STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145372	A. BUILDING _____ B. WING _____	06/27/2008

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEERBROOK CARE CENTRE	306 NORTH LARKIN AVENUE JOLIET, IL 60435

(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) COMPLETION DATE
F 000	INITIAL COMMENTS ANNUAL LICENSURE AND CERTIFICATION SURVEY. FEDERAL OVERSIGHT SUPPORT SURVEY EXTENDED SURVEY WAS CONDUCTED. VALIDATION SURVEY FOR SUBPART U: ALZHIEMER UNIT The facility is in substantial compliance with SUBPART U: Alzheimer Unit, 77 Illinois Administrative Code, Section 300.7000 for this survey	F 000		
F 221 SS=E	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on Record Review, Observation and Interview the facility failed to ensure that residents are free from physical restraints that are not required to treat the residents' medical symptoms. This is for five residents in the sample (R5, R10, R19, R20, R28) and two residents out side the sample (R90 and R180). Findings Include; The record of R5 a seventy-eight year old male admitted to the facility with diagnoses including	F 221		7/18/08

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

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F 221	Continued From page 1 Hypertension, Diabetes, Hypothyroid and Alzheimer dementia was reviewed. R5's record contains a care plan entry dated 4/29/08 for a low bed and movement alarm; an entry dated 5/22/08 for a clip alarm and an entry dated 6/11/08 for floor mattress. In an interview E12 (RN) , stated that these measures were in response to R5's falls or attempts to get out of bed and/or wheelchair. On survey date 6-18-08 R5 was in the second floor hallway adjacent to his room in a wheelchair with a vest-like device on, which went across his chest, over his shoulders and was secured behind his wheelchair. E12 was interviewed again and stated that the "vest" was used on R5 because he fell and/or attempted to get out of the wheelchair many times in the last two months. R5's clinical record lacked a physicians's order for a vest-like restraint, lacked a consent for vest-like restraint and lacked a plan of care for a vest-like restraint. On survey dates 6-17 and 6-18-08 R5 was observed in the dining room with the vest-like restraint which was not removed for lunch on both days of observation. E16 (LPN) stated that the vest-like restraint was called a "torso support" and was not a restraint. However, when she was shown R5's "torso-support" she agreed that the vest was not "self-release" when secured behind the resident's wheelchair. Also, R5's record still lacked a physicians's order, a plan of care and rational for the "torso support." The record of R28, a 95 year old male admitted to the facility with diagnoses including Syncope, Dementia and Encephalopathy was reviewed.	F 221		

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F 221	Continued From page 2 R28's record lacks a physician's order for a "torso support, lacks a signed consent for a "torso-support and lacks a plan of care with the rational for a "torso-support". On survey date 06-18-08 R28 was in the hallway near his room with a helmet and vest-like garment on as previously described. In an interview with E14 (LPN) stated that R28 needed the "torso-support" restraint because he has poor impulse control and has fallen a lot by trying to get out of his wheelchair. R90 was observed with a tray in front of his specialized wheelchair at all times (including during mealtime). In an interview E17 (CNA) stated that the tray in front of him keeps him from sliding out of the chair. E15 (CNA) stated that R19 has a "torso-support" because he has "fallen a lot." Review of the clinical record denotes that there were no physicians order, signed consent or a plan of care with rational for the usage of the tray or torso support. R180 was observed with a "torso-support" fastened in the back of her wheelchair and her record also lacked the above requirements for a restraint. R20 and R10 were also noted to have a "torso-support" and their records lacked the above requirements for restraints. E2, the assistant director of nursing provided the manufactures report of the "torso-support" being used in the facility. The manufactures safety information states, "The...Company recommends the following steps before any restrictive product is used;...a restraint should be used only when	F 221		

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F 221	Continued From page 3 practice alternatives have failed..." On 06-20-08 at 10:50 AM, several residents were observed with their restraints on & were not released during activities on the first floor dining room. These residents observed were R 40, 134, 90 with tray table and R 5 and R 19 with torso restraints.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported	F 225		7/9/08

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F 225	Continued From page 4 to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on Record Review and Interview the facility failed to fully investigate incidents and/or accidents for one of the 26 residents sampled. This is for R10. Findings include; The record of R10, a 53 year old female admitted to the facility with diagnoses of Fractured Leg, Anxiety, Hypothyroid and Mental Retardation was reviewed. A review of the incident reports for this resident revealed that she sustained a bruise on 3-19-08. The investigation of this incident lacked documentation that residents as well as staff were interviewed and also lacked a determination of how the bruise occurred. In an interview with E2, the director of nursing, she agreed that the incident was not fully investigated according to abuse investigation requirements.	F 225		
F 241 SS=E	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		7/10/08

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F 241	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that residents' dignity is preserved during mealtime. Findings include; 1. During the lunch meal on survey dates 6-17, 6-18 and 6-19-08 there were four tables where one resident received a lunch tray and the other three residents at the table waited 20 minutes to receive their lunch tray. One resident at one of the four tables was calling out "I'm hungry, I'm hungry". 2. A resident was observed in a wheelchair next to her dining table and the table height was at the resident's neck making the dining experience for this resident difficult. In an interview E16 (LPN), stated that all residents at the table should be served at the same time. E16 also stated that the resident whose table height was too high never complained that she had a hard time eating. On 06-20-08 at 10:50 AM, several residents were observed with their restraints on & were not released during activities on the first floor dining room. These residents observed were R 40, 134, 90 with tray table and R 5 and R 19 with torso restraints.	F 241		
F 252 SS=E	483.15(h)(1) ENVIRONMENT	F 252		7/10/08

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F 252	Continued From page 6 The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to clean medicine carts, medical refrigerators, emergency carts, medicine rooms, wheelchairs and feeding pumps. Examples include, During the medication room review on first and second floor on June 18, 2008 the medicine carts and the emergency cart on the 1st floor were observed with black and white encrusted substances spilled on the top and sides of the cart. The medicine refrigerators on the 2nd floor were soiled with brown spills covering the inside bottom and sides. Staff's personal items and clothing were observed to be store in the medication storage room. During the initial tour of the facility on 6/17/08 numerous feeding pumps were observed with accumulated encrusted yellow substance on the poles, pumps and stands. Wheelchairs were observed to be dirty and dusty with spills and debris.	F 252		
F 279 SS=G	483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.	F 279		7/10/08

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F 279	Continued From page 7 The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview the facility failed to: (1) Develop and implement a comprehensive plan of care for 5 residents in the sample (R5, R10, R20, R19, R28) and 2 residents outside the sample (R90, R180) for the use of restraints. (2) Develop skin prevention plan and to consistently implement specific interventions to prevent the development/worsening of facility acquired pressure ulcer on R 10 and R 20. These failures resulted in the following: (1) Facility acquired avoidable pressure ulcer (Unstageable) on R 10's right heel. (2) The development of tunneling on R 20's wound on the left foot. Findings include;	F 279		

