STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145634	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place Living & Rehab	6300 North California Avenue Chicago, IL 60659

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 44103 Based on observation, interview, and record review, the facility failed to provide privacy and promote dignity for one of one resident [R105] reviewed for urinary catheter use on the sample list of 31. Findings included: On 11/19/24 at 10:24 AM, R105's urinary catheter bag was hanging on the side of R105's bed, half filled with urine and visible from the hallway. The urinary catheter bag did not have a protective cover over the bag. R105 stated the [R105] is on the urinary catheter bag because of [R105's] wound. On 11/20/24 at 10:33 AM, interviewed V2 (Director of Nursing) and stated that urinary catheter bag placement should not be facing the door, and if it's facing the door, it should be inside of a bag for privacy. V2 stated that if the urinary catheter bag is exposed, it can potentially cause a dignity issue. R105's physician orders document in part: Indwelling Catheter Type: (urinary) Catheter Size: 16 FR, 10 cc (cubic centimeter) balloon Reason for use: Neurogenic Bladder (ordered 10/27/24). The facility's Privacy and Dignity policy dated 8/16/24 documents in part: It is the facility's policy to ensure that resident's privacy and dignity is respected by the staff at all times. Urine bags will be covered with the use of privacy bags.

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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44103 Based on observation, interview, and record review, the facility failed to ensure a low air loss mattress device was on the correct weight setting for one dependent resident (R105) of two residents with pressure ulcers on a sample list of 31 residents. Findings Include: R105's clinical records show an admitted [DATE] with included diagnoses not limited to Multiple Sclerosis and Stage 4 Pressure Ulcer. R105's physician orders read: Low Air Loss (LAL) Mattress ordered on 10/27/24. R105's skin care plan date initiated on 10/27/24 reads in part: R105 has a pressure injury on the sacral area with one intervention that reads, Check air mattress if functioning properly every shift and prn [as needed]. R105's weight shows 180 lbs dated 11/15/24. R105's Skin Risk assessment dated [DATE] shows a score of 10 (High Risk in developing a pressure ulcer). On 11/19/24 at 10:24 AM, R105's lying in bed alert and able to verbalize needs. Surveyor observed R105's low air loss mattress weight setting was set to 180 pounds (lbs). R105 stated [R105] has a wound above the tail bone area and is being seen by the wound care team. On 11/20/24 at 9:06 AM, V18 (Wound Care Coordinator/Registered Nurse) and V19 (Treatment Nurse/Licensed Practical Nurse both stated R105 came in with a stage 4 sacral pressure ulcer with wound treatment daily. Both stated R105's wound assessment scale (a tool used to assess risks of developing pressure ulcer) dated 11/11/24 is 10 which means R105 is high risk in developing pressure ulcer. Both stated R105 is on a low air loss mattress and supplements for wound healing. At 9:23 AM, R105's wound dressing was observed with V18 and V19. R105's wound dressing on the sacral area was intact. R105's low air loss mattress machine was observed set to 210 lbs. V18 stated that the purpose of the low air loss mattress is to offload the pressure point and alternates the weight of the resident to promote wound healing and prevention of developing pressure ulcer. V18 stated that the low air loss mattress should be set correctly and is based on the current weight of the resident. V18 stated nurses and wound care team should be monitoring and making sure that the low air loss mattress is in the correct setting and if it's in the wrong setting, the mattress could be so hard or so soft. For example, if it's in a low setting it's not doing its purpose and the resident will sink. At 9:33 AM, V18 checked R105's current weight recorded in the electronic health record and showed R105 weighed 180 lbs dated 11/15/24. V18 stated that R105's low air loss mattress weight setting should be set to 180 lbs. The facility's Specialized Mattress and Appropriate Layers of Padding policy dated 8/19/24 reads in part: use specialized air mattresses like Low Air Loss Mattress on residents with stage 3 and 4 pressure sores to ensure moisture, heat, and friction control.