STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6006746	A. BUILDING: _____ B. WING _____	11/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK CREST RESIDENCE	204 SOUTH STATE STREET ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	Initial Comments Annual Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 1 of 10: 330.715a) 330.715b) Section 330.715 Request for Resident Criminal History Record Information a) A facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) b) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. These REQUIREMENTS were not met as evidenced by: Based on interview and record review, the facility failed to perform criminal background checks on residents admitted to the facility. This applies to 10 residents (R1-R10) reviewed for criminal background checks in a sample of 10.	S9999		

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The findings include:

Facility roster dated 7/1/24-6/30/25 and provided 11/25/24, shows R1-R3 were residing in the facility on 11/25/24.

1. As of 11/26/24 at 3:00 PM, the facility failed to provide evidence that the following residents had a CHIRP (Criminal History Information Response Process) initiated with the state police within 24-48 hours of admission to the facility:

R1 (Admit 10/30/24)
R2 (Admit 4/27/22)
R3 (Admit 6/26/22)
R4 (Admit 3/19/20-

The facility provided an undated Uniform Conviction Information Act Name Inquiry form for R4 and a document showing results from the Illinois State Police received 9/23/20)
R10 (Admit 12/20/16- The facility provided undated Uniform Conviction Information Act Name Inquiry form for R10 and a document showing results from the Illinois State Police result dated 9/23/20.)

On 11/25/24 at 3:00 PM, V3 (Coordinator of Business Services) stated the facility did not yet perform a criminal background check on R1 because she was new to the facility. V3 stated she was also unable to locate criminal background checks initiated for R2 and R3 since their admission to the facility.

2. As of 11/26/24 at 3:00 PM, the facility failed to provide evidence that the following residents' names were checked against the Illinois Sex Offender Registry immediately on admission:

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S9999	Continued From page 2 R1 (Admit 10/30/24 with no registry check provided) R2 (Admit 4/27/22 with no registry check provided) R3 (Admit 6/26/22 with no registry check provided) R4 (Admit date 3/19/20 and registry checked on 9/11/20) R6 (Admit date 10/27/15 and registry check undated) R7 (Admit 6/4/16 and registry check undated) R8 (Admit 9/7/16 and no registry check provided) R9 (Admit 12/15/14 and registry checked on 1/14/15) R10 (Admitted 12/20/16 and registry checked on 9/11/20) 3. As of 11/26/24 at 3:00 PM, the facility failed to provide evidence that R1-R10's names were checked against the Illinois Department of Corrections website by the facility since admission to the facility. As of 11/26/24 at 3:00 PM, the facility failed to provide a policy regarding checking resident backgrounds to identify resident offenders. (C) Statement of Licensure Violations 2 of 10: 330.760d) Section 330.760 Personnel Policies d) The facility shall check the status of all applicants with the Health Care Worker Registry prior to hiring. This REQUIREMENT is not met as evidenced by:	S9999		

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Based on interview and record review the facility failed to perform timely healthcare worker background checks for two employees (V7 and V8).

This has the potential to affect all 3 residents (R1, R2, R3) residing in the shelter care facility.

The findings include:

V7 (Cook, Housekeeping) personnel file showed V7 was initially hired by the facility on 12/19/23, quit on 1/3/2024, and was rehired on 6/2/2024.

On 11/26/24, at 2:16 PM, V1 (Administrator/Executive Director) stated there is no documentation the Health Care Worker Registry inquiry, or criminal background check had been completed at any time for V7.
The census list provided by V1 at the time of survey entrance on 11/25/24, was dated 10/7/24 and showed that V7 was residing in room 31 within the shelter care licensed bed part of the facility. On 11/25/24 at 10:00 V2 (DON-Director of Nursing/Health and Wellness Coordinator) stated V7 was an employee who resided within the shelter care section of the facility.

On 11/25/2024, at 12:00 PM, V7 was observed serving the lunch meal to all the residents within the facility.