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F 279	Continued From page 8 The record of R5, a seventy-eight year old male admitted to the facility with diagnoses including Hypertension, Diabetes, Hypothyroid and Alzheimer dementia was reviewed. R5's record contains a care plan entry dated 4/29/08 for a low bed and movement alarm; an entry dated 5/22/08 for a clip alarm and an entry dated 6/11/08 for floor mattress. In an interview E12 (RN) , stated that these measures were in response to R5's falls or attempts to get out of bed and/or wheelchair. On survey date 6-18-08 R5 was observed in the second floor hallway adjacent to his room in a wheelchair with a vest-like device on, which went across his chest, over his shoulders and was secured behind his wheelchair. E12 stated that the "vest" was used on R5 because he fell and/or attempted to get out of the wheelchair many times in the last two months. Review of R5's clinical record denotes a lack of an assessment and plan of care for the use of the "torso-support" restraint. The record of R28, a 95 year old male admitted to the facility with diagnoses including Syncope, Dementia and Encephalopathy was reviewed. On survey date 06-18-08, R28 was observed in the hallway near his room with a helmet and vest-like garment on as previously described. During interview E14, (LPN), stated that R28 needed the restraint because he has poor impulse control and has fallen a lot trying to get out of his wheelchair. R28's record lacked an assessment and a plan of care for the use of the "torso-support" restraint. R20, R10, R19, R180 were all observed to be	F 279		

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F 279	Continued From page 9 wearing the "torso-support" restraints on multiple days throughout the survey. Review of all of the residents' clinical records denotes no assessment and plan of care for the use of the torso-support restraints. R90 was observed to have a tray in front of his specialized wheelchair at all times and during meals. R90's clinical record lacked an assessment and plan of care for the use of the tray. The record of R10, a 53 year old female admitted to the facility with diagnoses including Fractured Leg, Anxiety, Hypothyroid and Mental Retardation was reviewed. R10's record lacked a comprehensive assessment and a prevention plan for skin care. R10's record contains documentation that she developed a facility acquires pressure sore that was first noted on 3-17-08. The record of R20, an eighty-five year old male admitted to the facility with diagnoses including Seizure, Dementia and Renal Failure was reviewed. R20's record lacked a comprehensive assessment of the risk factors for skin breakdown and lacked a prevention plan for skin care. R20's record contains documentation that a facility acquired pressure sore was noted in March of 2008.	F 279		
F 281 SS=D	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced	F 281		7/10/08

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F 281	Continued From page 10 by: Based on observation and record review the facility failed to, 1. Ensure that physicians orders were followed in the administration of sliding scale insulin coverage 2. Ensure that physicians orders and facility policy were followed for the administration of medications. for 1 of 26 residents within the sample R5 and 1 resident outside of the sample R165. Findings include: 1. R5 is a 78 year old with diagnoses that include Hypertension, Diabetes, Pneumonia and Alzheimer disease. Review of R5's physicians order sheet denotes that R5 is to receive sliding scale insulin coverage according to accucheck results twice daily. Review of R5's Insulin /Glucose record denotes that for nine (9) dosages, (3/20, 3/22, 3/24, 3/30, 4/5, 4/9, 5/19/, 6/1, and 6/2/08) R5 did not receive the appropriate dose of insulin coverage as ordered by the physician. Review of the facility's policy and procedure for blood glucose monitoring denotes....Blood glucose monitoring will be performed by the licensed nurse...Administration of insulin per sliding scale will be based on the physicians ordered parameters. Per interview, E2 (DON) stated that accuchecks are to be done by the nurse and that the results and insulin coverage dose should be documented on the Insulin/Glucose record. 2. During the medication pass on 6/18/08 at 9:30 a.m. E12 (RN) was observed to prepare and administer medications to R165. During reconciliation of R165's administered medication	F 281		

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F 281	Continued From page 11 it was noted on the physicians order sheet and the medication administration record that R165's medications should have been administered at 5:00 a.m. Per interview E12 stated that R165 does not like to be awakened at 5:00 a.m. and that staff gives his medications at 9:00 a.m. E12 stated that she assumed that the physician had been notified and an order received to change the administration time of R165's medication.	F 281		
F 311 SS=D	483.25(a)(2) ACTIVITIES OF DAILY LIVING A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to ensure that R 17 was kept clean dry and free from pervasive urine odors. Findings Include: Upon entrance into room 117 during the initial tour of the facility on 6/17/08 with E18 (MDS Coordinator), a strong urine odor was noted. R17 was observed in bed totally saturated in wetness from her upper back to the lower leg area. R17's diaper, pants, blouse, bed pads and blankets were noted to be wet and to have a pungent urine odor. Multiple brownish, yellow rings were observed on R17's bed pad and blanket. Review of R17's minimum data set (MDS) denotes that R17 is totally dependent on staff in all areas of care.	F 311		7/26/08
F 314 SS=D	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a	F 314		8/1/08

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F 314	Continued From page 12 resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to: (1) Prevent the development of a facility acquired pressure ulcer for R20's left foot (2) Develop a preventive plan for potential alteration of skin integrity and the development of R 20's pressure ulcer. (3) Conduct a comprehensive assessment addressing the risk factors. (4) Consistently implement measures to promote healing and prevent further sores from developing. (5) Ensure pain is managed in the care of pressure sore treatments These failures resulted in R20's wound not accurately measured, development of an unstageable pressure ulcer to the left foot and unmanaged pain during dressing change. Findings include: R20 was observed on all days of the survey to be in use of a wheel chair with a formed pressure relieving device on the left leg. On 6/19/08 an observation with measurement was done to	F 314		

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F 314	Continued From page 13 R20's left lateral foot with E35 and E36. The wound was measured by E35 with assistance of E36 with measurements as follow: an unstageable area to the left lateral foot was identified measuring : 1.0 cm x 1.3 cm with 0.5 cm in depth . The wound was being packed with strips and a wound gel. From observation of the wound there appeared to be undermining , E35 was asked if there was any undermining or tunneling of the wound . E35 stated she was not aware and had not measured the wound for such. While E35 and E36 measured the wound for undermining, R20 was noted to move his foot and grimace. Both staff were asked after the treatment if R20 had been offered any thing for pain. Interview with E13,(staff nurse) stated nothing was offered for pain . A review of the plan of care for pain management during treatments was not identified. Measurements of the undermining were stated as following: At the 3:00 position measures 0.3 cm the 6:00 position a measurement was obtain of 0.1 cm; the 9:00 position measured 0.1 cm and the 12:00 position is identified to be 0.3 cm. A review of the facility's Weekly Comprehensive Wound Assessment Documentation sheet last notation of 6/9/08 recorded a measurement of 0.7 cm x 0.9 cm with a depth of 0.3 cm . The areas of undermining were not identified on the wound sheet. E36 stated the measurements are to be done weekly but R20's was not done because of her training and the facility was behind due to staff illness. During the daily meeting of 6/20/08, the facility was asked how and why R20 developed the	F 314		

