STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145880	A. BUILDING _____ B. WING _____	08/20/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLVIEW HEALTH CARE CENTER	512 NORTH 11TH STREET VIENNA, IL 62995

(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 520	Continued From page 77 reported a .5 millimeter blister to R5's forehead after having her hair blown dry. Interventions was to use caution when using heat related appliances. H. 7-24-2010 at 5:50 AM, staff found a skin tear to the back of R5's left leg that had dried blood on it. No interventions for this injury was identified. I. 7-27-2020 at 10:00 AM staff found a skin tear after removing the protective sleeves from R5 following a transfer to the shower. This resulted in a skin tear to R5's right hand-1.5 inches long. The intervention identified was to continue to wear the protective sleeves at all times except during bathing. On 8-13-2010 at 8:57 AM, care plan coordinator E3 stated that the facility has just been repeating the interventions because E3 does not know what else to do with the staff. 2. Review of the facility policy on bathing documents that residents are to have a minimum of two baths/showers per week. Review of the bath/shower records for all residents in the facility documents that 28 of 40 residents did not get their two baths/shower at least once in the last 6 weeks. An example is R7 who lives on Memory Lane and needs assistance in bathing only received one bath/shower for the week of 07-24-10, 7-31-10, and 08-07-10 . Another example is R18 who lives on Cherry Blossom and only received one bath/shower the weeks of 07-24-10 and 07-31-10. E21, Registered Nurse, was interviewed on 08-13-10 at 8:50 am and stated that the facility use to have bath aides and now they do not. She stated now it is hard for the aides to do all they have to do and get the baths done also.	F 520		

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F 520	Continued From page 78 During the resident group meeting on 08-11-10 at 1:30 PM, all 5 residents present agreed that they sometimes do not get their baths as they should. They stated that there was not enough staff at times to give baths On 8-13-2010 at 2:10 PM CNA E12 stated that sometimes when there are only two staff working evenings they are unable to get showers/baths done.	F 520		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1610l) Section 300.1610 Medication Policies and Procedures l) Oxygen may be administered in a facility. The oxygen supply shall be stored and handled in accordance with the National Fire Protection Association Standard No. 99: Standard for Health Care Facilities (2002, no later amendments or editions included) for nonflammable medical gas systems. The facility shall comply with directions for use of oxygen systems as established by the manufacturer and the applicable provisions of the NFPA Life Safety Code (see Section 300.340) and NFPA 99. This requirement was not met as evidenced by. Based on observations, interview, and record review, the facility failed to ensure that one of one randomly observed resident, R4, was safe from potential fire hazards where concentrations of oxygen, a fire accelerant, were elevated and	F9999		

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F9999	Continued From page 79 sources of fuel and ignition were present. Findings include: 1. On 08-11-10 at 10:50 am, R4 was observed sitting outside the beauty shop with her oxygen on per nasal cannula and the tubing connected to an oxygen concentrator which was observed on and plugged in to an outlet in the hallway. At this time there were 2 residents in the beauty shop, one getting a permanent and one in the beautician chair having her hair styled with an electric curling iron and sprayed with hair spray. Present within this room were cans of hair spray (with butane as a propellant per label review), permanent wave solution, vinyl capes, electric curling equipment, and electrical hair drying equipment. Labeling on the containers of hair spray indicated that the products were "flammable." At 11:00 am, Z2, Beautician, was observed to unplug the concentrator, push it into the beauty shop, plug it in an outlet in the room and push R4 in to the beauty shop. At this point, R4 moved from her wheel chair to the beautician chair and repositioned the nasal cannula. E1, Administrator, was made aware of the situation at 11:05 am. E1 stated that R4 needs to have her oxygen at all times even in the beauty shop. After the danger of the situation was explained again to E1, E1 stated she would remove R4 from the beauty shop. At 11:20 am, the beauty shop was again observed and R4 was having her hair done without her oxygen on and there was one other resident in the room. The concentrator was unplugged in the hallway and the nasal cannula was positioned on top of	F9999		