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| S9999 | Final Observations<br><br>STATEMENT OF LICENSURE VIOLATIONS<br><br>300.610a)<br>300.696a)<br>300.696c)7)<br>300.1210b)<br>300.3240a)<br><br>Section 300.610 Resident Care Policies<br>a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting.<br><br>Section 300.696 Infection Control<br><br>a) Policies and procedures for investigating, controlling, and preventing infections in the facility 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.<br><br>c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, | S9999 | | |

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| S9999 | Continued From page 1<br>United States Public Health Service, Department of Health and Human Services (see Section 300.340):<br>7) Guidelines for Infection Control in Health Care Personnel<br><br>Section 300.1210 General Requirements for Nursing and Personal Care<br><br>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.<br><br>Section 300.3240 Abuse and Neglect<br><br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act)<br><br>THESE REQUIREMENTS ARE NOT MET AS EVIDENCED BY:<br><br>1) Based on observation, interview and record review the facility failed to ensure staff disinfected glucose monitoring machines (glucometer) after resident use to prevent the spread of a blood borne pathogens.<br><br>This applies to 6 of 6 residents (R1,R4,R5,R8, R9,R11) reviewed for blood sugar monitoring in the sample of 24, and 22 residents in the supplemental sample (R25 through R46). R4, | S9999 | | |

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| S9999 | Continued From page 2<br>R11, R30, R38, and R35 were identified by the facility as having infectious blood borne diseases.<br><br>FINDINGS INCLUDE:<br>On 4/29/14 at 11:20 AM during the 11:00 AM blood glucose checks, E6 (RN) carried a uncovered plastic box, containing a glucometer, alcohol prep pads, and lancets from inside nurse's station to R26's room. R26 was lying in her bed. E6 donned a pair of gloves, cleansed R26's finger with alcohol prep pad, pricked R26's finger, placed blood glucose strip in glucometer and obtained blood drop. E6 then proceeded to wipe the glucometer with an alcohol wipe, place the glucometer back in the plastic box along with soiled gloves rolled inside out. E6 then washed her hands and returned to nurse ' s station, and then disposed of the gloves. R26's diagnosis includes Diabetes Mellitus and Dermatitis.<br><br>On 4/29/14 at 11:25 AM, E6 called R27 into the nurse ' s station to obtain a blood glucose check. When R27 entered nurse ' s station, R27 was observed with blood oozing from open sores on forehead, dried blood on right side of neck and blood stains to R27's shirt and sweat pants. R27 also had dried blood under his finger nails and hands. E6 proceeded to remove glucometer from plastic box, wipe the glucometer with alcohol prep pad, and then placed the glucometer on top of the document shredder with no barrier in place. E6 then placed blood glucose strip in glucometer and pricked R27 ' s finger and obtained the blood drop. E6 removed glucose strip from glucometer, removed soiled gloves with strip wrapped inside and disposed of gloves. E6 placed the glucometer back on top of the document shredder, washed her hands and then wiped the glucometer edges and screen with alcohol prep | S9999 | | |

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pad and placed glucometer back into the plastic box. R27 was allowed to leave the nurse ' s station without washing his hands or E6 cleansing R27's forehead area. E6 stated when asked why R27 had blood on his head and hands, "he always is scratching his head, we have him wash his hands and he starts scratching his head again." R27's diagnosis includes Eczema and Diabetes Mellitus.

On 4/29/14 at 11:45 AM, E7 (LPN) called R25 into the nurse ' s station for a blood glucose check. E7 removed glucometer from an uncovered plastic box and placed the glucometer on top of the paper shredder (without barrier). E7 then donned on a pair of gloves, placed glucose test strip in glucometer, wiped R25's finger with alcohol pad and pricked R25's finger. E7 then placed glucometer back on top of the paper shredder. E7 then grabbed the container of disinfectant towel with bleach, removed the towel wiped the glucometer for 20 seconds and then disposed of the towel. E7 then placed the glucometer back in the plastic box and then washed her hands.

