| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145670 | A. BUILDING _____ B. WING _____ | 03/06/2020 |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| CHALET LIVING & REHAB | 7350 NORTH SHERIDAN ROAD CHICAGO, IL 60626 |

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) |
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| F 0604<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to follow their Side Rail assessment for one resident (R116) of 4 reviewed for restraints in a sample of 44. Findings Include: Minimum (MDS) data set [DATE] documents: R116 has [DIAGNOSES REDACTED]. R116 is rarely or never understood. On 03/04/20 at 11:45 AM R116 was observed laying in bed with all four bed rails in the raised position with padded bumpers on the rails. Physicians Order dated 11/5/19 documents: May use two half side rails for bed mobility and transfer as needed. On [DATE] at 11:50 AM writer asked V5 (Certified Nursing Assistant) to see the position of the bed rails. V5 stated that all four rails were in the raised position, that usually there were only two rails up at the head of the bed. V5 state, I'm not sure why the rails are all up. R116 can still move her right arm, maybe that is why. V5 performed incontinence care and left the room and left the four side rails in the raised position. On [DATE] at 12:00 PM writer and V6 (Registered Nurse) went to R116's room and observed that all four bed rails were still in the raised position. V6 stated, There are four rails up. I will check the care plan and see if it is all right. It may be because of [MEDICAL CONDITION], or maybe they left them up after changing her. At 12 :45 PM V7 (Restorative Nurse) stated, On August 2, 2019 the facility changed their policy for use of two bed rails only. R116 originally had a care plan for four padded bed rails, I changed the care plan but neglected to change the bed rails form four to two rails. R116's physician's orders [REDACTED]. On [DATE] V7 stated R116 originally had consent for four side rails, but that changed on 11/6/19 to two side rails. On [DATE] at 11:30 AM, V3 (Director of Nursing) and V7 both stated there has to be a consent for the use of side rails. Side Rail/Other Devices Evaluation dated 1/9/2020 documents: use of two side rails. Mental Status: confused and forgetful. R116's Consent for use of Side Rails dated 11/6/19 documents: Type of Side rails used: 2 half side rails. The reason for use of side rails: History of falls, unsafe mobility in bed and wheelchair, agitation, [MEDICAL CONDITION] thrashing in bed. Side Rail policy dated 8/2/19 documents: If side rails are appropriate for the resident, a verbal or written consent will be obtained by the facility prior to the use of side rails. |
| F 0690<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview and record review, the facility failed to follow their care plan for indewelling catheter care for one (R293) of three residents reviewed for catheter in a sample of 44. Findings include: On [DATE] 10:45 AM, surveyor observed R293 on his bed with bloody urine in indwelling catheter and bag. With V9 (Nurse), R293 refused allowing us to look at the inserted catheter. Nurse's progress notes dated 3/2/20 indicate R293's catheter was reinserted around 11:00PM. No documentation shows that the facility document blood in R293's urine and that MD was notified. On [DATE] at 11:15 AM V9 stated, I just started my shift at 7:00 AM and didn't see his (R293) catheter yet. The catheter was reinserted yesterday. Physician order [REDACTED]. Catheter Care plan dated [DATE] indicates staff to monitor and document intake and output as ordered by MD. Nurse's progress note dated 3/2/20 indicates that no catheter assessment or output was documented on 11p-7am shift. On 3/5/20 at 2:00 PM V2 (Director of Nursing) stated, I don't have any documentation indicating night shift nurse assessed catheter and documented output. Change of condition policy revised on 9/2/19 documents: The facility must immediately inform the resident and resident physician and legal representative upon a significant change in the resident's physical, mental, or psychosocial status. |
| 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 check food temperatures before serving the pureed meals and all food items' temperatures half through the tray line to ensure hot foods maintained temperature on the steam tables during the tray line service. The facility kitchen staff failed to wash their hands for 20 seconds and between change of gloves. These failures have the potential to affect 189 residents. Findings include: On [DATE] at 10:44 AM V17 (Cook) was observed while pureeing the vegetables. No temperature was checked when removed from blender and poured into the serving dish. The pureed vegetables were placed on the steam table. On 3/03/20 at 11:06 AM V17 took the temperature of the lasagna, mixed vegetables, and fish all regular consistency. No puree temperatures were taken. Surveyor remained in the kitchen until half of the last cart for the fourth floor was filled. No temperature was taken during the tray line service. On 3/3/20 between 11:13 AM and 11:21AM R88 was served pureed meat and pureed vegetables. On 3/4/20 at 11:08 AM V14 (Registered Dietician) said the cook is supposed to take all food temperatures when it comes out of the oven and half way through the serving tray line. V14 said the purpose of checking the temperatures is to ensure the safe temperatures are held while serving. On 3/4/20 at 12:49 PM V14 said food temperature should be checked after the food has been pureed. V14 provided a Food Temperature Form. The form is dated 3/3/20. V14 explained the first column of boxes is for the food temperature to be recorded when out of the oven or after being pureed. The second column is for the food temperature taken half through serving the tray line. Records reviewed for food temperatures included the Food Temperature Form dated 3/3/20. Pureed Meat and Vegetables have no temperature recorded. The same form denotes hot foods should be greater than or equal to 165 degrees Fahrenheit prior to tray line and greater than or equal to 135 degrees Fahrenheit through end of tray line. On 3/4/20 an Inservice was provided regarding food serving temperatures. Holding Temperatures, the temperature will be taken and recorded for all hot and cold food items at each meal prior to starting tray service. Record temperatures on extended menus or temperature log reviewed on 3/4/20 denotes: Point of Service Temperatures: temperatures as served to the resident will be randomly monitored and recorded by conducting a test by the Dietary Manager or designee. On [DATE] at 10:44 AM V17 was observed to wash her hands with running water for less than 5 seconds after placing dishes in the dirty sink for washing and then returned to the food preparation area and began preparing pureed vegetables. On [DATE] at 10:51 AM V17 washed hands for 3 seconds and returned to food prep. On [DATE] at 10:59 AM V17 washed hands for 5 seconds and prepared to serve lunch from steam table. On [DATE] at 11:00 AM V18 (Dietary Aide) washed her hands for 10 seconds and then returned to the serving line. On [DATE] at 11:18 AM V17 walked away from the tray line and removed her gloves and had a piece of balled up foil paper in her hand and placed into her shirt's top right pocket; she then to the tray line and applied new gloves and continued serving. On [DATE] at 11:35 AM V17 changed gloves while in the tray line without washing her hands in between |

