cardiovascular - no edema issues.<br><br>Mini Nutritional assessment dated [DATE] showed a score of 6.0 (0-7 = malnourished).<br><br>On 1/14/25 at 9:15 AM, R35 was napping in his bed, appeared thin and frail.<br><br>(continued on next page) |

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| F 0692<br><br>Level of Harm - Actual harm<br><br>Residents Affected - Few | On 1/15/25 at 9:40 AM, V19 (R35's daughter) stated she thinks R35 looked skinnier now and is weaker than when he was admitted to the facility about six weeks ago. V19 stated she thinks R19 does not always get fed when R35 is not there.<br><br>On 1/15/25 at 10:36 AM, V19 stated R35 does not always get the magic cup along with his meals as recommended by the dietician. V19 stated she had fed him the magic cup before, and he enjoyed it and R35 will eat it all. V19 stated a couple weeks ago she came to visit R35 at about 11:00 AM and his breakfast tray was on the bedside table untouched. V19 stated about 2-3 weeks ago she visited her father at about 6:00 PM and he told her he was hungry and did not get any dinner. V19 stated as she was talking with her dad, a CNA (Certified Nursing Assistant) entered the room and surprisingly exclaimed, 'Oh, the tray is gone!'. V19 stated she had been asking the facility for a care-plan meeting and they haven't scheduled one yet.<br><br>On 1/15/25 at 12:41 PM, observed V17 (CNA) feed R35 lunch. R35 drank all the soup, ate all the carrots, about one quarter of the chicken & all the dessert. There was no 'magic cup' on the tray.<br><br>On 1/15/25 at 3:24 PM, V16 (Social Services Aide) stated, there was no IDT (Inter Disciplinary Team) meeting held for R35 for initial care-plan nor for the change of condition of losing weight.<br><br>On 1/15/25 at 3:08 PM, V2 (interim DON-Director of Nursing) stated, there was no IDT meeting conducted for R35 to address the decline in his body weight. V2 stated losing about 10 lbs. in one month is a change of condition.<br><br>On 1/15/25 at 1:50 PM, V15 (RD-Registered Dietician) stated she called the family and the daughter (V19). (V19) stated (R35) will not take any supplements other than the vanilla magic cup. V15 stated the facility did not try any interventions other than offering the ONS, snacks and smoothies. V15 stated, When residents don't like certain food, we look for their preferences and offer more choices, which was not done in this case and (R35) continued to lose weight. If (R35) continues to lose weight, he will lose lean body mass, lose his muscle mass, and his disease prognosis will decline.<br><br>On 1/16/25 at 12:11 PM, V15 (RD) stated there was no new interventions in place for R35's weight loss as of now.<br><br>On 1/16/25 at 1:40 PM, V14 (MD-Medical Director) stated he depends on the RD's recommendations for nutritional supplements to meet resident nutritional needs.<br><br>Policy on weight assessments and intervention with a review date of 2/26/22, showed, facility will begin nutrition interventions when a resident is identified as having significant weight loss. |

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| F 0693<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to correctly check G-tube (Gastrostomy) placement prior to administration of medications. This applies to 1 of 1 resident (R91) reviewed for G-tubes in a sample of 20.<br><br>The findings include:<br><br>On January 15, 2025 at 9:17 AM, V8 (RN/Registered Nurse) was administering medications for R91 through the G-tube. V8 drew air into a syringe and pushed the air into the G-Tube site while listening for sounds. V8 then administered R91's medications via the G-Tube. On January 16, 2025 at 9:26 AM, V8 said she would check placement by pushing 30 Milliliters of air and auscultating like she had yesterday. V8 then said she checked for residual.<br><br>On January 16, 2025 at 9:01 AM, V9 (RN) said they checked placement for the G-Tube by putting the stethoscope to their stomach and pushing air and listening for bubbling sounds to verify placement.<br><br>On January 16, 2025 at 9:16 AM, V10 (RN Supervisor) said they checked placement for the G-Tube by pushing air and auscultating for gurgling sounds.<br><br>On January 16, 2025 at 10:50 AM, V2 (DON/Director of Nursing) said to check for accurate placement of the G-Tube, they would check for residual. V2 said she would expect the staff to listen for bowel sounds.<br><br>R91's face sheet showed she was admitted to the facility on [DATE] with diagnoses including encounter for surgical aftercare following surgery on the digestive system and gastrostomy status.<br><br>The facility's Verifying Placement of Feeding Tube policy dated 2024 showed If performed in the facility, measure the pH of the gastric secretions: 1) Draw back on syringe to slowly obtain 5-10 ML [Milliliters] of aspirate, and empty into a clean medicine cup. 2) Dip the pH strip into the aspirate in the medicine cup. 3) Compare the color of the strip with color on the chart as per manufacturer's instructions. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to administer medications as ordered. There were 29 opportunities with 3 errors resulting in a 10.34% error rate. This applies to 2 of 10 residents observed in the medication pass.