CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-03							0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) M	IULTI	IPLE CONSTRUCTION	(X3) DATE SI	
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDIN	G	COMPLE	TED
		145655	B. WI	NG _		10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE	10/2	1/2011
VIPMA				3	93 EDWARDSVILLE ROAD VOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F	000			
F 272 SS=D	ASSESSMENTS The facility must conduct initially and periodical a comprehensive, accurate, standardized reproducible assessment of each resident's		Fź	272			11/19/11
	a comprehensive, a	accurate, standardized					
	resident assessmen by the State. The a least the following: Identification and de Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior Psychosocial well-b Physical functioning Continence; Disease diagnosis a Dental and nutrition Skin conditions; Activity pursuit; Medications; Special treatments Discharge potential Documentation of s the additional asses areas triggered by t Data Set (MDS); an	sident's needs, using the nt instrument (RAI) specified assessment must include at emographic information; patterns; eing; g and structural problems; and health conditions; al status; and procedures; ; ummary information regarding asment performed on the care he completion of the Minimum					
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

		HAND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145655	B. WI	NG _		10/2 ⁻	1/2011
NAME OF P	PROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 272	Continued From pa	ige 1	F	272	2		
	by: Based on observation interview, the Facili of siderails and for medication ordered for 1 of 7 residents behaviors and med Findings include: A) On 10/13/11, a bed with bilateral 1/ position in the center Director of Nurses, at that time, stated applied after R6 ret hospital with his fra R6's clinical reco assessment for the present. E10, Care that the bilateral sid bed when he return hospital on 9/1/11. siderails for turning confirmed that the bilateral benefit for the use of center of the bed.	ord was reviewed and no e use of the siderails was e Plan Coordinator, confirmed derails were applied to R6's ned to the Facility from the E10 stated that R6 uses the and positioning. E10 Facility does not have owing the medical reason, how ils or assessed risk versus of the 1/2 siderails in the					
	,	ecord documents that on ian ordered Provera 10					

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 272 Continued From page 2 F 272 milligrams orally three times a day due to elevated testosterone levels. On 10/11/11, at 2:10 PM, E2 and E11, Quality Assurance Nurse, were asked why R6 was receiving the Provera. Both E2 and E11 stated that R6 has sexual behaviors of grabbing both staff and resident's genitals and breasts. E2 said that R6's physician told her that R6's testosterone level was high for a man of his age. E2 confirmed that there is no documentation in R6's clinical record regarding this information. The Facility was unable to produce physician notes regarding the Provera. There is no assessment documentation in R6's clinical record regarding his sexual behaviors. There is no documentation assessing why behaviors occurred mainly on the night shift. There is no assessment documenting less restrictive methods attempted prior to utilizing the Provera. There is no documentation regarding assessing for adverse side effects when using Provera. 483.25 PROVIDE CARE/SERVICES FOR F 309 F 309 11/19/11 HIGHEST WELL BEING SS=G Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide appropriate

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 4 F 309 reason for calling the physician is left great toe very red, swollen, hot to touch, nail bed above nail red and top of the toe is purple. Temperature is 99 degrees, pulse is 90, blood pressure is 110/68. Pain is 3 out of 5. Pain medication given for comfort. Physician called and gave order for Rocephin 1 gm IM qd x 2 days then start Keflex 500mg every 6 hours x 8 days. Record also shows the above order for cleaning and treating the wound. Note at 2PM states R29 states foot and even her leg hurt half way up her calf. No drainage. NURSE/PHYSICIAN COMMUNICATION RECORD of 7-19-11 documents, "L (left) great toe declining". Time of Physician response states 12 noon with orders to send R29 to the ER for evaluation. Note at 10AM documents, "CNA (Certified Nurse Aide) came & told this nurse L toe looks worse very red & swollen hot to touch mushy on bottom & purple has yellow drainage coming out. Res was started on ABt (antibiotic) 7/17/11. Call placed to Dr. (Doctor) awaiting call back." Note at 12 noon documents, "Dr states send res to ER for eval. DON (Director of Nursing) states call Dr. back ask for culture order & ? about IV antibiotics. awaiting call back." (POS review shows no order was obtained for IV antibiotics.) Note at 3:20PM documents, "Spoke with Dr .-- at length re (regarding) res cond (condition), states to send res to ER if res chooses to go. This Nurse evaluated L great toe et (and) noted 0 increase in redness or swelling noted from eval on Sunday evening, res (resident) reassured and states does not want to go to ER ... " It is documented on 7-20-11 Nurses Notes that R29 left the facility with a family member at 8:30AM for a Doctor appointment. E1,

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IULTIPLE CONSTRUCTION	(X3) DATE S COMPL	SURVEY
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095	ЭЕ	
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F 309	could not find any in went on 7-20-11. S documented in the suggested to call R On 7-20-11 at 12:4 she took R29 to the on her buttock wou look at R29's toe. It is documented 7-20-11 that R29's swollen, red and pu yellow slough noted amount of serosand ambulates and full extremity without di inner arch and sligh WEEKLY WOUND TRACKING LOG of wound with treatment dressing with no pat toenail. Just startin nail bed. There is r slough or drainage.	d on 10-21-11 at 11AM, she formation as to where R29 she stated it is suppose to be Nurses Notes but it is not. E1 29's sister and she may know. OPM, Z4, R29's sister, stated e plastic surgeon who operated nd and the Surgeon did not d in the Nurses Notes on left toe continues to be imple with large amount of d, continues to have scant guinous drainage. R29 weight bearing to left lower fficulty. Left foot slight swollen at red in color. (Facility OR SKIN ABNORMALITY f 7-22-11 identifies left toe ent of Bactroban and dry in. ".2 slit on nail bed. 0 g to grow from bottom of toe no mention of color, swelling,	F	309		

Z5, N progress note of 7-21-11, that R29 was seen to follow up on a Vascular Ulcer to great left toe. Onset 5-7 days ago on antibiotic therapy. Denuded skin up to 1st knuckle. A large piece debrided off with slight bleeding. Wound base white. Rest of toe mushy under skin. Plan to send to Vascular Surgeon. Nurses Note 7-20-11 states R29 propels self around facility in wheel chair. Note of 7-22-11 states R29 has pain in left leg, 3 plus pitting edema noted in left leg and foot. It is

documented on 7-22-11 at 12 noon, Z4 was called to tell her of appointment for vascular

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938-0391		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER			3	REET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 309	to hospital now!" It R29 was admitted to and MRSA to R (rig medical records sh It is documente Physical of 7-23-11 hospital with chief of toe pain and redness few days. She had started noticing tha the beginning but n on the toe started to pain. Physical exam has significant eden wounds or ulcers. this time. It is docu and Plan: Left foot associated with leu Culture is positive of vancomycin, obtain care on consult. An evidence for periph Continue bacitracin foot for signs of ost It is documented R29's left foot, on 7 the great toe is see distal phalanx of the to bony erosion as could be due to priof lucency in the area fracture. Mild dege changes. Small po It is documented of 7-24-11 by Z3, P large ulceration dist	I, "I demand my sister be sent is documented at 6:25PM to the hospital for IV antibiotic pht) great toe. (Yet above ow it was the left great toe.) d in R29's Hospital History and , that R29 came to the complaint of having noted left as and swelling ongoing for a broken her toe nail and t there was some redness in o purulence or bleeding. Later o swell and she had severe mine showed left foot great toe ma and erythema. No open No purulent discharge noted at mented under Assessment diabetic ulcer with cellulitis kocytosis, subjective fever. of MRSA. Continue podiatry on consult, wound terial Doppler negative for eral vascular disease. topically. Obtain X-ray of the	F	309				

