STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E848	A. BUILDING _____ B. WING _____	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DECATUR REHAB & HEALTH CARE CENTER	136 SOUTH DIPPER LANE DECATUR, IL 62522

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F 000	INITIAL COMMENTS	F 000		
F 159 SS=F	Annual Licensure and Certification Survey 483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.	F 159		10/13/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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F 159	Continued From page 1 The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all residents having funds in the facility's Residents Fund pooled account received accrued interest and that quarterly statements provided to residents included all transactions. Thirty-nine of 41 current residents and 1 discharged residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40 and R41) have funds in the interest bearing checking account. The finding is: 1. The facility's "Trust Fund Balance Report" listed 39 current and 1 discharged residents with funds in the account. The last 3 months resident trust fund bank statements were reviewed. The bank account is an interest bearing checking account. E3, the Business Office Manager stated on 9-7-11 at 1:45 P.M. that all the residents funds	F 159		

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F 159	Continued From page 2 are together in the interest bearing checking account. E3 was asked about the amount of money on which interest is calculated. E3 did not know the amount of money in each resident's individual account on which interest would be calculated. E4, the Regional Supervisor was asked about the amount of money in each resident's individual account on which interest would be calculated. E4 stated $50.00. As a result of the practice, interest is being paid only to residents with individual balances over $50.00 in the pooled account. All other residents receive no accrued interest. 2. The written Resident Trust Funds quarterly statements were reviewed. The statements did not list an ongoing balance. The statements do not provide a balance after each transaction, so that the resident knows the amount of funds available following a transaction. The statements provide only beginning and ending balances. E3 stated that thirty-nine of 41 current residents and 1 discharged residents (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40 and R41) have funds in the interest bearing checking account. The Centers for Medicare and Medicaid Services 672 form completed on 9-6-11 reflects there are 41 residents in the facility.	F 159		
F 161 SS=F	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the	F 161		10/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 161	Continued From page 3 Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure that the facility's Resident Trust Fund Surety Bond was equal to or greater than the total amount of residents funds managed by the facility at anytime. Thirty-nine of 41 current residents and one discharged residents funds are being managed and held in a pooled checking account (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40 and R41). The finding is: During review of the resident trust funds records with the Business Office Manager, E3 on 9-7-11 at 1:45 P.M., the resident checking account bank statements were reviewed for the last 3 months. The balance was $38,496.83 on 6-3-11, $38,425.59 on 7-1-11, and $35,571.66 on 8-3-11. E3 stated and provided documentation that the current surety bond was for $30, 000. E3 stated that thirty-nine of 41 current residents and one discharged residents funds are being managed and held in a pooled checking account (R1, R2, R3, R4, R5, R6, R7, R8, R9, R10, R12, R13, R14, R15, R16, R17, R18, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39,	F 161		

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F 161	Continued From page 4 R40 and R41). The Centers for Medicare and Medicaid Services 672 form completed on 9-6-11 reflects there are 41 residents in the facility.	F 161		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		10/13/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 5 representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to preclude an employee with disqualifying findings on the Health Care Worker Registry from providing direct care services in the facility. Ten (10) employees personnel files were reviewed for pre-employment screening, one of which had a disqualifying finding against her. This has the potential to affect all 41 residents in the facility. Findings include the following: On 9-13-11 at 10:45 a.m. E10 ' s, CNA (Certified Nurse Aide) personnel file reflected that she was hired on 8-26-11. An undated facility document, Illinois Department of Public Health, Health Care Worker Registry (screen printout) reflected that there is a " Final Order " on 8-11-2011 for " Theft " under the subheading " Abuse, Neglect and/or Theft Administrative Findings " for E10. At this time E1, Administrator stated that E10 worked as a CNA in training, working with and shadowed by staff, but not by herself, from 8-26 to 9-9-11. E1 stated that during her employment E10 had no complaints against her and no negative personnel issues. E1 stated at this time that he was responsible for checking her background when she was hired but failed to recognize that E10 had been found guilty of theft on the Health Care Worker Registry. E1 stated he should have followed up on the Registry	F 225		

