

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/23/2013
NAME OF PROVIDER OR SUPPLIER TURNER MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946		
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W 331	Continued From page 28 replacement tubes are located and to replace tubes after use. 4. The facility will initiate a monitoring system to ensure that complete emergency supplies are available at all times in an unlocked area. a. A check list of emergency oxygen supplies will be developed and placed at the nursing station. b. QA (Quality Assurance) staff will be responsible for checking the oxygen supplies weekly to assure that all items are with the oxygen supplies. c. QA staff will notify the DON of missing items using the written checklist. Although the Immediate Jeopardy was removed, noncompliance continues at the time of the Exit since the facility has not had the opportunity to evaluate the effectiveness of their current plan.	W 331			
W9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS: 350.620a) 350.1210 350.1220k) 350.1230d)1)2)3) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in	W9999			

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W9999	<p>Continued From page 29 operating the facility and shall be reviewed at least annually.</p> <p>Section 350.1210 Health Services</p> <p>The facility shall provide all services necessary to maintain each resident in good physical health.</p> <p>Section 350.1220 Physician Services</p> <p>k) At the time of an accident, immediate first aid treatment shall be provided by personnel trained in medically approved first aid procedures.</p> <p>Section 350.1230 Nursing Services</p> <p>d) Direct care personnel shall be trained in, but are not limited to, the following:</p> <p>1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention</p> <p>2) Basic skills required to meet the health needs and problems of the residents.</p> <p>3) First aid in the presence of accident or illness.</p> <p>Section 350.3240 Abuse and Neglect</p>	W9999			

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W9999	<p>Continued From page 30</p> <p>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)</p> <p>These Regulations were not met as evidenced by:</p> <p>A. Based on interview and record review and review of the hospital reports, the facility failed to provide individuals with nursing services in accordance to their needs as evidenced for 1 individual who expired at the hospital on 03/30/2013. After this incident, the facility failed to have reproducible evidence that they had:</p> <ul style="list-style-type: none"> - Reviewed their current emergency systems to assure that appropriate nursing actions were taken prior to the ambulance's arrival for R12; - Ensured that the oxygen equipment is readily available for quick accessibility for all staff; and - Provided training and/or retraining to all staff on accessing oxygen equipment sets, including storage location and set up of the equipment. <p>Findings include:</p> <p>On 03/30/2013 when R12 was assessed by nursing staff at 12:15 A.M. and found to be experiencing shortness of breath (SOB) with observed cyanosis to his fingertips, nose and toes. R12's oxygen saturation reading was 79 at the time of this assessment. Nursing staff, nor direct care staff called 911. The facility's documentation states that nursing staff identified that R12 was in need of oxygen and left his bedroom to obtain the oxygen equipment. At the time nursing staff was obtaining the oxygen</p>	W9999			

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W9999	<p>Continued From page 31</p> <p>equipment, R12 began having emesis and nursing staff returned to R12's bedroom to assess him. Direct care staff did not go to obtain and bring the oxygen equipment to nursing staff because nursing staff had been informed by the facility that oxygen was considered a medication. The facility's direct care staff are not currently medication trained. As a result, oxygen was never administered to R12 at the facility. Upon the paramedics arrival to the facility at 12:34 A.M. R12 was then started on oxygen. The facility's documentation, coupled with the transporter report identifies that twenty minutes elapsed from the time R12 was assessed by nursing staff as in need of oxygen until the time the paramedics arrived at the facility and started him on oxygen. R12 was transported to the hospital and expired within two and a half hours of his arrival to the hospital from the facility.</p> <p>After this incident, the facility does not have reproducible evidence showing that they have reviewed their current systems to assure that appropriate nursing actions were taken during this incident; that the oxygen equipment is readily available for quick accessibility for all staff; and that all staff, inclusive of nursing staff and direct care staff are trained and/or retrained on oxygen equipment sets including storage location and set up of the equipment.</p> <p>The facility's Resident Care Services: Reference: 350.620 Emergency Services policy (with a review date of 06/01/11) states,</p> <p>"Purpose: To provide emergency care to consumer in distress.</p>	W9999			