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		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0938-0391
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F 309	It is somewhat fibro are suspicious for c appear to be some of the distal phalan; of the left hallux dis cellulitis and foot ulip part, treat with amp of the halluxcontin Hospital Dischar states discharge dia Osteomyelitis of the great toe; Status po phalanx of the left of ankle and left foot - Hospital Course: R admitted with sever and was admitted to diabetic foot ulcer a cellulites of the foot antibiotics because leukocytosis and fe having osteomyelitis. During interview Nurse (LPN) on 10- on 10-19-11 she wa toe was getting wor seen the toe before purple on bottom an yellow drainage. It needed to go to the antibiotic's for 2 day working. E20 called him of her concerns sent to the hospital. E2, Director of Nurs	tic and necrotic. X ray results osteomyelitis . There does destruction about the distal tip kAssessment: Osteomyelitis tal phalanx with associated ceration. Plan includes, in outation of the distal phalanx nue on current IV antibiotics rge Summary of 7-27-11	F	309			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 8 F 309 she told E2 and E2 stated to call Z2 back and see if they could treat the toe at the facility. R29 was not refusing to go to the hospital. It was the end of the shift so E21, Registered Nurse (RN) took over. On 10-19-11, E21 stated she was the Nurse who initially saw R29's toe on 7-19-11. Her great toe was red and swollen and real purple on the end with yellow drainage. It looked like a blister area on the end of the toe. She called Z2 and got an order for Rocephin IM and then Keflex. On 7-19-11, E20 stated R29's toe looked very bad and she had called Z2. It's the facility's Policy and Procedure to check with E2 or the Nurse on call, before sending residents to the hospital. E21 stated she thought E2 went and looked at the toe and thought they could treat it at the facility with IV antibiotics. E21 stated she was the one who had to call Z2 back and tell him E2 wanted to treat R29 in house. E21 stated Z2 was very upset. He wanted her sent to the hospital. He felt he was being seconded guessed. He asked E21 if she had seen the toe that day and she told him "NO", she had just come on duty. Z2 told her he did not understand why they did not want to send R29 out and said if she wants to go send her. E21 said she then looked at R29's toe and talked to R29. The toe didn't look any worse. Her accu check was good. E21 stated she told R29 the antibiotics had not had a chance to work. E21 states she felt she convinced R29 she didn't need to go the the ER. E21 stated she felt pressured not to send R29 to the hospital. E21 stated after R29 went to the hospital she talked to E1 and E2 of concerns of not doing what Z2 wanted. Facility Policy got in the way of good patient care. Z2 did not give an order to not send R29. He said she had just had 2 days of IM Rocephin. He wanted

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE S COMPL	SURVEY	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095	Ξ		
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F 309	her to go to the host told him that morning there was no written It was written on the but not on the POS On 10-19-11 at 3 gotten a report from her toe was worse. time. If the wound and is worse, some ordered for R29 to over reacted then the they send her back her. They called Z2 treat R29 at the fac concerns and though hospital. Z2 stated send R29 to the EF her is if she refused was becoming gang would not have mar would have lost the nothing in hospital for was gangrenous.)	pital based on what the Nurse ng. E21 stated at the time, n order to send R29 to the ER. e Nurse communication record	F3	309			

was gai E2 st not aware Z2 had ordered for R29 to go to the hospital. E20 had told her she was sending R29 out to the hospital and E2 told her she should ask for a culture and antibiotics and treat at the facility. E2 denied she told E20 not to send R29 to the ER. "If someone wants to go to the hospital it's her right." E2 stated she did not look at R29's toe before telling E20 to call Z2 and see if she could be treated at the facility. She stated there was no written Policy and Procedure that she or a charge Nurse had to approve before a resident was sent out to the hospital.

On 10-21-11 at 10:55PM, E22, LPN, stated it

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 12 F 309 but could find no order for it on the current physician's orders or on the hospital transfer sheet dated 10/9/11. **Dialysis Communication Reports are sent** home with R14 and have a section to be completed post dialysis by the facility. The report is blank for "Vascular Access Condition" for her 10/11/11 visit. The only other daily sheets are dated 10/1/11, 9/29/11, 9/22/11, and 9/27/11. The Treatment Administration Records, Medication Administration Records and the nurses notes were all reviewed and found to be void of any information regarding R14's catheter or shunt site and/or Bruit/Thrill. According to the facility's policy on Dialysis dated 11/1/07, residents receiving dialysis treatments will be appropriately assessed for complications and will together, with the dialysis treatment center, communicate and collaborate to assess, implement, evaluate, and revise the resident's plan of care. Under care of the shunt, it states care will be provided by a licensed nurse and include leaving dressing in place for 24 hours, closely inspect dressing for drainage and bleeding, sites are checked for patency and condition daily an upon return from dialysis "If a bruit changes in regularity or depth or if thrill is not able to be palpated, notify the physician immediately." The policy also indicates blood pressures or venous punctures will be not performed on the extremity where the shunt is located. In addition, the policy states the residents plan of care will include the following: Dialysis order -There are no orders on the POS for dialysis. Monitor Intake and Output (1&0) - review of the 1&0 sheet since her return from the hospital on 10/9/11 is incomplete. The COMPREHENSIVE

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 309 Continued From page 13 F 309 INTAKE & OUTPUT RECORD (8 HOUR SHIFTS) has no 24 hour totals recorded and only 6 of 11 shifts completed. The policy also indicates common nursing practice will be implemented that includes shunt assessment and monitoring. The Contract for Outpatient Dialysis Services indicates they will provide information on all aspects of the management of the residents care related to the provision of dialysis services including but not limited to bleeding/hemorrhage, infection/bacteria, and care of the dialysis site and disinfection of dialysis access site. 483.25(c) TREATMENT/SVCS TO F 314 F 314 11/19/11 PREVENT/HEAL PRESSURE SORES SS=G Based on the comprehensive assessment of a 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 record review, observation and interview, the facility failed to provide timely turning and repositioning and pressure sore identification, monitoring and treatment for 1 of 7 residents (R16) in the sample of 21 and 1 resident (R28) in the supplemental sample reviewed for turning and reposition and pressure sore prevention. This failure resulted in R28 developing an unstageable left heel pressure

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		I AND HUMAN SERVICES			FORM	02/25/2012 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE		
		145655	B. WING		10/2 ⁻	1/2011	
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
VIPMA	NOR			393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLÉTION		
F 314	Continued From pa sore.	ge 14	F 31	4			
	Findings include:						
	8-18-11, document impairment, total de persons physical as transfers, bilateral u impairment and two R16's Care Plan, ge documented R16 w repositioned every During observat repositioned every During observat repositioned. Interv (RN), on 10-12-11 a was"pulled up and position was observ her positioning with remaining and unre and sides switched Assistant (CNA) an checking R16 adult 10-12-11 at 11:40a reposition R16.	ependence of two plus asistance with mobility and upper and lower extremity o Stage II pressure sores. coal date 11-17-11, vas to be turned and 2 hours and as needed. ion of R16's turning and 0-12-11 from 9:25a.m. to s not timely turned and view of E14, Registered Nurse at 9:25a.m., E14 stated R16 switched her sides." R16's ved the same before and after coccyx and buttock pressure elieved with being pulled up . E13, Certified Nursing d E5 (CNA), were observed diaper for incontinence, on .m., E5 and E13 did not					
	severe cognitive im one person physica transfer, bilateral up impairment and at i development. The facility's We Abnormality Trackin 8-5-11, documenter	ed 9-22-11,documented pairment, total dependence of al assist with mobility and oper and lower extremity risk for pressure sore eekly Wound or Skin ng Log, week ending date d a 5.0cm x 4.0cm vas found on R28's left heel on					