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F 225	Continued From page 6 finding before permitting her to work in the facility. The Centers for Medicare and Medicaid Services 672 form completed on 9-6-11 reflects there are 41 residents in the facility.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure that documentation was maintained to verify that 3 of 10 newly hired employees were properly screened for eligibility prior to being permitted to work. Also, the facility ' s guiding policy related to reporting allegations of abuse fails to mirror regulation which requires immediate reporting to the Administrator. These failures have the potential to affect all 41 residents in the facility. Findings include the following: 1. On 9-13-11 at 10:45 a.m. personnel files were reviewed with E1, Administrator. According to these records and verified by E1, E11, Certified Nurse Aide (CNA) was hired on 5-31-11 and E12, Registered Nurse was hired on 7-7-11. Personnel records yielded no documented evidence that the Health Care Worker Registry was checked for either employee prior to being hired. E1 stated that he recalled checking their status but verified that no such record could be found. Personnel records reflect that CNA, E13 was	F 226		10/13/11

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F 226	Continued From page 7 hired on 5-25-11 and was permitted to work through 6-7-11 (13 calendar days) without having fingerprints collected for a background check. This was beyond the maximum permitted 10 days after E10 authorized the fingerprints (on 5-25-11). E1 verified by time reporting documentation that E1 worked beyond the maximum permitted 10 days. Facility policy titled " Abuse Prevention Program " dated 11-4-10 states under " Pre-Employment Screening of Potential Employees ...This facility will not knowingly employ any individual convicted of resident abuse or misappropriation of resident property. The facility will not knowingly employ any staff convicted of any of the crimes listed in the Illinois Healthcare Worker Background Check Act ...or with findings of abuse listed on the Illinois Health Care Worker Registry. Prior to a new employee starting a work schedule this facility will ...Check with the Illinois Health Care Worker Registry on any individual being hired for a position ... " 2. While direct care workers E9 Licensed Practical Nurse, E14, E15, and E17 CNA ' s, and E16 Housekeeper each stated on 9-7-11 between 9 a.m. and 4 p.m. that they are required to immediately report allegations of resident mistreatment to E1, Administrator, guiding facility policy permits another option of reporting to someone other than the Administrator. Facility policy titled " Abuse Prevention Program " dated 11-4-10 states under " Internal Reporting Requirements and Identification of Allegations ...Employees are required to immediately report any occurrences of potential/alleged mistreatment they observe, hear about, or suspect to a supervisor or the administrator ...All residents,	F 226		

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F 226	Continued From page 8 visitors, volunteers, family members or others are encouraged to report concerns or suspected incidents of potential/alleged mistreatment to a supervisor or administrator ...Supervisors shall immediately inform the administrator or designee of all reports of potential/alleged mistreatment ... " E1 stated on 9-13-11 at 11:30 a.m. that it is the intent of the facility for staff to report to the Administrator; and/or to someone else only in his absence. E1 verbalized that there have been no incidents of failures or delayed reporting by staff. The Centers for Medicare and Medicaid Services 672 form completed 9-6-11 reflects there are 41 residents in the facility.	F 226		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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 observation, interview, and record review the facility failed to provide pressure relieving cushions for the wheelchairs of R4, R9, and R3. These are three of six residents sampled for pressure sores from a total sample of eleven. In addition the facility failed to have an individualized care plan for R4's pressure sore.	F 314		10/13/11

