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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Validation Survey for Subpart U: Alzheimer Unit Winchester House is in substantial compliance with Subpart U, 77 Illinois Administrative Code 300.7000.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		11/13/11

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

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain residents' privacy when providing wound treatments to 2 residents (R17 and R8), in the sample of 26. The findings include: 1. R17 has a physician's order for wound care to her left leg two times a day, according to the 10/16 - 11/15/11 physician's order sheet (POS). On 10/17/11 at 2:20 PM E8 (Nurse) changed the dressing on R17's left lower leg. E8 did not close the door or pull the privacy curtain before starting the treatment. R17 was in her wheelchair within view of the hallway. On 10/19/11 at 4:15 PM E2 (Director of Nursing) confirmed that staff should close the door and pull the privacy curtain prior to starting treatment. 2. On 10/18/11 at 10:15 AM, in room 3101, E10 (Licensed Practical Nurse) was observed doing a treatment to R8's right buttock/hip area. R8 was in bed lying on her left hip with her right hip and right buttocks exposed. E10 failed to close R8's privacy curtain. R30 (R8 ' s roommate) was present in the room, in bed, in full view of R8 receiving a treatment to her hip/buttock area. At no time during the treatment to R8's buttock/hip area did E10 close R8's privacy curtain.	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221		11/15/11

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F 221	Continued From page 2 The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that 1 resident had a physician's order for bilateral full side rails, and failed to ensure that the resident was assessed and care planned for bilateral side rails, prior to implementing this restraint. This is for 1 resident (R21) out of 5 reviewed for restraints in the sample of 26. The findings include: On 10/18/11 at 9:50 AM R21 was in her bed (with head of the bed elevated 30 degrees) with both full side rails up. R21 was yelling, "help me, help me." R21 was not yet dressed and was still wearing a hospital gown. At this time, E7 (CNA) came to R21's room. E7 said she did not know why R21's side rails were up. E7 placed R21's head of the bed down to the flat position and left the room. On 10/18/11 at 9:55 AM E4 (Clinical Coordinator) said that somebody from the night shift probably put the side rails up. E4 said that R21 is not assessed to use side rails per her last assessment in the medical record. R21 did not have a physician's order for bilateral full side rails, per review of the current physician's order sheet (POS) in the medical record.	F 221		

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F 221	Continued From page 3 Additionally, R21 did not have a consent, assessment, or care plan for the use of the side rails according to review of the medical record. R21 has hemiplegia and requires extensive, 1-person assist with bed mobility according to the annual Minimum Data Assessment (MDS) dated 9/12/11. Section P (Restraint) of the MDS does not indicate that R21 uses side rails and therefore no corresponding assessment was triggered. On 10/19/11 at 12:10 PM, E4 said that there was no consent and no physician's order for the use of bilateral full side rails.	F 221		
F 241 SS=G	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review the facility failed to maintain the dignity of residents when they questioned residents about how they were going to spend their money before allowing them to withdrawal the money from their trust fund. This failure affects 105 residents who have their money managed by the facility, including R29, R31, R32, R33 and R20. This failure resulted in the 1 resident (R29) feeling emotionally distressed after she was disallowed from using her trust fund money to buy a birthday present for her daughter.	F 241		11/10/11

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F 241	Continued From page 4 The findings include: On 10/18/11 during the resident group interview R20, R29, R31, R32 and R33 all stated that E11 (Payables Clerk) will not give them their trust fund money until the residents tell E11 how they plan to spend the money. R29 said that she wanted to buy her daughter a birthday present but was told by E11 that she could only spend the trust fund money on herself and could not use it to buy a birthday present for her daughter. On a subsequent interview on 10/20/11, R29 stated that E11 (Payables Clerk) is rude to her when R29 requests to withdrawal money from her trust fund account. R29 said that she felt distressed when E11 told her she could not use her trust fund money to buy a present for her daughter. R29 said that she has worked hard all her life and doesn't feel that she has to tell E11 how she is going to spend her money, or that she should be restricted from how she can spend her money. On 10/19/11 at 1:35 PM E11 said that she does ask the residents what they plan to spend their money on before she gives them their money. E11 said that she does tell the residents that they are not allowed to spend their money on anyone else but themselves. E11 said that she did tell R29 that she could not use her money to buy her daughter a birthday present. E11 said that she was following a public aid rule. The facility manages funds for 105 residents who receive public aid according to the "RTF Bals" form dated 10/20/11.	F 241		