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 314 Continued From page 15 F 314 8-1-11. Interview of E7, Treatment Nurse, on 10-13-11 at 1:40p.m., E7 stated she started as the Treatment Nurse on 8-5-11 and R28's entire left heel was very, very deep purple and boggy, mushy, when she saw it. E7 also stated she documented the measurements of R28's left heel on the Tracking Log, week ending date 8-5-11 and future Tracking Logs. R28's Weekly Wound or Skin Abnormality Tracking Log, week ending 8-12-11, documented R28's left heel as an unstageable 5.0cm x 4.0cm "escar (eschar)" area. Review of R28's chart did not document R28's left heel was monitored for pressure sore development until it was found on 8-1-11 as a 5.0cm x 4.0cm unstageable area. R28's MDS, dated 9-22-11. document she was at high risk for pressure sore development. R2's Skin Risk Evaluation and Plan of Care, goal date 12-25-11, documented R28 was at risk for skin breakdown. It was also noted R28's left heel pressure sore was not documented on her Care Plan with goals identified and/or interventions for her left heel. The facility's Wound Prevention/Skin and Wound Treatment policy and procedure, dated 10-1-08, documented, in part, residents will exhibit no evidence of sign breakdown or will regain skin integrity. It was also documented that all residents at risk will have skin condition checked and documented daily. Interview of E16. Medical Records. on 10-14-1 at 1:15p.m., E16 stated she was not finding Weekly Skin Condition Evaluation sheets for 7-11, 8-11 and 9-11. E16 then provided, on 10-14-1 at 1:50p.m., Weekly Skin Condition Evaluations, dated 2-11 to 10-11, which did not

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	JRVEY
		145655	B. WI	√G		10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ΥΙΡΜΑ	NOR				93 EDWARDSVILLE ROAD VOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	document skin brea	ge 16 akdown of R2's left heel until	F	314			
F 322 SS=D		REATMENT/SERVICES - S SKILLS	F	322			11/19/11
	resident, the facility who is fed by a nas receives the approp to prevent aspiratio vomiting, dehydratio	rehensive assessment of a must ensure that a resident o-gastric or gastrostomy tube priate treatment and services n pneumonia, diarrhea, on, metabolic abnormalities, eal ulcers and to restore, if ating skills.					
	by: Based on record re facility failed to prop for 1 of 1 residents	NT is not met as evidenced eview and observation, the perly administer medications (R16) reviewed for enteral ministration in the sample of					
	documented "Tram take 2 tablets by me hours." During observati 10-12-11 at 10:35a Nurse (LPN), crush HCL 450mg" and p plastic container. E medication and pou "Tramadol HCL" po	Order, dated 7-30-11, adol HCL 50mg tab (tablet) outh or per tube every 6 ion of the medication pass, on .m., E15, Licensed Practical ned two tablets of "Tramadol laced each tablet in a separate 15 did not dissolve the ured the undissolved wder in R16's enteral tube the syringe with water. Each					

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145655	B. WIN	√G _		10/2	1/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD		
VIPMA	NOR				WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 322 F 323 SS=G	container was obse that was not admini The facility's Me an Enteral Tube po documented "3. Mi ml of water." 483.25(h) FREE OF HAZARDS/SUPER' The facility must en environment remain as is possible; and	erved with remaining powder istered. dication Administered through licy and procedure, not dated, ix crushed medications with 15 F ACCIDENT		322			11/19/11
	by: Based on record re observation, the fac transfer for a residen functioning; and fail supervision, care pl residents 4 of 10 re reviewed for falls in resulted in R2 fall a failure also resulted her right hip. Findings include: 1. R2's Investigation documented R2 wa the floor, bedside.	NT is not met as evidenced eview, interview and cility failed to provide a safe ent with a history of falls; failed it's siderail was properly led to provide timely lanning and fall prevention for esidents (R2, R3, R8 and R15) a sample of 21. This failure and fracturing his left hip. This d in R15 falling and fracturing on Report, dated 5-23-11, is found, on 5-20-11, sitting on It was also noted R2 had a intia and was attempting to					

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES	
CENTERS FOR MEDICARE	& MEDICAID SERVICES	
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 02/25/2012 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
		145655	B. WI	√G		10/21/2011	
NAME OF PROVIDER OR SUPPLIER VIPMANOR				39	REET ADDRESS, CITY, STATE, ZIP CODE 93 EDWARDSVILLE ROAD VOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	N SHOULD BE COMPL E APPROPRIATE DA	
F 323	ambulate resulting right ankle pain and Report, dated 6-17- found sitting on the was also noted R2 unassisted. R2's Ir 7-11-11, document floor in his room. It was a risk factor for R2's Investigation documented R2 was	ge 18 in a fall. R2 complained of d edema. R2's Investigation 121, documented R2 was floor in a puddle of urine. It was attempting to ambulate nvestigation Report, dated ed R2 was found sitting on the was also documented R2 r weakness and Dementia. on Report, dated 10-3-11, is found, on 7-11-11, leaning mates bed. It was also noted	F	323			

R2 sustained a left hip fracture. R2's Fall Risk Assessments, dated 5-11 and 6-11, documented R2 was a high risk for falls. It was also noted R2 had a history of falls, impaired gait and balance and disoriented times three at all times. R2's Plan of Care, current, did not document R2's falls or interventions to prevent further falls.

R2's Behavioral Tracking, dated 7-11, 8-11 and 9-11, documented "Continuously getting out of wheel chair" with documented interventions. R2's Care Plan did not document R2's behavior or interventions documented on R2's Behavior tracking Sheet.

The facility's Fall Management policy and procedures, dated 11-07, documented "the facility will identify residents at risk for falls and implement interventions to minimize fall occurrences and injury real ted to falls." It was also noted A Fall Risk Evaluation and Care Plan will be completed when the resident is identified to be at risk for fall or has had a fall to ensure that appropriate interventions are put into place."

2. According to the Minimum Data Set (MDS) dated 03/18/11, R15 requires extensive assist of

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO.	0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) N	1ULT	IPLE CONSTRUCTION	(X3) DATE SU	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BU	ILDIN	NG	COMPLE	IED
		145655	B. WI	NG_		10/0	1/0011
		145055				10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR				WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 323	and ambulation. Th has a moderate cog sitting and standing plan dated 05/05/17 falls requiring ADL goal listed on the ca listed as "resident w trying to get out of w On 06/08/11, a Communication Re "fallen forward from The document indic hematoma to the rig Further notations in notified with no new 06/08/11 listed inter verbal cues and off when noted sleepin On 06/25/11 a indicated that R15 w room next to her be was complaining of right lower extremit where x-ray results femoral fracture res Hospital records als sample was obtained on 07/18/11, d R15 had an unwithe injury noted. New ir plan, dated 07/18/1 bed alarm." On 10/	y, transfers, toilet use, hygiene le MDS also indicates that R15 gnitive impairment and has balance deficits. The care 1 identifies R15 at high risk for assistance and supervision. A are plan dated 05/05/11 was vill have fewer episodes of wheelchair." "Nurse/Physician cord" indicated that R15 had n her wheelchair to the floor." cated that R15 sustained a ght side of the forehead. dicated that the physician was v orders. The care plan dated rventions, in part as, "give fer to lay down after meals or ig in wheelchair." "Resident Occurrence Report" was found on the floor in her ed. It further indicated that R15 right hip pain and pain to the y. R15 was sent to the hospital showed a right subcapital sulting from trauma from a fall. so indicated that a urine ed in the emergency rrival indicating R15 also had oction. The only new o place was "Increase	F	323			