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. 45110 Based on observation, interview and record review the facility failed to distinguish between a behavior slide versus a fall, and failed to follow their fall occurrence policy for one [R119] resident reviewed for falls on the sample list of 31 residents. Findings include: R119 's clinical record indicates the follow in part; R119 was admitted the medical diagnosis of cerebral infarction with hemiplegia and hemiparesis affecting left dominant side, coronary angioplasty, ventricular tachycardia, cardiac implants, major depressive disorder, generalized weakness, anxiety, and alcohol abuse with withdrawal. R119's Minimum Data Set [MDS] section [C] Brief interview Mental Status he scored [04] indicates R119 is moderately impaired. R119's care plan indicates the following: 8/9/24- R119 demonstrate cognitive impairment related to psychiatric disorder, history of substance abuse, impaired decision making, poor logic and poor ability to understand cause and effect. Poor judgement and awareness. 6/17/24- R119 has an impaired mobility. 8/6/23- R119 is at high risk for falls related to cognitive deficit, poor balance, limited mobility. 11/19/24- R119 has behavior of sliding onto the floor when experiencing any abdominal discomfort. [Behavior Care Plan was entered after care plan was requested by the state survey agency] On 11/19/24 at 10:43 AM, during initial interview with R82 in his room behind his privacy curtain by the window, surveyor heard a noise. Surveyor observed R82's roommate R119 on the floor next to his bed, with his head resting on the wheelchair's leg rest. Surveyor called for R119's nurse, V8 [Licensed Practical Nurse]. Surveyor explained to V8 that she heard a noise and observed R119 on the floor with his head on top of the wheelchair leg rest. On 11/19/24 at 10:45 AM, V8 [Licensed Practical Nurse] entered the room and moved the wheelchair off the mat to reach R119. V8 stated, I am not sure who placed the wheelchair next to R119's bed on his floor mat. I see his head was resting on the wheelchair leg. V8 asked surveyor if R119 hit his head on the wheelchair leg. Surveyor said, she did not witness the fall, but observed R119 head on top of the wheelchair's leg rest. V8 asked R119 if he hit his head, R119 did not respond. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/19/24 at 10:55 AM V8 stated, R119 has a behavior of sliding out of the bed. R119 did not fall out of bed, he slides out of bed. Surveyor asked V8, because the occurrence was not witnessed, how do she [V8] know it was a slide versus a fall. V8 stated, V2 [Director of Nursing] told the nursing staff that R119 has a behavior of sliding out of the bed, so it is not treated as a fall, it is documented as a behavior. Anytime R119 is observed on the floor, it is automatically documented as behavior slide. I will take R119 vital signs and notify the nurse practitioner and family member. R119 is confused and he is not able to communicate his needs. Nursing staff make frequent rounds on R119. Sometimes R119 responds to my questions, but I am not sure the answer is true, because R119 is very confused. R119 is not answering me today.' Reviewed R119's progress note indicates in part: 11/19/24 at 10:53 V8 [Licensed Practical Nurse] Note. R119 continues to slide out of bed onto the landing pad located on the floor next to his bed. R119 was removed from the floor by the certified nurse assistant and placed back in bed. R119 was redirected, re-oriented and re-educated on the importance of staying in bed and pressing his call button when needing assistance. Writer assessed R119, and he was clean and dry, vital signs within normal limits. Nurse practitioner and R119's family made aware. [There was no information regarding R119's head was on top of the wheelchair's leg, and no neurological assessment noted.] On 11/21/24 at 11:00 AM, V16 [Restorative Director/Registered Nurse] stated, I assist with fall interventions along with the director of nursing [V2]. A fall means rather if the resident intentionally or unintentionally falls on the floor. A fall is sometimes considered a change of plane. R119 is very confused and is a high fall risk. R119 has a behavior of sliding out of bed. If R119 is observed on his floor mat and he intentionally place himself there, then it is not a fall. R119 is