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F 241	Continued From page 5 B. Based on observation and interview the facility failed to use the resident's name when speaking to the resident, and failed to knock on residents' doors and request to enter before entering residents' rooms. This failure affects R17 and the residents in the 2300 wing. The findings include: On 10/17/11 at 2:05 PM R17 was in room 3312 (hallway bathroom) with E5 (CNA) and E6 (CNA). E5 repeatedly referred to R17 as " Mama. " E5 and E6 both said that they did not know R17's name. E5 and E6 said that they did not work on the 3300 wing. On 10/18/11 at 2:45 PM E3 (Laundry Clerk) was observed to enter multiple resident rooms on the 2300 wing without knocking and without asking permission to enter. The rooms include 2306, 2315, 2319, 2323, 2325 and 2320. Residents were observed in 3 of these rooms.	F 241		
F 309 SS=G	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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 adequately assess and	F 309		11/18/11

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F 309	Continued From page 6 describe an area of coccyx excoriation; failed to develop a care plan to address the excoriation, and failed to follow the physician's order to treat the excoriation. These failures resulted in 1 resident (R15) developing 3 open areas on the coccyx. The findings include: R15 was re-admitted to the facility on 8/19/11. According to the physician's order sheet (POS). R15 had multiple diagnoses, including, Methicillin Resistant Staphylococcus Aureus (MRSA) of the blood and Kidney failure with dialysis. R15's coccyx and buttock's area did not exhibit excoriation or skin breakdown upon readmission according to the nursing readmission assessment Body Audit conducted on 8/19/11. According to the Non-Intact Cutaneous Evaluation (NICE) dated 9/21/11, R15 was first noted with excoriation of the coccyx on 9/21/11 The NICE assessment does not adequately describe the extent of the excoriation, and no measurements were documented. The assessment simply describes the area as "pink." The subsequent assessments on 9/28, 10/5 and 10/12 also lack measurements and simply say "pink." R15 had a physician's order, initiated 9/22/11, for a Duoderm to the coccyx every 3 days, according to the POS. R15 was due for a dressing change on 10/16/11 but there is no documentation in the treatment record to show that this treatment was done. On 10/18/11 a skin check was done on R15. The Duoderm on R15's coccyx was moist, and the ends were curling up. There was no date on the Duoderm. R15's coccyx was excoriated and there were 3 small open areas. E9 (Nurse) was	F 309		

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F 309	Continued From page 7 present for this observation. E9 said that the openings were new. E9 confirmed that there was no documentation that a treatment was done on 10/16/11. Additionally, there was no care plan addressing R15's excoriation or skin condition in general. This was confirmed by E2 (Director of Nursing) on 10/20/11.	F 309		
F 314 SS=G	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 and record review the facility failed to provide treatment and/or accurately document the development of a stage 4 open necrotic pressure sore for 1 of 9 residents reviewed for pressure sores (R8) out of a total sample of 26. This failure resulted in R8 not receiving treatment to a pressure sore until it was a stage 4 (necrotic) . Findings Include: During R8's treatment on 10/18/11 at 10:15 AM R8 had a stage 4 necrotic pressure sore to the	F 314		11/18/11

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F 314	Continued From page 8 right buttock/hip area. E10 stated (Licensed Practical Nurse) that area measures 7 cm. x 4 cm. x 0 cm. (Centimeter) The circumference of the pressure sore has dark necrotic tissue at the base from the 9 o' clock area through the 3 o'clock and a slightly lighter necrotic tissue at the upper circumference. The center area was open with a white area in the center and a depth of 2 cm. to 3 cm. R8 is a very thin resident. E10 cleansed the area with Normal Saline then applied Santyl ointment to the pressure sore. R8's dietary notes document that R8 is 5 feet 6 inches tall. R8 was admitted to the facility on 2/17/10 weighing 116.4 pounds. Presently R8 weighs 106.7 pounds. Further review of R8's medical record indicates R8 had no treatment for the Stage 4 necrotic pressure sore on the right hip/buttock area until 10/17/11 when it was discovered at stage 4 necrotic pressure sore.	F 314		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that restorative programs have been addressed appropriately and adequately. Additionally, that comprehensive	F 318		11/18/11

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assessments had been initiated and /or completed including the progress or lack of progress in achieving maximum range of motion (ROM), and failed to implement policy for quarterly documentation of residents' progress as a method to re-evaluate the effectiveness of the restorative program. This affects 2 of 8 residents who received ROM in the sample of 26 and 2 residents (R27 and R28) in the supplemental sample.