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F 314	Continued From page 14 wound. On 6/23/08, the facility presented a physician's order dated 3/6/08 for treatment. The facility had no reason for the development of the wound.	F 314		
F 315 SS=G	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to: (1) Complete an accurate and thorough assessment of factors that may predispose R27, R 26, R10, R 19, R4 & R 7's incontinence. (2) Thoroughly evaluate causes of R26, R 7 & R 27's decline in Bowel and Bladder. (3) Obtain accurate voiding patterns of the residents. (4) Provide an individualized plan to address the specific needs of the residents. (4) Provide proper incontinence care (5) Provide justification for the use of indwelling urinary catheter for R 30 and R 5. For 7 of 26 sampled residents R4, R5,R7,R19,R26,R27 and R30 These failures resulted in:	F 315		8/1/08

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F 315	Continued From page 15 (a) Decline in R26 , R 7 and R 27's Bowel and Bladder functioning from continent to incontinent. (b) R 10 verbalizing that it bothers her to wet in her diaper and that she wanted to be helped in the bathroom more often. Examples include: Review of R 26 ' s bowel and bladder assessment disclosed that that on 11-29-07 R 26 was assessed as continent of bowel and bladder. The assessment showed R 26 has no history of incontinence and does not need a toileting schedule or training. A decline in R 26 ' s bowel and bladder function was noted on 04-18-08 per B&B assessment sheet. The assessment showed that R 26 now becomes occasionally incontinent (incontinent 2 or more times a week, but not daily). Review of the Activities of Daily Living -Resident Assessment Protocol sheets occasionally incontinent of B&B because she sometimes waits too long. R 26 was identified with functional incontinence but there was no analysis or assessment on how the facility identified her as such. Review of the plan of care disclosed that R 26 will be toileted after meals and at bed time. There was no individualized plan to address the specific toileting needs of R 26 and what ' s the facility plan to improve or maintain her bowel and bladder functions. Review of R 10 ' s Minimum Data Set dated 04-29-08 showed that R 10 was occasionally incontinent of bowel and bladder. There was no comprehensive assessment done to evaluate R 10 ' s incontinence. There was no voiding pattern	F 315		

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F 315	Continued From page 16	F 315		

obtained, type of incontinence was not identified and no plan of care was developed to address her incontinence. This information was presented to the Administrative staff on 06-20-08.

On 06-21-08 the Administrative staff presented a form and claimed that the staff went and interview of R10. R10 was asked questions and agreed that it bothers her to wet in her diaper and that she wants to be helped in the bathroom more often.

Review of R 7 ' s Minimum Data Set dated 01-19-08 and 05-11-08 showed that R 7 had a decline in bladder functioning. On 01-19-08 disclosed that R 7 was usually incontinent of bladder and on 05-11-08 Minimum Data Set showed that R 7 becomes occasionally incontinent. There were no assessment conducted regarding R 7 ' s decline and no plan of care was develop for R 7 ' s incontinence.

R 30 and R 5 were observed with indwelling catheters. Review of the clinical records showed that there were no medical justification for the use of these catheters and no plan of care was developed.

R27 was observed on days of the survey to be in the use of an adult brief. The facility documents resident to be incontinent of urine . The physician notation documents urinary incontinence and urinary frequency. Interview with E3 and record review of MDS of 5/31/08 identifies as usually continent . A 6/22/08 assessment of tolieting motivation and preference assessment interview indicates the question " Does it bother you to wet in your diaper ?" it is checked "yes". There was no analysis of the voiding patterns for R27. There

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F 315	Continued From page 17 was no analysis or indication if there was a decline in the incontinence patterns for urination. R19 was observed on all days of the survey to be in use of a torso restraint and to be wearing an adult brief. The facility has identified R19 to be frequently incontinent of urine and requires tolieting . A review of the clinical record and observation R19 is incontinent of urine and bowel . The facility assessment of bowel and bladder does not identify the type and cause of R19 urinary incontinence. There was no tracking of the pattern available at survey time to indicate R19's specific voiding patterns to prevent frequent incontinence episodes for R19. R4 was observed to be in the facility's Alzheimer unit and to be in contact isolation for the vancomycin resistance enterococcus. R4 is identified to be incontinent of bowel and bladder on the MDS of 4/11/08. From observation and interview, the facility has not identified the voiding patterns for R4's urinary incontinence. The plan of care does not identify staff intervention for the pattern for the isolation.	F 315		
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation record review and staff interview the facility failed to ensure that systems are in place to ensure that residents receive medications as ordered. This is for 1 of 44 opportunities of medications	F 333		7/14/08

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F 333	Continued From page 18 observed during the medication pass conducted on 6/18/08 at 8:02 am with E13 (RN). Example includes: R80 who has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) was observed to receive his morning medications on 6/18/08 at 8:02 am... E13 was observed to administer to R80 pills by mouth and one inhaler medication. E13 stated to surveyor that one medication, the inhaler ADVAIR 250-50 Diskus, was not available. E13 stated the medication was not available the day before on 6/17/08 and R80 had not received his 9:00 am or 5:00 pm dose as per interview and record review R80 had missed three doses of the Advair inhaler: 2 doses on 6/17/08 the 9:00 am and 5:00 pm dose and the 9:00 am dose on 6/18/08. E13 stated the medication was ordered but the facility had not received it. This was brought to the attention of E2 (Director of Nursing) who stated the pharmacy was gong through some changes and had not given the facility information on how to call for needed medications.	F 333		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically	F 334		7/25/08

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F 334	Continued From page 19 contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the	F 334		

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F 334	Continued From page 20 pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to: - provide education regarding the benefits and potential side effects of immunizations. - track / monitor each residents vaccination status (including medical contraindications or delayed administration). -provide the immunizations to residents that had signed consents and physicians order to receive the influenza and pneumococcal immunizations. for 8 of 26 residents within the sample (R7,9,10,15,16,17,24,and 26 and 1 resident outside of the sample R27). Findings include: Review of clinical records denotes that R7 had physicians orders and a signed consent for the influenza and pneumococcal immunization to be given dated 2/11/08. Review of the clinical record and immunization log obtained by the facility on 6/19/08, denotes that R7 had not received either of the ordered immunizations.	F 334		