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 323 Continued From page 20 F 323 station and took two steps forward. R15 was guickly assisted back to sitting position in wheelchair. There was no chair alarm that sounded. E7 was asked if R15 had a chair alarm, and her response was that she wasn't sure. There is no documentation in the medical record to indicate if a chair alarm was ever applied or in use as of this survey date. 3. R8's Physician Order Sheet for October 2011 documents a diagnosis, in part, Schizophrenia and Dementia. R8's most current Care Plan dated May 2010 identifies R8 as needing assistance of 1 staff for transfer using a gait belt. R8's MDS of 9-1-11 identifies R8 as having disorganized thinking and a history of falls with injury. R8's Care Plan of May 2010 identifies R8 as being at risk for falls and having a history of a fracture of left hip. Care Plan approach includes in part, chair and bed alarm and remind to request assistance with transfers and toileting. Care plan also documents R8 is to be transferred with a gait belt. On 10-12-11, at 12:30PM was observed to be transferred from her wheel chair to her bed by E17, CNA and Z1, Hospice CNA. E17 and Z1 failed to use a gait belt when transferring R8. R8 did not have a chair or bed alarm. Facility Occurrence Report shows R8 had 7 falls between February 2011 and October 2011. Interventions for the falls include, in part; Provide safety education, ensure call light within reach, remind resident to request assist with toileting and transfer as needed. R8's current MDS shows disorganized thinking. Occurrence Report of 8-17-11 documents R8 obtained a large hematoma to the right side of the forehead, abrasion to the bridge of the nose with

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) Mul A. Build	TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145655	B. WING	i	10/2 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR			393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 325	(2) Receives a ther nutritional problem. This REQUIREMEN by: Based on interview review, the facility for provide assistance	his is not possible; and apeutic diet when there is a	F 32	25		
	intake for 2 of 7 res nutritional status in Findings include: 1. The Minimum E identifies R5 to hav The MDS indicates up/supervision for e Sheet (POS) for Oc receives a mechan sauces/gravy and N daily (TID), all items 9/26/11 identifies R loss within the past past 180 days. The weight. The proble able to feed herself noted difficulty swa plan also identifies eating program. Int menu, assist with tr to eat 75% or more food uneaten, recon- significant weight lo	idents (R5, R13) reviewed for a sample of 21. Data Set (MDS) dated 9/2/11 e had a decline in weight.				

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FORM APPROVED
OMB NO. 0938-0391

CENTENS FOR MEDICARE &						0900-0091	
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	145655	B. WIN	1G		10/2	1/2011	
NAME OF PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE			
V I P MANOR				3 EDWARDSVILLE ROAD			
			W	OOD RIVER, IL 62095			
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
Prealbumin 23/6 (15- On 10/11/11 at 11 tray at bedside in her baked potatoes, grout bread, dessert and a set up her tray putting her potato. The bread herself very slowly an complaining that it wa it was hard), bites of h carrots, no dessert ar her skim milk. No sub food uneaten. R5 sta the whole potato had On 10/12/11 at not baked beans, and pic bites of the meat, 100 none of the beets. 50 was no milk on her tr once her tray was set According to E3 Li (LPN) on 10/12/11 at her room. Quarterly nutritiona 9/2/11 indicates R5 to house supplements th the med pass, and av Resident meal cor incomplete with "hall" from 10/1/11 through	nal 3/5 - 4/8) and a normal 38). 30am, R5 was served her room. She had a large nd meat, carrots, wheat container of skim milk. Staff g sour cream and butter on d was left in the bag. R5 fed d ate only 50% of her potato as uncooked (testing showed her meat, 50% of her nd 50% of her tea, 100% of ostitutes were offered for ited she would have eaten it been cooked soft. on, R5 received ground pork, kled beets. She ate only 0% of the baked beans and % of tea was drank. There ray. No staff were present to p. censed Practical Nurse 1pm, R5 prefers to eat in al progress notes dated olerates her diet well, gets nee times daily along with rerages 50-75% meal intake. nsumption records are written in for 19 of 33 meals 10/12/11 noon meal and no d for any meals. The house	F	325				

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Facility ID: IL6009534

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 325 Continued From page 24 F 325 implemented with the boundaries of the resident's wishes and/or health care directives. The facility did not take into account that eating in her room without staff encouragement could be a factor in her weight loss. The policy also indicates residents with significant weight loss are to be reviewed weekly at the standards of care committee meeting which is attended by the Registered Dietician or designee with each discipline prepared to discuss the cause for decline and risk factors. The policy also indicates the % of fortified supplements consumed will be recorded in the MAR (medication Administration Record) by nursing and reviewed/monitored by the RD. The policy also indicates all meal consumption will be reflected in percentage of food consumed. 2. The MDS dated 8/30/11 identifies R13 as being totally dependent on staff for eating. The October 2011 POS indicates R13 receives a pureed diet with house supplements and Med Pass 60cc three times daily. The POS also includes an order to "monitor intake." The Weight sheet shows a gradual weight loss from 134 pounds in April 2011 to 124.8 pounds in October. The care plan includes a goal to eat 75% of each meal. On 10/12/11 and 10/13/11 at noon showed R13 to receive a pureed diet and be fed. She ate only a small amount both on 10/12 and 10/13/11. Intake records show no intake recorded for 10/1 or 10/2 and blanks for 7 meals from 10/1 through 10/13 noon meal. 483.25(I) DRUG REGIMEN IS FREE FROM F 329 F 329 11/19/11 UNNECESSARY DRUGS SS=D Each resident's drug regimen must be free from

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU			(X3) DATE SI COMPLE	JRVEY
		145655	B. WI	NG _		10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
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F 329	drug when used in duplicate therapy); without adequate m indications for its us adverse consequer should be reduced combinations of the Based on a compre- resident, the facility who have not used given these drugs u therapy is necessar as diagnosed and o record; and residen drugs receive gradu behavioral interven	An unnecessary drug is any excessive dose (including or for excessive duration; or nonitoring; or without adequate se; or in the presence of neces which indicate the dose or discontinued; or any	F	329	9		
	by: Based on record re failed to assess for tracking and plan for 11 residents (R6, R medications in a sa Findings include: 1. R6's clinical re 7/28/11, his physici	NT is not met as evidenced eview and interview, the facility need, evaluate behavior or medication reduction for 3 of 11 and R12) reviewed for mple of 21.					

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document shows that from 7/1-7/31/11. this behavior occurred 18 times on the night shift, once on the day shift and once on the evening shift. There is no other documentation in R6's clinical record regarding his sexual behaviors;

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PRINTED: 02/25/2012

(X5) COMPLETION

DATE

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 329 Continued From page 27 F 329 why behaviors occurred mainly on the night shift; any less restrictive methods attempted prior to utilizing the Provera; and assessing for adverse side effects of using Provera in a male. The Nursing 2011 Drug Handbook states that Provera "suppresses ovulation, possibly by inhibiting pituitary gonadotropin secretion, thus preventing follicular maturation and causing endometrial thinning". There is no documentation in the drug handbook regarding the use of Provera in males. 2. R11's October 2011, Physician Order Sheet (POS), documents R11 has a diagnosis, in part, Anxiety, depressive Disorder and Psychosis. R11 has an order of 10/31/09 for Risperdal .5 mg daily and an order Alprazolam 2.5 mg BID (twice a dav) and .5mg HS (bedtime). R11's Minimum Data Set (MDS) of 12/6/10, 5/3/11 and 7-13-11 documents no behaviors. Record review of R11's Behavior Intervention forms from March, 2011 thru October 12, 2011 document R11 behaviors include: withdrawn due to mood: verbal distress/tearfulness: and decreased socialization (prefers to stay in room to crochet). Behavior Intervention forms show no behaviors during these months. Record review of R11's medical record shows there is no comprehensive Physician note justifying the use of the Alprazolam and Risperdal and that a reduction would be contraindicated. E19, CNA, stated on 10/13/11 at 12:45PM, R11 has no problems with behaviors. At 12:50PM, E8, Licensed Practical Nurse (LPN), stated R11 had no behaviors. At 1PM, E20, LPN stated she has never seen R11 have any behaviors. Record review shows there is no evaluation of