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W9999	<p>Continued From page 32 Procedure:</p> <ol style="list-style-type: none"> 1. As soon as a consumer is noted to have a change in condition or emergency, the nurse is to be summoned immediately to to consumers location. Change in condition may consist of by is not limited to the following: change in temperature, breathing rate (e.g. shallow; fast); pulse; blood pressure; color of skin; resident's general actions... If nurse does not or is unable to respond in an emergency situation 911 is to be called... 2. Nurse will assess consumer's vitals and general actions immediately for change in condition... 3. If a negative change in condition is noted the nurse will immediately notify the physician for further orders and or/direction... The nurse may choose to send the consumer to the emergency room if the nurse feels the condition of the consumer warrants it. 4. If during an assessment an emergency situation is noted, (e.g. no pulse, no breathing, extreme difficulty or very shallow breathing) nurse will tell a fellow worker to call 911 and nurse will start life saving measures..." <p>Further review of this policy states that the facility's nurse will record this event in the individual's nurse's notes, detailing changes in the individual's condition, specific time frames and what emergency measures were provided.</p> <p>The Nurses Notes for R12 dated 03/29/2013 for 11:00 P.M. states, "Consumer (R12) in bed, blood glucose 303. No s/sx (signs/symptoms) of distress will cont. (continue) to monitor."</p>	W9999			

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W9999	<p>Continued From page 33</p> <p>The next Nurse's Notes entries dated 03/30/2013 which are completed by E13 (LPN/Licensed Practical Nurse) states, " 12:15 A (A.M.) Consumer (R12) in bed. SOB (short of breath) P (pulse) 125 R (respirations) Sat O2 (saturated oxygen level) 79% T (temperature) 99.3 Expiratory wheeze noted. Accu check 365. Alerted staff for assistance. Heart rhythm regular. fingertips, toes and nose - cyanotic. Directed staff to elevate HOB (head of bed) and monitor consumer while nurse notified physician and assembled O2 equipment. 12:23 A Notified HMC (initials of a local hospital) of consumer condition. 12:25: A Z6 (Physician on call) returned call as physician on call for E14 (Physician/Medical Director for the facility). Ordered sent to HMC ER (emergency room). 12:27 A Notified ... Co (county) Ambulance. 12:29 A Consumer had small emesis. Cleaned mouth with consumer on L (left) side. 12:35 A Ambulance arrived. Gave brief report. Ambulance crew transported consumer to gurney. Applied O2..."</p> <p>Review of R12's Nurses Notes for 03/30/2013 for the time period of 12:15 A.M. - 12:35 A.M. reflects that twenty minutes elapsed from the time E13 (LPN) assessed R12 until the ambulance arrived. These notes do not reflect that oxygen was started for R12 as an emergency measure as based on his symptoms of being short of breath and his pulse ox reading of 79 prior to the ambulance crew's arrival to the facility. R12's Nurse's Notes indicate that he went approximately twenty minutes in need of oxygen after E13 left his (R12's) room to get the oxygen equipment.</p>	W9999			

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W9999	Continued From page 34 R12's bedroom was observed on 04/04/13 at 11:45 A.M. with E19 (QIDP - Qualified Intellectual Disabilities Professional). It was observed that R12 had been in Room 1 which is located two doors down from the nurse's station. E13 (LPN) was interviewed by telephone on 04/04/2013 at 2:40 P.M. and confirmed that she was the nurse on duty on 03/30/2013 when R12 was sent to the emergency room. E13 stated, " R12 stated that he felt bad all over and was experiencing shortness of breath. I checked his pulse, temp and did an accucheck. I was getting the oxygen concentrator and the cannula and was on my way to get the tubing out of the crash cart when staff called out that R12 had vomited. I ran back to his room. After that I called the hospital for orders to send him (R12) out and then I called the ambulance." When E13 was asked if she started R12 on oxygen prior to the ambulance's arrival to the facility, she stated, "No." When E3 was asked why direct care staff didn't get the oxygen equipment for her on 03/30/2013, she stated, "We've (nurses) been told that oxygen is a medication and that staff can not handle the oxygen equipment." The Pre hospital Care Report dated 03/30/2013 which is completed by the ambulance company states that a phone call was received at, "00:28" (12:28 A.M. on 03/30/2013) from the facility and that the ambulance arrived at the facility at, "00:34" (12:34 A.M.). The "Illinois * Emergency Medical Services" narrative report dated 03/30/2013 states,	W9999		