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F 334	Continued From page 21 Review of R17's physicians order sheet denotes orders for the administration of the influenza and pneumococcal immunizations to be given. Review of the clinical record denotes that no immunizations had been given and that no education to the resident or family regarding the benefits and potential side effects of the immunizations had been done by the facility. Review of R24's and R27's clinical records denotes consents for refusal of the influenza and pneumococcal immunizations. There was no education or follow up by the facility to ensure that the residents or their families understood the benefits and potential side effects of the immunizations. Review of R26's clinical record denotes that the facility was unable to obtain the influenza vaccine to be given to the resident upon admission 11/5/07. There was no follow up to ensure that the vaccination was given when received by the facility. Review of R10's clinical record denotes that she was admitted into the facility 2/1/08 with orders for the influenza and pneumococcal immunizations to be given if not contraindicated. Further review denotes consents for the immunizations signed by R10 dated 2/1/08. As of 6/19/08 the immunizations had not been given and no follow up by the facility had been done. Review of R9, R15 and R16's clinical record denote no education was given to the residents or their families regarding the benefits and potential side effects of the pneumococcal immunizations.	F 334		

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F 334	Continued From page 22 Per interview on 6/19/08 E11 (infection control nurse) stated that she had just started the immunization program, and that the facility had no surveillance program in place at this time. E11 further stated that she had just received a list of resident on 6/18/08 who according to the MDS needed immunizations. E11 further stated that she was reviewing the list but was not familiar with the coding of the items on the list.	F 334		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse	F 356		7/7/08

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F 356	Continued From page 23 staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to display the required posting of working staff. Findings include: Upon entrance into the facility's front lobby and during tour of the facilities's entire 1st, 2nd floors and Alzheimer unit, a visible staff posting was not displayed as required. Per interview with E2 (DON) and E3 (ADON) both stated that the staff posting should be displayed at the receptions desk in the front lobby. Both E2 and E3 confirmed to the surveyor that the staff posted was not displayed as required.	F 356		
F 369 SS=D	483.35(g) DIETARY SERVICES - ASSISTIVE DEVICES The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on Record Review, Observation and Interview, the facility failed to provide residents with special eating equipment and utensils when necessary. This is for two residents in a sample of 26 (R20 and R182) This failure resulted in these residents having poor intake at mealtime. Findings include;	F 369		7/21/08

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F 369	Continued From page 24 The record of R20, an eighty-five year old male admitted to the facility with diagnoses including Seizures, Dementia and Renal Failure was reviewed. R20's record lacked documentation that he had difficulty at mealtime. During all days of the survey 6-17-08 to 6-20-08 R20 was observed having difficulty eating which resulted in his food spilling onto his tray and onto his chest and lap. In an interview E16, (LPN) stated that R20 should be using a different type of eating utensils. During lunch observation on 6-19-08 R182 had difficulty eating as evidenced by the majority of her lunch spilled onto her tray. In an interview E16, stated that R182 could use a divided plate and that she would be evaluated.	F 369		
F 371 SS=F	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions. This REQUIREMENT is not met as evidenced by: Based on observation and interview, 1. The facility's dishwasher failed to sanitize at the proper temperature an chemical concentrations. 2. The facility failed to protect food during storage. Examples include;	F 371		7/10/08

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F 371	Continued From page 25 On June 17, 2008 after the breakfast meal the dish machine's final rinse cycle did not reach 180 degrees Farenheit. The heat sensitive tapes that was sent through the final sanitizing rinse did not change color. The kitchen staff stated that they had a back up chemical sanitizing system. During the testing of the back-up chemical sanitizing the chemical test strips also failed to change to the appropriate color. The thermometer on the dishwasher was inaccurate. The thermometer indicated the final rinse was 180 degrees Farenheit. Kitchen staff stated the repairman would be called. The dish washer was repaired. Food was observed being stored at the end of the walk in refrigerator. The food was noted to be wet from condensate dripping from the coolant coils. Food was removed or destroyed from this area.	F 371		
F 373 SS=K	483.35(h) PAID FEEDING ASSISTANTS A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system.	F 373		6/27/08

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F 373	Continued From page 26 A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160: o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following: Feeding techniques. Assistance with feeding and hydration. Communication and interpersonal skills. Appropriate responses to resident behavior. Safety and emergency procedures, including the Heimlich maneuver. Infection control. Resident rights. Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse. A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.	F 373		

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F 373	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to: (1) Ensure that the non nursing feeding assistants have completed a State approved training course prior to feeding residents. (2) Have a state-approved training program for paid feeding assistants. (3) Assess each resident requiring assistance with feeding to determine which residents could safely be fed by a Feeding Assistant (4) Provide supervision by an RN or an LPN. (5) Ensure paid feedings assistants did not feed residents who have difficulty swallowing. These failures resulted in an Immediate Jeopardy. The Immediate Jeopardy was identified on 06/18/2008 at 1:10 PM. The Immediate Jeopardy began on 06/18/2008 at 10:15 AM when non nursing staff E4 (Alzheimer Coordinator) and E27 (Village Tech. Coordinator) were observed feeding residents R140 and R174 who were both on mechanically altered diets. While the immediacy was removed on 06/18 /2008 at 10:10 PM the facility remains out of compliance at Severity Level 2. Additional time is needed to monitor and evaluate the effectiveness of the revised policies and procedures to ensure their implementation. This applies to 5 of 16 residents in the facility (R3, R28, R29, R40, and R44) who were identified as feeders with complicated feeding	F 373		

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	145372	A. BUILDING _____ B. WING _____	06/27/2008

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F 373	Continued From page 28 problems and this applies to 19 paid feeding assistants who had not had the appropriate training through a State approved program. Findings include: On 06-17-08 at 10:00 AM, during the entrance conference, E1 the (Administrator) was asked if the facility had a paid feeding assistant program. E1 stated " I am not sure. I will let you know. " On 06-18-08 E1 presented a list of residents on the feeding program. The list disclosed that there were 11 total residents in the facility that were totally fed by the staff. The breakdowns were as follows: · 5 residents on the Alzheimer ' s Unit (R 115, 25, 110, 178 and R 185) · 1 resident on the 1st floor (R150) and · 5 residents on 2nd floor (R90, 56, 40, 134 and R163). The facility provided 19 names of non nursing employees that fed residents. Interview with the Administrative staff E1, E2, and E3 (Administrator, Director of Nursing and the Assistant Director of Nursing) on 06-17-08 at 2:00 PM, the staff stated that their feeding assistants had been trained by a Speech Pathologist for an hour and a half session. E3 (ADON) stated "The Speech Therapist was knowledgeable to train the staff. " E1, E2, and E3 were not aware of the state required training course and was not familiar with the requirements under the feeding assistant program. E24 (Speech Pathologist) was interviewed via phone on 06-18-08 at 11:10 AM. E24 stated " I was asked to in service the non nursing	F 373		

