STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145939	A. BUILDING _____ B. WING _____	03/04/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WATERFRONT TERRACE	7750 SOUTH SHORE DRIVE CHICAGO, IL 60649

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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.** Based on observation, interview, and record review, the facility failed to maintain dignity and privacy for 5 residents (R29, R50, R67, R98 and R205) in a sample of 52 residents. Findings include, 1. On 3/01/20 at 9:50 am, R29 was observed in bed sleeping on a bare mattress. 2. On 3/01/20 at 9:56 am, R98 was observed in bed sleeping on a bare mattress. 3. On 3/01/20 at 10:09 am, R50 stated since being admitted to the facility he does not have his clothes or any other clothes. R50 was observed wearing a hospital gown. On 3/03/20 at 9:48 am, V2 (Director of Nursing) stated staff need to make residents beds and they should not be sleeping on a bare mattress. Facility policy (Rev. 8/2009) Quality of Life-Dignity documents in part: Each resident shall be cared for in a matter that promotes and enhances quality of life, dignity, respect and individuality. 1. Residents shall always be treated with dignity and respect. 4. Residents shall be encouraged and assisted to dress in their own clothes rather than in hospital gowns. Findings include: 4. On 03/01/20 09:55 AM R205 noted in bed with urine drainage bag visible from the hallway with no privacy bag. On 3/1/20 at approximately 1:13pm, V2, DON (Director of Nurses), stated the urine drainage bag should be dated whenever changed and should be covered with a drainage bag for privacy. V2 explained that the urine drainage bag is changed every 15 days. At 1:17pm, V2 stated the urine drainage bag should have a privacy bag. 5. On 3/3/20 at approximately 9:09am, V18, RN (Registered Nurse), did not privacy provide privacy for R67 when G-T (Gastrostomy -Tube) medication was being administered; the privacy curtain was not long enough to cover R67 and the door was left opened. The facility policy on Quality of life Dignity, with revised date (NAME)2009, indicated that each resident shall be cared for in a manner that promotes and enhances quality of life, dignity, respect and individuality. The policy interpretation and implementation includes but not limited to respecting resident's private space at all times and helping the resident to keep urinary catheter bags covered.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** Based on observation, interview, and record review, the facility failed to ensure that call lights were within reach for 5 residents (R11, R14, R37, R50 and R58) in the sample of 52 residents. Findings include, On 3/01/20 at 9:45 am, R14 was observed in bed, call light was not within reach. On 3/01/20 at 9:47 am, R58 was observed in bed, call light was not within reach. On 3/01/20 at 9:47 am, R50 was observed in bed, call light was not within reach. On 3/01/20 at 9:57 am, R37 stated she has to use the bathroom, however is not able to call for help due to the call light being out of reach. On 3/01/20 at 10:03 am, R11 was observed in bed, call light was not within reach. On 3/03/20 9:48 am, V2 (Director of Nursing) stated call lights need to be within reach of the residents at all times. Facility policy (Rev.11/13) Answering the Call Light documents in part: The purpose of this procedure is to respond to the resident's requests and needs. 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility failed to include Physician order [REDACTED]. Findings include: R16's clinical document review revealed no Advanced Directives/Physician order [REDACTED]. On 03/02/20 at 11:29am, V2 (Director Of Nursing) stated the Advanced Directives including Physician order [REDACTED]. V2 stated she did not know why. Facility Do Not Resuscitate Order/POLST Policy, dated 11/2013, states : Do not resuscitate orders must be signed by the residents Attending Physician on the physicians order sheet maintained in the residents medical record.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow to follow generally accepted standards of professional practice in [MEDICATION NAME] fluid medication administration for one resident (R94); and failed to check G-T (Gastrostomy Tube) placement before administering medication for one resident (R67) reviewed for standards of professional practice in the sample of 52. 1. On 3/1/20 at approximately 9:50am, R94 was noted in the room with IV antibiotic on going through the PICC (Percutaneous Inserted Central Catheter) line with flowmeter set at 100ml (Milliliter). R94 stated V4, LPN (Licensed Practical Nurse), my nurse, just attached the antibiotic to the line in her arm. At 9:52am, the surveyor asked V4 about the IV. V4 stated she just hung up the IVPB (Intravenous Piggy Back) and when the surveyor asked V4 about certification in administering IV medication, she then stated, Oh no, V5, RN (Registered Nurse), started the IVPB at 9:30am and I just signed it out. On 3/1/20 at approximately 11:22am, V3, ADON (Assistant Director of Nurses), stated the RN hangs the IV medication, and the LPN monitors the smooth running of the IV. On 3/4/20, the facility is unable to provide any documentation showing that V4 was educated and certified on PICC (Percutaneous Inserted Central Catheter). 2. On 3/3/20 at approximately 9:24am, during medication pass observation with V18, RN (Registered Nurse), V18 administered medication to R67 via G-T (Gastrostomy-Tube) without checking the tube placement. When the surveyor brought this observation to V18's attention, V18 stated, I know I should have checked for the G-T placement before given the medication, I'm sorry. The facility policy on Administering Medications through and Enteral Tube, with revised date 11/2013, indicated that purpose of the procedure is to provide guidelines for the safe administration of medication through an enteral tube. The steps in the procedure includes, but not limited to, checking the G-T (Gastrostomy - Tube), auscultation of the abdomen.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** Based on observation, interview, and record review, the facility failed to ensure that hand splints or other restorative devices were applied on residents' extremities. This failure affects 1 resident (R58) out of 8 in the sample of 52 residents, reviewed for restorative care. Findings include: On 3/01/20 at 9:48 am, R58 was observed. R58's left hand is