very confused with a BIMS sore of 4, but he can make an intentional decision to get on the floor. If R119 is on the floor, it is always a behavior slide, the floor mat helps to reduce the risk of injury, it does not 100% eliminate injury. On 11/20/22 at 11:34 AM, V2 [Director of Nursing] stated, A fall is a change of plane. However, that rule does not apply to R119, because he slides out of bed, and it was considered a behavior. During the Behavior Committee Meeting on 1/18/24. The interdisciplinary team decided R119 had a behavior. The difference from a fall and a behavior slide is that the behavior slide is usually witness, but when R119 is observed on the floor, and no one witnesses him sliding to the floor, it is usually still a behavior slide. It is a fall when R119 is observed off the floor mat then it should consider a fall. R119 have not had any documented falls since 12/12/23 but had several bed slides. If R119 was observed on the floor next to his bed with his head resting on the wheelchair footrest, then V8 should have documented and treated the incident as a fall not a behavior slide. V8 should have started neurological assessments and completed risk management fall incident report. R119 needs a sitter by his bed side 24 hours per day. The facility is not able to provide a sitter. R119's family member cannot afford a sitter as well. Maybe this is not the right facility for R119, because we cannot provide one to one monitoring that he needs. I will in-service the staff between the difference between a fall versus a behavior slide. R119's care plan was updated on 11/19/24, that's why you don't see the behavior care plan dated for 1/18/24. I am not sure what happened to the original behavioral care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Policy: Fall Occurrence dated 7/26/24. If a resident had fallen, the resident is automatically considered a high risk for falls. An incident report will be completed by the nurse each time a resident fall. The incident may be written in the nurse note or other parts of the resident's medical record that will remain accessible to any person who has the right to access the residents record.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40061 Based on observations, interviews, and record reviews, the facility failed to follow R95 and R110's care plans by not administering the ordered oxygen flow rates, label R40's oxygen tubing, store R86's oxygen tubing while not in use and have oxygen signage for R399 for five out of a total sample of 31 residents. Findings include: R40's Admission Record documents in part a primary diagnosis of chronic respiratory failure with hypoxia (low oxygen content in the blood). R40's Order Summary Report documents in part orders to change oxygen tubing every night shift every [Sunday] for infection control (active 10/03/2024) and oxygen continuous 2 [liters per minute] via nasal cannula every shift (active 10/03/2024). On 11/19/2024 at 11:18 AM, R40 was sitting in the common/dining room reading. R40 received 2 liters of oxygen via nasal cannula. The nasal cannula was not labeled and R40 did not recall the last time staff changed it. On 11/20/2024 at 10:42 AM, V2 (Director of Nursing) stated the nasal cannula should be changed weekly or as needed. V2 stated whoever changes the nasal cannula should also label it. Reviewed facility's Oxygen Therapy and Administration policy, last revised on 8/16/2024. Under Procedure, it documents in part: Date your equipment. 47304 The findings include: R86's admission record showed admitted on 1/4/2021 with diagnoses not limited to Chronic respiratory failure with hypoxia, Other emphysema, Generalized anxiety disorder, Other specified symptoms and signs involving the circulatory and respiratory systems, Personal history of covid-19, Chronic obstructive pulmonary disease. R399's admission record showed admitted on 11/13/2024 with diagnoses not limited to Other specified chronic obstructive pulmonary disease, Other pericardial effusion, Unspecified right bundle-branch block , Generalized anxiety disorder, Solitary pulmonary nodule, Acute respiratory failure with hypoxia, Bronchiectasis, Unspecified atrial flutter, Single subsegmental thrombotic pulmonary embolism without acute cor pulmonale, Paroxysmal atrial fibrillation. On 11/19/24 at 10:17 AM Observed R86 sitting on the side of the bed, alert, and oriented x 3, verbally responsive, with oxygen tank and Oxygen tubing hanging on it, not stored properly. R86 said he is using oxygen at 3L/min as needed. He uses it almost daily. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 11/19/24 at 10:38AM Observed R399 lying in bed, alert and verbally responsive. With oxygen inhalation via nasal cannula at 4Lmin. No oxygen signage by the door entrance. V6 (Licensed Practical Nurse / LPN) requested by R399's doorway and stated there should have a signage for oxygen in use by the room entrance / door. On 11/20/24 At 10:43am V2 (Director of Nursing / DON) said has been working in the facility for almost 3 years. Stated Oxygen cannula / tubing should be stored properly not the touching the floor. If O2 tubing is not being used should be kept inside a clear bag to maintain cleanliness and prevent contamination. V2 said signage should be posted by the doorway for a warning for everyone to be aware that oxygen is in use. R86's order summary report dated 11/19/24 with active order not limited to Oxygen at 3liter/min via nasal cannula as needed for SOB (shortness of breath). R399's order summary report dated 11/19/24 with active order not limited to Oxygen continuous 3-4 L/min via nasal cannula every shift. Baseline care plan dated 11/15/2024 documented in part: R399 has Oxygen Therapy related to COPD, Emphysema, Atrial fibrillation. Give oxygen as ordered by the physician - continuous oxygen at 3-4L/min/nasal cannula. Facility's Oxygen storage policy dated 8/16/24 documented in part: It is the policy of the facility to store oxygen safely and properly. 44103 On 11/19/24 at 10:36 AM, Surveyor observed R95 lying in bed and using oxygen (O2) via nasal cannula (NC). R95 was not interviewable. R95's oxygen flow rate was set to 4 liters per minute (LPM). At 10:38 AM, Surveyor asked V20 (Agency Registered Nurse) to check R95's oxygen setting. V20 entered R95's room and verified R95's oxygen flow rate was set to 4LPM. On 11/19/24 at 10:55 AM, Surveyor observed R110 lying in bed and was using oxygen via nasal cannula. R110's oxygen flow rate was set to 4 LPM. R110 stated [R110] has sleep apnea and uses oxygen to help [R110] breath better. R110 stated R110 does not walk and needs staff assistance to get up from bed. At 10:59 AM, Surveyor asked V21 (Registered Nurse) to check R110's oxygen setting. V21 entered R110's room and verified R110's oxygen flow rate was set to 4LPM. V21 stated that R110's oxygen should be set to 3LPM. On 11/20/24 at 10:33 AM, interviewed V2 (Director of Nursing) and stated that the nurses are supposed to be monitoring that the resident's oxygen is in the right setting. V2 stated that O2 setting is based on the physician's order and should be followed for the effective use of the oxygen on the resident. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R95's clinical records show an admitted [DATE] with included diagnoses but not limited to Chronic Respiratory Failure with Hypoxia. R95's Minimum Data Set (MDS) dated [DATE] shows R95 has memory problem and dependent on staff with transfers. R95's physician orders read in part: Oxygen continuous 2-3L/min via nasal cannula every shift for sob [shortness of breath] (ordered 3/09/24). R95's care plan documents in part: R95 has order for oxygen secondary to diagnosis of Chronic Obstructive Pulmonary Disease (date initiated 10/10/22) with one intervention that reads, Give oxygen as ordered by the physician. Administer 2-3 L/NC continuous. R110's clinical records show an admitted [DATE] with included diagnoses but not limited to Obstructive Sleep Apnea and Chronic Respiratory Failure with Hypoxia. R110's MDS dated [DATE] shows R110 is cognitively intact and requires substantial/maximal assistance with bed mobility. R110's physician orders read in part: Apply oxygen 2-3 lpm to keep O2 sat greater than or equal to 90% as needed (ordered 10/16/24). R110's care plan documents in part: R110 is at risk for altered respiratory status/difficulty breathing related to Sleep Apnea and Chronic Respiratory Failure (dated initiated 1011/24) with one intervention that reads, Give oxygen as ordered by the physician. Oxygen at 2-3 LPM/NC as needed. The facility's Oxygen Therapy and Administration policy dated 8/16/24 reads in part: Oxygen therapy shall be administered to patients as indicated and upon a physician's order. Procedure: Confirm order from physician (this should include liter flow, FiO2 and delivery device).