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F 314	Continued From page 9 Findings include: 1. The September 2011 Physician's Orders document R4 is a resident with Dementia with Agitation and Pressure Sores. The Minimum Data Set dated 6/28/2011 documents R4 has impairment of both sides of her lower extremities. R4 uses a wheelchair for locomotion. A dressing change on R4 was observed on 9/7/2011 at 2:00 PM by E9, Licensed Practical Nurse. A stage II pressure sore was present. The pressure sore surrounded the coccyx area on both sides of the buttocks. The wound tracking sheet shows the facility found this area on 8/10/2011. The measurement dated 8/30/2011 (the most recent measurement) shows the left buttock as 1.8 centimeters long x 1.6 centemeters wide by 0.2 centemeters deep. The right side as 2.4 cm long by 1.8 cm wide by 0.2 cm deep. The wound tracking sheet shows the status of both areas as deteriorating. R4's clinical record shows no Care Plan for pressure sores. E9, Licensed Practical Nurse stated on 9/7/2011 at 2:00 PM he was not aware that R4 did not have a cushion in her wheelchair or a care plan for pressure sores. E9 stated the pressure area has deteriorated since the last measurement. 2. The September 2011 Physician's Orders show R3 has diagnoses of Peripheral Neuropathy and Pressure Sores. On 9/6/11 and on 9/7/11 R3 was up in his wheelchair without a wheelchair cushion. The Pressure Ulcer Assessment 6/21/11 shows R3 is a high risk for Pressure Sores.	F 314		

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F 314	Continued From page 10 3. The September 2011 Physician's Orders show R9 has diagnoses of Parkinson's Disease and Anorexia. On 9/7/2011 R9 was up in her wheelchair at 5:30 PM without a wheelchair pressure reducing cushion. The Pressure Sore assessment dated 6/2/2011 documnets R9 is a high risk for pressure sores. The facility Preventative Skin Care Policy states, "...6. Special mattresses and/or chair cushions will be used on any resident identified as being at high risk for potential skin breakdown..."	F 314		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review facility staff failed to assist or supervise R4 while she was attempting to put on her pants. As a result R4 fell and hit her face. R4 sustained a laceration and a contusion that required a visit to the emergency room and four stitches. R4 is 1 of 4 residents reviewed for falls on the sample of 11. Findings include The September 2011 Physician's Order sheet	F 323		10/13/11

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F 323	Continued From page 11	F 323		

documents R4 has diagnoses of Dementia with Agitation, Affective Disorder, and a Status Post Hip Fracture. The March 31, 2011 Falls Assessment shows R4 is a high risk for falls based on occasional confusion, visual impairment, loss of balance, use of assistive device, psychotropic medications, antihypertensives, dementia, and previous fracture. The Care Plan dated 5/2/2011 documents R4 had falls on 3/31/2011, 4/18/2011, 4/27/2011, and 6/30/2011.

The 3/29/2011 and the 6/28/2011 Minimum Data Sets both document R4 needs assistance with dressing. The (MDS assessment tool) Resident Characteristic Report for 6/21/2011 through 6/27/2011 (the seven days before R4 fell) indicates she needed supervision with dressing that entire week. R4 had a fall with injury on 6/30/2011 while trying to dress herself.

The Incident Investigation Form dated 6/30/2011 states: "...CNA (Certified Nursing Assistant) took (R4) her clothes so (R4) could get up this AM. CNA left room to see to other residents, a few minutes later, resident was yelling out for help & CNA ran down to her room. (R4) was on the floor (with) a small laceration to her eyebrow area & swelling noted. Nurse notified...Assisted up by staff. MD (Medical Doctor) notified & Pt. sent to ER (emergency room) for possible sutures. Pt. returned to facility (with) 4 sutures to (left) eyebrow area..."

The Incident Report Form dated 6/30/2011 states "...CNA took res her clothes from closet...shortly afterward CNA heard bed alarm & resident yelling 'help.' When checked by CNA , res was on her

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DECATUR REHAB & HEALTH CARE CENTER	136 SOUTH DIPPER LANE DECATUR, IL 62522

