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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 520	Continued From page 35 residents living at the facility. Findings include: E2 stated at 9:45AM on 12/22/11 that a physician has only attended one quarterly QA meeting this calender year. E1 stated at 10:10 AM on 12/22/11 that a physician has only been able to attend one of the three quarterly QA meetings held for 2011. The fourth quarter meeting has not been held yet for the year. QA meeting attendance records for the first three months of 2011 (6/7/11), the second three months of 2011 (undated) and the third three months of 2011(9/13/11) indicated that a physician was only present at the 6/7/11 meeting. The Centers for Medicare and Medicaid Services (CMS) form # 672 completed by the facility indicated that the current resident census was 76.	F 520		
F9999	FINAL OBSERVATIONS Licensure Violations: 300.610a) 300.1210b)5)6) 300.3240a) Section 300.610 Resident Care Policies	F9999		

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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 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:

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest

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practicable level of functioning.

6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents.

Section 300.3240 Abuse and Neglect
a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)

Based on observation, interview and record review the facility failed to implement care plan interventions of personal body alarms and supervision during toileting for two residents (R7, R15). R7 fell, fractured her right humerus and sustained a subdural hematoma.

Findings include:

1. R7's quarterly MDS (Minimum Data Set) dated 8/25/11 documented a BIMS (Brief Interview for Mental Status) score of 13, indicating cognitively intact. R7's ambulation score was coded a two (2) for assistance of one. R7's annual MDS dated 11/21/11 documents a BIMS score of 14; cognitively intact. R7's ambulation within resident's room was coded as an 8 meaning that the activity did not occur.

R7's social progress note dated 11/14/11

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documented no problems with communication and alert and oriented times three.

R7's safety assessment tool dated 11/14/11 documented a score of 30 indicating the facility needed to implement fall precautions.

R7's fall care plan dated 11/18/11 includes an intervention of a chair pad alarm to be placed in recliner. On 11/17/10 a problem of an unsteady shuffling gait and unable to ambulate independently was added.

This same care plan includes an entry dated 3/19/11 which reads "Res (resident) got up out of recliner to get a piece of candy, lost balance and fell."

Nursing notes dated 12/2/11 document that "res (resident) continues to receive skilled PT (physical therapy) for strengthening, transfer training, ...and gait training....She can currently ambulate 25 ft (feet) with r.w. (roller walker) mod (moderate) assist in therapy..."

On 12/3/11, R7's nursing notes document R7 was found on the floor in her room, under her sink, and lying on her left arm with a laceration above her right eye. R7 was moaning and yelling "it hurts it hurts". The right arm was noted to have instant swelling. R7 was sent to the emergency room.

Observation sheet of witness or first employee on the scene reported by E12 (Certified Nursing Assistant) documents that on 12/3/11, R7 was found on the right face down, in her room at side of her bed, with personal body alarm not

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F9999	Continued From page 39 sounding. This form documents that resident said she was trying to go to the sink. R7's incident and accident investigation for the fall on 12/3/11 document R7 was face down on floor on top of her left arm under the sink. On 12/22/11 at 8:25 a.m. E12 (Certified Nursing Assistant) stated that while walking by R7's room she glanced in and saw R7's legs so she entered the room to find R7 lying on her stomach with her head turned to the right and a lot of blood so she ran to get E11 (Licensed practical Nurse). E12 stated that a body alarm was not sounding. On 12/20/11 st 4 p.m. E11(Licensed Practical Nurse) stated that on 12/3/11 it was reported by E12 (Certified Nursing Assistant) that R7 was on the floor. E11 assessed R7 and found her to be face down, left arm under her with blood on the right side of her face, complaining of right arm pain and a laceration above left eyebrow. E11 stated that R7 was alert and talking. E11 stated that R7 never walks by herself and an alarm was not sounding. E11 stated she could not remember if an alarm was on the bed or chair. Consultation report by Z6 (Consulting Hospital Physician) dated 12/03/2011 notes under History of Present Illness that "She (R7) was getting up out of a chair, she took 1 to 2 steps, and she fell, that is all she remembers, although she is unsure is she had loss of consciousness...she did bump her head." R7 was admitted to the hospital after the fall on 12/3/11 and did not return to the facility until 12/8/11. R7's twenty four hours nursing	F9999		

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admission record dated 12/8/11 documented R7's physicial condition as poor, confused mental status and restless.

R7's history and physical dated 12/3/11 documents R7 fell at the nursing home and had a brief loss of consciousness. A CT (computerized tomography which allows for a detailed image to be taken of the internal tissues of the body) was performed and demonstrated atrophied brain with a 1 by 6 centimeter thick large subdural hematoma and a left frontotemporal lesion. R7 also had a right humerus shaft fracture.

R7's nurses notes on 12/9/11 documents R7 was placed on hospice.

On 12/20/11 at 1:20 p.m., Z2 (R7's son) and Z3 (R7's daughter and power of attorney) stated R7 could not walk, was alert and sat in her recliner every day.

