STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145500	A. BUILDING _____ B. WING _____	09/23/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HILLSBORO REHAB & HCC	1300 EAST TREMONT STREET HILLSBORO, IL 62049

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. Complaint#1142860/IL#54525 - No deficiencies	F 000		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to ensure good incontinent care for 3 of 8 residents (R5, R14 and R15) reviewed for incontinency, in the sample of 21. 1. R5's Care Plan of 3-25-11 identifies R5 as having Activity of Daily Living (ADL) deficit. Care Plan approach, in part, is to check and change every 2 hours and provide incontinent care. R5 was observed on 9-21-11 at 11:25AM to be toileted by E12 and E13, Certified Nurse Aids (CNA's). R5's incontinent brief was saturated with urine and oozed feces when placed on the toilet. E12 was observed to wipe R5 between the buttocks and anal area with a wash cloth and water. E12 did not wash R5's buttocks, penis, scrotum and pubic area that had been soiled with urine. 2. R14's Minimum Data Set (MDS), dated 8-22-11, documented R14's diagnosis as	F 312		10/7/11

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

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F 312	Continued From page 1 Dementia and total dependence on two plus persons physical assistance with mobility, transfer, toileting and hygiene. During observation of R14's incontinent care, on 9-20-11 at 2:15p.m., E7, E8 and E9, CNA's, did not completely cleanse R14's lower back, upper bilateral thighs and retract foreskin to completely cleanse R14's penis. R14's bed pad was observed wet with urine from his lower back to his upper bilateral thighs and small fecal matter smears were observed during his incontinent care;. 3. R15's MDS, dated 8-1-11, documented R15's diagnosis as Alzheimer's Disease and extensive assistance of one to two plus persons physical assistance with mobility, transfer, toileting and hygiene. During observation of R15's incontinent care, on 9-20-11 at 3:05p.m., E11 (CNA) and E14 (CNA) did not completely clean R15's upper bilateral thighs, lower back and buttocks. R15's bed pad was observed urine soaked from her lower back to her upper bilateral thighs and R15 had a large formed bowel movement.	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 323		10/7/11

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F 323	Continued From page 2	F 323		

by:
Based on record review and interview the facility failed to ensure staff use a gait belt when ambulating residents to prevent falls and injuries for 1 of 7 residents (R9) reviewed for falls/injuries in a sample of 21. This failure resulted in R9 obtaining a fractured patella.

The findings include:

1. Documentation of R9's current diagnoses listed on the admitting face page include; Muscle Weakness, Abnormal Gait, Dementia with Behaviors, Anxiety, and Parkinsons. The Minimum Data Set (MDS) dated 1/3/11 documents R9 required extensive assistance with transfers, was unable to maintain balance without assistance, and was incontinent of bowel and bladder frequently. R9's Plan of Care documents that he is at high risk for falls, with the intervention listed; "transfers with assist of staff gait belt and walker/wheelchair."

Nurses Notes dated 1/29/11, 11:30 AM document, "Resident confused per usual. CNA (certified Nurses Aid) reports that resident was incontinent of BM (bowel movement) so she assisted him into room (another resident's room) d/t (due to) the floor in his room was wet and resident was up ambulating with his walker." The facility's Disciplinary Action Form dated 1/29/11, documents that E15 CNA, "did not have a gait belt on resident on 1/29/11 and the resident fell." An x-ray of the knee dated 1/29/11 documents, "nondisplaced fracture right patella." The facility policy, revised 3/1/01 and titled; Ambulation Belt (Transfer of Gait Belt) documents, "Use ambulation belt during ambulation, transfer or

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F 323	Continued From page 3 movement of residents." On 9/22/11 at 12 noon E2 Director of Nurses, (DON), stated, I wrote that CNA up the same day for safety violations, she did not have a gait belt on the resident. There was a second incident after that and E15 was terminated.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record	F 329		10/7/11

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F 329	Continued From page 4 review, the facility failed to assess 2 of 21 residents (R5, R7) reviewed for unnecessary drugs on the sample of 21. Findings include: 1. The Minimum Data Set (MDS) of 10/15/10 identifies R7 was admitted to the facility on 10/5/10 with diagnoses of Cerebral Spinal stenosis, Insomnia, sleep apnea and reflux, from another long term care facility. He shares a room with his wife. Section E - MDS identifies R7 to have no behaviors at all on admission. Physician's Orders identify that Climara (Estrogen substitute) 0.05mg every week was ordered on 1/15/11. There is no Behavioral assessment in the clinical record. Behavioral tracking sheets identity the target behavior for the Climara is inappropriate touching of female staff. However, there was no assessment available in the chart that indicates the extent of the behavior at the time it was ordered and why it would merit the use of Climara or what interventions staff attempted prior to the medication. On 9/20/11 at 3:30pm, E6, Social Service Designee said she was responsible for the behavioral tracking sheets and such but stated she had no assessment on R7 at all. E6 stated the facility does not do anymore than what's on the MDS. E6 stated R7's behaviors did not target any one individual and was persistent at times. On 9/21/11, E2 Director of Nurses (DON) stated R7's behaviors including touching female staff and was sometimes aggressive when doing so. E2 stated redirection at times helped but not all the time. E2 was unable to provide documentation as to how many incidents occurred and when exactly the behaviors began.	F 329		