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F 323	Continued From page 12 floor. CNA noted bleeding & swelling to (left) eye/cheek area...Nurse asked resident what happened. Res replied - 'I got my foot caught.' E2 Director of Nurses stated on 9/9/2011 at 10:00 AM, "...(R4) had her slacks half way up and decided she had to go to the bathroom. She forgot she had her pants half way up. She tripped herself when she tried to walk. The CNA should not have left her alone to put on her own pants. That is why she fell..." E5 Occupational Therapy Assistant stated on 9/9/11 at 10:00 AM, "...(R4) has no safety awareness. You cannot leave her alone without supervision. She will not follow direction..." B. Based on observation, interview, and record review the facility failed to ensure that electrical extension cords were not used to power an electromechanical medical device used by R29, 1 of 6 supplemental residents in the facility with such devices. The facility failed to ensure that extension cords were not used to power high amperage devices such as window air conditioning units in 23 of 27 resident bedrooms. These failures represent a potential fire safety risk potentially affecting 9 of 11 sampled residents (R1, R2, R3, R4, R6, R7, R8, R9, and R10) residing in 8 bedrooms and occupants of the remaining 15 bedrooms. Findings include the following: 1. On 9-6-11 at 11:15 a.m. an electromechanical low air flow mattress used by R29 was plugged into an extension cord in R29's bedroom. The window air conditioner unit in this room was	F 323		

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	14E848	A. BUILDING _____ B. WING _____	09/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DECATUR REHAB & HEALTH CARE CENTER	136 SOUTH DIPPER LANE DECATUR, IL 62522

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F 323	Continued From page 13 also plugged into an extension cord. This extension cord was plugged into an (extension cord) electrical power strip which was connected to the wall outlet. E2, Director of Nursing stated on 9-13-11 at 11:45 a.m. that there are no other electromechanical medical devices in the facility being powered by extension cords. E2 stated that 6 residents use electromechanical medical devices. 2. E18, Maintenance Supervisor stated on 9-13-11 at 10 a.m. that 26 of 27 resident bedrooms in the facility are equipped with window air conditioning units. E18 stated that 23 of the 26 air conditioning units are powered with extension cords plugged into wall outlets. Some air conditioning units were also powered by the use of electrical power strips connected to wall outlets. E18 stated that there are limited electrical outlets available in resident bedrooms which require the use of extension cords. E18 stated that he was unaware of any rules prohibiting use of extension cords for these devices. E18 stated that while some residents do not use the air conditioners, others use them daily through the cooling season. E1, Administrator stated on 9-13-11 at 1 p.m. that it is not financially feasible to install wall outlets in resident bedrooms. E1 indicated that the extension cords were being used on a 'temporary' basis. Air Conditioner Manufacturer documentation (User's Manual) for one style of air conditioner being used states " ...Temporary Use of an Extension Cord ...We strongly discourage (bold emphasis) the use an extension cord due to potential safety hazards ... "	F 323		

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F 323	Continued From page 14 C. Based on observation, interview, and record review the facility failed to maintain hot water temperatures at a safe level at the hairwashing sink in the beauty shop. This has the potential to cause burns and could affect any residents using the beauty shop services. Findings include the following: On 9-13-11 at 9:30 a.m. hot water at the hairwashing sink in the beauty shop measured 127 degrees Fahrenheit (F.) above the maximum permitted 110 degrees F. Water felt extremely hot at this location. Steam vapor was present when hot water was permitted to flow from the hand held sprayer. E18, Maintenance Supervisor stated at this time that he was unsure of the heating source of this water and did not know if the heating source had any thermal regulating device such as a thermostatically controlled mixing valve. E18 stated that he checks the hot water at this location once weekly and last checked it about a week earlier. E1, Administrator provided documentation of hot water weekly checks. Log documentation yielded no information regarding hot water monitoring at this location. E1 stated that the door to this room is locked at all times. E1 and E18 stated that resident use of beauty shop services varies from week to week. E1 and E18 stated that there have been no injuries reported from contact with excessively hot water. The Centers for Medicare and Medicaid Services 672 form completed on 9-6-11 reflects there are 41 residents in the facility.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		10/13/11