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indicates R12 saw the nurse practitioner and is

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STATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD	ULTIPLE CONSTRUCTION DING	(X3) DATE S COMPLE	URVEY
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NAME OF F	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP COL	DE	
VIPMA	NOR			393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F9999	or older seeking ad Background checks resident's name, da identifiers as requir Police. This regulation was VIP Manor failed to for the survey of 09 Based on record re failed to initiate resi within 24 hours for R24, R25, R26, R2 Findings include: On 10/11/11 ten resi including their crimic checks and the req the ten background initiated within 24 h Admitted Backgr R22 10/4/11 R23 9/27/11 10/ R24 9/27/11 10/ R25 8/30/11 9/2 R26 8/31/11 9/2 R27 9/8/11 On 10/13/11 at 10:3 asked about the cri checks that were no admission. She cor	ILCS 2635] for all persons 18 mission to the facility. ILCS 2635] for all persons 18 mission to the facility. Is shall be based on the ate of birth, and other ed by the Department of State in ot met as evidenced by: follow their plan of correction /16/2010. View and interview the facility dent background checks 6 of 10 residents (R22, R23, 7) in the supplemental sample. Sident files were reviewed nal background uired website checks. Six of checks were not nours. Ound Check Initiated 10/11/11 (3/11 (3/11 (3/11) (7/11) (7/11) (7/11) (7/11) (7/11) (7/11) (7/11) (7/11) (7/11) (7/11) (7/11) (7/12) (7/11) (7/12) (7/1	F999	99		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/25/2012 APPROVED 0938-0391
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NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
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		(Repeat B)				
	300.610a) 300.1210b) 300.3220f) 300.3240a)	ocidant Caro Dolinion				
		esident Care Policies				
	procedures, govern the facility which sh Resident Care Polic least the administra the medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by th	have written policies and ing all services provided by all be formulated by a cy Committee consisting of at itor, the advisory physician or by committee and nursing and other services in policies shall be in compliance rules promulgated thereunder. es shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a				
	Section 300.1210 G Nursing and Persor	General Requirements for nal Care				
	and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	provide the necessary care in or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each to total nursing and personal				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 02/25/2012 APPROVED : 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	JLTIPLE CONSTRUCTION	(X3) DATE S COMPLE	URVEY
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NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
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F9999	Continued From pa care needs of the re	-	F99\$	999		
	administered as ord physician orders sh director of nursing of within 24 hours after issued to assure fa orders. (Section 2 Section 300.3240 A a) An owner, licens agent of a facility sh resident. These regulations w Based on observati review, the facility fa treatment for wound residents (R8) and reviewed for wound monitor and Care F for 1 of 1 residents the sample of 21. developing cellulitis left great toe amput Findings include: 1. R29's Physician	hent and procedures shall be dered by a physician. All new all be reviewed by the facility's or charge nurse designee er such orders have been cility compliance with such 104(b) of the Act) abuse and Neglect ee, administrator, employee or hall not abuse or neglect a were not met as evidenced by: on, interview and record ailed to provide appropriate ds/ulcers for (1) of 7 sampled 1 supplemental resident (R29) care and failed to assess and Plan for Dialysis complications (R14) reviewed for Dialysis in This failure resulted in R29 , osteomyelitis and having her tated.				
	2011 documents R a diagnosis, in part	29 is a 50 year old female with of Insulin Dependent Hypertension, Crohn's				

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FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 33 F9999 Disease, Back Surgery, Cardiovascular Accident, Decubitus Ulcers, Wound Right Hip Closure and Blood Dyscrasia. R29 has a Physician order on 7-17-11 to give Rocephin 1 gram IM (intermuscular) gd (every day) x 2 days then start Keflex 500 mg by mouth 1 every 6 hours x 8 days for treatment to cellulitis of the left great toe. Cleanse area and apply Bactroban ointment and dry dressing q (every) day and PRN (as needed). POS documents an order of 7-19-11 "May send res (resident) to ER (Emergency Room). POS shows an order of 7-19-11 for Bactrin DS BID (twice a day) po (by mouth) x 10 days. It is documented on 7-21-11 on the POS to refer to a vascular surgeon to evaluate and treat left great toe. POS documents an order on 7-22-11 to send R29 to the ER for evaluation per family demand. R29's Wound Culture of left great toe on 7-19-11 shows MRSA (Methicillin Resistant Staph Aureus) which was resistive to Bactrim DS. The culture does not identify sensitivity to Keflex. NURSE/PHYSICIAN COMMUNICATION RECORD of 7-17-11 has documentation that reason for calling the physician is left great toe very red, swollen, hot to touch, nail bed above nail red and top of the toe is purple. Temperature is 99 degrees, pulse is 90, blood pressure is 110/68. Pain is 3 out of 5. Pain medication given for comfort. Physician called and gave order for Rocephin 1 gm IM gd x 2 days then start Keflex 500mg every 6 hours x 8 days. Record also shows the above order for cleaning and treating the wound. Note at 2PM states R29 states foot and even her leg hurt half way up her calf. No drainage.

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		145655	B. WING	G	10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ige 34	F999	99		
	RECORD of 7-19-1 toe declining." Tim 12 noon with orders evaluation. Note at (Certified Nurse Aid toe looks worse ver mushy on bottom & coming out. Res w 7/17/11. Call place back." Note at 12 r send res to ER for of Nursing) states call & ? about IV antibio (POS review shows antibiotics.) Note a with Dr at length (condition), states t chooses to go. Thi et (and) noted 0 ind noted from eval on (resident) reassure go to ER" It is documented in R29 left the facility 8:30AM for a Docto Administrator, state could not find any in went on 7-20-11. S documented in the suggested to call R On 7-20-11 at 12:4 she took R29 to the	N COMMUNICATION 1 documents, "L (left) great e of Physician response states is to send R29 to the ER for 10AM documents, "CNA de) came & told this nurse L ty red & swollen hot to touch a purple has yellow drainage as started on ABt (antibiotic) d to Dr. (Doctor) awaiting call noon documents, "Dr states eval. DON (Director of Dr. back ask for culture order otics. awaiting call back." is no order was obtained for IV t 3:20PM documents, "Spoke re (regarding) res cond o send res to ER if res is Nurse evaluated L great toe crease in redness or swelling Sunday evening, res d and states does not want to 7-20-11 Nurses Notes that with a family member at or appointment. E1, ed on 10-21-11 at 11AM, she nformation as to where R29 She stated it is suppose to be Nurses Notes but it is not. E1 29's sister and she may know. 0PM, Z4, R29's sister, stated e plastic surgeon who operated nd and the Surgeon did not				