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F 373	Continued From page 29	F 373		

personnel. Nothing was said about feeding assistant program. I have no idea on what was that. My goal for my in service is to review safe feeding technique. The diet and liquid consistency and positioning." E24 stated, "I have not attended a State approved feeding assistant program. "

Per interview with the Alzheimer ' s Nurse on 06-18-08 at 12:40 PM, the Nurse identified R174 and R91 as feeders. The Nurse said that R 174 was on aspiration precaution. The Nurse also stated that R25, 130, 115, 110 and R120 required additional assistance by staff to complete their meals. The nurse also stated that the activity Aides assist with feeding and that , 2 of my 3 kids ages 18 and 15 years old, help with feeding residents when they are at the facility. When the Nurse was asked how the non nursing staff knows who to feed or who ' s on aspiration precaution or on altered diets, the Nurse stated "There was a list here at the (nursing station), it's not here anymore. "

On 06-18-08 at 10:50 AM, 2 non nursing staff , E4(Alzheimer's Coordinator and E27 (Alzheimer's Tech. Coordinator) were observed in the Alzheimer's Unit feeding R174 and R140 with pureed cookies. Both residents had been identified by staff as at risk for aspiration.

Per interview on 06-18-08 at 1:00 PM, E4 stated " I feed residents in the unit, I received my training for an hour last week from the Speech Therapist. "

Per interview with the Staffing Coordinator/E6 on 06-18-08 at 10:35 AM, E6 stated that she gets direction from the CNA's as to whom to feed. E 6

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F 373	Continued From page 30 stated " I feed residents on all sorts of diets." E6 further stated "My feeding in-service was for an hour, I worked as a CNA in 1986 but I am no longer on the registry." The Social Service Staff/ E23 was interviewed on 06-18-08 at 10:45 AM. E23 disclosed the same as E 6 and added that the nurses are usually passing their meds at meal time but the CNA ' s are there just in case. Further review of the list of residents identified on a feeding program and interview with the Administrative staff disclosed that the facility does not have a system in identifying residents that are at risk, on aspiration precaution, have the potential for choking and needing 1:1 assistance at meal times. On 06-18-08 at 2:38 PM, the facility Administrative staff were asked how were the 11 residents identified as total feed. The Assistant Director of Nursing stated "We went around and checked the residents. There were no residents identified in the Alzheimer's unit that should be in the feeding program." The facility was unable to provide the facility policy and procedure on their paid feeding assistant program. On 06-19-08, R30 was observed in the second floor dining room with his wife. R30 was served his lunch and began to feed himself. After a few bites of his Pureed meat, R30 began coughing and choking. The nurse passing medications went to assist the resident. R30's wife stated that he did not have his scopolamine patch on and that was why he was choking and coughing. The nurse stated that she would get his "patch" and left the dining room. Twenty minutes later, R30	F 373		

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F 373	Continued From page 31 began to eat and again began to choke. The staff in the dining room did not respond and the surveyor asked that R30's tray be removed and kept warm until he received his "patch". Review of R30's plan of care dated 05-13-08 showed that R30 has the potential for ASPIRATION related to DYSPHAGIA. R30's care plan intervention showed the following: · Monitor chewing & swallowing ability. · Monitor closely at mealtimes, suction if aspiration should occur. · Encourage good fluid intake while eating; monitor the ability to swallow ... · Offer small sips and bites during meals. There were no staff at R30's side during the observation to assist R30 to adhere to these interventions. Random review of 2 resident ' s (R29 and R157) plan of care disclosed: (1) R29's is at risk for aspiration and usually staff has to assist her during meal time. (2) R157 requires mechanical altered diet. At risk for CHOKING/SWALLOWING DIFFICULTY. These two residents were not included in the list that was presented by the facility as residents who require assistance. However R29 and R127 were confirmed by the staff as being on aspiration risk precautions. Review of pharmacy diet print out disclosed the following information: · R30 - puree diet, honey thick liquids Up at 90 degrees all meals Chin tuck with all liquids Double dry swallow with all consistency	F 373		

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F 373	Continued From page 32 ASPIRATION PRECAUTION · R46 - pureed diet, 1:1 ALL MEALS · R180 - Dysphagia, pureed with thin liquids when patient is awake. · R25 - Pureed diet, nectar thick liquids, ASSIST WITH MEALS · R10 - pureed diet, thin liquid, FEEDER ASSISTANCE · R 179 - pureed, nectar thick liquids, ASPIRATION PRECAUTION · R157 - pureed diets, thin liquids, ASPIRATION PRECAUTION Interview with the nurse on 6-19-08 at 11:50 AM, the nurse disclosed "R157 is fed by staff since she was at Alzheimer ' s unit." (R157 is currently at the 1st floor regular unit.) On 06-21-08, the facility requested the Speech Pathologist to screen residents and found the following: · Alzheimer ' s Unit 6 residents totally fed 8 residents on aspiration precautions. · 2nd Floor 5 residents totally fed. 1 resident on aspiration precaution. 8 residents on aspiration precaution. · 1st floor 2 residents totally fed. 5 residents at risk for precaution. The facility Administrative staff confirmed that the facility had not had an IDPH approved feeding assistant program and none of the staff had received any training through state approved	F 373		

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F 373	Continued From page 33 program. On 06/18/2008 at 1:10 PM, E1 and E2 were informed of the Immediate Jeopardy relating to the facility's paid feeding assistants program. The surveyor confirmed that the facility took the following steps to remove the immediacy of the situation: Effective 06/18/2008 at 12:30 PM, the facility will not be utilizing a Paid Feeding Assistants Program. The facility stopped utilizing the paid feeding assistants. Inservices were conducted to all facility staff. Nurse Managers were assigned to specific floors to assure that sufficient CNA and licensed staff would be present to meet the mealtime needs of the residents. A plan of removal was provided to the survey team at 2:30 PM. The Policy & Procedure for Residents that need assistance with meals was developed, reviewed and revised. The Assistant Director of Nursing/Restorative Director interviewed residents, nurses and CNA's regarding the eating needs and risk precautions of the residents. The Speech Pathologists screened residents. List of residents identified needing assistance and with altered diets were developed care plans updated and staffs were in serviced. Resident's diet cards were updated.	F 373		
F 425 SS=D	483.60(a),(b) PHARMACY SERVICES The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425		7/21/08

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F 425	Continued From page 34 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation record review and staff interview the facility failed to provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident For 1 of 44 opportunities of medications observed on 6/18/08 medication pass for R80. Example includes: R80 who has a diagnosis of Chronic Obstructive Pulmonary Disease (COPD) was observed to receive his morning medications on 6/18/08 at 8:02 am. E13 was observed to administer to R80, pills by mouth and one inhaler medication. E13 stated to surveyor that one medication, the inhaler ADVAIR 250-50 Diskus, was not available. E13 stated the medication was not available the day	F 425		