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W9999	<p>Continued From page 35 Chief Complaint: SOB (Shortness of Breath)</p> <p>"Narrative: In summary EMS (Emergency Medical Services) was called... for the 73 year old male (R12) having SOB. Upon arrival, EMS found pt. (patient) alert to normal status on his side in hospital bed having trouble breathing using accessory muscles. Nursing staff (unidentified) states pt was having trouble breathing at 11:30 and had gotten worse... Pt was placed on cot and secured... placed on 15 L (liters) NRB (per non re breather mask), pt was placed on a cardiac monitor showing s tach (sinus tachycardia), pt received 20 ga (gauge) IV (intravenous) to L (left) AC (antecubital), pt was given Neb (nebulizer) treatment enroute, pt was given 40 mg (milligrams) Lasix IV. Pt vitals taken and monitored. Pt was transferred ... and care turned over to the er (emergency room) staff."</p> <p>This report also notes the following vitals and levels upon the EMS's arrival to the facility and during the time R12 was being transported to the hospital:</p> <p>P (pulse) 125 enroute 138 R (respirations) 36 enroute 30 B/P (blood pressure) 135/87 enroute 128/92 BS (blood sugar) 365 Rhythm S tach (Sinus Tachycardia) O2 Sat (Oxygen saturation) 79 enroute 74</p> <p>Z3 (Paramedic) and Z4 (Intermediate Paramedic) were interviewed on 04/05/13 at 11:35 A.M. regarding R12's condition at the time of their arrival to the facility on 03/30/2013 and stated, "R12 was short of breath and very congested. You could hear him breathing when we entered</p>	W9999			

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W9999	<p>Continued From page 36</p> <p>the room. You could see he was having trouble breathing and was breathing with his accessory muscles (stomach/diaphragm). At the time of our arrival he was able to follow basic commands, but with difficulty. We started him on oxygen and when we were in route he (R12) was given Lasix and a nebulizer treatment." When Z3 and Z4 were asked if R12 was on oxygen at the time of their arrival to the facility, they both stated, "No."</p> <p>The Emergency Room report dated 03/30/2013 01:00 identifies, "Patient (R12) complains of severe difficulty breathing. Symptoms began suddenly. The symptoms are constant... Patient has moderate respiratory distress.. This patient presents with a complaint of shortness of breath. The course has been increasing. The symptoms have been occurring for 2 hour(s)... witnessed to be getting more SOB over the last 2 hours..." R12 was admitted to the Special Care unit of the hospital from the emergency room.</p> <p>R12's History and Physical/Preliminary Report dated 03/30/2013 states,</p> <p>"HISTORY OF PRESENT ILLNESS: ... Upon arrival to the emergency room, the patient was found to be in significant respiratory distress and x-rays revealed what appeared to be bilateral pneumonia and possible congestive heart failure. Laboratory values also revealed a significantly elevated Troponin level consistent with a possible myocardial infarction. During the process of ER treatment, the patient was given 20 mg of Lasix, 4 mg of morphine, 3.375 grams of Zosyn and was placed on 15-liter non-breather mask. The patient was then transported rapidly to the special care unit where, unfortunately, he expired prior to</p>	W9999			