Findings include:

1) Review of current POS (Physician order sheet) shows that R13 is a 40 year old with diagnoses including status post cardiac arrest, anoxia brain injury and quadriplegia.

R13 was observed on 10/18/2011 at 11:45 A.M. and on 10/19/2011 at 2:00 P.M. Both times R13 was in bed. R13 has contractures of elbows, wrists, fingers and feet. R13 had no adaptive equipment for his contractures.

E 12 (restorative aide) stated on 10/19/2011 at 1:20 P.M. that R13's middle joints for all fingers are almost at a fixed position. E12 also stated that R13 is still able to slightly open the finger joints when E12 tries to open them during PROM (passive range of motion) exercises. E12 also stated that there was a splint or other adaptive device that R13 used to wear a year ago for the contracted fingers. E12 further stated that she is not aware of what happen to the adaptive device/splint.

E13 (restorative nurse) stated on 10/19/2011 at around 1:20 P.M. that R13 has no current

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restorative /contracture assessment to evaluate the progress or lack of progress and further develop interventions. E13 further stated that she has plan to provide R13 with an adaptive equipment however, this plan has not been implemented as of yet. E13 also stated that R13 could benefit from an adaptive device/splints to support and prevent decline in range of motion /contractures including the foot drop.

Review of R13's clinical chart showed that there was no documentation to indicate that a restorative/contracture assessment was done. Review of current care plan lacked documentation to indicate that R13's limited range of motion and contractures were being addressed.

2) The POS (physician order sheet) dated 10/2011 showed that R22 is 56 years old with diagnoses including hemiplegia and seizure. R22 has a history of MVA/quadraperesis (motor vehicular accident).

R22 was observed on 10/18/2011 at 11:30 A.M. and on 10/19/2011 at 1:30 P.M. R22 was poorly positioned in a reclining wheelchair. R22 was leaning to the right side and both arms were dangling down the side of wheelchair. R22 was also observed with a neck contracture. R22's head/neck was contracted and was almost on a fixed position to his right shoulder. R22 has no adaptive equipment to support his head, neck and arms. .

E12 (restorative aide) and E13 (restorative nurse) stated on 10 19/2011 at 1:30 P.M. that

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R22 has a contracture of the neck. E13 also stated that there was no current restorative/contracture assessment to address this problem. E13 further stated that she has implemented her plan yet to provide R22 with adaptive equipment to support the neck /head for comfort and to prevent decline in range of motion.

R22's clinical record showed that the last restorative assessment was done on 1/25/2011. This documentation showed that R22 has limited range of motion of the neck, arms, both shoulders, elbows, hands, legs and feet. There is no plan of care for the range of motion or how the facility plans to prevent an increase of the contractures for R22.

3) The POS (physician order sheet) dated 10/2011 shows that R27 is 60 years old with diagnoses including multiple sclerosis and depression.

On 10/19/2011 at 1:40 P.M., R27 had contractures of both hands. R27 was not wearing any adaptive device or splint for the hand contractures.

E12 (restorative aide) and E13 (restorative nurse) stated on 10/19/2011 at 1:40 P.M. that R27 could benefit from using a hand splint to prevent decline in range of motion. E13 also stated that there was no restorative assessment to evaluate effectiveness of current treatment (PROM) to determine progress or lack of progress.

R13's clinical record shows that there was

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no documentation to indicate a restorative/contracture assessment was done. Review of care plan showed that there is no plan of care for the range of motion or how the facility plans to prevent a decline of the contractures.

4) The POS (physician order sheet) dated 10/2011 shows that R28 is 70 years old with diagnoses including Parkinson's disease, depression and dementia.