V8 (CNA-Certified Nursing Assistant) personnel records were reviewed, V8's records showed V8 was hired on 12/10/22 and the inquiry of the Health Care Worker registry was not completed until 12/31/22. Additionally, V8's record did not include that the Health Care Worker inquiry included all agencies required to be queried, including Illinois Sex offender, DOC (Department

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of Corrections) sex offender, DOC inmate search, DOC FBI (Federal Bureau of Investigation) wanted fugitive, and HHS (Health and Human Services) OIG (Office of Inspector General) exclusion lists.

As of 11/26/24 at 4:00 PM the facility was unable to provide a policy regarding completion of employee Health Care Worker Registry checks.

(C)
Statement of Licensure Violations 3 of 10 :
330.770b)1)
330.770c)1)2)3)
330.770d)
330.770e)
330.770f)
330.770g)

Section 330.770 Disaster Preparedness

b) Each facility shall have policies covering disaster preparedness, including a written plan for staff, residents and others to follow. The plan shall include, but not be limited to, the following:

1) Proper instruction in the use of fire extinguishers for all personnel employed on the premises;

c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to:

1) Ensure that all personnel on all shifts are trained to perform assigned tasks;

2) Ensure that all personnel on all shifts are

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S9999	Continued From page 5 familiar with the use of the fire-fighting equipment in the facility; and 3) Evaluate the effectiveness of disaster plans and procedures. d) Fire drills shall include simulation of the evacuation of residents to safe areas during at least one drill each year on each shift. e) The facility shall provide for the evacuation of physically handicapped persons, including those who are hearing or sight impaired. f) If the welfare of the residents precludes an actual evacuation of an entire building, the facility shall conduct drills involving the evacuation of successive portions of the building under conditions that assure the capability of evacuating the entire building with the personnel usually available, should the need arise. g) A written evaluation of each drill shall be submitted to the facility administrator and shall be maintained for one year. These REQUIREMENTS were not met as evidenced by: Based on interview and record review, the facility failed to have policies including instruction in the use of fire extinguishers, fire drills being conducted quarterly for each shift, disaster drills to be held twice annually, and simulation of evacuation of residents (including handicapped persons). The facility also failed to conduct fire quarterly for each shift and disaster drills twice annually for each shift. This applies to 3 of 3 residents (R1-R3) reviewed for safety in the sample of 10.	S9999		

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The findings include:

On 11/25/24 at 10:00 AM, V1 (Administrator/Executive Director) and V2 (DON - Director of Nursing / Health and Wellness Coordinator) stated they had three Sheltered Care Residents (R1-R3) at the facility. V1 and V2 stated V4 (Former DON/Health and Wellness Coordinator) recently quit and took fire drill documentation with him when he left, and the facility had no copies of the fire drills completed at the facility.

Facility Form Fire Drills Must Be Completed Quarterly, revised 10/20/23, shows fire drills must be completed every three months plus or minus 10 days. The fire drill forms show a fire drill was conducted at the facility on 3/29/24 at 10:28 AM, 6/20/24 at 9:30 AM. The drills do not indicate the drills were completed on all three shifts at the facility.

On 11/26/24 at 3:18 PM, V1 stated she was unsure if there were other disaster drills held at the facility in the last year. V1 stated V4 may have completed tornado drills in the past year but was unsure of when and how many.

On 11/26/24, review of the facility Emergency Preparedness binder documents failed to show any policy regarding disaster drills to be completed twice annually or any documentation that drills were completed.

Facility document Emergency Preparedness -Fires, dated 9/2020, shows, "The Fire Response Plan is intended to provide guidelines for the center to prevent fires, respond to fire emergency conditions, care for members and train

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employees on emergency procedures .... Administrative controls: 2. Written plans, training, and drills ... Employee Training 1. Proficiency through instruction and hands on practice. 2 Conduct a safe and orderly relocation/evacuation ...." The documents fails to specify fire drills will be completed quarterly for all shifts at the facility- including plans for evacuation drills and fire extinguisher instructions.