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W9999	<p>Continued From page 37 the process of completing the history and physical examination...</p> <p>VITAL SIGNS: ... Temperature 98; blood pressure 88/64; pulse 116 and thready; respirations 32 and labored. Skin: Condition at this time reveals mottling from the ankles to the waist...</p> <p>IMPRESSION: 1. ACUTE CONGESTIVE HEART FAILURE. 2. ACUTE MYOCARDIAL INFARCTION WITH IMPENDING DEMISE.</p> <p>PLAN: The patient actually went into complete cardiopulmonary arrest prior to the completion of the physical examination. The patient did have a documented DO NOT RESUSCITATE form on his chart ... therefore, no resuscitative measures were initiated..."</p> <p>The hospital Discharge Summary/Preliminary Report dated 03/30/2013 states that R12 expired at 2:52 A.M. of Cardiopulmonary Arrest.</p> <p>Z5 (Emergency Room (ER) Physician from 03/30/2013) was interviewed on 04/05/2013 at 12:01 P.M. and stated, "R12 was in respiratory distress when he arrived here (to the emergency room). R12's condition improved somewhat, but then he quickly took a turn for the worse." During this interview Z5 was informed that prior to the arrival of the paramedics to the facility, R12 was experiencing shortness of breath (SOB) and had a pulse ox (oximeter) reading of 79. When Z5 was asked if he would have expected oxygen to have been started by the facility's nursing staff prior to the paramedics arrival with R12 displaying</p>	W9999			

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W9999	<p>Continued From page 38</p> <p>these symptoms (pulse ox of 79 and SOB) , he stated, "With that low of a oxygen saturation level, coupled with shortness of breath, the nurse should have started R12 on oxygen immediately."</p> <p>During the telephone interview with E13 (LPN) on 04/04/2013 at 2:40 P.M. she stated, "No," when asked if she started R12 on oxygen prior to the ambulance's arrival to the facility. E13 went on to say, "I was getting the oxygen concentrator and the cannula and was on my way to get the tubing out of the crash cart when staff yelled out that R12 had vomited. I ran back to his room. After that I called the hospital for orders to send him (R12) out and then I called the ambulance." When E13 was asked where and how the oxygen concentrator is stored at the facility, she stated, "The concentrator and the cannula are in the closet and the oxygen tubing is either in the treatment closet or on the crash cart." When E13 was asked if all components for the oxygen equipment are stored together in one place, she stated, "No, they (the oxygen equipment - concentrator, cannula, saline and tubing) are not kept completely together in one place. The concentrator and the saline/cannula are kept in the closet across the hall from the nurse's station. The tubing is either on the crash cart or in the treatment closet." When E13 was asked why she didn't stay with R12 (on 03/30/2013) and have direct care staff get the oxygen set for her, she stated, "We have been told that oxygen is considered a medication and that the direct care staff cannot go get the oxygen (equipment) for the nurses."</p> <p>During this interview, E13 stated that she had been working at the facility for the past four</p>	W9999			

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W9999	<p>Continued From page 39</p> <p>months. E13 stated, "No" when asked if she was aware that the facility has now assembled all pieces of the oxygen set together in the closet across from the nurse's station.</p> <p>E14 (LPN) was interviewed on 04/04/2013 at 4:05 P.M. regarding the oxygen sets and stated, "The concentrator is kept in the closet across from the nurses station and the tubing is kept in the treatment closet or on the emergency cart." When E14 was asked if direct care staff can get the oxygen set in the event of an emergency, she stated, "They told us (nurses) that oxygen is a medication. Direct care staff can't get the oxygen equipment for the nurses because it is a medication."</p> <p>Z9 (Pharmacy representative for the facility) was interviewed by telephone on 04/05/13 at 10:25 A.M. regarding oxygen being considered a medication. When asked, he (Z9) stated, "Oxygen is not considered to be a medication. I have never considered it (oxygen) as a medication when completing my medication reviews." I</p> <p>The facility's undated policy entitled, "Oxygen Administration" identifies,</p> <p>"BASIC RESPONSIBILITY: LICENSED NURSE</p> <p>PURPOSE To administer oxygen to the resident when insufficient oxygen is being carried by the blood to the tissues..." This policy also states,</p> <p>"EQUIPMENT</p> <ol style="list-style-type: none"> 1. oxygen cylinder on stand, of concentrator. 2. Safety strap or chain if using oxygen cylinder 	W9999			