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F 425	Continued From page 35 before on 6/17/08 and R80 had not received his 9:00 am or 5:00 pm dose as per interview and record review R80 had missed three doses of the Advair inhaler: 2 doses on 6/17/08 the 9:00 am and 5:00 pm dose and the 9:00 am dose on 6/18/08. E13 stated the medication was ordered but the facility had not received it. This was brought to the attention of E2 (Director of Nursing) The pharmacy sent a memo dated 6/19/08 regarding the Re-ordering procedure for medication. A new system went into place on June 12 th and should experience normal service flows by the end of this week .	F 425		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of	F 431		7/21/08

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F 431	Continued From page 36 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to have systems in place to monitor the temperatures for medications stored in the second floor medication room and ensure stored medication with expired expiration are identified. This has the potential to effect the residents for the second floor Example includes: On 6/18/08 during observation of the second floor medication room with E14, the room was noted to have a heavy coat of black substance on the floor. The medication and treatment carts were noted to have brown and whitish substance on handles and cabinets . The room's two refrigerator's ice compartments were thick with frost. The food refrigerator temperature was not registering from the duel thermometer observed. The refrigerator containing medications had a duel temperature which read 50 degrees (F) and 20 degrees (F) . E14 was asked which temperature was to be read. She stated she did not know how to read the gauge. The facility did not have documentation that they were keeping track of the refrigerator temperature or identify corrective	F 431		

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F 431	Continued From page 37 action taken if temperatures are not identified in the acceptable range. An opened stock medication of Sodium Bicarbonate tablets were observed in the cabinet of the medication room with other stock medication. The expiration date was identified to be April ,2008. A bag of intervenous fluids of 0.45% Sodium Chloride was noted with other fluids to have an expiration date of April,2008. Interview with E14 as to what was the system to check for dates (E14) unit supervisor was not aware.	F 431		
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure staff wash hands after direct contact with residents and after performing incontinence care. For 3 of 26 sampled residents R19, R27 and R28 Example includes: Observation of residents during the tour conducted 6/17/08 at approximately 10:00 am on the second floor; R28 was observed to be in a torso restraint in a wheel chair. R28 was noted to have sediment in eye, to be unshaven, and smelled of urine and feces. E17 (Restorative	F 444		7/21/08

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F 444	Continued From page 38 Certified Nurses Aide) stated she was helping out on the floor that day and was going to change R28. E3, Assistant Director of Nursing, was with surveyor. R28 was not attempting to stand and E17 asked for assistance from E26 who was not wearing or used a gait belt to assist in transfer. Staff was noted to pull R28 up by under the arms and seat of the pants and transfer him from the wheel chair to the bed. R28 was noted to be wearing a diaper and feces was noted. After the care was rendered , E26 was noted to take the soiled clothing out into the hall way with the same gloves place the linen in the hamper then go to the soiled utility room, discard the trash and then wash hands at the nurses rest room after touching door handles with gloved hands. On 6/17/08 at 10:20 am R27 was observed with morning care. A wet towel was given to R27 given by E25. R27 had family in attendance during this observation. During the observation, R27 stated during this care that she was burning between her legs. E3 was in attendance. R27 was observed to be wearing adult briefs and which were removed .E25 washed the top of R27 ' s pubic area and not the labia area as identified in the facility ' s policy and procedure. After the morning care, E3 and E25 pulled R27 up to the wheel chair using her arms at no time was a gait belt used or noted to be available. E25 was noted to render care to R27 and used the same pair of gloves during transfer, opening doors and dressing R27 without changing gloves or washing hands. R19 was observed toileted on 6/19/08 with E20 (CNA). E20 stated she had " pooh-pooh " in the diaper. After R19 was finished on the toilet E20 wiped her with tissue paper and applied a new	F 444		

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F 444	Continued From page 39 diaper. E20 was noted to place R19 back into the wheel chair, place the torso restraint back on her and place resident in the hallway all using the same pair of gloves E20 failed to remove gloves and wash hands after rendering care to R19.	F 444		
F 465 SS=B	483.70(h) OTHER ENVIRONMENTAL CONDITIONS The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain furnishings and equipment in a clean and orderly condition. Examples include; During the environmental tour of the facility on 6/18/08 the oxygen concentrators in room 106 and 225 were observed to have an accumulation of dust and debris. -In the Village unit their were food spills on the window sills and window frames in the dining room.. -- -There was loose wall paper by the air conditioner in the Village unit dining room. -The laminated finish on the cabinets by the sink and the nurses's station door in the Village dining room was observed to be worn off in six inch strips.	F 465		6/30/08

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F 465	Continued From page 40 - A high back chair in the village ding room had a rough, splintery back. - There was no thermometer in the refrigerator in the village dining room. -There was a loose grab bar in the corridor by room 133. - A chair in room 105 had loose legs. The cross brace for the legs had come unglued and was separated from the legs.	F 465		
F 467 SS=B	483.70(h)(2) OTHER ENVIRONMENTAL CONDITIONS - VENTILATION The facility must have adequate outside ventilation by means of windows, or mechanical ventilation, or a combination of the two. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain ventilation fans in resident bath rooms in working order. Examples include; Exhaust fans in resident bath rooms did not work in rooms 206, 221 on the second floor and in all the odd numbered in the Village unit..	F 467		6/30/08
F 497 SS=E	483.75(e)(8) REGULAR IN-SERVICE EDUCATION The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be	F 497		8/1/08

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F 497	Continued From page 41 sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to: (1) Have systems in place to ensure each nurse aide has no less than twelve hours of in-service education per year. (2) Ensure staff demonstrates competencies by consistently applying interventions to meet the resident ' s needs. This is for 5 of 5 (CNAs) Certified Nurse Aides (E29, E30, E31, E32 and E33) reviewed. Example includes: Interview with Human Resource Director on 06-18-08 at 2:40 PM indicated that there was no system to determine how many hours of training staff have received or that the training is based on the performance reviews. Review of each C.N.A's inservice sheets disclosed inservices such as bedpan maintenance, preparation for survey, uniform policy, pads, and names of people, etc. The continuing education that was recorded was not based on the out come review of the staff and the	F 497		

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F 497	Continued From page 42 weaknesses of the staff were not identified and/or addressed.	F 497		
F 498 SS=E	483.75(f) PROFICIENCY OF NURSE AIDES The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to ensure staff are proficient with resident care issues in the areas of incontinence care, morning care, transfer techniques and gait belt use For 3 of 26 sampled residents R19, R27 and R28 Example includes: Observation of residents during the tour conducted 6/17/08 at approximately 10:00am on the second floor, R28 was observed to be in a torso restraint in a wheel chair. R28 was noted to have sediment in the eye, to be unshaven, and smelled of urine and feces. The restraint was noted to be placed on backwards, with straps facing toward the back of the chair. E17 (Restorative Certified Nurses Aide) stated she was helping out on the floor that day and was going to change R28. E3, Assistant Director of Nursing, was with surveyor. E17 was observed to attempt to transfer R28 from the wheel chair to the toilet by her self. E17 did not use a gait belt during the transfer attempt. R28 was not attempting to stand and E17 asked for assistance from E26, who was not wearing or use a gait belt	F 498		8/1/08