On 10/19/2011 at 1:45 P.M., R28 had contractures of right 4th and 5th fingers. R28 was not wearing any adaptive device or splint for the contractures.

E12 (restorative aide) and E13 (restorative nurse) stated on 10/19/2011 at 1:45 P.M. that R28 could benefit from using a hand/finger splint to prevent decline in range of motion. E13 also stated that there was no restorative assessment to evaluate effectiveness of current treatment (PROM) to determine progress or lack of progress.

R28's clinical record lacks documentation to indicate that a restorative assessment was done. Review of care plan showed that there is no plan of care for R28's range of motion.

The concerns regarding range of motion were discussed with E1 (Administrator) and E2 (Director of Nursing) on 10/19/2011. On 10/20/2011, E2 provided copies of PROM minutes log services for R13, R22, R27 and R28. However, there was no further documentation provided to indicate a restorative/contracture

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F 318	Continued From page 13 assessment was done. E2 also confirmed that it is the facility's policy that restorative/contracture assessment is to be done and documented every 3 months and if there is a significant change. On 10/20/2011 at 1:30 P.M., E13 (restorative nurse) stated " I just realized (R13, R22, R27 and R28) restorative assessments are kept in a folder in my office." E13 also stated that though she is aware of the contractures, E13 has not reevaluated the progress or lack or progress to ensure a decline in range of motion is prevented. E13 also stated that "the facility has no system in place to address contractures."	F 318		
F 323 SS=D	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: Based on observation, interview and record review the facility failed to provide supervision for 1 resident (R17) who was at risk for falls (out of 6 residents reviewed for falls), in the total sample of 26. The findings include: According to the re-admission-nursing note, R17	F 323		11/15/11

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is a 90-year-old resident who was re-admitted to the facility on 9/6/11. The most recent Minimum Data Sets (MDS) dated 10/2/11 assesses R17 as requiring extensive, 1-person physical assist to use the toilet and to transfer. The MDS further documents R17 as having bilateral lower extremity limitations. R17's Fall Care Plan (review date 12/27/11) documents that R17 is at risk for falls. The care plan states, "At risk for falls r/t deconditioning due to surgical procedure and hospitalization, ...needing assistance with ADL' and mobility....some short term memory loss with poor safety awareness."

On 10/17/11 at 2:05 PM R17 was in room 3312 (hallway bathroom) with E5 (CNA) and E6 (CNA). R17 stated " They put me on the toilet and I sat there for 20 minutes." E5 and E6 said that they do not work on the 3300 hallway and that they did not put R17 onto the toilet. E5 and E6 said that they do not know who put R17 on the toilet or how long R17 had been sitting on the toilet. E5 and E6 said that they did not know the resident's name. E6 said that she saw the light on in the bathroom and went to get E5 for assistance to help get R17 off the toilet.

On 10/17/11 at 2:15 PM E7 (CNA) stated that she assisted R17 onto the toilet but then left the floor to go take care of some important personal business in the Human Resources department. E7 said that she told the nurse she was leaving the floor and that R17 was on the toilet.

On 10/17/11 at 2:16 PM Z1 (R17's Son) said that he arrived in R17's room 10 minutes ago and has been waiting for her. Z1 said that he did not think it was safe to leave R17 on the toilet by herself.

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F 441 SS=E	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 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.	F 441		11/14/11

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F 441	Continued From page 16 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain current standards of infection control practices which: 1) Ensured glucose monitoring machines were disinfected before and after used on residents who required blood glucose monitoring. 2) Ensured facility staff washes their hands when needed during medication administration, wound dressing and provision of hygiene care. 3) Ensured staff wore gloves when injectable medications were administered 4) Ensured gastric tube feeding pump machines were kept clean 5) Ensured clean field was maintained during a wound dressing changed. This is for 4 residents in the sample of 26 (R2, R7, R17, R18,) and 5 residents in the supplemental sample (R34, R35, R36, R37 and R38). Findings include: 1) On 10/18/2011 at 11:53 A.M., during the medication pass observation with E14 (licensed practical nurse), E14 had loosely cover the glucometer (blood sugar) machine with 1 sheet of disinfecting disposable towelette. The glucometer was not entirely covered with the towelette. E14 proceeded to check R36's blood sugar. E14 did a finger stick with a lancet, dab a small amount of blood on the strip that was attached to the glucometer wiped off R36's bloody finger with an alcohol pad. After this procedure, E14 threw all of biohazardous material in the medication cart's	F 441		

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waste container. E14 then again loosely covered the glucometer with 1 piece of the disinfecting towelette. E14 failed to wipe the glucometer entirely with the disinfecting towelette and failed to ensure that the glucometer's surface area was thoroughly wet from the disinfecting towelette for 2 to 3 minutes.