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W9999	<p>Continued From page 40 on a stand.</p> <p>3. Nasal cannula, face mask, or nasal catheter as ordered.</p> <p>4. Connecting tubing</p> <p>5. Oxygen flow meter and gauges.</p> <p>6. "Oxygen in Use" sign</p> <p>7. Humidifier bottle, either pre filled and sealed, or sterile container with sterile distilled or de ionized water.</p> <p>8. Water soluble lubricant..."</p> <p>Further review of this policy does not identify the location of where the oxygen equipment is to be stored at the facility, nor that direct care staff can not secure the oxygen equipment for nursing staff in the event of an emergency.</p> <p>After this incident, the facility does not have reproducible evidence showing that they have reviewed their current systems to assure that appropriate nursing actions were taken during this incident on 03/30/13; that the oxygen equipment is readily available for quick accessibility for all staff; and that all staff, inclusive of nursing staff and direct care staff are trained and/or retrained on oxygen equipment sets including storage location and set up of the equipment.</p> <p>These failures pose a threat to the health and safety of all individuals of the facility (R1-R11, R13 - R35).</p> <p>(A)</p>	W9999			

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W9999	Continued From page 41 Complaint Investigation: 1351255/IL62390 Licensure Violations: 350.620a) 350.760a)b)c) 350.1060j) 350.1210 350.1220j) 350.1230d) 350.3240a) Section 350.620 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility which shall be formulated with the involvement of the administrator. The policies shall be available to the staff, residents and the public. These written policies shall be followed in operating the facility and shall be reviewed at least annually. Section 350.760 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility	W9999			

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W9999	<p>Continued From page 42</p> <p>shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed.</p> <p>b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections.</p> <p>c) Depending on the services provided by the facility, each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, as applicable (see Section 350.340):</p> <p>Section 350.1060 Training and Habilitation Services</p> <p>j) Appropriate records shall be maintained for each resident functioning in these programs. These shall show appropriateness of the program for the individual, resident's response to the program and any other pertinent observations and shall become a part of the resident's record.</p>	W9999			

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W9999	Continued From page 43 Section 350.1210 Health Services The facility shall provide all services necessary to maintain each resident in good physical health. Section 350.1220 Physician Services j) The facility shall notify the resident's physician of any accident, injury, or change in a resident's condition that threatens the health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. Section 350.1230 Nursing Services d) Direct care personnel shall be trained in, but are not limited to, the following: 1) Detecting signs of illness, dysfunction or maladaptive behavior that warrant medical, nursing or psychosocial intervention. Section 350.3240 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)	W9999			

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W9999	Continued From page 44 These Regulations were not met as evidenced by: Based on observation, interview, record review, and review of records from the physician's office, the facility has neglected to develop and implement a system which proactively ensures that individuals of the facility are free from sexual abuse for 1 individual, (R5) who have had or who presently have signs and/or symptoms of a possible sexually transmitted disease (STD). An open, ongoing Illinois State Police (ISP) investigation continues due to a prior allegation of sexual abuse of July 2011 and the facility has failed to: 1) Thoroughly investigate suspicious blistering with drainage and having a odor in the genitalia area for R5 who was found on 11/14/12 to have suspicious blistering and bruising to his penis and scrotum of unknown origin as per the facility's policy: a) Notify the physician and/or the physician assistant of R5's symptoms at the time of his appointment on 11/14/12 for accurate assessment by professional staff; and b) Implement prevention recommendations for continued monitoring and recognizing symptoms and behaviors associated with STD's for individuals who have been potentially exposed to a sexually transmitted disease as recommended by the CDC (Center for Disease Control) for special populations, and as based on certain STD's dormancy period.	W9999			