(C)
Statement of Licensure Findings 4 of 10 :
330.790a)
330.790d)

Section 330.790 Infection Control

a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code and Control of Sexually Transmissible Infections Code. Activities shall be monitored to ensure that these policies and procedures are followed.

d) The facility shall establish an infection prevention and control program (IPCP) that shall include, at a minimum, an antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

The REQUIREMENT was not met as evidenced by:

Based on interview and record review the facility failed to develop policies for controlling and preventing infections in the facility. The facility also failed to establish an antibiotic stewardship

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program.

This applies to all 3 residents (R1, R2, and R3) residing in the facility and reviewed for infection control and prevention in the sample of 10.

The findings include:

On 11/26/24 at 10:07 AM, V2 (DON- Director of Nursing/Health and Wellness Coordinator) stated they do not have an antibiotic stewardship program or policy.

On 11/26/24 at 10:00 AM, the surveyor was presented with 3 binders. One was called infection control, and none of them had any infection control or antibiotic stewardship policies or procedures in them. Another binder about 6" thick was called Covid and it had a large amount of announcements from Illinois Department of Public Health in them.

As of 11/26/2024 at 4:15 PM, the facility had failed to submit any Infection Prevention and Control Program (IPCP) policy and procedures, or any antibiotic stewardship program polices or procedures.

(C)
Statement of Licensure Findings 5 of 10 :
330.792a)
330.792b)1)2)3)

Section 330.792 Testing for Legionella Bacteria

a) A facility shall develop a policy for testing its water supply for Legionella bacteria. The policy shall include the frequency with which testing is conducted. The policy and the results of any tests and corrective actions taken shall be made

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available to the Department upon request. (Section 3-206.06 of the Act)

b) The policy shall be based on the ASHRAE Guideline "Managing the Risk of Legionellosis Associated with Building Water Systems" and the Centers for Disease Control and Prevention's "Toolkit for Controlling Legionella in Common Sources of Exposure". The policy shall include, at a minimum:

1) A procedure to conduct a facility risk assessment to identify potential Legionella and other waterborne pathogens in the facility water system;

2) A water management program that identifies specific testing protocols and acceptable ranges for control measures; and

3) A system to document the results of testing and corrective actions taken.

The REQUIREMENT was not met as evidenced by:

Based on interview and record review, the facility failed to develop a water management program and policies for conducting risk assessment, testing protocols, control measures, and testing corrective actions for Legionella and other waterborne pathogens. This applies to all 3 residents (R1, R2, and R3) residing in the facility and reviewed for Legionella in the sample of 10.

The findings include:

On 11/25/24 at 11:00 AM, V1 (Executive Director/Administrator) stated V6 (Maintenance Director) would know about the facility ' s

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Legionella assessment, testing, and protocols.

On 11/25/24 at 2:00 PM, V2 (DON - Director of Nursing/Health and Wellness Coordinator) stated that V6 said he does not do anything with Legionella.

On 11/25/24 at 3:15 PM V10 (Maintenance Assistant) stated he is not aware of any policy for testing of Legionella and other waterborne pathogens. He is not aware of any testing controls for Legionella.

On 11/25/24 at 3:50 PM, V6 (Maintenance Director) stated he has worked at the facility for 20 years. V6 stated that he did not know what Legionella is. V6 stated he is not aware of a policy, assessment, or testing for Legionella or other waterborne pathogens for the facility. V6 stated he does not have any protocols or control measures to prevent Legionella or other waterborne pathogens. V6 stated he does not have any online tools that the facility has completed to determine where Legionella can grow or any control measures.

The facility ' s Legionella policy dated 11/2022 does not have any information on Legionella testing, frequency of testing, corrective actions, risk assessments, testing protocols or acceptable ranges for the control measures.