Review of the manufacturer's specification for the disinfecting towelette showed the following:
- For cleaning instructions: " use one (disinfecting towelette) to completely pre-clean surface of all gross debris.
- For use as disinfectant: " use a second (disinfecting towelette) to thoroughly wet the surface. Repeated use of the product maybe required to ensure that the surface remains visibly wet for 2 minutes. This contact time will not be sufficient to some of the organisms. "

The manufacturer's specification also showed the following contact time for the towelette to disinfect the surface from the following organisms:
- Pseudomonas aeruginosa = 3 minutes
- Salmonella = minutes
- Staphylococcus aureus =3 minutes
- VRE (vancomycin resistant enterococcus) = 2 minutes
- MRSA (methicillin resistant staphylococcus aureus) = 2 minutes
- HIV = 2 minutes
- Hepatitis = 2 minutes

2) At 11:56 A.M., (same medication pass observation, 10/18/2011), E14 put a drop of hand sanitizer in her hand, then put her hands together and rubbed the top of her left and right hand

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F 441	Continued From page 18 once, a 3 second procedure. E14 applied gloves on, entered R36's room and instilled R36's eye drop medication. E14 removed her gloves, disposed it, and failed to wash her hands when she went back to her medication cart. 3) E14, while wearing gloves, took a piece of the disinfecting towelette and loosely covered the glucometer machine and failed to completely cover the device. E14 proceeded to go to R37's room and check R37's blood sugar. E14 did a finger stick with a lancet, dabbed a small amount of blood on the strip that was attached to the glucometer, wiped off R37's bloody finger with an alcohol pad. After this procedure, E14 threw all of biohazardous material in the medication cart's waste container. E14 then loosely covered the glucometer with 1 piece of the disinfecting towelette. E14 again had failed to wipe the glucometer entirely with the disinfecting towelette and failed to ensure that the glucometer's surface area was thoroughly wet from the disinfecting towelette for 2 to 3 minutes. 4) E14 then removed her gloves, put a drop of hand sanitizer in her hand, and rubbed together her hands in quick motion. E14 then aspirated 2 units of Humulin insulin and injected this medication into R37 without wearing gloves. E14 then proceeded to prepare and administer 2 oral medications to R37. After the oral medications, E14 opened 2 ampules of nebulizer treatment medication and administered the breathing treatment to R37. 5) E14 proceeded to administer R38 medications after E14 was done with R37. E14 put a drop of hand sanitizer in her hand rubbed her hands	F 441		

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together in a quick motion. E14 put on gloves, grabbed the glucometer with still the same disinfecting towelette that was used after R37's was tested for the blood sugar. E14 proceeded to test R38's blood sugar. After E14 was done with the blood sugar test, E14 had covered the glucometer machine loosely with the disinfecting towelette in few seconds, then placed the machine into the designated pouch, then into the medication cart drawer.

6) E14 put on a drop of hand sanitizer in her hand, rubbed her hands together, and then aspirated 5 units of Novolog Insulin. E14, without wearing gloves, had injected the insulin to R38.

7) E14 put on a drop of hand sanitizer in her hand, rubbed her hands together. E14 returned to R36 and injected R36 with 5 units of Humulin R insulin without wearing gloves.

During this medication pass observation, E14 failed to wash her hands in between these different routes of medication administration. E14 also failed to ensure that the glucometer machine was properly disinfected before and after each usage.

The facility's policy directed staff to wash their hands with an antimicrobial soap when hands are contaminated with proteinaceous material, or are visibly dirty or soiled with blood or other body fluids.