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W9999	Continued From page 45 Findings include: On 04/02/13 at 3:00 P.M, it was identified that on 11/14/12, the facility failed to thoroughly investigate suspicious blistering and bruising to R5's penis and scrotum. R5 was assessed by the physician's assistant (Z2) however as based on documentation and interview with Z2, the facility failed to notify him of drainage and odor from R5's penis. No testing was completed during this appointment. ISP continues to have an open, ongoing investigating of a founded, facility reported allegation of sexual abuse. The facility neglected to develop and implement a system which proactively ensures that all individuals of the facility are monitored for signs and symptoms and behaviors associated with sexually transmitted disease(s) during this ongoing police investigation and as based on the dormancy periods of certain STD's. 1) Review of facility's Policy Client Protections dated 08/09/2011 states that the, "facility is committed ensuring clients of the facility are not subjected to physical, verbal, sexual, or psychological abuse or punishment... Investigations are required as a result of an allegation of abuse or neglect or for serious incidents and accidents, or for incidents of unknown origin as indicated in those respective policies."	W9999			

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W9999	<p>Continued From page 46</p> <p>The facility's policy for Injury of Unknown Origin (undated) states,</p> <p>"In the event a staff member observes as injury of bruise on a consumer, a verbal report will immediately be made to the nurse on duty and complete an Incident Accident Form... The nurse on duty will initiate a formal investigation. All staff with any contact with the resident in the recent past will complete a "Witness Report Form" to determine if any staff member note anything out of the ordinary with the resident that could have caused the injury of unknown origin. The investigative team will review all documentation, conduct interviews and attempt to draw a conclusion as to the cause of the injury. All procedures outlined in the client protection policies will be followed as they apply. All results of investigations will be reported to the Human Rights committee for review and to assist in determining cause and effect."</p> <p>Review of the facility's Resident Statistics 2013 sheet identifies that R5 is a 57 year old male functioning at a profound level of intellectual abilities. This sheet also identifies that R5 is non-mobile and nonverbal.</p> <p>On 03/29/2013, R2, R5, R6, R8, R10, R11, R12, R19, R20, R21, R22, R23, R24, R25, R26, R27, R28, R29, R30, and R31 were observed from 11:00 AM to 3:30 PM as part of the complain survey investigation regarding potential sexual abuse. E2 (DON) and direct support staff (E5, E6, E8, E9, E10, E11, and E12) were present during the respective observations of the individuals. During the observation of R5 on</p>	W9999			

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W9999	<p>Continued From page 47</p> <p>03/29/13, R5 did not verbally communicate with the nurse surveyor and did not respond or show understanding when the surveyor explained to him the reason for the observation. As observed, R5 would not be able to verbally communicate to others that he has been, or is being sexually abused.</p> <p>Record review for R5 showed that Nurse's Notes dated 11/14/12 stated that he had three blisters on the left side of his penis and quarter size bruising to his scrotum during ADL's (Activities of Daily Living) Drainage was noted from the blisters accompanied with a odor. R5 was sent to clinic for follow up. There is no documentation within these Nurse's Notes identifying that professional staff at the clinic were alerted of R5's exact symptoms and of his possible exposure to sexually transmitted disease(s).</p> <p>The CDC's 2010 STD Treatment Guides for Special Populations identifies, "Primary prevention and anticipatory guidance to recognize symptoms and behaviors associated with STD's are strategies that can be incorporated into any or all types of health care visits."</p> <p>At the time of R5's visit to the clinic on 11/14/12 he was diagnosed with excoriation. The facility received new orders to apply Triple Antibiotic Ointment twice daily and as needed, and Bactrim DS 800/160 twice daily for 10 days.</p> <p>R5's History and Physical dated 11/14/2012 includes an active diagnosis of skin excoriation and exposure to venereal disease. This report states, "...caregiver states: nursing home noticed on left side of penis and scrotum. They wonder if</p>	W9999			