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 47304 Based on observation, interview and record review, the facility failed to ensure medication was administered and not left at bedside for 1 (R113) resident reviewed for medication administration in a sample of 31. Findings include: R113's admission record showed admitted on 6/24/2023 with diagnoses including Hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side, Occlusion and stenosis of left carotid artery, Other sequelae of cerebral infarction, Other specified arthritis multiple sites, Deficiency of other vitamins, Thyrotoxicosis, Nicotine dependence cigarettes, Chronic obstructive pulmonary disease, Essential (primary) hypertension, Other psychoactive substance abuse, Chronic viral hepatitis C. On 11/19/24 at 10:31 AM Observed R113 sitting on the side of the bed, alert and verbally responsive. Observed 1 white round pill inside the medication clear cup at bedside table. R113 stated he does not know what medication it was. Requested V5 (Registered Nurse/RN) in R113's room and said it could be a thyroid medication from 11-7 shift nurse. She said medication should not be left at bedside. R113 stated nobody told me nothing, I don't know what it is. On 11/20/24 At 10:43am V2 (Director of Nursing / DON) said has been working in the facility for almost 3 years. Stated nurses are expected to administer medications as ordered by the doctor. Nurses are expected to make sure that resident took the medication before leaving the room. Nurse is not supposed to leave the medication at bedside that is a standard nursing practice. V2 said unless resident is able to self-administer medication then it could be left at bedside but it should have an order, an assessment that resident is able to self-administer. R113's physician order summary report dated 11/19/24 showed active order not limited to Methimazole Tablet 5 MG Give 1 tablet by mouth one time a day for hyperthyroidism scheduled at 6am. Order does not reflect R113 may self-administer medication. No assessment for self-administration evaluation found in R113's electronic health record. MDS (Minimum Data Set) dated 9/17/24 showed R113's cognition was moderately impaired. Facility's medication pass policy dated 8/16/24 documented in part: It is the policy of the facility to adhere to all federal and state regulations with medication pass procedures. Facility's medication storage, labeling and disposal policy dated 8/16/24 documented in part: Medications will be secured in locked storage area. Facility's Nurse job description (undated) documented in part: Administer medications.

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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** 47304 Based on observation, interview, and record review, the facility failed to properly date opened multi-dose respiratory inhalers and nasal spray, failed to store unopened multi-dose eye drop solution and discard expired multi dose medications for 6 residents (R38, R58, R75, R103, R111, R125) from 3 of 6 medication carts reviewed for medication storage and labeling. Findings include: R38's admission record showed admitted on [DATE] with diagnoses including Type 2 diabetes mellitus with unspecified diabetic retinopathy, Primary open-angle glaucoma bilateral, Age-related nuclear cataract bilateral. R58's admission record showed admitted on [DATE] with diagnoses including Diabetes mellitus, Legal blindness, Chronic obstructive pulmonary disease, Essential (primary) hypertension. R75's admission record showed admitted on [DATE] with diagnoses including Other sequelae of nontraumatic intracerebral hemorrhage, Thyrotoxicosis, Essential (primary) Chronic obstructive pulmonary disease. R103's admission record showed admitted on [DATE] with diagnoses inlcuding Spondylosis without myelopathy or radiculopathy lumbar region, Essential (primary) hypertension, Chronic obstructive pulmonary disease. R111's admission record showed admitted on [DATE] with diagnoses including Type 2 diabetes mellitus, Epilepsy, Personal history of Covid-19, Chronic diastolic (congestive) heart failure, Essential (primary) hypertension. R125'a admission record showed admitted on [DATE] with diagnoses including Displaced fracture of base