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F 498	Continued From page 43 to assist in transfer. Staff was noted to pull R28 up by under the arms and seat of the pants and transfer him from the wheel chair to the bed. R28 was noted to be wearing a diaper and feces was noted. E17 was observed to take a towel and wet the end of the towel to clean R28 ' s buttock. E17 did not wash R28 ' s peri area or penis. Placed another adult diaper on R28. No protective barrier was applied. E17 failed to follow the facility's procedure in set up, washing, rinsing and drying. On 6/17/08 at 10:20am R27 was observed with morning care. A wet towel was given to R27 by E25. R27 had family in attendance during this observation. A basin was not used. No oral care was done. During the observation, R27 stated during this care that she was burning between her legs. E3 was in attendance. R27 was observed to be wearing adult briefs and was removed .E25 washed the top of R27 ' s pubic area and not the labia area as identified in the facility ' s policy and procedure. After the morning care, E3 and E25 pulled R27 up to the wheel chair using her arms. At no time was a gait belt used or noted to be available. R19 was observed toileted on 6/19/08 with E20 (CNA). R19 was noted to be in a torso restraint and a wheel chair. The torso restraint was removed and R19 was assisted to the toilet by pulling R19 by her arm up to the grab bars. R19 was wearing an adult brief. E20 stated she had " pooh-pooh " in the diaper. After R19 was finished on the toilet, E20 wiped her with tissue paper and applied a new diaper. E20 failed to wash and dry and apply protective measures to R19 ' s bottom. E20 was asked on 6/20/08 if she had a gait belt. E20 stated she lost her gait belt	F 498		

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F 498	Continued From page 44 and had not had a gait belt for a while	F 498		
F 520 SS=F	483.75(o)(1) QUALITY ASSESSMENT AND ASSURANCE A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview the facility failed to: 1. Maintain a quality assessment and assurance committee consisting a physician designated by the facility. 2. Monitor systems and identify concerns affecting quality of care issues in the facility. 3. Develop an action plan to address incidents,	F 520		6/27/08

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F 520	Continued From page 45 accidents and injuries of unknown origin. 3. Monitor the effect of action plans and identifying the root causes of care concerns. 4. Develop training for identify concern issues regarding incidents and accidents, assessment on bowel and bladder functioning, inaccurate measurement of pressure ulcer, correct application of restraints. 5. Monitor and develop feedback mechanisms and processes to revise plans that have not achieved or sustained desired outcomes. These failures have a potential to affect all residents in the facility Examples include: (1) During the survey on 06-18-08 thru 06-27-08 the survey team determined a substandard quality of care and Immediate Jeopardy condition existed in the paid feeding assistant program, the facility has no system in identifying residents at risk for aspiration precaution or allowing untrained non nursing personnel to fed residents on altered diets and, the CNA's in charged in assigning residents that needs to be fed by the non nursing staffs. The facility Administrative staff confirmed that the staffs used as feeding assistants did not go thru State approved program. Two employees identified as feeding assistant disclosed they work under the directions of the CNA's. (2) On 06-18-08 and 06-19-08, interview with the Administrator/E 1 disclosed that the Medical does not attend the QA meetings. On 06-19-09, E 1 stated the medical Director has not been in their QA meetings for 3 consecutive times.	F 520		

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F 520	Continued From page 46 Review of the attendance sheet provided by the Director of Nursing on 06-19-08 disclosed that on May 2008, the Medical Director or designee was not in attendance. (3) Interview with the Director of Nursing/E2 on 06-19-08 at 3:25 PM, E2 was unable to described the facility method to identifying issues which requires QA and the how the committee respond to the identified quality deficiencies. E2 stated that she had not reviewed the QA book and was unaware of what the facility was working on and unable to described a sample of the quality deficiencies that was identified and dealt with in the facility. The surveyor confirmed that the facility took the following steps to remove the immediacy of the situation: Effective 06/18/2008 at 12:30 PM, the facility will not be utilizing a Paid Feeding Assistants Program. The facility stops utilizing the paid feeding assistants. In services were conducted to all facility staffs. Nurse Managers were assigned to specific floors to assure that sufficient C.N.A. and licensed staffs would be present to meet the mealtime ' s needs of the Residents. A plan of removal was provided to the survey team at 2:30 PM. The Policy & Procedure for Residents that need assistance with meals was developed, reviewed and revised. The Assistant Director of Nursing/Restorative Director interviewed residents, nurses and C.N.A ' s regarding the eating needs and risk precautions of the residents. The Speech Pathologists screened	F 520		

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F 520	Continued From page 47 residents. List of residents identified needing assistance and with altered diets were developed care plans updated and staffs were in serviced. Resident ' s diet cards were updated. Resident was identified with bruises of unknown origin, residents sustained fractures from staff. CNA not using gait belt when assisting residents during transfer and ambulation. The Quality Assurance Committee did not evaluate, investigate thoroughly or make recommendations to prevent these identified facility deficiencies from reoccurrence.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.662g) 300.662h)1) 300.662h)2) 300.662l) Section 300.662 Resident Attendants g) As part of the comprehensive assessment (see Section 300.1220), each resident shall be evaluated to determine whether the resident may or may not be fed, hydrated or provided personal hygiene by a resident attendant. Such evaluation shall include, but not be limited to, the resident's level of care; the resident's functional status in regard to feeding, hydration, and personal hygiene; the resident's ability to cooperate and communicate with staff. h) A facility may not use on a full-time or other paid basis any individual as a resident attendant in the facility unless the individual: 1) has completed a Department-approved	F9999		

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F9999	Continued From page 48 training and competency evaluation program encompassing the tasks the individual provides; and 2) is competent to provide feeding, hydration, and personal hygiene services. (Section 3-206.03(c) of the Act) The individual shall be deemed to be competent if he/she is able to perform a hands-on return demonstration of the required skills, as determined by a nurse. l) Each resident attendant shall be given instruction by a nurse or dietician concerning the specific feeding, hydration, and/or personal hygiene care needs of the resident whom he or she will be assigned to assist. These Requirements were not met as evidenced by: Based on observation, interview, and record review the facility failed to: (1) Ensure that the non nursing feeding assistants have completed a State approved training course prior to feeding residents. (2) Have a state-approved training program for paid feeding assistants. (3) Assess each resident requiring assistance with feeding to determine which residents could safely be fed by a Feeding Assistant. (4) Provide supervision by an RN or an LPN. (5) Ensure paid feedings assistants did not feed residents who have difficulty swallowing. This applies to 5 of 16 residents in the facility (R3, R28, R29, R40, and R44) who were identified as feeders with complicated feeding problems, and this applies to 19 paid feeding assistants who had not had the appropriate training through a State approved program.	F9999		