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W9999	<p>Continued From page 48 the skin got caught in his zipper."</p> <p>Review of the Incident Report dated 11/14/12 for R5 states, "Consumer up for ADL's (activities of daily living) during shower and DSP (Direct Service Person) noted 3 blisters to left side penis and quarter size bruise to scrotum. noted drainage with odor from blisters area cleansed and dried placed dry dressing to site sending into walk in clinic." No documentation is noted on this report as to the cause of these symptoms or the origin of this questionable injury. Further review of this report does not identify that an investigation was started by the facility as per their own policy for injuries of unknown origin.</p> <p>E1 (Administrator) was interviewed on 3/28/13 at 2:27 PM related to R5's record review and his 11/14/12 diagnosis of, "exposure to venereal disease." E1 stated, "There has not been a sexual incident in the past year. There hasn't been an incident since 2011 or 2012." When asked about the diagnosis of venereal exposure on R5 notes from the physician, E1 stated "It was corresponding with the case from before. All clients were tested at that time and there is still an ongoing police investigation." When asked for specific details related to incident on 11/14/12 involving R5, E1 stated "let me get E2 (DON), it's a medical issue." When asked for the investigation for R5's incidents from 11/14/12, E1 stated" We thought it was a skin issue, and didn't see any reason to do an investigation. It didn't raise any red flags."</p> <p>E2 (DON) was interviewed on 3/28/13 at 2.36 PM. and stated, "That was MRSA. He has history of areas to his groin and forehead" when asked</p>	W9999			

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W9999	<p>Continued From page 49</p> <p>about the incident on 11/14/12 involving blisters on R5's penis. E2 left to go get the record and returned with R13's chart. When the surveyor pointed out to E2 that this was not the right client, she stated, "I thought you were talking about R13. Everything I said prior just forget". E2 stated R5 was, "diagnosed with MRSA" when he was seen on 11/14/12. When asked if R5's area was healed, E2 stated "Yes". When asked about the facility's investigation of blisters on penis, E2 stated, "An investigation was not completed. I will call E14 (physician) to check on the recent diagnosis of exposure to venereal disease".</p> <p>E11 (Direct Support Person) was interviewed on 4/2/13 at 4:42 P.M. regarding how often Direct Support staff complete skin assessments. E11 stated, "We look them (the individuals) over during ADL's (Activity of Daily Livings) but not a deep check like the nurses do. We used to have a paper that we had to look at them really closely, but they stopped that the middle of last year. They said the nurses were doing them now. We used to do them every shift. I'm not sure how often the nurses do the assessment but I know that if I tell them there is a bruise, they are running in to check on them." When E11 was asked if he worked with R5 and what he remembered about the incident of 11/14/12, he stated " I kind of remember it. It was on his scrotum and it looked like or someone told me that he (R5) had got his penis zipped it up". When E11 was asked if R5 wear pants with zippers, he stated, "Sometimes, but not too often."</p> <p>During the survey dates, the facility did not provide the survey team with reproducible evidence showing that an investigation had been</p>	W9999			

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W9999	<p>Continued From page 50</p> <p>completed by the facility on 11/14/12 upon becoming aware of R5's suspicious injury of unknown origin as per their policy.</p> <p>Z7 (Registered Nurse at the Clinic) was interviewed by telephone on 3/29/13 at 8:30 A.M. regarding R5's 11/14/12 appointment. and stated, "Yes, I put him in the room. I did not see the area on penis/scrotum. I don't normally look." When Z7 was asked about R5's History and Physical report listing exposure to venereal disease, she stated, "That may have been something from a long time ago." When Z7 was asked if this information could be verified, she stated, " I don't really know how to check that." When Z7 was asked why the diagnosis of exposure to venereal disease would be still on R11's report, she stated, "We have to go into the computer system manually and remove it (the diagnosis)." Z7 was then asked if a culture was done of the blisters on R5's penis when he was seen on 11/14/12 and she stated, "No culture was done. He was given antibiotics and an antibiotic cream. I am not sure why a culture was not done, but I know the Physician Assistant (Z2) who saw him would have done an STD (sexually transmitted disease) screening if he suspected anything."</p> <p>Z2 (Physician's Assistant) was interviewed by phone 10:25 A.M. on 4/02/13 at related to R5 medical appointment on 11/14/12 and stated, " R5 was diagnosed with excoriation after visualizing the area on his penis and scrotum." When Z2 was asked if he had treated the blisters on R5's penis and scrotum as MRSA (methicillin resistant staphylococcus aureus), he stated, "No, I did not order a culture, but he (R5) was given Bactrim to cover in case it was MRSA". During</p>	W9999			