8) On 10/18/2011 at 2:15 P.M., E14 (licensed practical nurse) changed R7's wound dressing on the right buttock. E14 placed an open pack of a 4x4 gauze dressing and 1 ampule of saline

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solution directly on top of an overbed table. E14 also placed 1 tube of a chemical debridement medication directly on the same overbed table. There was also a pair of scissors on top of this table. E14 had used these treatments and the scissors when R7's wound dressing was changed. No clean barrier was placed on top of the overbed table before placing the wound treatment supplies on its surface. This is to ensure a clean field and prevent any cross contamination.

9) On 10/18/2011 at 12:15 P.M., E14 stated that she used 1 sheet of the disinfecting towelette to disinfect the glucometer machines.

R17 was re-admitted to the facility on 9/6/11 with multiple diagnoses, including Chronic Obstructive Pulmonary Disease according the physician's order sheet (POS).

On 10/17/11 at 2:05 PM R17 was in room 3312 (hallway bathroom) with E5 (CNA) and E6 (CNA). E5 and E6 were observed lowering R17 back into her wheelchair after taking her off the toilet. R17's oxygen tubing was on the floor and the nasal cannula was in contact with the bathroom floor. E5 picked up the tubing from the floor and placed the nasal cannula onto R17's face, touching the nasal cannula with her soiled gloved hands. E5 said that she did not change her gloves after providing incontinence care and prior to touching R17's nasal cannula. E5 said she was going to take off her soiled gloves and wash her hands when she was all finished taking care of R17.

On 10/17/11 at 2:20 PM E8 (Nurse) was

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F 441	Continued From page 21 observed doing dressing changes on R17's two leg wounds. R17 preferred to stay in her wheelchair while E8 did the dressing change. E8 placed a towel on the floor in front of R17's wheelchair. E8 removed the 1st soiled dressing, cleaned the wound with sterile water and patted the wound dry. E8 removed her soiled gloves but did not wash her hands before donning a new pair of gloves. E8 then applied the new dressing on the 1st wound. E8 removed the 2nd soiled dressing, cleaned the wound with sterile water and patted the wound dry. Again, E8 removed her soiled gloves but did not wash her hands before donning a new pair of gloves. E8 then applied the new dressing on the 2nd wound. After completing both dressing changes, E8 picked up the soiled wet towel from the floor and placed it onto R17's bed. On 10/17/11 at 2:40 PM R2 was in her room in her recliner chair with her tube feeding running. The arms of the recliner chair were soiled with multiple tube feeding formula drips. The tube-feeding pump was soiled with multiple drips and spills. Additionally a visible crusting of dried formula was noted on the control buttons of the pump. On 10/18/11 at 10:08 AM R2 ' s tube feeding pump was still soiled with dried formula spills. On 10/18/11 at 10:12 AM E4 (Clinical Coordinator) viewed R2's feeding pump and agreed that it was soiled. E4 said that the pumps should be cleaned as soon as they become soiled.	F 441		

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F 441	Continued From page 22 On 10/18/11 between 10:19 AM - 10:33 AM the following residents' pumps were observed with dried tube feeding spills: R35, R34 and R18.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE FINDINGS 300.610a) 300.1210b) 300.1210d)5) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures, governing all services provided by the facility which shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee and representatives of nursing and other services in the facility. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing	F9999		

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F9999	Continued From page 23 care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: 300.1210d)5) d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. 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 observation, interview and record review the facility failed to adequately assess and describe an area of coccyx excoriation; failed to develop a care plan to address the excoriation,	F9999		

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and failed to follow the physician's order to treat the excoriation. These failures resulted in 1 resident (R15) developing 3 open areas on the coccyx.
The failure resulted in R8 not receiving treatment to a pressure sore until it was a stage 4 (necrotic) .