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CENTER STATEMENT AND PLAN C	RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION	AND HUMAN SERVICES <u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145655	(X2) M A. BU B. WII	ILDIN NG _ ST		FORM OMB NO. (X3) DATE SL COMPLE	
	-				WOOD RIVER, IL 62095		
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F9999	It is documented in that R29's left toe of and purple with larg noted, continues to serosanguinous dra full weight bearing to difficulty. Left foot s slight red in color. OR SKIN ABNORM 7-22-11 identifies le Bactroban and dry on nail bed. 0 toen bottom of toe nail b color, swelling, slou Z5, Nurse Practione note of 7-21-11, that on a Vascular Ulce days ago on antibio to 1st knuckle. A la slight bleeding. Wo mushy under skin. Surgeon. Nurses Note 7-20-7 around facility in wh states R29 has pain edema noted in left documented on 7-2 called to tell her of surgeon. Z4 stated to hospital now!" It R29 was admitted to and MRSA to R (rig medical records sh It is documented in	the Nurses Notes on 7-20-11 continues to be swollen, red ge amount of yellow slough have scant amount of ainage. R29 ambulates and to left lower extremity without slight swollen inner arch and (Facility WEEKLY WOUND MALITY TRACKING LOG of eft toe wound with treatment of dressing with no pain. ".2 slit hail. Just starting to grow from hed. There is no mention of ugh or drainage.) er, documented on a progress at R29 was seen to follow up r to great left toe. Onset 5-7 bit ctherapy. Denuded skin up arge piece debrided off with bund base white. Rest of toe Plan to send to Vascular	F9	999	λ		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 36 F9999 hospital with chief complaint of having noted left toe pain and redness and swelling ongoing for a few days. She had broken her toe nail and started noticing that there was some redness in the beginning but no purulence or bleeding. Later on the toe started to swell and she had severe pain. Physical examine showed left foot great toe has significant edema and ervthema. No open wounds or ulcers. No purulent discharge noted at this time. It is documented under Assessment and Plan: Left foot diabetic ulcer with cellulitis associated with leukocytosis, subjective fever. Culture is positive of MRSA. Continue vancomycin, obtain podiatry on consult, wound care on consult. Arterial Doppler negative for evidence for peripheral vascular disease. Continue bacitracin topically. Obtain X-ray of the foot for signs of osteomyelitis... It is documented on the Hospital X ray of R29's left foot, on 7-22-11, Soft tissue swelling of the great toe is seen. Irregularity of the tuft of the distal phalanx of the great toe. This may be due to bony erosion as a result of osteomyelitis. This could be due to prior trauma. A small linear lucency in the area, possibly a more recent fracture. Mild degenerative osteoarthritic changes. Small posterior calcaneal spur. It is documented on R29's Consultation Report of 7-24-11 by Z3, Podiatrist, R29 does have a large ulceration distal tip of the left hallux. There is exposed bone of the distal phalanx tip present. It is somewhat fibrotic and necrotic. X ray results are suspicious for osteomyelitis . There does appear to be some destruction about the distal tip of the distal phalanx...Assessment: Osteomyelitis of the left hallux distal phalanx with associated

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Facility ID: IL6009534

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		HAND HUMAN SERVICES					APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145655	B. WI	NG _		10/2 [.]	1/2011
NAME OF F	PROVIDER OR SUPPLIER	<u></u>			REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR				393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ULD BE	(X5) COMPLETION DATE
F9999	cellulitis and foot ule part, treat with amp the halluxcontinue Hospital Discharge discharge diagnose the distal phalanx o post amputation of great toe; Cellulitis significantly improve came to the ER and her right great toe a hospital She has a was diagnosed to h was started on IV a wound and the leuk diagnosed as havin amputation of the d toe for the osteomy During interview wit Nurse (LPN) on 10- on 10-19-11 she wa toe was getting wor seen the toe before purple on bottom an yellow drainage. It needed to go to the antibiotics for 2 day working. E20 called him of her concerns sent to the hospital. E2, Director of Nurs are sending a resid she told E2 and E2 if they could treat th not refusing to go to	ceration. Plan includes, in butation of the distal phalanx of e on current IV antibiotics Summary of 7-27-11 states es, in part: Osteomyelitis of of the left great toe; Status the distal phalanx of the left of the ankle and left foot - red. Hospital Course: R29 d admitted with severe pain in and was admitted to the a left diabetic foot ulcer and have cellulites of the foot, and antibiotics because of the kocytosis and fever. R29 was ng osteomyelitis and underwent distal phalanx of the left great	F9!	999			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145655	B. WIN	NG _		10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER		I		REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR		I	_	393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa over.	ige 38	F99	999)		
	initially saw R29's to was red and swoller with yellow drainage on the end of the to order for Rocephin 7-19-11, E20 stated and she had called and Procedure to cl call, before sending stated she thought and thought they co IV antibiotics. E21 had to call Z2 back treat R29 in house. upset. He wanted the was being secor if she had seen the "NO", she had just did not understand R29 out and said if E21 said she then le to R29. The toe did accu check was go the antibiotics had r E21 states she felt not need to go the t pressured not to se stated after R29 we E1 and E2 of conce wanted. Facility Po patient care. Z2 did R29. He said she hen Rocephin. He want based on what the	stated she was the Nurse who oe on 7-19-11. Her great toe on and real purple on the end e. It looked like a blister area be. She called Z2 and got an IM and then Keflex. On d R29's toe looked very bad Z2. It's the facility's Policy theck with E2 or the Nurse on g residents to the hospital. E21 E2 went and looked at the toe build treat it at the facility with stated she was the one who and tell him E2 wanted to E21 stated Z2 was very her sent to the hospital. He felt nded guessed. He asked E21 toe that day and she told him come on duty. Z2 told her he why they did not want to send she wants to go send her. looked at R29's toe and talked d not look any worse. Her od. E21 stated she told R29 not had a chance to work. she convinced R29 she did the ER. E21 stated she felt end R29 to the hospital. E21 ent to the hospital she talked to erns of not doing what Z2 olicy got in the way of good d not give an order to not send tad just had 2 days of IM ted her to go to the hospital Nurse told him that morning. me, there was no written order					

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145655	B. WI	NG _		10/2	/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR				393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Nurse communication On 10-19-11 at 2:19 a report from a Nur- toe was worse. He time. If the wound if and is worse, some ordered for R29 to Ho over reacted then the they send her back, her. They called Z2 treat R29 at the fac concerns and though hospital. Z2 stated send R29 to the ER her is if she refused would not have made would have lost the nothing in hospital re was gangrenous.) E2 stated on 10-21- aware Z2 had order hospital. E20 had to out to the hospital af for a culture and an facility. E2 denied s to the ER. "If some hospital it's her righ at R29's toe before if she could be treat there was no writter she or a charge Nu resident was sent of	ER. It was written on the ion record but not on the POS. 5PM, Z2 stated he had gotten se that R29's wound on her was not at the facility at the is not getting better in 2 days one needs to look at it. He be sent to the hospital. If he ne worst thing that happens is . If needed they would admit 2 back and said E2 wanted to ility. Z2 stated he had ght R29 should go to the he did not rescind the order to 8. The only reason not to send 4 to go. Z2 stated if the toe grenous then waiting 2 days de a difference. She probably toe anyway. (There is records that show R29's toe -11 at 10:45 AM, she was not red for R29 to go to the old her she was sending R29 and E2 told her she should ask tibiotics and treat at the she told E20 not to send R29 one wants to go to the t." E2 stated she did not look telling E20 to call Z2 and see ted at the facility. She stated in Policy and Procedure that rse had to approve before a	F9	9999			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 40 F9999 been the rule around the facility that you had to get approval to send a resident to the hospital. They wanted residents to be treated in the facility unless it was an emergency. On 10-21-11 at 11AM, E1, Administrator, stated there was no written Policy and Procedure to not send a resident to the hospital unless the DON or charge Nurse approves. The do want the Nurses to run it through the DON before sending out unless it's an emergency due to some Nurses getting carried away and sending a resident out when they could be treated at the facility. On 10-20-11 at 3:05PM, Z3, R29's Surgeon/Podiatrist, stated trauma could have caused injury to R29's left great toe. Even rubbing shoe on toe could have caused the injury. She does not have much feeling in the toe and she could be doing damage without knowing it. Z3 stated they possibly could have saved the toe if it was treated earlier. When he saw it, bone was exposed and it was too late. Once bone is exposed it has to be amputated. Possibly with IV antibiotics and staying off her feet, the toe may have been saved. It could have healed. Two days could make a difference. 2. R8 was observed on 10-12-11 at 12:30PM, to have two ulcerated areas on her right foot and one on her left foot. E7, Treatment Nurse, was present and confirmed the areas and stated they were not pressure sores. Record review of R8's Medical Record and Treatment Administration Record (TAR) show R8's ulcerated areas on her feet were not