of neck of right femur, Osteonecrosis due to previous trauma right femur, Paroxysmal atrial fibrillation, Chronic diastolic (congestive) heart failure, Nonrheumatic mitral (valve) stenosis, Essential (primary) hypertension. On [DATE] at 11:05 AM A Medication cart was inspected with V7 (Registered Nurse / RN), found R38's Latanoprost ophthalmic solution sealed / unopen inside the medication cart. Pharmacy label indicated refrigerate unopened, store opened at room temperature. Discard after 6 weeks. V7 said unopen Latanoprost eyedrops should be refrigerated. At 11:17 AM A Medication cart was inspected V8 (Licensed Practical Nurse / LPN) and found the following inside the medication cart: 1. R58's Latanoprost ophthalmic solution sealed / unopen. Pharmacy label indicated Refrigerate unopened, store opened at room temperature. Discard after 6 weeks. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. R58's Latanoprost ophthalmic solution date opened [DATE]. Pharmacy label indicated Refrigerate unopened, store opened at room temperature. Discard after 6 weeks. V8 stated medication should have been discarded 6 weeks after opening. 3. R75's Symbicort inhaler date opened [DATE]. Pharmacy label indicated Discard within 3 months after opening. V8 said it should have been discarded in June. 4. R103's Symbicort inhaler opened, no open date. Pharmacy label indicated Discard within 3 months after opening. 5. R111's Fluticasone 50mcg nasal spray opened with no open date. 6. R125's Albuterol Sulfate Inhaler opened with no open date. Pharmacy label indicated Discard 12 months after removal from pouch. V8 said medication should have an open date once opened to know when to discard. She said medication has an expiration don't want to give expired meds. Stated Latanoprost ophthalmic solution should be refrigerated when not opened. On [DATE] At 10:43am V2 (Director of Nursing / DON) has been working in the facility for almost 3 years. She said nurses are expected to date when medication is opened including inhaler, nasal spray, etc. Medications should be labeled and dated once opened so there is awareness when to dispose the medication. V2 said if medication is used when it should have been discarded It will affect the effectivity of the medication. She said Latanoprost eyedrop should be kept in fridge when not in use. Could potentially affect the potency of the medication if not stored properly. She said if expired medication was not discarded could potentially use the medication and have an adverse reaction to the resident. R38's physician order summary (POS) report dated [DATE] showed an active order for Latanoprost solution 0.005% instill 1 drop in both eyes at bedtime for glaucoma. R58's POS report dated [DATE] showed active order for Latanoprost ophthalmic emulsion 0.005% instill 1 drop in both eyes at bedtime. R75's POS report dated [DATE] showed active order for Symbicort inhalation Aerosol ,d+[DATE].5mcg (micrograms)/act (actuator) 1 puff inhale orally two times a day for SOB (shortness of breath) / wheezing. R103's POS report dated [DATE] showed active order for Symbicort inhalation Aerosol ,d+[DATE].5mcg/act 2 inhalation inhale orally every 12 hours for asthma rinse mouth after every application. R111's POS report dated [DATE] showed active order for Fluticasone Propionate nasal suspension 50mcg 1 spray in each nostril two times a day for treatment. R125's POS report dated [DATE] showed active order for Albuterol Sulfate HFA Inhalation Aerosol solution 108mcg/act 1 puff inhale orally one time a day for SOB / Chronic obstructive lung disease. (continued on next page)

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	145634	A. Building B. Wing	11/22/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Astoria Place Living & Rehab	6300 North California Avenue Chicago, IL 60659

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Facility medication storage, labelling and disposal policy dated [DATE] documented in part: It is the facility's policy to comply with federal regulations in storage, labeling and disposal of medications. Medications will be stored safely under appropriate environmental controls. Follow pharmacy recommendation as to when the medication should be discarded after opening.