At 11:56 AM E7 called R28 into the nurse ' s station for a blood glucose check and used the alternative machine previously used by E6 (Nurse). E7 donned on gloves, wiped glucometer with alcohol pad, and pricked R28's finger and then placed glucometer back on top of the paper shredder. E7 wearing same gloves, picked up glucometer again, placed it on a paper towel and wiped the edges and screen for 10 seconds. The glucometer was then placed back in plastic box. E6 and E7 stated on 4/29/14 at 12:30 that they only use two glucometers for blood glucose checks for all resident requiring blood glucose monitoring. E6 was asked how often the

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glucometer is cleaned E6 responded "we will probably before use and you can wipe with the alcohol wipes in between." E6 went on to add that E2 (Director of Nursing) had advised them use alcohol wipes for cleaning. E7 stated the glucometer should be cleaned with the disinfectant cloth after use and wet for 45 seconds.

E2 stated on 4/30/14 at 12:00 PM "I never had told anyone to use alcohol wipes to cleanse the glucometer. I did not know that this was their practice."

On 4/29/14 at 4:03 PM, E10 (nurse) stated that she will be doing blood sugar monitoring to the residents. E10 stated the facility uses one glucometer for the residents in the C-wing, D-wing and E-wing (even rooms only). E10 took out a glucometer from an uncovered plastic box that was stored on top of the nursing station counter and wiped the glucometer with an alcohol prep pad and placed this machine directly on top of the nursing station counter (without any barrier). R4 has among his multiple diagnoses, Infectious Blood Borne Disease and has a physician's order for blood glucose checks twice a day. E10 then, pricked R4's finger, obtained blood and measured R4's blood sugar with gloved hands. After this procedure, E10 wiped the used glucometer with an alcohol prep pad and placed the glucometer directly on top of the nursing station counter (without any barrier). E10 then, recorded the results of R4's blood sugar level in the MAR (Medication administration Record) and proceeded to prepare R38 for blood sugar monitoring.

When E10 stated that she was ready to prick R38's finger to obtain blood, E10 was stopped

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and was asked how the glucometer should be disinfected in between resident use. E10 responded that she uses the alcohol prep pad to clean the glucometer in between residents use. E10 was asked if she is aware of R4 ' s diagnosis related to any blood borne infection. E10 stated that she is not aware of this. E10 then looked at R4's MAR and stated that R4 has a diagnosis of Infectious Blood Borne Disease. After checking R4's diagnosis, E10 was then observed wiping the same glucometer using a disinfectant towel with bleach for 10 seconds (the machine was not visibly wet) and placed the glucometer directly on top of the nursing station counter (without any barrier). The disinfectant towel with bleach directions shows the following, "wipe surface with towel until completely wet, let stand for 1 minute." When E10 stated that she was ready to prick R38's finger to obtain blood, E10 was stopped and was told that the when she wiped the glucometer for 10 seconds, the machine was not visibly wet. E10 then re-wiped the glucometer for 1 minute (the machine was visibly wet).

The facility identified 28 residents with diagnosis of Diabetes Mellitus and has scheduled blood glucose monitoring ordered. (R1, R4, R5, R8, R9, R11, R25 through 46). The facility identified 5 of these 28 residents (R4, R11, R30, R38, and R45) with infectious blood borne diseases.

Facility Blood Glucose Machine Policy dated 5/20013 states:
All residents requiring blood glucose monitoring will have a clean machine for testing.
Equipment:
Blood glucose machine
PDI sani-cloth wipes or
Clorox Healthcare Hydrogen Peroxide Cleaner Disinfectant wipes

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Procedure:
-Before and after each use clean/disinfect outside of the meter with PDI Super Cloth wipes or Clorox Healthcare Hydrogen Peroxide Disinfectant wipes.

-Treated surface of the blood glucose monitoring machine must remain visibly wet for full 2 minutes. Use additional wipes if needed to assure continuous 2 minutes wet contact time. Let air dry (for PDI wipes). If using Clorox Healthcare Peroxide Cleaner Disinfectant wipes, allow 30 seconds wet contact time and allow to air dry.