(C)
Statement of Licensure Violations 6 of 10: 330.1110e)

Section 330.1110 Medical Care Policies

e) Each resident admitted shall have a complete physical examination, within five days prior to

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admission, or within 72 hours after admission to the facility. This examination shall include documentation of the presence or the absence of tuberculosis infection by tuberculin skin test in accordance with Section 330.1135 and an evaluation of the resident's condition and recommendations for their care including personal care needs and permission for participation in the activity program.

This REQUIREMENT is not met as evidenced by:

Based on interview and record review, the facility failed to ensure residents had a completed physical examination within 5 days prior to admission or 72 hours after admission. This applies to 3 of 3 (R1, R2, R3) residents reviewed for initial physical examinations in the sample of 10.

The findings include:

R1's admission record showed R1 was admitted to the facility on 10/30/24. During review of R1's medical record on 11/25/24 at 1:38 PM, V2 (DON - Director of Nursing / Health and Wellness Coordinator) stated R1's admission history and physical examination was a document dated 9/30/24, office visit, by R1's health care provider. The document dated 9/30/24, did not include the presence or absence of tuberculosis or indicate recommendations for personal care needs or participation in the activity program.

R2's admission record showed R2 was admitted to the facility on 4/27/2022. During review of R2's medical record on 11/25/26 at 1:44 PM, V2 stated R2's initial history and physical assessment was completed on 8/5/22. The document dated 8/5/22, did not include the presence or absence

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of tuberculosis or indicate recommendations for personal care needs or participation in the activity program.

R3's admission record showed R3 was admitted to the facility on 6/26/22. On 11/25/24 at 2:08 PM, V2 stated an office visit summary dated 8/8/22 was R3's initial completed physical examination. The document dated 8/8/22, did not include the presence or absence of tuberculosis or indicate recommendations for personal care needs or participation in the activity program.

As of 11/26/24 at 3:00 PM, the facility did not provide a policy regarding an initial physical examination as requested.

(C)
Statement of Licensure Violations 7 of 10 :
330.1160a)
330.1160b)
330.1160c)
330.1160d)
330.1160e)
330.1160f)

Section 330.1160 Vaccinations

a) A facility shall annually administer or arrange for administration of a vaccination against influenza to each resident, in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention that are most recent to the time of vaccination, unless the vaccination is medically contraindicated, or the resident has refused the vaccine. Influenza vaccinations for all residents age 65 and over shall be completed by November 30 of each year or as soon as practicable if vaccine supplies are

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not available before November 1. Residents admitted after November 30, during the flu season, and until February 1 shall, as medically appropriate, receive an influenza vaccination prior to or upon admission or as soon as practicable if vaccine supplies are not available at the time of the admission, unless the vaccine is medically contraindicated, or the resident has refused the vaccine. (Section 2-213(a) of the Act)

b) A facility shall document in the resident's medical record that an annual vaccination against influenza was administered, arranged, refused, or medically contraindicated. (Section 2-213(a) of the Act).

c) A facility shall administer or arrange for administration of a pneumococcal vaccination to each resident in accordance with the recommendations of the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, who has not received this immunization prior to or upon admission to the facility unless the resident refuses the offer for vaccination, or the vaccination is medically contraindicated. (Section 2-213(b) of the Act).

d) A facility shall document in each resident's medical record that a vaccination against pneumococcal pneumonia was offered and administered, arranged, refused, or medically contraindicated. (Section 2-213(b) of the Act).

e) A facility shall distribute educational information provided by the Department on all vaccines recommended by the Centers for Disease Control and Prevention's Advisory Committee on Immunization Practices, including, but not limited to the risks associated with

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OAK CREST RESIDENCE	204 SOUTH STATE STREET ELGIN, IL 60123

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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shingles and how to protect oneself against the varicella-zoster virus. The facility shall provide the information to each resident who requests the information and each newly admitted resident. The facility may distribute the information to residents electronically. (Section 2-213(e) of the Act).

f) A facility shall document in the resident's medical record that he or she was verbally screened for risk factors associated with hepatitis B, hepatitis C, and HIV, and whether or not the resident was immunized against hepatitis B. (Section 2-213(c) of the Act).