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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. 44103 Based on observation, interview, and record review the facility failed to ensure prepared foods stored in the walk-in cooler were properly dated, labeled and discarded on the use by date. These failures have the potential to affect 154 residents in the facility who are receive an oral diet. Findings Include: On 11/19/24 at 9:08 AM during the initial kitchen tour in the kitchen with V23 (Cook), there was a food cart with trays of prepared foods such as ham sandwich, vanilla pudding, chocolate pudding, cups of fruits, and pitchers of lemonade. The prepared foods on the tray had no labels when they were prepared. The plastic cover covering the food cart had no label. V23 called V22 (Dietary Aide) and entered the main cooler. V22 stated that the plastic cover should have a date labeled when they were made to know when the food should be discarded. Surveyor and V22 also found a bag of opened grated parmesan cheese with the label that reads prepared date 11/9/24 and used by 11/16/24 (no manufacturer's expiration date noted). V22 stated prepared date is the same as opened date on the label. There was also a tray of pie crust inside a clear bag with no label. On 11/19/24 at 11:38 AM, interviewed V24 (Dietary Manager) and stated, We keep everything for 7 days after opening 7 days we throw it out. Dry goods after opening good for 6 months. If it says used by, we wait for few more days. If it's not in the box and no expiration date, we go by the used by date. All prepared foods should be labeled and dated. They are good for 7 days. We discard on the 7th day. If prepared foods are in the cart, the cart should be covered with plastic cover and labeled and dated whatever day it was prepared. The facility's Receiving policy dated 10/19 documents in part: All food items will be appropriately labeled and dated either through manufacturer packaging or staff notation. The facility's roster dated 11/19/24 documents 156 residents residing in the facility with 2 residents who are NPO (Nothing by Mouth).

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 46342 Based on observation, interview and record review the facility failed to follow their infection prevention and control policy by failing to don proper personal protective equipment, failing to handle soiled linen properly and failing to perform hand hygiene after handling soiled linen. These failures have the potential to affect all 45 residents residing on the one residental floor at the facility. Findings include: On 11/19/24 at 11:45 AM, there was orange signage for Enhanced Barrier Precautions (EBP) posted on the outside of R77's door. On 11/19/24 at 11:47 AM, V12 (Certified Nursing Assistant) viewed the orange signage for Enhanced Barrier Precautions posted outside R77's room and stated that sign tells V12 that R77 is on Enhanced Barrier Precautions which means that when V12 goes into R77's room to provide direct resident care V12 wears a gown and gloves. V12 stated if V12 is only going into the room to drop something off such as R77's food tray and V12 is not going to touch the resident then V12 only has to use hand sanitizing solution before and after entering the room, no gown or gloves are required. V12 stated if R77 was on contact isolation, then there would be a different type of sign posted outside R77's room and then anytime V12 enters R77's room V12 would have to put on a gown, and gloves whether V12 is providing direct care or not. On 11/19/24 at 12:10 PM, V13 (Certified Nursing Assistant) stated V13 reads the infection control signs posted outside the resident's rooms to see what type of isolation the resident is on. V13 stated R77 is on Enhanced Barrier Precautions. V13 stated when V13 is doing any activities of daily living requiring V13 to touch R77, then V13 puts on gloves and a gown but if V13 is only entering the room to deliver R77's meal tray or is not going to touch R77 then V13 does not need to put on any personal protective equipment, only hand hygiene before and after entering the room. On 11/19/24 at 12:27 PM, V13 entered R77's room carrying R77's lunch tray. V13 did not have on a gown or gloves. On 11/19/24 at 12:47 PM, V4 (Infection Preventionist Nurse) stated R77 is on Contact Isolation precautions for Extended-Spectrum Beta-Lactamases (ESBL) in wound. V4 viewed the orange Enhanced Barrier Precaution sign posted outside R77's room and stated that is not the correct sign. It should be the Contact Isolation Precautions sign. V4 stated V4 has confirmed with wound care that R77 is still having draining from R77's wound despite completing course of antibiotics and that R77's wound was re-cultured to make sure the ESBL is gone. V4 stated the results of the culture is not back yet and therefore R77 is still on Contact Isolation precautions until the wound cultures results get back. V4 stated staff should be wearing a gown and gloves anytime they are entering R77's room. V4 stated if the staff is not wearing the appropriate PPE the potential problem is the infection can spread to other residents. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R77's diagnoses inlcude Hemiplegia And Hemiparesis Following Cerebral Infarction Affecting Right Dominant Side, Other Specified Symptoms And Signs Involving The Circulatory And Respiratory Systems, Chronic Embolism And Thrombosis Of Right Femoral Vein, Vascular Dementia, Moderate, With Other Behavioral Disturbance, Chronic Systolic (Congestive) Heart Failure, Vitamin D Deficiency, Dysphagia, Insomnia, Morbid (Severe) Obesity Due To Excess Calories, Aphasia Following Cerebral Infarction, Atherosclerotic Heart Disease Of Native Coronary Artery Without Angina Pectoris, Type 2 Diabetes Mellitus, Hypertension, Diabetes Mellitus Due To Underlying Condition With Diabetic Neuropathy, Unspecified Psychosis Not Due To A Substance Or Known Physiological Condition, Major Depressive Disorder, Recurrent, Moderate, Cellulitis. R77's Order Summary Report dated 11/08/24 documents in part, Isolation-Contact precautions. Reason for isolation: ESBL in wound. R77's Lab Results Report collected 11/05/24, report date 11/08/24 documents in part, wound positive for ESBL. R77's progress note in electronic health record (EHR) dated 11/08/24, 11:20 documents in part, (R77) wound culture positive for ESBL. R77's infection control care plan dated 11/08/24 documents in part, (R77) is on contact isolation related to positive ESBL to back wound with interventions including to maintain contact isolation precautions in accordance with Centers for Disease Control (CDC) guidelines. The facility policy titled Infection Prevention and Control dated 07/31/24 documents, 1.) A sign will be provided outside the room for residents on transmission-based precaution indicating the type of the precaution (Contact, Droplet, or EBP). 2.) Hand hygiene will be performed by staff before and after direct patient contact and after each situation that necessitates hand hygiene. Alcohol-based hand rubs or hand washing x 20 seconds will be used. 3.) Standard Precaution - based on principle that all blood, body fluids, secretions, excretions except sweat, non-intact skin, and mucous membrane may contain transmissible infectious agents. Infection prevention practices include hand hygiene, use of gloves, gown, or mask depending on anticipated exposure, and safe injection practices. 4.) Contact Precaution - intended to prevent transmission of infectious agents spread by direct or indirect contact with patient or the environment and use of gown and gloves is necessary prior to room entry. U.S. Department of Health and Human Services Center for Disease Control and Prevention sign titled, Contact Precautions documents in part, Providers and Staff Must Also: 1.) Put on gloves before room entry. Discard gloves before room exit. 2.) Put on gown before room entry. Discard gown before room exit. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	45110 On 11/19/24 at 11:01 AM surveyor observed V12 [Certified Nurse Assistant] walking down the hallway and passes the nursing station holding soiled linen hanging down with yellow, brownish stains next to her uniform with bare hands and went into the soiled utility room. V12 came immediately out of the soiled utility room and entered the clean supply room and came out with an under brief and towel in her hands. On 11/19/24 at 11:02 AM, V12 stated I removed soiled linen from a resident's bed that had urinated on the sheets and took the linen into the soiled utility room. Then I went into the clean supply room for an under brief and towel. I did not wash my hands I was rushing and forgot. I was supposed to place the soiled linen in a plastic bag, soon as I removed them from the bed and washed my hands. I should not have walked down the hallway with the soiled linen, due to infection control. I will go a wash my hands now. On 11/20/24 at 2:00 PM, V2 [Director of Nursing] stated, My expectation for handling soiled linen is when the linen is removed from the bed, the nursing staff should immediately place the linen into a plastic bag, then take the back to the soiled utility room. Then staff then should immediately wash their hands to prevent the spread of infection and or cross contamination between the soiled linen and clean linen from one resident to another. On 11/22/24 at 110:59 AM, V2 [Director of Nursing] via email said, the facility does not have policy for nursing staff handling linen. Policy: Infection Prevention and Control dated 7/31/24. Standard precautions Based on principle that all blood, body fluids, secretions, excretions, may contain transmissible infectious agents. Infection prevention practices include hand hygiene, use of gloves, gown, mask.