-Surface of Blood Glucose Monitoring Machine, if visibly soiled need to physically clean to remove gross soil with one wipe and then a second wipe to disinfectant the surface.
-Wash and dry hands thoroughly after procedure.

The cleaner disinfectant towels with bleach provided by the facility

Based on observation, record review and interview,the facility failed to prevent potential cross contamination of body fluids from one resident to others in the faciity. R27 was noted with dried blood on his hands and nail and with open wounds to his face and scalp.

This applies to 1 resident (R27) in the supplemental sample reviewed for infection control.

The findings include:

R27's diagnosis includes Diabetes Mellitus, Exzema past diagnosis of infected dermatitis.

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R27's BMI (Brief Mental Interview) dated 4/2/14 assessed R27 a 12 (alert and orientated). On 4/29/14 at 11:10 AM, R27 was observed at a long table in dining room during activities. R27 was playing the card game 21 and also playing with plastic chips. R27 had blood oozing from open sores on his forehead and scalp. R27 also had dried blood on both hands, under his fingernails and dried blood smears on clothing. At 11:25 AM was called into medication room/nurses station by E6 for accucheck with blood on head and hands. R27 was allowed to leave the medication room without washing his hands or E6 cleaning the blood off R27's forehead. R27 returned to the table at 11:30 AM where where he had been seated, picked up his cards and plastic chips and returned the items back to E12 (Activity Director). The items were commingled with the other playing cards and plastic chips returned from other residents. On 4/29/14 at E11 (activity director) provided a list which identified 19 other residents involved in the same activity. On 5/01/14 at 11:45 AM was asked how often the facility cleans activity equipment used by residents. E11 stated they once a week the plastic chips and any other object is put in a bucket of isopropyl alcohol/water and rinsed. R27's care plan goals for resisting care initiated 7/18/13 through 7/7/14 document "the resident will comply with care, specifically with regard to following nursing recommendation to refrain from picking at his scalp (7) days per week. Interventions include: evaluate when the best time of day is to provide care. Provide care consistent with (R27) 'schedule" based on when resident is most calm/relax. R27's care plan interventions dated initated 7//7/13 through 7/7/14 for excoriation to his face and scalp due to eczema and picking at his skin includes "Avoid scratching and keep hands and body parts from

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excessive moisture. Encourage R27 to stop scratching when observed." E2 (DON) stated 5/5/14 at 2:00 PM that R27's hands and forehead should be washed on an "as needed basis."

Facility Procedure for Cleaning All Equipment states:
1) All equipmnet handled by residents such as bingo chips, checker pieces, chess pieces, dominios, Chinese checkers are cleaned with an alcohol solution one time a week. If required all above parts are cleaned as needed.

2) Popcorn machine cleaned before and after every use cleaning procedure is vinegar and water.

3) All ball equipment is cleaned weekly or as needed.

4) All other activity materials usd are cleaned weekly or as needed.

(A)

300.1210b)
300.1210d)1)
300.1620c)
300.1630d)
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

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| S9999 | Continued From page 9<br>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.<br><br>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:<br><br>1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.<br><br>Section 300.1620 Compliance with Licensed Prescriber's Orders<br><br>c) Review of medication orders: The staff pharmacist or consultant pharmacist shall review the medical record, including licensed prescribers' orders and laboratory test results, at least monthly and, based on their clinical experience and judgment, and Section 300.Appendix F, determine if there are irregularities that may cause potential adverse reactions, allergies, contraindications, medication errors, or ineffectiveness. This review shall be done at the facility and shall be documented in the clinical record. Any irregularities noted shall be reported to the attending physician, the advisory physician, the director of nursing and the administrator, and shall be acted upon.<br><br>Section 300.1630 Administration of Medication<br><br>d) If, for any reason, a licensed prescriber's medication order cannot be followed, the licensed | S9999 | | |

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prescriber shall be notified as soon as is reasonable, depending upon the situation, and a notation made in the resident's record.

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)

THESE REQIREMENTS ARE NOT MET AS EVIDENCED BY:
Based on observation, record review and interview the facility failed to obtain order clarification and failed to follow physician order for administration of psychotropic medication.