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) contracted; however, no restorative device in place. On 3/02/20 at 11:50am, R58 was in the dining room, no restorative device in place. On 3/02/20 at 12:28pm, V10 (Restorative CNA) stated she has a list from the therapy department as to which residents need restorative devices. V10 also stated no residents on the third floor are on the list for the use of splints. V10 further stated if she sees a resident that needs a splint or other restorative device, she refers the resident to the therapy for an assessment. Regarding R58, she was told that the resident refused to wear a splint. On 3/02/20 at 12:38pm, V12 (Director of Therapy) said R58 won't let staff touch his hands, that is why he does not have a splint in place due to behaviors. On 3/02/20 at 1:20pm, V12 said R58 had a decline in mobility and ADL (Activities of Daily Living) that is why he was assessed in January. V12 also stated R58 had a splint ordered before and restorative should have continued with the splint. V12 further stated after reviewing therapy notes, R58 was previously discharged with a palmer splint and it should be continued with restorative. R58's 1/25/19 Occupational Therapy Discharge Summary documents in part: Resident discharged from therapy to remain at the facility and referred to restorative program with left palmer guard. Facility policy (Rev. 11/2013) Rehabilitative Nursing Care documents in part: Rehabilitative nursing care is provided for each resident admitted . 3. the facilities rehabilitative nursing care program is designated to assist each resident to achieve and maintain an optimal level of self-care and independence. 4. Rehabilitative nursing care is performed daily for those residents who require such service. Such program includes, but is not limited to: d. Assisting residents to adjust to their disabilities, to use their prosthetic devices, and to redirect their interests, if necessary;
F 0693 **Level of harm** - Minimal harm or potential for actual harm **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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to check the G-T (Gastrostomy Tube) placement before administration of G-T medication for one resident (R67) reviewed for G-T medication administration in the sample of 52. This failure affects R67 and has the potential to affect all seven residents listed as having [DEVICE] in the facility. Findings include: On 3/3/20 at approximately 9:24am, during medication pass observation with V18, RN (Registered Nurse), V18 administered medication to R67 via G-T (Gastrostomy-Tube) without checking the tube placement. When the surveyor brought this observation to V18's attention, V18 stated, I know I should have checked for the G-T placement before given the medication, I'm sorry. The facility policy on Administering Medications through and Enteral Tube, with revised date 11/2013, indicated that purpose of the procedure is to provide guidelines for the safe administration of medication through an enteral tube. The steps in the procedure includes but not limited to checking the G-T (Gastrostomy - Tube), auscultation of the abdomen.
F 0694 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide for the safe, appropriate administration of IV fluids for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer IV antibiotics using qualified trained staff for 1 of 2 residents (R94) reviewed for [MEDICATION NAME] fluid medication administration in the sample of 52. On 3/1/20 at approximately 9:40am on the 1st floor, V4, LPN (Licensed Practical Nurse) was noted passing medication. On 3/1/20 at approximately 9:50am, R94 was noted in the room with an IV antibiotic going through the PICC (Percutaneous Inserted Central Catheter) line with flowmeter set at 100ml (Milliliter). R94 stated V4, LPN (Licensed Practical Nurse), just attached the antibiotic to the line in her arm. At 9:52am, the surveyor asked V4 about the IV. V4 stated she just hung up the IVPB (Intravenous Piggy Back), and when the surveyor asked V4 about certification in administering IV medication, she then stated, Oh no V5, RN (Registered Nurse), started the IVPB at 9:30am, and I just signed it out. Review of R94's (Electronic Medication Administration Record) with V4 showed that the IVPB medication was signed out for 8:00am. V4 stated I signed it out for 8:00am because it was scheduled for 8:00am. V4 stated the physician or the Nurse practitioner was not notified. The surveyor then made V4 aware that the medication was administered 30 minutes late. V4 then acknowledged that it was late and stated it was because V5 was running around in the building attending to other issues in the building and she has to pass medication on her floor. On 3/1/20 at 10:00am, V5 explained that V4 administered the medication at 8:00am, then changed the statement to she administered the medication. When asked as to documentation showing that she did administer the medication, V5 stated, I'm not even sure when the medication was given. I was busy with the other surveyors. Review of facility camera from 9:00am to 11:00am did not show any time that V5 entered R94's room. On 3/1/20 at approximately 11:22am, V3, ADON (Assistant Director of Nurses), stated the RN hangs the IV medication and the LPN monitors the smooth running of the IV. On 3/2/20 at approximately 3:54pm, V2 was unable to present any documentation to show that V4 was trained and certified to administer medications through PICC line. On 3/4/20, the facility is unable to provide any documentation showing that V4 was educated and certified on PICC (Percutaneous Inserted Central Catheter).