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

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.

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| F 0812<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Many | (continued... from page 1)<br>and continued to serve. On [DATE] at 12:09 PM V19 (Dietary Aide) said kitchen staff should wash their hands for 20 seconds. On [DATE] at 12:24 PM V20 (Dietary Aide) said she should wash her hands for 1 minute. On 03/04/20 at 11:12 AM V16 (Dietary Aide) said he is supposed to wash his hands as soon as he enters the kitchen, before assisting with something different than what he was doing, and when changing gloves. On 03/04/20 at 12:29 PM V14 said dietary staff should wash their hands for 20 seconds. V14 said they are supposed to wash their hands between each task, after answering the kitchen phone and before they touch anything else, and whenever changing their gloves. Review of the facility policy for Hand Washing provided by V14, revision date 9/[DATE]9, denotes hand hygiene is recommended during the following situations: After removing gloves. Handwashing with soap and water for at least 15 seconds is recommended. Review of handwashing in-service dated December 2019 provided by V14 denotes: Wash hands: during food preparation as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks. Before donning gloves for working with food. Scrub for a minimum of 10-15 seconds within the 20 second hand washing procedure. On 3/5/20 V17's signature was verified by V14 as number 3 for December 2019 Handwashing in-service indicating V17 received the Handwashing training. |
| F 0813<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Have a policy regarding use and storage of foods brought to residents by family and other visitors.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**<br>Based on observation, interview, and record review the facility failed to follow their policy to label food brought from outside the facility with arrival date and to discard food after 3 days from the pantry refrigerators. This failure has the potential to affect 189 residents. Findings Include: On [DATE] at 10:40 AM the 2nd floor pantry refrigerator was inspected with V12 (Nurse) present. V12 opened the locked door using a code. A container with a store bought soup labeled Lobster Bisque was found. No name or date indicating when it was brought to the facility and who it belongs to was written on the container. The bottom of the container had a black manufacturer printed date of [DATE] stamped on it. V12 dumped the soup in the sink and it was chunky and did not go down the drain. A second container without a name or date was found. The container had no label and was cylinder shaped, clear, about a quart size with red liquid in it. The liquid had separated into a thick liquid on the bottom and almost clear red on the top. V12 said she did not know what it was and threw it in the garbage can. V12 said the facility policy is to keep food for 3 days before tossing. V12 said Housekeeping is responsible for cleaning the snack fridges. On [DATE] at 10:57 AM the 3rd floor pantry refrigerator was inspected with V13 (Nurse). V13 unlocked the pantry door using a code, without entering the code the door is locked. A store bought container labeled Buffalo Rotisserie Chicken was found inside a black bag tied with a knot. There was not a name on the container or date it was brought in. There was a facility food ticket with R152's name on it dated [DATE] in the bag. V13 said the container should have a name and date on it. V3 (Director of Nursing) said the residents put the food in that refrigerator themselves. On [DATE] at 9:40 AM V3 said the purpose of dating the food when it comes in is to know when to dispose of it. V3 said a resident could get sick if they consumed expired food that has gone bad. The facility policy for Food from the Outside review dated [DATE] denotes: All food brought by visitors or family members from the outside of the facility will be labeled with the date it was brought to the facility. After ,[DATE] days these food items will be discarded. All undated food items will be discarded to ensure safety of the residents. |