This applies to 1 of 14 residents (R11) reviewed for use of Psychotropic medications in the sample of 24.

This failure resulted in R11's verbalization of hearing voices and wanting to hurt someone.

FINDINGS INCLUDE:

During the initial tour of the facility held on 4/28/14 at 10:30 PM, R11 stated that the nurses are not giving her Seroquel medication. Per R11 because she had missed more than 5 days of the Seroquel medication, she is starting to hear voices.

R11's annual MDS (Minimum Data Set) dated 4/11/14 shows a BIMS (Brief Interview for Mental Status) score of 15, indicating that the resident is cognitively intact and would only require supervision with all ADL's (Activities of Daily Living).

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R11's POS (Physician Order Sheet) dated 4/1/14 through 4/30/14 showed multiple diagnoses which included Schizophrenia, Schizo-affective disorder and depressive disorder. The POS showed multiple orders which included, Quetiapine (Seroquel) 400mg, 1 tablet by mouth every 12 hours which was started on 4/4/13. The same POS showed an order to "discontinue Seroquel 400mg PO q 12 hours" and a handwritten physician order dated 4/10/14 to "increase Seroquel 400mg AM, 500mg HS."

R11's Psychiatric progress notes dated 4/11/14 showed, "Hallucinations: Present," "Delusions: Present," "Patient is: Deteriorated." The same progress notes showed, "increase Seroquel 400mg in morning & 500mg at bed time to treat her depression and psychosis."

R11's MAR (Medication Administration Record) for "Seroquel 400mg PO (by mouth) q (every) 9 AM. showed an encircled nurses initial on 4/26/14 and an N/A (Not available) printed on 4/27/14 and 4/28/14. The same MAR for "Seroquel 500mg PO at HS (bedtime) showed nurses initials on 4/15/14, 4/19/14, 4/20/14 and 4/24/14 and N/A printed on 4/13/14 and 4/27/14. A copy of the above MAR was requested on 4/28/14 at 11:30 AM and upon review of the copy that was given, the previously initialed Seroquel 500mg at HS on 4/15/14, 4/19/14, 4/20/14 and 4/24/14 were encircled, which was different from the original MAR that was earlier reviewed. On 4/28/14 at 12:00 PM, E2 (Director of Nursing) was informed of the discrepancies between the original review of the MAR and the copy that was provided to the State Agency. On 4/28/14 at 12:30 PM, E2 stated that he talked to E7 (Nurse) about the discrepancies. Per E2, E7 admitted

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| S9999 | Continued From page 12 | S9999 | | |

encircling her initials for Seroquel 500mg at HS for 4/15/14, 4/19/14, 4/20/14 and 4/24/14 after it was reviewed and before copying the MAR for the State Agency. E2 stated that an encircled initial in the MAR meant that the medication was not given to the resident. Per E2, R11 never received the ordered Seroquel 500mg at HS, since it was ordered on 4/10/14, because the pharmacy never delivered the said medications because it needed clarification. According to E2, no one followed up with regards to clarifying the Seroquel order until 4/28/14.

In an interview held on 4/30/14 at 11:12 PM, E7 stated that R11 did not received the Seroquel 500mg at HS on 4/15, 4/19, 4/20 and 4/24/14, because the medication was not available in the facility. E7 also stated that she gave R11's last Seroquel 400mg on 4/25/14 at 9 AM (last tablet in the medication card) and when she came back to work on 4/28/14, the Seroquel 400mg was not available in the medication cart because pharmacy did not refill.