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F 329	Continued From page 5 E2 stated she thought he was admitted on the Climara but chart review showed he was not. E2 agreed the facility had no assessment prior to the initiation of the the Climara although tracking sheets were in place in December 2010 and the care plan dated 12/10 identifies inappropriate female staff touching. Tracking Sheets for December identified no inappropriate touching occurring during that month. January 2011 tracking sheets has "C" charted beginning on 6-2 shift 1/4/11 and increasing through 1/22/10 then again 1/26/11-1/28/11. There is no assessment toward this behavior and no documentation as to when it started. The January nurses notes reflect inappropriate touching on 1/4/11 twice, 1/5/11, 1/8/11 three times and then on 1/10/11, the physician was notified and ordered the Climara Patch - change weekly. The MDS dated 1/10/11 identifies no "physical behavioral symptoms directed toward others"but has identified R7 to have "other behavioral symptoms not directed toward others" and indicated it was "worse." There is no additional information gathered toward R7's inappropriate groping, grabbing and touching of female staff following the initiation of the Climara. February 2011 tracking sheet shows only one occurrence on 2/8/11. March 2011 tracking sheets show behaviors only occurring on one 6-2 shift on 3/9/11. April and May 2011 have no recorded inappropriate touching occurring. June 2011 has three 10-6 shifts 6/11/11-6/13/11 as having two occurrence with interventions being ineffective. July, August and September 2011 tracking sheets show no behaviors identified. On 8/22/11, the Climara was reduced to 0.025 weekly.	F 329		

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F 329	Continued From page 6 2. Based on review of R8's Physician Order Sheet for September 2011 documented that she has a diagnosis in part of Alzheimer's, Anxiety, and Depression. She has a care plan dated 8/18/11 that address problems of verbally aggressive with staff when she is redirected from the door, refusing to sleep at times, and wanting her mom and dad. On 9/20/11 R8 was observed at lunch being encouraged to eat by E5, Unit Director. She was not very successful getting R8 to eat but R8 did not seem to be under stress. R8 was talking about going to see her mother. On 9/21/11 R8's chart was reviewed and it was documented in the nurses notes that she had been up all night on 9/21-22/11. On 9/21/11 her doctor was contacted. A new order for Risperdal 0.5 milligrams by mouth three times a day for increased anxiety and behaviors however, no assessment was done prior to the initiation of the Risperdal. The concern was addressed with E5, Unit Director, on 9/21/11 at 2:00 PM whether Risperdal was appropriate for the types of diagnosis that R8 had. She latter came back and said the Risperdal had been discontinued and that Depakote 125 milligram three times a day was to be started for dementia and increased behaviors.	F 329		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		10/7/11

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F 441	Continued From page 7 Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 8 Based on record review and observation, the facility failed to provide timely gloving and handwashing for 3 of 8 residents (R5, R14 and R15) observed for incontinent care in the sample of 21. Findings include: 1. R14's Minimum Data Set (MDS), dated 8-22-11, documented R14's diagnosis as Dementia and total dependence on two plus persons physical assistance with mobility, transfer, toileting and hygiene. During observation of R14's incontinent care, on 9-20-11 at 2:15p.m., E7, Certified Nursing Assistant (CNA), did not change her gloves or wash her hands after cleaning fecal matter and then touching R14's clean linens, bed pillow, equipment and upper and lower extremities. 2. R15's MDS, dated 8-1-11, documented R15's diagnosis as Alzheimer's Disease and extensive assistance of one to two plus persons physical assistance with mobility, transfer, toileting and hygiene. During observation of R15's incontinent care, on 9-20-11 at 3:05p.m., E11 (CNA) and E14 (CNA) did not change gloves or wash their hands after cleaning fecal matter and then touching R15's clean linens, equipment, bedding and upper and lower extremities. 3. R5's Care Plan of 3-25-11 identifies R5 as having Activity of Daily Living (ADL) deficit. Care Plan approach, in part, is to check and change every 2 hours and provide incontinent care. R5 was observed on 9-21-11 at 11:25AM to be incontinent of urine. E12, Certified Nurse	F 441		

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F 441	Continued From page 9 Assistant (CNA) provided incontinent care and failed to remove her soiled gloves and wash her hands before handling R5's new disposable incontinent brief and pants.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.610a) 300.1210b) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	F9999		

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F9999	Continued From page 10	F9999		

care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

Section 300.3240 Abuse and Neglect

a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.

These Regulations were not met as evidenced by:

Based on record review and interview the facility failed to ensure staff use a gait belt when ambulating residents to prevent falls and injuries for 1 of 7 residents (R9) reviewed for falls/injuries in a sample of 21. This failure resulted in R9 obtaining a fractured patella.

The findings include:

1. Documentation of R9's current diagnoses listed on the admitting face page include Muscle Weakness, Abnormal Gait, Dementia with Behaviors, Anxiety, and Parkinsons. The Minimum Data Set (MDS) dated 1/3/11 documents R9 required extensive assistance with transfers, was unable to maintain balance without assistance, and was incontinent of bowel and bladder frequently. R9's Plan of Care documents that he is at high risk for falls, with the intervention listed; "transfers with assist of staff gait belt and walker/wheelchair."

Nurses Notes dated 1/29/11, 11:30 AM

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F9999	Continued From page 11 document, "Resident confused per usual. CNA (certified Nurses Aid) reports that resident was incontinent of BM (bowel movement) so she assisted him into room (another resident's room) d/t (due to) the floor in his room was wet and resident was up ambulating with his walker." The facility's Disciplinary Action Form dated 1/29/11, documents that E15 CNA, "did not have a gait belt on resident on 1/29/11 and the resident fell." An x-ray of the knee dated 1/29/11 documents, "nondisplaced fracture right patella." The facility policy, revised 3/1/01 and titled; Ambulation Belt (Transfer of Gait Belt) documents, "Use ambulation belt during ambulation, transfer or movement of residents." On 9/22/11 at 12 noon E2 Director of Nurses, (DON), stated, I wrote that CNA up the same day for safety violations, she did not have a gait belt on the resident. There was a second incident after that and E15 was terminated. (B)	F9999		