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F 371	Continued From page 15 considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to maintain the mechanical chemical sanitizing dishwasher properly to ensure cleaning and sanitization of dishes and food utensils. Dishware, cooking, and food handling utensils were not maintained in a clean, sanitary condition while being stored. The interior of the ice machine was not maintained in a clean sanitary condition so as to protect ice from cross contamination. These failures have the potential to affect all 41 residents of the facility. Findings include: 1. On 9-6-11 at 9:30 a.m. the single tank chemical sanitizing dishwashing machine was in operation processing dishes and food utensils. The chlorine sanitizer concentration was checked using the facility chlorine test kit and registered 0 (zero) parts per million of available chlorine rather than the minimum required 50 parts per million for effective sanitization. E6, Dietary Manager stated that all dishes and food utensils had just been processed from the morning meal. E6 examined the chlorine dispensing reservoir and	F 371		

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F 371	Continued From page 16 found it to be completely empty. E19, Cook stated at this time that she failed to check the chlorine concentration prior to using the machine earlier. 2. On 9-6-11 at 9:30 a.m. metal pans were stacked in a nested fashion on the drying rack in the food preparation area. When pulled apart the pans were wet and permitted moisture to flow from them. Moist food matter was present inside of several steam table and cooking pans. Dried food matter was present on the outer surfaces of the large colander/strainer. Heavy baked on deposits were present on nested sheet pans. On 9-6-11 at 10:50am 8 coffee cups ready to use for lunch, had food debris on the inside. On 9-7-11 at 8:30am with E8 Dietary Manager, 5 dipper type scoops in the storage drawer of the kitchen had dried on food debris on the food contact surfaces. 3. On 9-13-11 at 9:40 a.m. the inner deflector shield of the ice machine was soiled with a slimy mildew-like substance. Ice intended for resident consumption was in direct contact with the deflector shield. Unidentified pink dried matter was also present on the ledge of the inner ice storage bin door. The Centers for Medicare and Medicaid Services 672 form completed on 9-6-11 reflects that 41 residents reside in the facility.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441		10/13/11

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F 441	Continued From page 17 of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, one nurse failed to wash her hands during medication administration. Also, one nurse failed	F 441		

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F 441	Continued From page 18 to wash his hands before a dressing change. These failures involved R9 and R4, two of eleven sampled residents. Findings include: 1.On 09/07/11 at 12:15p.m. E7, Licensed Practical Nurse (LPN), failed to wash her hands or use an antiseptic gel after administering medication to one resident and before she prepared and administered medication to R9. The facility Medication Administration Policy states "Appropriate hand washing or use of an alcohol based gel must be performed throughout the medication pass" (p.2). The policy states that "it is acceptable to use an antiseptic gel type solution between residents" (p.2). 2. The September 2011 Physician's Orders shows R4 has diagnoses of Dementia with Agitation and Pressure Sores. A dressing change was observed on the coccyx of R4 on 9/7/2011 at 2:00 PM by E9 Licensed Practical Nurse. Before E9 started the dressing change he did not wash his hands. Following the dressing change, E9 stated he failed to wash his hands.	F 441		
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the	F 458		

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F 458	Continued From page 19 facility failed to provide at least 80 square feet of space per resident in 27 of 27 multiple resident rooms on 2 of 2 resident living corridors. This has the potential to affect all 41 residents. Findings include: Review of documented historical room size information reflects that the double occupancy resident bedrooms do not meet the minimum required square footage. Room sizes are previously measured as follows: Rooms 1 and 2 measure 77.9 square feet per bed. Rooms 3,4,5,6,7,8,9,10,11,12,13,16 (currently being used for Physical Therapy),17,18,19,20,21,22,23,24,25,26, and 28 measure 74.3 square feet per bed. Rooms 27 measures 68.5 square feet per bed. Room 30 measures 77.5 square feet per bed. All the resident room are certified for Title 19 (medicaid). The Centers for Medicare and Medicaid Services 672 form completed on 9-6-11 reflects there are 41 residents in the facility.	F 458		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities.	F 463		10/13/11