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145655	B. WI	√G _		10/2 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR			_	393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	assessed. At 1:20F she had just looked looks arterial and R was informed there TAR for treatment t no assessment. At not find an assess the policy is to do a document and then weekly.	PM, E1, Administrator, stated at R8's feet and stated it 8 needs a doppler study. E1 was a treatment order on the to the left lower extremity but 1:50PM, E1 stated she could nent on R8's feet. E1 stated n initial assessment and assess and document (B) (B) esident Care Policies have written policies and sing all services provided by all be formulated by a cy Committee consisting of at ator, the advisory physician or	F99	999			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI	LTIPLE CONSTRUCTION		(X3) DATE SU COMPLE	JRVEY
		145655	B. WINC	3		10/2-	1/2011
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, S			
VIPMA	NOR			393 EDWARDSVILLE R WOOD RIVER, IL 62			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORREC CTIVE ACTION SHO NCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa meeting.	ge 42	F999	99			
	Section 300.1210 G Nursing and Persor	General Requirements for nal Care					
	and services to atta practicable physica well-being of the re- each resident's con plan. Adequate and care and personal of	provide the necessary care ain or maintain the highest I, mental, and psychological sident, in accordance with nprehensive resident care I properly supervised nursing care shall be provided to each total nursing and personal esident.					
	pressure sores, hea breakdown shall be seven-day-a-week enters the facility w develop pressure s clinical condition de sores were unavoid pressure sores sha services to promote	ram to prevent and treat at rashes or other skin practiced on a 24-hour, basis so that a resident who ithout pressure sores does not ores unless the individual's emonstrates that the pressure lable. A resident having II receive treatment and healing, prevent infection, ressure sores from developing.					
	Section 300.1220 S Services	Supervision of Nursing					
	nursing services of 3) Developing an up each resident base comprehensive ass and goals to be acc	upervise and oversee the the facility, including: p-to-date resident care plan for d on the resident's sessment, individual needs complished, physician's orders, and nursing needs. Personnel,					

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		AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145655	B. WI	NG		10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR				93 EDWARDSVILLE ROAD NOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	representing other s activities, dietary, ar are ordered by the p the preparation of th plan shall be in writt modified in keeping indicated by the res shall be reviewed a Section 300.3220 M f) All medical treatm administered as orc physician orders sh director of nursing of within 24 hours after issued to assure fac orders. (Section 2-1 Section 300.3240 A a) An owner, licens agent of a facility sh resident. These regulations w Based on record re interview, the facility turning and repositi identification, monit residents (R16) in th reviewed for turning sore prevention. Th	services such as nursing, nd such other modalities as physician, shall be involved in he resident care plan. The ing and shall be reviewed and g with the care needed as sident's condition. The plan it least every three months. Medical Care nent and procedures shall be dered by a physician. All new hall be reviewed by the facility's for charge nurse designee er such orders have been cility compliance with such 104(b) of the Act)	F9	999			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY		
		145655	B. WI	NG _		10/21	1/2011		
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE				
VIPMA	NOR			393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE		
F9999	Continued From pa Findings include:		F99	999	9				
	8-18-11, documente impairment, total de persons physical as transfers, bilateral u impairment and two R16's Care Plan, go documented R16 w	ependence of two plus ssistance with mobility and upper and lower extremity o Stage II pressure sores.							
	repositioning, on 10 12:20p.m., R16 was repositioned. Interv (RN), on 10-12-11 a was "pulled up and position was observ her positioning with remaining and unre and sides switched. Assistant (CNA) an checking R16 adult	of R16's turning and 0-12-11 from 9:25a.m. to s not timely turned and view of E14, Registered Nurse at 9:25a.m., E14 stated R16 switched her sides." R16's ved the same before and after coccyx and buttock pressure elieved with being pulled up . E13, Certified Nursing d E5, CNA were observed 's diaper for incontinence, on .m. E5 and E13 did not							
	severe cognitive im one person physica transfer, bilateral up	ed 9-22-11, documented pairment, total dependence of a assist with mobility and oper and lower extremity risk for pressure sore							
	Tracking Log, week documented a 5.0c	y Wound or Skin Abnormality c ending date 8-5-11, m x 4.0cm unstageable area s left heel on 8-1-11.							

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		TIPLE CONSTRUCTION	(X3) DATE SL COMPLE	JRVEY
		145655	B. WI	NG _		10/2	1/2011
NAME OF P	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ΥΙΡΜΑ	NOR			_	393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 45	F9:	999			
	1:40p.m., E7 stated Nurse on 8-5-11 and very, very deep pur she saw it. E7 also measurements of F Log, week ending of Tracking Logs. R24 Abnormality Trackin documented R28's 5.0cm x 4.0cm "eso Review of R28's ch heel was monitored development until it 5.0cm x 4.0cm unst dated 9-22-11, doct pressure sore deve R2's Skin Risk Eval date 12-25-11, doct skin breakdown. It pressure sore was Plan with goals ide her left heel. The facility's Wound Treatment policy ar 10-1-08,documenter no evidence of sign integrity. It was als residents at risk wil and documented da Interview of E16, M 1:15p.m., E16 state Skin Condition Eval	art did not document R28's left d for pressure sore t was found on 8-1-11 as a tageable area. R28's MDS, ument she was at high risk for lopment. Iuation and Plan of Care, goal umented R28 was at risk for was also noted R28's left heel not documented on her Care entified and/or interventions for d Prevention/Skin and Wound hd procedure, dated ed, in part, residents will exhibit a breakdown or will regain skin o documented that all I have skin condition checked					

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	02/25/2012 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SU COMPLE	JRVEY
		145655	B. WING _		10/2 ⁻	1/2011
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR			393 EDWARDSVILLE ROAD WOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	dated 2-11 to 10-11	ge 46 Skin Condition Evaluations, , which did not document skin left heel until 8-15-11. (B)	F9999			
	 a) The facility shall procedures, govern the facility which sh Resident Care Polic least the administrative medical advisor representatives of r the facility. These p with the Act and all These written polici operating the facility least annually by th written, signed and meeting. Section 300.1210 G Nursing and Persor b) The facility shall 	Aursing and other services in policies shall be in compliance rules promulgated thereunder. es shall be followed in y and shall be reviewed at is committee, as evidenced by dated minutes of such a				

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE	
		145655	B. WI	√G		10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
ΥΙΡΜΑ	NOR				93 EDWARDSVILLE ROAD NOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F9999	 well-being of the research resident's complan. Adequate and care and personal of resident to meet the care needs of the resident to meet the care needs of the resident to meet the care needs of the resident in the resident that the resident is that each resident in the resident resident resident resident resident resident and assistance to perform the DON shall sinursing services of a services b) The DON shall sinursing services of and personal care are representing other services and goals to be account of the preparation of the preparation of the preparation of the preparation of the previewed are shall be reviewed are services and solution and the previewed are shall be reviewed are shall be revi	sident, in accordance with nprehensive resident care d properly supervised nursing care shall be provided to each e total nursing and personal esident. orecautions shall be taken to idents' environment remains hazards as possible. All shall evaluate residents to see receives adequate supervision orevent accidents. Supervision of Nursing upervise and oversee the the facility, including: p-to-date resident care plan for d on the resident's sessment, individual needs complished, physician's orders, and nursing needs. Personnel, services such as nursing, nd such other modalities as physician, shall be involved in he resident care plan. The ing and shall be reviewed and g with the care needed as sident's condition. The plan it least every three months.	F9	999			