The findings include:

R15 was re-admitted to the facility on 8/19/11. According to the physician's order sheet (POS). R15 had multiple diagnoses, including, Methicillin Resistant Staphylococcus Aureus (MRSA) of the blood and Kidney failure with dialysis. R15's coccyx and buttock's area did not exhibit excoriation or skin breakdown upon readmission according to the nursing readmission assessment Body Audit conducted on 8/19/11. According to the Non-Intact Cutaneous Evaluation (NICE) dated 9/21/11, R15 was first noted with excoriation of the coccyx on 9/21/11 The NICE assessment does not adequately describe the extent of the excoriation, and no measurements were documented. The assessment simply describes the area as "pink." The subsequent assessments on 9/28, 10/5 and 10/12 also lack measurements and simply say "pink." R15 had a physician's order, initiated 9/22/11, for a Duoderm to the coccyx every 3 days, according to the POS. R15 was due for a dressing change on 10/16/11 but there is no documentation in the treatment record to show that this treatment was done.

On 10/18/11 a skin check was done on R15. The Duoderm on R15's coccyx was moist, and the ends were curling up. There was no date on the Duoderm. R15's coccyx was excoriated and

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there were 3 small open areas. E9 (Nurse) was present for this observation. E9 said that the openings were new. E9 confirmed that there was no documentation that a treatment was done on 10/16/11. Additionally, there was no care plan addressing R15's excoriation or skin condition in general. This was confirmed by E2 (Director of Nursing) on 10/20/11.

During R8's treatment on 10/18/11 at 10:15 AM R8 had a stage 4 necrotic pressure sore to the right buttock/hip area. E10 stated (Licensed Practical Nurse) that area measures 7 cm. x 4 cm. x 0 cm. (Centimeter) The circumference of the pressure sore has dark necrotic tissue at the base from the 9 o' clock area through the 3 o'clock and a slightly lighter necrotic tissue at the upper circumference. The center area was open with a white area in the center and a depth of 2 cm. to 3 cm. R8 is a very thin resident. E10 cleansed the area with Normal Saline then applied Santyl ointment to the pressure sore.

R8's dietary notes document that R8 is 5 feet 6 inches tall. R8 was admitted to the facility on 2/17/10 weighing 116.4 pounds. Presently R8 weighs 106.7 pounds. Further review of R8's medical record indicates R8 had no treatment for the Stage 4 necrotic pressure sore on the right hip/buttock area until 10/17/11 when it was discovered at stage 4 necrotic pressure sore.

300.3260k)

Section 300.3260 Resident's Funds

k) The facility shall place any monthly allowance

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to which a resident is entitled in that resident's personal account, or give it to the resident, unless the facility has written authorization from the resident or the resident's guardian, or if the resident is a minor, his parent, to handle it differently.

These Regulations were not met as evidenced by:

Based on interview and record review the facility failed to maintain the dignity of residents when they questioned residents about how they were going to spend their money before allowing them to withdrawal the money from their trust fund. This failure affects 105 residents who have their money managed by the facility, including R29, R31, R32, R33 and R20.

This failure resulted in the 1 resident (R29) feeling emotionally distressed after she was disallowed from using her trust fund money to buy a birthday present for her daughter.

The findings include:

On 10/18/11 during the resident group interview R20, R29, R31, R32 and R33 all stated that E11 (Payables Clerk) will not give them their trust fund money until the residents tell E11 how they plan to spend the money. R29 said that she wanted to buy her daughter a birthday present but was told by E11 that she could only spend the trust fund money on herself and could not use it to buy a birthday present for her daughter.

On a subsequent interview on 10/20/11, R29 stated that E11 (Payables Clerk) is rude to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145460	A. BUILDING _____ B. WING _____	10/20/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINCHESTER HOUSE	**1125 NORTH MILWAUKEE AVENUE LIBERTYVILLE, IL 60048**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F9999	Continued From page 27 when R29 requests to withdrawal money from her trust fund account. R29 said that she felt distressed when E11 told her she could not use her trust fund money to buy a present for her daughter. R29 said that she has worked hard all her life and doesn't feel that she has to tell E11 how she is going to spend her money, or that she should be restricted from how she can spend her money. On 10/19/11 at 1:35 PM E11 said that she does ask the residents what they plan to spend their money on before she gives them their money. E11 said that she does tell the residents that they are not allowed to spend their money on anyone else but themselves. E11 said that she did tell R29 that she could not use her money to buy her daughter a birthday present. E11 said that she was following a public aid rule. The facility manages funds for 105 residents who receive public aid according to the "RTF Bals" form dated 10/20/11.	F9999		