These REQUIREMENTS were not met as evidenced by:

Based on record review and interview, the facility did not provide documentation of the education, consent or declination was provided for the pneumonia, shingles, and hepatitis B vaccines, nor was the screening for hepatitis B, hepatitis C, and HIV completed, and R1 was not offered the annual influenza vaccine for the current season.

This applies to 3 of 3 residents (R1-R3) reviewed for immunizations in a sample of 10.

The findings include:

1. R1's admission record showed R1 was 87 years old and admitted to the facility on 10/30/24.

R1's medical record was reviewed on 11/25/24 and did not contain any evidence of education regarding the influenza, pneumonia, shingles, or hepatitis B vaccine was offered or declined, or that the screening was completed for Hepatitis B, Hepatitis C and HIV.

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V2 (DON - Director of Nursing / Health and Wellness Coordinator) was asked for documentation of R1's vaccinations and screening. On 11/26/24 at 9:00 AM, V2 stated there is no documentation regarding R1's vaccination status or screening available. V2 also stated R1 did not receive, nor was offered, the influenza vaccine for the current season.

2. R2's admission record showed R2 was 90 years old and admitted to the facility on 4/27/22. R2's medical record was reviewed on 11/25/24 and did not contain any documentation regarding education and consent or declination regarding the pneumonia, shingles, and hepatitis B vaccinations and did not contain a screening form for hepatitis B, hepatitis C, and HIV.

V2 was asked for documentation regarding vaccinations and screening. On 11/26/24 at 9:00 AM, V2 stated there was no documentation regarding R2's vaccination status and screening had been completed.

3. R3's admission record showed R3 was 88 years old and admitted to the facility on 6/26/22. R3's medical record was reviewed on 11/25/24 and did not contain any documentation regarding education, consent or declination of the pneumonia, shingles, or hepatitis B vaccinations and did not have a screening form completed for Hepatitis B, Hepatitis C or HIV. V2 was asked to provide documentation regarding the vaccination status and screening form. On 11/26/24, at 9:00 AM, V2 stated there was no documentation regarding R3's vaccination status and screening had been completed.

The facility did not provide a policy regarding

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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S9999	Continued From page 16 Immunizations and Hepatitis and HIV screening when requested. The Facility provided a document titled "Medical Policy" dated 6/2020, that showed the facility will adhere with minimum requirements of the Illinois Department of Public Health. (C) Statement of Licensure Violations 8 of 10: 330.1510a)4) Section 330.1510 Medication Policies a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. 4) If the facility elects to administer medications to some residents for control purposes, the medications shall be administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Medications shall not be recorded as having been administered prior to their actual administration to the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to administer medications in accordance with professional standards. This applies to 2 of 3 residents (R2 and R3) reviewed for medication administration in a sample of 10. The findings include:	S9999		

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S9999	Continued From page 17 During the facility medication administration observation, there were 16 opportunities for the 3 shelter care residents and 3 errors. The errors included 2 omitted doses and 1 medication that should not be crushed. R2's physician orders showed R2 was to receive aspirin 81 mg chewable daily, and vitamin B-12 50 mcg (Micrograms) daily. On 11/26/24 at 8:50 AM, V2 (DON-Director of Nursing/Health and Wellness Coordinator) was preparing medications for R2. V2 stated the aspirin 81 mg and the vitamin B12 50 mcg., were not available to administer to R2. R2 did not receive either medication on 11/26/24. R3's physician orders showed R3 had an order for diltiazem 24 HR (Hour) ER (Extended Release) 120 mg capsule to be administered daily. The manufacturer guidelines for diltiazem extended-release tablets, dated 5/19, showed do not crush or chew the capsules. On 11/26/24, at 8:35 AM, V2 was preparing R3's medications for administration and had placed all medications, including diltiazem, in one cup. V2 stated she was going to crush all the medications together and mix them with applesauce prior to administration. Surveyor stopped V2 from crushing the diltiazem medication prior to administration. As of 11/26/24 at 3:00 PM, the facility did not provide a policy for medication administration upon request. (B)	S9999		