<br><br>The findings include:<br><br>1. On January 15, 2025 at 8:19 AM, during the observation of medication administration, V8 (RN/Registered Nurse) prepared R205's medications. R205 had Amoxicillin-Pot Clavulanate Tablet 875-125 MG (Milligrams) and crushed the medication. V8 also took a PreserVision eye vitamin AREDS (Age-Related Macular Degeneration) 2 soft gel and crushed the soft gel.<br><br>On January 16, 2025 at 9:26 AM, V8 said the Amoxicillin Clavulanate could be crushed. V8 said if the medication had potassium in it, she should have melted it. V8 said PreserVision also needed to be melted, and she should have put it on hold instead of administering the medication.<br><br>R205's face sheet showed she was admitted to the facility on [DATE] with diagnoses including injury of left ankle, macular degeneration, acute respiratory failure with hypoxia and hypercapnia, and need for assistance with personal care. R205's POS (Physician Order Set) showed an order for Amoxicillin-Pot Clavulanate Tablet 875-125 MG with instructions to Give 1 tablet by mouth two times a day for aspiration pneumonia for 6 days, ordered on January 13, 2025 and with a discontinued date of January 16, 2025. R205's discontinued POS also showed an order for PreserVision AREDS 2 Oral Capsule (Multiple Vitamins [with] Minerals) with instructions to Give 1 capsule by mouth two times a day for Supplement, with a start date of January 14, 2025 and a discontinued date of January 15, 2025. R205's January 2025 MAR (Medication Administration Record) showed she received the Amoxicillin-Pot Clavulanate and PreserVision AREDS 2 Oral capsule on January 15, 2025.<br><br>2. On January 15, 2025 at 8:56 AM, during the observation of medication administration, V8 prepared R91's medications. R91 had a Terazosin 2 MG capsule due. V8 crushed the Terazosin capsule and put it in a medication cup and poured water into the cup. V8 asked if she could replace the capsule with another capsule. At 9:17 AM, V8 took the capsule with water to R91's room and administered the same medication to R91 through the G-Tube (Gastrostomy).<br><br>On January 16, 2025 at 9:26 AM, V8 said she should have melted the capsule or opened it and administered it. V8 said she should have called the doctor and asked to change the medication and had called the doctor after the medication administration.<br><br>R91's face sheet showed she was admitted to the facility on [DATE] with diagnoses including hypertensive heart and chronic kidney disease without heart failure, with stage 1 and benign prostatic hyperplasia (BPH) without lower urinary tract symptoms. R91's POS showed an order for Terazosin HCl (Hydrochloride) Oral Capsule 2 MG with instructions to Give 1 capsule via G-tube one time a day for BPH, ordered on December 16, 2024.<br><br>On January 16, 2025 at 9:01 AM, V9 (RN) said soft gels cannot be crushed, and capsule cannot be crushed, but should be opened. V9 also said Amoxicillin-Clavulanate cannot be crushed because it was enteric coated.<br><br>(continued on next page) |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On January 16, 2025 at 9:16 AM, V10 (RN Supervisor) said soft gels, capsules, and Amoxicillin-Clavulanate could not be crushed. V10 said they would need to check with the pharmacy prior to crushing any medications, and with antibiotics, defer to the Infectious Disease team.<br><br>On January 16, 2025 at 10:50 AM, V2 (DON/Director of Nursing) said the Amoxicillin-Clavulanate could not be crushed because it was enteric coated, soft gels could not be crushed, and capsules could not be crushed. V2 said capsule should be opened.<br><br>The facility's [Pharmacy] provided a list of Common Oral Dosage Forms That Should Not Be Crushed dated 2024, which included Amoxicillin/Potassium Clavulanate<br><br>The facility's Administering Medications policy revised April 2019 showed: The individual administering the medication checks the label three times to verify the right resident, right medication, right dosage, right time, and right method (route) of administration before giving the medication. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>Based on observation, interview and record review the facility failed to maintain the kitchen facility in a manner to prevent foodborne illness. This applies to 99 residents in the facility receiving dietary services.<br><br>Findings include:<br><br>On 01/14/25 at 03:13 PM, V2 DON (Interim Director of Nursing) confirmed 99 residents were being served from dietary services on entry to the facility 01/14/25.<br><br>On 01/14/25 at 10:33 AM, the kitchen tour began in the lower-level kitchen with V4 Dietary Manager<br><br>The dry storage contained:<br><br>A dented can of pinto beans 6 pounds 15 ounces<br><br>A dented can of great northern beans 6lbs 15 ounces<br><br>A dented can of pears 6.56 pounds<br><br>Two dented cans of pear halves 6.56 pounds.<br><br>A 20lb tub of cherry pie filling opened in use no delivery date, opened on or use by date.<br><br>The facility policy Production, Purchasing, Storage - Receiving dated 1/25 states date foods prior to placing in storage areas. Store distress / recalled products in a separate, designated area, marked with a sign return to supplier.