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F9999	Continued From page 49 Findings include: On 06-17-08 at 10:00 AM, during the entrance conference, E1 the (Administrator) was asked if the facility had a paid feeding assistant program. E1 stated, "I am not sure. I will let you know." On 06-18-08 E1 presented a list of residents on the feeding program. The list disclosed that there were 11 total residents in the facility that were totally fed by the staff. The breakdowns were as follows: 5 residents on the Alzheimer ' s Unit (R 115, 25, 110, 178 and R 185) 1 resident on the 1st floor (R150) and 5 residents on 2nd floor (R90, 56, 40, 134 and R163). The facility provided 19 names of non nursing employees that fed residents. Interview with the Administrative staff E1, E2, and E3 (Administrator, Director of Nursing and the Assistant Director of Nursing) on 06-17-08 at 2:00 PM, the staff stated that their feeding assistants had been trained by a Speech Pathologist for an hour and a half session. E3 (ADON) stated, "The Speech Therapist was knowledgeable to train the staff." E1, E2, and E3 were not aware of the state required training course and were not familiar with the requirements under the feeding assistant program. E24 (Speech Pathologist) was interviewed via phone on 06-18-08 at 11:10 AM. E24 stated, "I was asked to in service the non nursing personnel. Nothing was said about feeding assistant program. I have no idea on what was that. My goal for my in service is to review safe feeding technique. The diet and liquid	F9999		

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F9999	Continued From page 50	F9999		

consistency and positioning." E24 stated, "I have not attended a State approved feeding assistant program."

Per interview with the Alzheimer's Nurse on 06-18-08 at 12:40 PM, the Nurse identified R174 and R91 as feeders. The Nurse said that R174 was on aspiration precaution. The Nurse also stated that R25, 130, 115, 110 and R120 required additional assistance by staff to complete their meals. The nurse also stated that the activity Aides assist with feeding and that two of my three kids ages 18 and 15 years old, help with feeding residents when they are at the facility. When the Nurse was asked how the non nursing staff knows who to feed or who is on aspiration precaution or on altered diets, the Nurse stated, "There was a list here at the (nursing station), it's not here anymore."

On 06-18-08 at 10:50 AM, two non nursing staff , E4 (Alzheimer's Coordinator and E27 (Alzheimer's Tech. Coordinator) were observed in the Alzheimer's Unit feeding R174 and R140 with pureed cookies. Both residents had been identified by staff as at risk for aspiration.

Per interview on 06-18-08 at 1:00 PM, E4 stated, "I feed residents in the unit, I received my training for an hour last week from the Speech Therapist."

Per interview with the Staffing Coordinator/E6 on 06-18-08 at 10:35 AM, E6 stated that she gets direction from the CNA's as to who to feed. E6 stated, "I feed residents on all sorts of diets." E6 further stated, "My feeding in-service was for an hour. I worked as a CNA in 1986 but I am no longer on the registry."

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F9999	Continued From page 51 The Social Service Staff/ E23 was interviewed on 06-18-08 at 10:45 AM. E23 disclosed the same as E6 and added that the nurses are usually passing their meds at meal time but the CNA's are there just in case. Further review of the list of residents identified on a feeding program and interview with the Administrative staff disclosed that the facility does not have a system identifying residents that are at risk, on aspiration precaution, have the potential for choking and needing 1:1 assistance at meal times. On 06-18-08 at 2:38 PM, the facility Administrative staff were asked how were the 11 residents identified as total feed. The Assistant Director of Nursing stated, "We went around and checked the residents. There were no residents identified in the Alzheimer's unit that should be in the feeding program." The facility was unable to provide the facility policy and procedure on their paid feeding assistant program. On 06-19-08, R30 was observed in the second floor dining room with his wife. R30 was served his lunch and began to feed himself. After a few bites of his Pureed meat, R30 began coughing and choking. The nurse passing medications went to assist the resident. R30's wife stated that he did not have his scopolamine patch on and that was why he was choking and coughing. The nurse stated that she would get his "patch" and left the dining room. Twenty minutes later, R30 began to eat and again began to choke. The staff in the dining room did not respond and the surveyor asked that R30's tray be removed and kept warm until he received his "patch."	F9999		

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F9999	Continued From page 52 Review of R30's plan of care dated 05-13-08 showed that R30 has the potential for ASPIRATION related to DYSPHAGIA. R30's care plan intervention showed the following: Monitor chewing & swallowing ability. Monitor closely at mealtimes, suction if aspiration should occur. Encourage good fluid intake while eating; monitor the ability to swallow ... Offer small sips and bites during meals. There were no staff at R30's side during the observation to assist R30 to adhere to these interventions. Random review of two resident's (R29 and R157) plan of care disclosed: (1) R29's is at risk for aspiration and usually staff has to assist her during meal time. (2) R157 requires mechanical altered diet. At risk for CHOKING/SWALLOWING DIFFICULTY. These two residents were not included in the list that was presented by the facility as residents who require assistance. However R29 and R127 were confirmed by the staff as being on aspiration risk precautions. Review of pharmacy diet print out disclosed the following information: R30 - puree diet, honey thick liquids Up at 90 degrees all meals Chin tuck with all liquids Double dry swallow with all consistency ASPIRATION PRECAUTION R46 - pureed diet, 1:1 ALL MEALS R180 - Dysphagia, pureed with thin liquids when patient is awake. R25 - Pureed diet, nectar thick liquids, ASSIST	F9999		

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F9999	Continued From page 53 WITH MEALS R10 - pureed diet, thin liquid, FEEDER ASSISTANCE R 179 - pureed, nectar thick liquids, ASPIRATION PRECAUTION R157 - pureed diets, thin liquids, ASPIRATION PRECAUTION Interview with the nurse on 6-19-08 at 11:50 AM, the nurse disclosed, "R157 is fed by staff since she was at Alzheimer's unit." (R157 is currently at the 1st floor regular unit.) On 06-21-08, the facility requested the Speech Pathologist to screen residents and found the following: Alzheimer's Unit 6 residents totally fed 8 residents on aspiration precautions. 2nd Floor 5 residents totally fed. 1 resident on aspiration precaution. 8 residents on aspiration precaution. 1st floor 2 residents totally fed. 5 residents at risk for precaution. The facility Administrative staff confirmed that the facility had not had an IDPH approved feeding assistant program and none of the staff had received any training through state approved program. (A)	F9999		