

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145475</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ANN'S HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>770 STATE STREET CHESTER, IL 62233</b>		
(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 89 address the ongoing identified issues of falls and infection control. On the prior Annual Survey dated 2/15/10, citations for notification of physicians, accommodation of needs, pain control, catheter care, accidents/supervision, psychotropic medication/monitoring; labeling of drugs were cited. The current survey also identified and cited the same issues. E2 was asked about the status of the facility's Quality Assurance Committee and replied, "It all went downhill when the DON left." On 12/14/10 at 11:00 AM, E2, Registered Nurse, stated that the former Director of Nursing had left on maternity leave in August 2010. E2 stated that she was attempting to fill in for some of the DON's duties, but she E2, was not the Acting Nursing Director. E2 indicated the current Nursing Director had turned in her resignation about 2 weeks ago, and the facility currently had no director of nursing. On 12/14/10 at 11:30 AM, E1, Administrator, stated that E2 was considered the Acting Nursing Director until 12/8/10, when E2 quit to work at another facility. E1 indicated E2 now only worked a few hours a week to help out with DON duties until a new DON could be found. E1 stated the facility did not have a nursing director since 12/8/10.	F 520			
F9999	FINAL OBSERVATIONS  LICENSURE VIOLATIONS  300.2940g)1)2) 300.3140e)1)2)  300.2940 Electrical Systems	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145475</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ANN'S HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>770 STATE STREET CHESTER, IL 62233</b>		
(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	
F9999	<p>Continued From page 90</p> <p>g) Nurses' Calling System</p> <p>1) Each resident room shall be served by at least one calling station and each bed shall be provided with a call station. One call station may serve two adjacent beds. Call shall register at the nurses' station and shall activate a visible signal in the corridor at the resident's door, and in the nurse's station. In multicorridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two or more calling stations, identifying lights shall be provided at the nurse's station.</p> <p>2) A nurses' call station shall be provided for residents' use at each resident's toilet, bath, and shower location. The cord shall be long enough to reach within six inches of the floor.</p> <p>300.3140 Electrical Requirements</p> <p>e) Nurses' Calling System.</p> <p>1) In resident areas, each room shall be served by at least one calling station and each bed shall be provided with a call station. One call station may serve two adjacent beds. Call shall register at a central station serving the floor. In intermediate facilities only, an intercommunication system which provides only voice communication between a resident room and the nurses' station will be approved by the Department.</p> <p>2) A nurses' call emergency station shall be provided for residents' use at each resident's toilet, bath, and shower location. The cord shall be long enough to reach within six inches of the floor. See Section 300.3140 (e)(1) for exception of intermediate facilities only</p> <p>These regulations were not met as evidenced by:</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145475</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ANN'S HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>770 STATE STREET CHESTER, IL 62233</b>		
(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	
F9999	<p>Continued From page 91</p> <p>Based on observation and interview, the facility failed to provide a call system in residents' rooms which provided audible or visual communication directly to facility staff at the nurse's station for Rooms 102, 103, 104, 108, 109, 111 and 114 on the 1st floor front hallway and Rooms 212, 215, 216, 217 and 217-A on the 2nd floor front hallway. This effected 12 (R42, R23, R4, R16, R43, R44, R13, R6, R8, R18, R10 and R45) of 12 residents in these rooms, resulting in the potential for serious harm for all of these residents.</p> <p>Findings include:</p> <p>On 12/15/10, at 11:53 AM, the call light was activated in Room 111. The light above the door activated and a visual and audible signal was noted at a panel in an unoccupied work area which staff do not monitor near the reception area on this hallway. Staff did not utilize this work area as a nurses station, and no staff monitored the call system from this area. The following resident rooms on first floor utilize the call system which were visualized at this panel : Rooms, 101, 102, 103, 104, 108, 109, 111, and 114.</p> <p>On 12/15/10, at 12:00 PM, E1, Administrator, noted the call system on the first floor sounds and lights at the panel which was not utilized as a work area. E1 reported there was a light above the dining room door on first floor which lights when residents in this area need assistance.</p> <p>On 12/15/10, at 12:05 PM, the call light was activated in Room 102. The light above the dining room door was activated; however, this light could not be visualized from the First Floor</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145475</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ANN'S HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>770 STATE STREET CHESTER, IL 62233</b>		
(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	