F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to make arrangements to obtain resident's personal items upon admission for one resident (R50) in a sample of 52 residents reviewed for provision of social services. Findings include: R50 was admitted to the facility on [DATE]. On 3/01/20 at 10:09 am, R50 stated since being admitted to the facility he does not have his clothes or any other clothes. R50 was observed wearing a hospital gown. On 3/02/20 at 12:20 pm, V11 (Social Service Director) stated, when residents are admitted to the facility, social service department makes the arrangements to pick up residents' belongings. This process is done right away, and it should not be more than 30 days. Regarding R50,V11 stated he was not aware the resident had any belongings, however, will check with admissions to verify it. On 3/02/20 at 12:57 pm, V2 (Director of Nursing) stated she must be honest because she does not know about R50's personal belongings from admission or what the resident has now. The facility has no record of it. Facility policy (rev. 11/2013) Personal Property documents in part: 5. The resident's personal belongings and clothing shall be inventoried and documented upon admission and as such items are replenished.
F 0803 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.** Based on observation, interview and record review, the facility failed to follow their menu. This has the potential to affect all 104 residents who receive oral diets from the facility's kitchen. Findings include: On 3/01/20 at 12:06pm, Dietary staff were observed preparing lunch treys in the kitchen. Lunch included baked chicken, baked potato, diced carrots, and a bread roll. During the plating, V8 (Cook) was plating chicken, some residents got a drumstick, drumstick plus a wing, or a Saddle leg (drumstick and thigh). On 3/01/20 at 12:50pm, V7 (Dietary Manager) stated the protein serving size of the chicken is 3 ounces (oz). On 3/01/20 at 12:52pm, surveyor requested V7 to debone the meat and weigh meat portion. Meat weighed 2 ounces. V7 stated it should be 3 ounces. On 3/01/20 at 1:03 pm, V7 said the kitchen served 104 residents for lunch. Facility's lunch menu documents: baked chicken (3 oz).
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to label opened food items and discard expired food. These failures have the potential to affect all 104 residents who receive oral diets from the facility's kitchen. Findings include, On [DATE] at 9:10 am, during the initial kitchen tour with V7 (Dietary Manager), the walk-in refrigerator contained a pan of raw chicken and cooked beans. Both were undated. There was also unsealed ground pork; top of the pork was dried and undated chicken salad. V7 was not wearing a hair net or a beard guard. On [DATE] at 1:57pm, V9 (Cook) was plating lunch. However he not wearing a beard guard. On [DATE] at 1:03pm, V7 said the kitchen served 104 residents for

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F 0812 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) lunch. Facility policy Refrigerated Food documents in part: Refrigerated food prepared in the healthcare community is labeled with the date to discard or to use by. Facility policy HAIR RESTRAINTS/JEWELRY/NAIL POLISH documents in part: Food and nutrition services employees shall wear hair restraints and beard guards. Hairnets will be worn at all times in the kitchen. Beard guards or masks will be worn as indicated.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observation, and interview, the facility failed to follow standard infection control practices in regards to urine collection bag and respiratory equipment storage and labeling, for two of three residents (R41 and R205) reviewed for infection prevention and control in a sample of 52. Findings include: 1. On 03/01/20 at approximately 9:45am, R41 noted in the room with oxygen in use from the portable green oxygen tank. R41's oxygen tubing on the oxygen concentrator, portable green oxygen tank, and humidifier attached to the concentrator were noted with no date. On 03/01/20 at approximately 12:44pm, R41's oxygen tubing on the green oxygen tank was noted uncontained and not dated. When the surveyor asked V4 LPN (Licensed Practical Nurse) about the tubing storage, V4 stated the tubing should be stored in a plastic bag. 3. On 03/01/20 09:55am, R205 was noted in bed, urine drainage bag and tubing noted not labeled with the last time it was changed. On 3/1/20 at approximately 1:13pm, V2 DON (Director of Nurses) stated the urine drainage bag should be dated whenever is changed and should be covered with a drainage bag for privacy. V2 explained that the urine drainage bag is changed every 15 days.