On 12/19/11 at 9:30 a.m. during initial tour R7's door was closed and E3 (Assistant Director of Nursing) stated that R7 " was dying" .

2. Facility incident report documents that on 12-04-11 R15 sustained a fall while alone in the bathroom. The facility accident investigation report dated 12-4-11 indicates that R15 should not be left unsupervised while in the bathroom.

On 12-19-11 during observation of R15 from 10:40 a.m. to 1:40 p.m., R15 was in her wheelchair, away from her call light, lethargic and difficult to keep aroused to answer questions or eat lunch. On 12-19-11 at 1:35 p.m. E22 (Certified Nurse Aide) stated that R15 had been

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F9999	Continued From page 41 more lethargic for the past month. On 12-19-11 at 1:40 p.m. E22 and E23 (Certified Nurse Aides) assisted R15 to transfer from the wheelchair into the bathroom and onto the toilet. E22 and E23 closed R15's bathroom door and both E22 and E23 left R15's room leaving R15 unattended and unsupervised in the bathroom. E26 (Minimum Data Set/Care Plan Coordinator) stated on 12/20/11 at 9:40 a.m. that the facility staff should not leave a resident at high risk for falling unattended in the bathroom and that that approach was recommended on the facility Accident Investigation Report after R15's fall on 12-04-11. B. Based on observation and record review, the facility failed to ensure that toxic chemicals and sharp items were kept in locked areas inaccessible to residents in a shower room on one of two residential wings. During the general tour of the facility with E25 (Maintenance Director) on 12/21/11 at 10:20 AM, a wall cabinet was unlocked inside the unlocked A wing shower room. The cabinet contained at least a dozen plastic disposable razors. Also a spray bottle of Rite Quat 256 Disinfectant, posting warnings of "Keep out of reach of children , Harmful if inhaled or absorbed through the skin," was hanging on a wall bracket nearby. A list prepared by E2 (Director of Nursing) of cognitively impaired, independently ambulatory residents living on A wing included R27, R28, R29 and R30. The Centers for Medicare and Medicaid Services (CMS) form # 672 completed by the	F9999		

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facility indicated that the current resident census was 76.

(B)

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300.1210d)2)3)5)
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. Restorative measures shall include, at a minimum, the following procedures

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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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:

2) All treatments and procedures shall be administered as ordered by the physician.

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

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. (Section 2-107 of the Act)

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F9999	Continued From page 44 Based on observation, record review, and interview, the facility failed to reposition, failed to use gel cushion properly to provide pressure relief and failed to ensure the pressure ulcer dressing was intact and in place for four residents (R1,R2,R4,R15). R1 developed a Stage III pressure ulcer after admission which has declined to Stage IV and developed another unstageable pressure ulcer. R2 developed multiple Stage III pressure ulcers in house. Findings include: The current physician's order sheet dated 11/1/11 through 11/30/11 documents that R1 was admitted to this facility on 7/28/11. R1 has diagnoses of Alzheimer's Dementia, Urinary Tract Infection, Depression, Hypertension and Deep Vein Thrombosis. The current care plan dated 8/2/11 and updated 10/24/11 documents that R1 has some long/short term memory deficits. It also documents that R1 cries out often and has experienced delusions on occasion. Documented under Problem: Self care deficit, turning in bed R/T (related to) weakness and confusion. The Goal is: (R1) will maintain the ability to remain mobile in bed with extensive assist of two. This care plan identifies activities as a problem due to R1's confusion which places her at risk for skin break down due to her not moving much. Documented in this care plan under Problem: Pressure Sores: 8/2/11 Stage III to left heel not open. 10/9/11 Stage III to left heel Eschar has autolyticly debrided. 11/9/11, (R1) has multiple	F9999		

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F9999	Continued From page 45 wounds. Stage III heel, skin tear to left posterior lower extremity and right anterior left extremity. Denuded skin under breasts. Stage III fissure under left and right side of Abdomen, Stage IV to left sacrum, Petechia to left upper arm and scattered rashy scabs to arms, legs and buttocks. On 9/27/11 Bruise to forehead- Hit with mechanical lift. On 10/1/11 skin tear to right elbow- unknown. On 12/19/11 at 9:30AM, R1 was in bed lying on her back. At 10:00 AM 11:00AM and 12:00 PM, R1 was still on her back in bed. At 1:00PM, 2:00PM and 3:00M, R1 was in bed on her back . According to pressure ulcer tracking records on 11/14/11, the Stage III pressure ulcer to the Sacrum measured 2.8 centimeters(cm) by 1.6cm by 0.2cm deep. On 12/20/11 at 10:30AM to 11:30 AM, E3 (Assistant Director of Nurses) and E13 (Treatment Nurse) did measurements and treatments to R1's skin tears and pressure ulcers. The Stage III pressure ulcer to left heel is heeled. The skin tears are all closed with scabs. The pressure ulcer on the sacrum is now Stage IV and measured 1.9cm by 1.6cm by 1.5cm. with undermining and tunneling present at average extent of 4.6 cm. Another unstageable pressure ulcer was identified on this date superior to sacral wound measuring 3.0cm by 3.2 cm by unknown depth. with bogginess and heavy amount of serosanguineous drainage, and odorous slough. E13 stated that this is a new pressure area that has developed since she measured last week. E13 stated that R1 spends most of the day in bed.	F9999		

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During this dressing change, R1 called out and cried complaining of pain. E13 asked E11(Licensed Practical Nurse/ medication nurse) to administer pain medication while doing the treatment to the Sacral wounds. R1 continued to cry with pain during the treatment and afterward. R1 was sent to the hospital at 11:30 AM for intractable pain control and wound clinic referral.