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F 463	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain the emergency nurse call system in a functional and accessible condition. One of 4 central shower rooms had a shower stall that was not equipped with a means to access and activate the emergency nurse call device. Each of the four central shower rooms and R3's toilet room, 1 of 11 sampled residents, had cords that were inaccessible or poorly functioning for residents using shower or toilet facilities in the event of a fall or other emergency. These failures have the potential to affect all 41 residents. Findings include: 1. On 9-14-11 at 9:45 a.m. the South hall Bathroom #2 shower stall was not equipped with a means to activate the adjacent wall mounted emergency nurse call station. The call station was equipped with only a cord approximately 18 inches long, well above the floor, next to the toilet. Each of the remaining 3 central bathing rooms (South #1, North #1 & #2) were equipped with emergency nurse call device pull cords that were 12 inches to 3 feet from the floor surface. Cords were routed through metal eyelets on the wall and were difficult to activate the call stations in some instances when pulled. Accessibility and functionality of the emergency nurse call devices would be problematic for a fallen or otherwise incapacitated resident. 2. On 9-6-11 at 4:30pm the bathroom emergency	F 463		

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F 463	Continued From page 21 nurse call light had a short cord attached to the wall mounted call station only reached the toilet paper holder. This is approximately 2 feet off the floor. R3's roommate is ambulatory and can access the toilet room. This bathroom is shared by an adjoining bedroom.	F 463		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations were not met as evidenced by: Based on interview and record review facility staff failed to assist or supervise R4 while she was attempting to put on her pants. As a result R4 fell and hit her face. R4 sustained a laceration and a	F9999		

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F9999	Continued From page 22	F9999		

contusion that required a visit to the emergency room and four stitches. R4 is 1 of 4 residents reviewed for falls on the sample of 11.

Findings include

The September 2011 Physician's Order sheet documents R4 has diagnoses of Dementia with Agitation, Affective Disorder, and a Status Post Hip Fracture. The March 31, 2011 Falls Assessment shows R4 is a high risk for falls based on occasional confusion, visual impairment, loss of balance, use of assistive device, psychotropic medications, antihypertensives, dementia, and previous fracture. The Care Plan dated 5/2/2011 documents R4 had falls on 3/31/2011, 4/18/2011, 4/27/2011, and 6/30/2011.

The 3/29/2011 and the 6/28/2011 Minimum Data Sets both document R4 needs assistance with dressing. The (MDS assessment tool) Resident Characteristic Report for 6/21/2011 through 6/27/2011 (the seven days before R4 fell) indicates she needed supervision with dressing that entire week. R4 had a fall with injury on 6/30/2011 while trying to dress herself.

The Incident Investigation Form dated 6/30/2011 states: "...CNA (Certified Nursing Assistant) took (R4) her clothes so (R4) could get up this AM. CNA left room to see to other residents, a few minutes later, resident was yelling out for help & CNA ran down to her room. (R4) was on the floor (with) a small laceration to her eyebrow area & swelling noted. Nurse notified...Assisted up by staff. MD (Medical Doctor) notified & Pt. sent to ER (emergency room) for possible sutures. Pt.

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F9999	Continued From page 23 returned to facility (with) 4 sutures to (left) eyebrow area..." The Incident Report Form dated 6/30/2011 states "...CNA took res her clothes from closet...shortly afterward CNA heard bed alarm & resident yelling 'help.' When checked by CNA , res was on her floor. CNA noted bleeding & swelling to (left) eye/cheek area...Nurse asked resident what happened. Res replied - 'I got my foot caught.' E2 Director of Nurses stated on 9/9/2011 at 10:00 AM, "...(R4) had her slacks half way up and decided she had to go to the bathroom. She forgot she had her pants half way up. She tripped herself when she tried to walk. The CNA should not have left her alone to put on her own pants. That is why she fell..." E5 Occupational Therapy Assistant stated on 9/9/11 at 10:00 AM, "...(R4) has no safety awareness. You cannot leave her alone without supervision. She will not follow direction..." (B)	F9999		