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S9999	Continued From page 18 Statement of Licensure Violations 9 of 10: 330.1930 Section 330.1930 Hygiene of Dietary Staff Food Service personnel shall be in good health, shall practice hygienic food handling techniques, and good personal grooming. The REQUIREMENT was not met as evidenced by: Based on observation and interview, the facility failed to perform hand washing when entering the kitchen and handling resident ' s food. This applies to all 3 residents (R1, R2, and R3) residing in the facility reviewed for hygienic food handling in the sample of 10. The findings include: On 11/25/24 at 11:50 AM, V7 (Cook/Kitchen Aide) entered the kitchen, did not perform hand hygiene, and went into the basement and brought up a can of oranges. V7 opened the can of oranges and then started plating them. V7 then served oranges to R3. On 11/25/24 at 11:59 AM, V7 pushed the kitchen door open with his gloved hands, adjusted his paints and shirt, and did not remove the gloves or perform hand sanitize. V7 then went to the refrigerator and took out pre-made salads, and then served one to R3. On 11/25/24 at 12:06 PM, V7 came into the kitchen again, pushed open the door with his gloved hands, grabbed 2 bowls of stew and did note remove the gloves or perform hand hygiene. V7 then gave one bowl of stew to R3.	S9999		

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S9999	Continued From page 19 On 11/25/24 at 12:09 AM, after serving R3, V7 came back into the kitchen with same gloved hands and grabbed a few more bowls of soup and left the kitchen with them. On 11/25/2024 at 12:12 PM, V7 came back into the kitchen, pushed the door open with the same gloved hands, and did not perform any hand hygiene. V7 put the last 9 bowls of soup on a rolling cart. V7 then served them to the residents in the dining room including R2 and R1. On 11/26/2024 at 10:12 AM V5 (Cook/Dietary Manager) V5 stated that when entering the kitchen everyone should wash their hands with soap and water to avoid cross contamination of the food. (C) Statement of Licensure Violations 10 of 10: 330.2000 Section 330.2000 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 700). The REQUIREMENT was not met as evidenced by: Based on observation and interview, the facility failed to ensure that food was properly covered and the kitchen staff ' s hair was restrained while preparing and handling residents food. This applies to all 3 residents (R1, R2, and R3) residing in the facility reviewed for food sanitation in the sample of 10.	S9999		

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The findings include:

On 11/25/24 at 10:03 AM during the initial tour of the kitchen, V9 ' s (Cook/Dietary Co-Manager) was cutting up onions and carrots and her hair is down her back in a pony-tail and in not retrained with a hair net on any other restraint. When entering the walk-in refrigerator on the right shelf, there were 6 raw pork loins sitting in a tray about 3 feet off the ground and uncovered with salt sprinkled on the top. V9 stated she is cooking the pork loin for lunch that day.

During kitchen observations on 11/25/24 at 10:03 AM, 11:50 AM, and 3:31 PM, V9 did not wear any hair restraint on her pony tail while in the kitchen preparing food for residents.

On 11/25/24 at 11:50 AM, V9 served sliced or cubed pork loin and vegetable stew with carrots, potatoes, celery in a chicken broth, a roll of bread, a side salad, and oranges.

On 11/25/24 at 11:50 AM, V7 (Cook) entered the kitchen and did not wear a hair or beard restraint and started opening a can of oranges. On 11/25/2204 at 11:59 AM, 12:01 PM, 12:06 PM, and 12:12 PM, V7 came in out of the kitchen taking salad and bowls stew and at no time was he wearing a hair or beard cover.

On 11/26/24 at 10:12 AM, V5 (Cook/Dietary Co-Manager) stated that in order to keep hair from getting into the food, all hair including ponytails and braids should be covered with a hair net. V5 further stated that beards should also be covered. V5 stated that all food, including raw pork should be labeled and covered so that the expiration date is known, and food does not get contaminated.

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