2. R2's admission record documents R2 was readmitted to the facility on 10/11/11 with diagnoses that includes left femoral fracture, Deep Vein Thrombosis, and Dementia. R2's physician orders dated 12/15/11 and Wound Assessment Details Report dated 12/13/11 documents R2 developed a suspected deep tissue injury to the left heel on 11/07/11 and a Stage II pressure sore on the coccyx area on 12/13/11.

On 12/20/11 at 9:15 a.m., 9:30 a.m., 9:30 a.m., and 10:00 a.m., R2 was sitting in a wheelchair in her room. At 10:10 a.m., E17 (Certified Nursing Aide) transferred R2 from the wheelchair to the toilet. R2 had a plastic covered alarm pad sitting on top of her gel cushion on the wheelchair seat. R2 had an open area on the coccyx area that was not covered with a dressing. E17 stated that there was no dressing found in R2's incontinence brief or slacks at this time nor when E17 got R2 up for breakfast around 6:45 a.m..on 12/20/11. E17 stated she was not aware that R2 even had a pressure sore.

At 10:25 a.m. on 12/20/11, E11 (Licensed Practical Nurse) applied a dressing to R2's Stage III area on the coccyx and measured the area as

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0.6 long x 0.5 wide x 0.1 centimeters deep. The Wound Assessment report dated 12/13/11 documents that the open area on R2's coccyx area measured 0.60 x 0.30 x 0.10.

R2's care plan dated 10/25/11 documents R2 is occasionally incontinent of bowel and bladder, is at risk for skin breakdown, needs extensive assist with turning, repositioning, transferring, and dressing related to recent left hip fracture. The care plan also notes that R2 developed a new pressure sore on the left heel on 11/7/11 and developed a Stage III pressure ulcer on the coccyx on 12/13/11 (both while in the facility).

3. R4's care plan dated 10/12/11 documents R4 has confusion/memory problems related to Alzheimer disease, is unable to reposition or transfer herself, requires assist of two staff with transfers using a mechanical lift, is not ambulatory, is incontinent of bowel and bladder, and developed a pressure ulcer on 04/13/11 and on 12/16/11 while in the facility. R4's pressure ulcer scale dated 12/20/11 documents R4 is assessed as high risk for developing pressure ulcers.

On 12/20/11 from 9:00 a.m. to 11:10 a.m., R4 was sitting in a wheelchair. An interview with E15 on 12/20/11 showed that R4 transferred from bed to wheelchair around 6:40 a.m. for breakfast and breakfast was served around 8:00 a.m..

At 11:10 a.m., R4 was transferred from her wheelchair to R4's bed in order for the treatment nurse (E13) to be able to check to see if R4 had a dressing in place on her coccyx and to measure

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the Stage II pressure ulcer. R4 was incontinent of bowel. Some of the bowel had seeped up under the lower part of the dressing covering the open area on the coccyx.

E13 (Treatment Nurse) measured the open area as 2.5 centimeters long x 2.0 centimeters wide and with a 0.7 centimeters long x 0.5 centimeters wide x 0.0 deep reddened area surrounding the open area. There was heavy serous drainage that saturated the dressing covering the wound. Both sides of R4's buttocks were red and had indented area from the creases of the incontinence brief.

A new order dated 12/20/11 documents E13 requested a new treatment for R4's Stage II pressure sore related to increased serous drainage. E13 stated on 12/21/11 at 11:30 a.m., that the size of the wound had not increased but that there was more serous drainage since the last assessment on 12/15/11.

4. R15's admission form documents R15 was admitted to the facility 11-13-11 with a deep tissue injury (DTI) to the right sacral area of the buttocks which developed into a stage IV pressure ulcer within 24 hours after admission.

R15's Care Plan instructs staff to turn and reposition R15 every hour as an approach for pressure ulcer prevention and to promote wound healing. On 12-19-11 R15 was observed from 9:40 a.m. to 1:40 p.m. sitting in a wheelchair in R15's room. During this observation, R15 was not turned or repositioned by staff at any time nor did R15 reposition independently.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145248	A. BUILDING ______ B. WING ______	**12/22/2011**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORTON VILLA CARE CENTER	**190 EAST QUEENWOOD ROAD** **MORTON, IL 61550**

(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 49 E13 (Restorative Nurse) stated on 12-21-11 at 9:00 a.m. that all residents in the facility should be assisted by staff to turn and reposition every two hours and more frequently if they have a pressure ulcer. (B)	F9999		