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		I AND HUMAN SERVICES				FORM	02/25/2012 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SU COMPLE	
		145655	B. WI	IG		10/2	1/2011
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR				93 EDWARDSVILLE ROAD VOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 48	F9	999			
	These Regulations were not met as evidenced by:						
	transfer for a resider to ensure a residen functioning; and fai supervision, care p 4 of 10 residents (I for falls in a sample R2 fall and fracturin	view, interview and cility failed to provide a safe ent with a history of falls; failed it's siderail was properly led to provide timely lanning and fall prevention for R2, R3, R8 and R15) reviewed of 21. This failure resulted in ng his left hip. This failure also ng and fracturing her right hip.					
	documented R2 wa the floor, bedside. diagnosis of Demen ambulate resulting right ankle pain and Report, dated 6-17- found sitting on the was also noted R2 unassisted. R2's Ir 7-11-11, document floor in his room. It risk factors of weak R2's Investigation F documented R2 wa against his roomma R2 sustained a left R2's Fall Risk Asse	on Report, dated 5-23-11, is found, on 5-20-11, sitting on It was also noted R2 had a ntia and was attempting to in a fall. R2 complained of d edema. R2's Investigation -11, documented R2 was floor in a puddle of urine. It was attempting to ambulate nvestigation Report, dated ed R2 was found sitting on the twas also documented R2 had cness and Dementia. Report, dated 10-3-11, is found on 7-11-11 leaning up ate's bed. It was also noted hip fracture.					

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

PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391

CENTERS FOR MEDICARE & MEDICAID SERVICES						ONB NO.	0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		145655	B. WING			10/21/2011	
NAME OF PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, ZIP CODE		
ΥΙΡΜΑ	NOR				93 EDWARDSVILLE ROAD NOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE AP DEFICIENCY)		OULD BE COMPLETION	
F9999	Continued From page 49 was also noted R2 had a history of falls, impaired gait and balance and was disoriented times three at all times.		F99	999			
	falls or interventions Behavioral Tracking documented "Conti chair" with docume Plan did not docum	f Care did not document R2's s to prevent further falls. R2's g, dated 7-11, 8-11 and 9-11, inuously getting out of wheel nted interventions. R2's Care tent R2's behavior or mented on R2's Behavior					
	procedures, dated identify residents at interventions to mir injury real ted to fal Risk Evaluation and when the resident is or has had a fall to	anagement policy and 11-07, includes, "the facility will t risk for falls and implement nimize fall occurrences and ls." It was also noted A Fall d Care Plan will be completed s identified to be at risk for fall riate interventions are put into					
	dated 03/18/11, R1 one staff for mobilit and ambulation. Th has a moderate cos sitting and standing plan dated 05/05/17 falls requiring ADL goal listed on the ca	Minimum Data Set (MDS) 5 requires extensive assist of ty, transfers, toilet use, hygiene he MDS also indicates that R15 gnitive impairment and has balance deficits. The care 1 identifies R15 at high risk for assistance and supervision. A are plan dated 05/05/11 was will have fewer episodes of wheelchair."					
		rse/Physician Communication hat R15 had "fallen forward					

FORM CMS-2567(02-99) Previous Versions Obsolete

FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING B. WING 145655 10/21/2011 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 393 EDWARDSVILLE ROAD **VIPMANOR** WOOD RIVER, IL 62095 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE **REGULATORY OR LSC IDENTIFYING INFORMATION**) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F9999 Continued From page 50 F9999 from her wheelchair to the floor." The document indicated that R15 sustained a hematoma to the right side of the forehead. Further notations indicated that the physician was notified with no new orders. The care plan dated 06/08/11 listed interventions, in part as, "give verbal cues and offer to lay down after meals or when noted sleeping in wheelchair." On 06/25/11 a "Resident Occurrence Report" indicated that R15 was found on the floor in her room next to her bed. It further indicated that R15 was complaining of right hip pain and pain to the right lower extremity. R15 was sent to the hospital where x-ray results showed a right subcapital femoral fracture resulting from trauma from a fall. Hospital records also indicated that a urine sample was obtained in the emergency department upon arrival indicating R15 also had an urinary tract infection. The only new intervention put into place was "Increase monitoring as needed." On 07/18/11, documentation indicated that R15 had an unwitnessed fall from her bed with no injury noted. New interventions on R15's care plan, dated 07/18/11 were, in part as, "chair or bed alarm." On 10/13/11 at 11:00 am, R15 was observed standing in front of wheelchair at nurses station and took two steps forward. R15 was guickly assisted back to sitting position in wheelchair. There was no chair alarm that sounded. E7 was asked if R15 had a chair alarm. and her response was that she was not sure. There is no documentation in the medical record to indicate if a chair alarm was ever applied or in use as of this survey date.

FORM CMS-2567(02-99) Previous Versions Obsolete

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: IL6009534

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DEPART CENTER	PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		145655	B. WING			10/21/2011	
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
V I P MANOR					93 EDWARDSVILLE ROAD VOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	Continued From pa	ge 51	F99	999			
	documents a diagn and Dementia. R8' dated May 2010 ide	Order Sheet for October 2011 osis, in part, of Schizophrenia 's most current Care Plan entifies R8 as needing ff for transfer using a gait belt.					
	disorganized thinkir injury. R8's Care P as being at risk for fracture of left hip. include, in part, cha to request assistant	I identifies R8 as having ng and a history of falls with lan of May 2010 identifies R8 falls and having a history of a Care Plan approaches air and bed alarm and remind ce with transfers and toileting. uments R8 is to be transferred					
	transferred from he E17, CNA and Z1, I	30PM was observed to be or wheelchair to her bed by Hospice CNA. E17 and Z1 belt when transferring R8. R8 or bed alarm.					
	between February 2 Interventions for the safety education, er remind resident to r	Report shows R8 had 7 falls 2011 and October 2011. e falls include, in part; Provide nsure call light within reach, request assist with toileting eded. R8's current MDS d thinking.					
	obtained a large he forehead, abrasion a large amount blee	of 8-17-11 documents R8 matoma to the right side of the to the bridge of the nose with eding from the nares and e and was sent to the hospital					

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DEPAR ⁻ CENTEI	PRINTED: 02/25/2012 FORM APPROVED OMB NO. 0938-0391						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145655	B. WI	NG		10/21/2011	
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
VIPMA	NOR				93 EDWARDSVILLE ROAD VOOD RIVER, IL 62095		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F9999	NOR SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 52 Occurrence Report of 10-9-11 reflects R8 fell out of her wheelchair and landed on her face. Recommendation is to increase monitoring as needed. Antibiotic, 3 day bladder tracking to be initiated on 10-17-11 when antibiotic completed. R8 was observed on 10-11-11 at 10:30AM to have a black and blue bruised face. 4. During the initial tour conducted on 10/11/11 of the 500 hall at 10:45 AM an air mattress was observed on the second bed in room 510 with side rails on both sides. The bed was occupied by R3. The head of the bed was elevated and there was a gap under the side rails of 4 inches at the point of where the bed was bent. When pressure was applied to the mattress edges where the bed bent, a gap of 8 inches was measured. It was brought to the attention of E1, Administrator, at 10:55 AM on 10/11/11. An attempt was made to adjust the height of the side rails to eliminate the gap and it was determined the side rails could not be adjusted. At 11:30 AM the side rails could be adjust to eliminate the gaps under the side rails. (B)		F9	9999			

Facility ID: IL6009534

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