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W9999	<p>Continued From page 51</p> <p>this telephone interview, Z2 stated that he had not been suspicious of R5's injury because he was under the impression that he (R5) had sustained this injury from catching his skin in the zipper of his jeans. Z2 stated that there was, "...No drainage or odor" noted at time of R5's visit. Z2 also stated that he had not been informed that R5's blisters had been draining and that there was an odor associated with the drainage at the time of R5's visit to the clinic. When Z2 was asked if he would have completed further assessment if he had of known about R5 having drainage and discharge from his penis and that an investigation of sexual abuse was still ongoing, he stated, "Yes, if I had this information during R5's visit to the clinic (on 11/14/12), further testing would have been completed."</p> <p>E14 (Physician/Medical Director) was interviewed by telephone on 3/29/13 at 11:45 A.M. and stated, "That was a whole separate incident. Everyone in the facility had to be screened due to sexual exposure," when asked why R5 had a diagnosis of exposure to venereal disease listed on his diagnosis on his History and Physical report. When E14 was asked why this diagnosis would still be carried on R5's current diagnosis list, he stated, "The computer adds past diagnoses when we print it out." When E14 was asked if there is a difference between exposure and screening of venereal disease, he stated, "The difference would be based on whoever put the information in the computer. We did not find anyone else at facility who was positive for an STD after 2011."</p> <p>In review of R11's 2011 laboratory results dated 07/28/2011, it is noted that the KOH (a test where</p>	W9999			

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W9999	<p>Continued From page 52</p> <p>potassium hydroxide is used to reveal fungal cells under microscope) was not completed and that the results of his Wet Prep testing were negative. Confirmed per interview with Z8 (lab technician) by telephone on 04/04/13 at 9:30 A.M.. Z8 stated, "The KOH test was not done. The KOH test would only show yeast and the Wet Prep would give clue cells to show bacteria."</p> <p>Telephone interview with Z10 (Women's Health Gynecologist) on 04/02/13 at 2:30 P.M. also confirmed that the KOH and the Wet Prep testing would only detect yeast and/or bacterial vaginosis and that these two testings would not pick up some sexually transmitted diseases (STD's). Z10 also stated that many sexually transmitted diseases have a dormancy period and can lie dormant for months or even years. Z10 stated that once an individual has been exposed and/or potentially exposed, continual monitoring and repeat testing is often necessary to rule out an STD.</p> <p>During the telephone interview with E14 (Physician) on 4/03/2013 at 11:40 A.M., E14 was asked his professional opinion as if he would expect the facility to have some type of monitoring system in place to monitor for sexually transmitted disease especially due to the open, ongoing ISP investigation, and he stated, " I am not going to let you put words in my mouth."</p> <p>In review, the facility failed to thoroughly investigate suspicious blistering with drainage having an odor for R5 who was found to have injury to his penis and bruising to the scrotum on 11/14/12 of unknown origin. After this discovery, the facility failed to: complete and investigation;</p>	W9999			

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/23/2013
NAME OF PROVIDER OR SUPPLIER TURNER MANOR		STREET ADDRESS, CITY, STATE, ZIP CODE P.O.BOX 303, 901 OGLESBY ROAD HARRISBURG, IL 62946		
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W9999	Continued From page 53 notify the physician and/or the physician's assistant on 11/14/12 of R5's symptoms and/or his history of possible exposure to STD's to ensure a complete and accurate assessment by professional staff; This failure potentially affects all thirty four (R1 - R34) individuals of the facility. (B)	W9999		