<br><br>The facility policy Production, Purchasing, Storage -Food and Supply Storage states refer to the Food Storage Chart in policy to determine discard dates for food items. Fruit puree/fillings and sauces are good for one month after opening and must be refrigerated.<br><br>On 01/14/25 at 10:38 AM, V5 Director of Culinary Services and V6 Chef joined V4 and surveyor on kitchen tour.<br><br>On 01/14/25 at 10:45 AM, a walk-in cooler contained a 32-ounce container of vanilla Greek yogurt with an expiration date of 1/8/25.<br><br>On 01/14/25 at 10:50 AM, the walk-in freezer contained:<br><br>Two bags of white shrimp 71-90 count without a delivery date or expiration date.<br><br>Three facility wrapped packages identified by V4 as corned beef without label identifying contents, delivery date, opened on date or use by date.<br><br>Two large factory wrapped slabs of meat identified by V4 as New York strip steaks without delivery dates or use by date.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Four large factory wrapped slabs of meat identified by v4 as brisket without delivery dates or use by dates.<br><br>A large metal pan labeled Tuna Casserole with an expiration date of 12/11/24.<br><br>A large clear factory sealed bag of tater tots without any label to identify contents, delivery date or use by date.<br><br>A 30-pound box of pearled onions. The box and inner bag containing onions were opened to air.<br><br>The facility policy Production, Purchasing, Storage -Food and Supply Storage states wrap food tightly to prevent cross contamination.<br><br>On 01/14/25 at 11:11 AM, the first-floor walk-in cooler contained a large clear facility bin containing raw poultry in a creamy orange marinade with a use by date of 1/10/25.<br><br>On 01/14/25 at 11:20 AM, three red sanitization buckets were in use on the first-floor kitchen. V4 Dietary Manager tested the sanitization levels. Red sanitization bucket #1and #2 tested at 100 ppm (Parts Per Million). V6 Chef was observed dumping red sanitization bucket #3 prior to V4 testing its sanitization level. V6 stated he refilled the bucket to determine if there was an issue with the dispenser. V4 tested the sanitizer level of bucket #3 at 100 ppm.<br><br>The facility policy Sanitization and Infection Prevention / Control- Sanitizing Food Contact Surfaces states the sanitizer solution must be at 200 ppm to 400 ppm for the J 512 Sanitizer. If the concentration of the sanitizing solution does not meet the standard the solution is mixed manually: each batch is tested and recorded. Associate advises the manager / supervisor so that the supplier can be contacted for repair of the unit.<br><br>The unit kitchenettes were toured with V4 Dietary Manager, V5 Director of Culinary Services and V6 Chef.<br><br>On 01/15/25 at 05:16 PM, The unit kitchenettes were toured with V4 Dietary Manager, V5 Director of Culinary Services and V6 Chef. V28 [NAME] tested the sanitizer level of the 4th floor kitchenette red bucket using an alternate brand of testing strips. V28 [NAME] stated she had filled and already tested the red sanitization bucket in use. The Sanitizer level measured 150 ppm. V6 Chef stated the strips are the same as other brand of strips and are ok to use.<br><br>On 01/16/25 at 01:42 PM, V4 Dietary Manager stated the kitchen follow a chart as to when food expires. Dented cans are not to be used and should be moved to the area where dented cans are located. Serving food from dented cans may cause residents to become sick. V4 stated he believed the opened cherry pie filling should be dated and refrigerated per facility policy. Food items should be dated with the opened on and use by dates. Without a date staff would not know how long a food item is good to use and serve. V4 stated he did not know if someone would become ill from eating the cherry pie filling that had been accessed and left in the dry storage rather than being refrigerated. V4 stated staff should be checking the dates on food items and not serving expired food items. It the yogurt had been served it has the potential to call sickness. The Shrimp and beef should have been dated so we know when it came out of the box and when it should be used by. Food should be labeled and dated when it is taken out of its original container. All staff are responsible for making sure expired food is thrown out and label and dated.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | V4 stated the sanitizer dispenser was not dispensing the correct amount of sanitizer. V4 stated he was unaware of any prior issues with the dispenser. The red sanitization buckets are to be changed every two hours. The sanitizer level should be changed every time it is changed. The sanitizer range should be 200 ppm to 400 ppm. V4 stated they are not required to document if the sanitizer level is 200ppm or 400ppm only that it is in range. V4 stated he did not know why the red sanitizing buckets were not in range if they had been tested and changed as they were supposed to be. V4 declined to answer as to the outcome for residents related to the use of sanitizing solution not in range during food preparation.<br><br>The facility Red Bucket Logs for January are initialed but do not indicate the sanitizers parts per million level. |