In an interview held on 4/30/14 at 2:25 PM, Z3 (Pharmacist) stated that when the physician changed the order for R11's Seroquel from 400mg every 12 hours to Seroquel 400mg every AM and Seroquel 500mg at HS on 4/10/14, this exceeded the recommended dose of the medication. Per Z3, the pharmacy did not send the new order of Seroquel but instead, sent a communication to the facility on 4/11/14, to verify the order before the Seroquel medication could be dispensed. According to Z3, the facility did not respond so, another communication was sent to the facility on 4/16/14 to obtain physician clarification of the Seroquel order. Per Z3 the facility only responded on 4/28/14 with new order for Seroquel 400mg twice daily. Z3 stated that

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | IL6004964 | A. BUILDING: _____ B. WING _____ | 05/06/2014 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| JOLIET TERRACE NURSING CENTER | 2230 MCDONOUGH JOLIET, IL 60436 |

| (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) COMPLETE DATE |
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| S9999 | Continued From page 13<br>after receiving this order (order does not exceed the recommended dose), the pharmacy delivered the medication, the evening of 4/28/14.<br><br>The above information showed that R11 did that receive the ordered Seroquel 400mg at 9 AM for 3 days (on 4/26, 4/27 and 4/28/14) and the ordered Seroquel 500mg at HS was not verified with the physician and the resident did not received the Seroquel ordered for HS for at least 16 days (since ordered on 4/10/14 through 4/27/14).<br><br>On 4/29/14 at 10:46 AM during group meeting with Z4 (program facilitator) , R11 verbalized, "I actually wanted to hurt somebody, because I was not given my Seroquel for so long." During the same group meeting, R11 stated that she started hearing voices and sees things she should not see, because she was not receiving her Seroquel medications.<br><br>In an interview held on 5/5/14 at 10:15 AM, Z5 (Psychiatrist) stated that he ordered R11's Seroquel medications to be increased on 4/11/14 because the resident's depression and psychosis had deteriorated and that some residents respond better if the Seroquel is increased to 900mg to 1200mg per day. Z5 stated that the facility nurse did not call him for any order verification for this medication nor was he notified that R11 was not receiving the Seroquel medication for days. According to Z5 he was only notified of the Seroquel dosage concerns on 4/28/14. Per Z5, R11 not receiving her Seroquel medications for multiple days and dosages, could have contributed to R11's further decline in mental status, depression and psychosis, especially if she had verbalized hearing voices and wanting to hurt someone. | S9999 | | |

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Plan of Correction
F441

Submission of this abatement for Joliet Terrace is not a legal admission that a deficiency exists or that this immediate jeopardy was correctly cited. In addition, preparation and submission of this abatement does not constitute an admission or agreement of any kind by the facility of the truth of any facts set forth in this allegation by the surveyor's agency.

1. The facility has taken the following actions concerning the alleged deficiency identified in the CMS-2567:
    a. On 4/30/2014, our vendor provided new Ultra Track accucheck machines for all 28 residents that need glucose monitoring. Each residents will have their name on the individual machine.
    b. The facility provided a list in the MAR of residents who will have the own machine.
    c. All disinfectant procedures will continue to be used on the individual accucheck machines.
    d. R27 wound was clean, has order for cream and nailed trimmed. Care plan was updated.

2. The facility will ensure all nurses will properly disinfect the accucheck machine before and after each use to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection.
    a. The Blood Glucose Machine Disinfecting policy and procedure was updated to reflect the correct disinfecting procedure.
    b. Upon new admission, each resident that requires glucose monitoring will have their own machine and the list in the MAR will be updated.

3. The following measures have been taken by the facility to ensure that proper practices continue:
    a. All nursing including new hires were educated on the following:
        1. Disinfecting the accucheck machine
        2. Blood glucose monitor will be disinfected before and after each individual use.
        3. Use the facility recommended disinfectant towel with 1:10 dilution of bleach (DISPATCH DISINFECTION TOWEL WITH BLEACH).
        4. Moistened wipe must have 2 minutes wet contact with the accucheck (wipe down the blood glucose monitor over it entire surface, being careful not to get liquid inside the screen.)
        5. Allow to air dry.
        6. Infection control policy and procedure.
    b. All activities staff were re-educated on the facility procedure for cleaning all equipment.

4. The Director of Nursing or designee will monitor continued compliance via the following Quality Improvement Programs:

A. QA Tool has been developed to monitor the disinfecting of the accucheck machine, once per day.
B. A QA has been developed for activities to ensure the cleaning of activities equipment once per week or as needed.
C. The results of the monitoring completed under this POC are submitted to the QA/QI committee for review and follow up.

Completion date: 6/10/2014