F9999	<p>Continued From page 92 nurses station.</p> <p>On 12/17/10, at 10:12 AM, R6 was lying in his bed in Room 212. R6 noted he has problems with staff answering his call light. He noted "It only buzzes once." R6 explained he had to hit the call light many times to call for staff's assistance. R6's call light was activated. There was a short buzz sound and a light on a panel lit in an area which staff did not monitor. There was no visual signal or further audible signal at the nurses station on the second floor.</p> <p>On 12/17/10, at 10:25 AM, E10, Certified Nurse's Aide, indicated when R6 activated his call light from Room 212, the call light made a different sound. E10 indicated he thought there was a light at the nurses station that also notified staff; however, he was not sure where.</p> <p>On 12/17/10, at 10:35 AM, the call light in Room 215 was activated. Again, there was a short buzz sound and a light on a panel lit up in an area which staff did not monitor. There was no visual signal or further audible signal at the nurses station on the second floor.</p> <p>On 12/17/10, at 10:45 AM, E18, Maintenance Director, noted the call system for the east and north hallways on the first and second floors have a visual signal which lights at a panel at the old nurses stations. He confirmed staff do not work in these areas and the call lights are not monitored in these areas. E18 explained the call light system in these areas sound differently than other areas of the building. He indicated on the first floor, when the call system was activated a light goes off near the dining room, not at the first floor nurses station. He reported when the call</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145475</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ANN'S HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>770 STATE STREET CHESTER, IL 62233</b>		
(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	
F9999	<p>Continued From page 93</p> <p>system was activated on the second floor, a light did activate at the nurses station. E18 noted he was unaware the light at the second floor nurses station was out.</p> <p>On 12/122/10, at 10:20 AM, E16, Licensed Practical Nurse, indicated she usually had the Certified Nurse's Aides go check the residents in the rooms on the front hallway. She indicated there was no visual signal at the nurses station. E16 noted the call system did make a noise; however, during the afternoon when it was busy and noisy, staff were unable to hear the call light.</p> <p>The facility's incident logs for 2010 were reviewed. R4, R6, R8, R10 and R13 had histories of falls and all reside in the areas effected by this call system.</p> <p style="text-align: right;">(A)</p> <p>300.615e) 300.615f)</p> <p>Section 300.615 Determination of Need Screening and Request for Resident Criminal History Record Information</p> <p>e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act [20 ILCS 2635] for all persons 18 or older seeking admission to the facility. Background checks shall be based on the resident's name, date of birth, and other</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145475</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ANN'S HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>770 STATE STREET CHESTER, IL 62233</b>		
(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	
F9999	<p>Continued From page 94</p> <p>identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act)</p> <p>f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at <a href="http://www.isp.state.il.us">www.isp.state.il.us</a> and the Illinois Department of Corrections sex registrant search page at <a href="http://www.idoc.state.il.us">www.idoc.state.il.us</a> to determine if the individual is listed as a registered sex offender.</p> <p>This requirement is NOT MET as evidence by:</p> <p>Based on interview and record review, the facility failed to request criminal background checks within 24 hours of admission for nine (R6,R8,R11,R34,R37,R38,R39,R40,R41) of 10 new admissions reviewed; and failed to check for the residents' names on the Illinois Sex Offender Registration and Illinois Department of Corrections sex registrant search page for seven (R6,R8,R34, R38, R39,R40 and R41) of 10 new admissions reviewed.</p> <p>Findings include:</p> <p>On 12/21/10, E1, Administrator provided the criminal background checks and Illinois State Police (ISP) and Illinois Department of Corrections (DOC) website checks for the last ten admissions to the facility. The following was noted.</p> <p>R6 was admitted to the facility on 11/18/10. The facility did not request R6's criminal background check until 12/15/10. The facility did not check the ISP or DOC website for his name until 12/17/10.</p> <p>R8 was admitted to the facility on 11/13/10. The</p>	F9999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/30/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145475</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>01/06/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>ST ANN'S HEALTHCARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>770 STATE STREET CHESTER, IL 62233</b>		
(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	
F9999	<p>Continued From page 95</p> <p>facility did not request R8's criminal background check until 11/18/10. The facility did not check the DOC website for his name until 12/17/10.</p> <p>R11 was admitted to the facility on 12/7/10. The facility did not request R11's criminal background check until 12/15/10.</p> <p>R34 was admitted to the facility 10/25/10. The facility did not request R34's criminal background check until 10/28/10. The facility did not check the ISP and DOC website for her name.</p> <p>R37 was admitted to the facility on 10/15/10. The facility did not request R37's criminal background check.</p> <p>R38 was admitted to the facility on 10/20/10. The facility did not request R38's criminal background check until 10/22/10. The facility did not check the DOC website for her name until 12/17/10.</p> <p>R39 was admitted to the facility on 10/20/10. The facility did not request R39's criminal background check until 10/22/10. The facility did not check the ISP or DOC website for his name.</p> <p>R40 was admitted to the facility on 12/9/10. The facility did not request R40's criminal background check on 12/15/10. The facility did not check the ISP or DOC website until 12/15/10.</p> <p>R41 was admitted to the facility on 10/22/10. The facility did not request R41's criminal background check until 10/22/10. The facility did not check the ISP website for her name until 12/17/10.</p> <p>On 12/21/10, at 10:50 AM, E1 confirmed the criminal background checks, ISP and DOC</p>	F9999			