STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6002901	A. BUILDING: _____ B. WING _____	10/24/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EVENGLOW LODGE	215 EAST WASHINGTON PONTIAC, IL 61764

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S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210b) 300.1210d)6 300.3240a Section 300.610 Resident Care Policies 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. 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 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: 6) All necessary precautions shall be taken to assure that the residents' environment remains	S9999		

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S9999	Continued From page 1	S9999		

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.

These Requirements are not met as evidenced by:

A) Based on record review and interview the facility failed to provide safety measures during a transport for 1 resident (R17) of 6 reviewed for falls in the sample of 15. This failure resulted in a fall with R17 sustaining a fractured right wrist. Also based on observation, record review and interview the facility failed to protect residents from potential combustion hazards by allowing one resident to have a portable oxygen tank while in the beauty shop, failed to ensure that hair dryers were equipped with filters to prevent fire hazards, and failed to ensure that potentially hazardous cleaning chemicals were stored in locked areas to prevent resident access. This has the potential to affect two residents (R8, R16) reviewed for safety in the sample of fifteen and four residents (R20, R21, R22, R23) in the supplemental sample.

Findings include:

The facility's Physician Order Sheet (POS) dated October 2014 documents R17 has the following diagnoses: Myalgia, Anemia, Dementia, Epilepsy, and Obesity.

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S9999	Continued From page 2	S9999		

The facility's Minimum Data Set (MDS) dated 8/27/14 indicates that R17 is dependent upon 2 staff members for bed mobility, transfers, locomotion when off unit in a wheelchair, and toilet use. R17 is also documented on this MDS as non-ambulatory and only able to have stable balance with staff assistance.

The facility's Care Plan dated 3/26/14 with revisions through 9/10/14 documents that R17 will be provided assistance of 2 staff members during bathing and a mechanical lift for transfers due to weakness from Myalgia. This care plan also documents that R17 is at risk for falls.

On 10/21/14 at 10 AM during initial tour E4 MDS Coordinator stated R17 had fallen the previous night, sustained a fractured wrist and was sent to the emergency room.

The facility's Occurence Report dated 10/20/14 for R17 documents "resident being pushed back to room in shower chair [without] belt. Resident fell forward, [complained of] wrist pain [and] hip pain on [right] side." This report documents the occurence as being related to/ caused by staff failure to use safety belts on the shower chair.

The emergency room report dated 10/20/14 documents "fall from chair, initial encounter and Colles' fracture right wrist (fracture of the radius bone on the thumb side of the hand between the elbow and wrist)."

The facility's Procedure for Using the Spa Chair and Lift documents "...Assist the resident onto the [...] lift either in their room or in the tub room....the waist belt is to be applied once the resident is on the [...] lift seat. If the resident has poor upper

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S9999	Continued From page 3 body strength or is unable to support themselves in an upright position, the upper strap/ chest belt is to be used."	S9999		

On 10/22/14 at 3 PM E2, Director of Nursing stated that it is part of the staff orientation to use the belts with the shower chair and if staff were not using the belts on the chair, (E2) would expect staff to wrap a gait belt around the resident and the chair inclusively.

On 10/22/14 E16 and E17 Certified Nursing Assistants both stated that it was part of their orientation and training to use the belts with the shower chair

1. On 10/23/14 at 9:30 am three residents from the certified unit (R16, R21, R22) were getting their hair done in the facility beauty shop. R16 was seated in a wheelchair with her hair in rollers. A portable oxygen tank with a nasal cannula was on the back of R16's wheelchair. A hair dryer was running near R16. There was no posting in the Beauty Shop that stated oxygen was not allowed.

Beautician E3 stated at that time, R16 routinely brings her oxygen tank with her to the shop with the tank shut off. E3 then assisted R16 out of the wheelchair so she could sit under the hair dryer. E3 stated R16 was brought down to the beauty shop by a family member, E4 who is a nurse in the facility. E3 stated she had been told that it was alright to leave the oxygen tanks on the wheelchair as long as the oxygen has been turned off. E3 stated R16 is the only resident that comes to the beauty shop with oxygen.

On 10/23/14 at 9:35 am, R16 stated that she has always brought her oxygen with her to the beauty shop turned off.

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S9999	Continued From page 4 R16's October 2014 Physician Order Sheet list orders for oxygen at 2 liters/minute via nasal cannula. On 10/23/14 at 10:00 am, Director of Nurse's E2 stated the oxygen tank should have been removed from R16's wheelchair before she was taken into the beauty shop. E2 stated she was aware that it is not acceptable to allow tanks or concentrators of oxygen in the beauty shop because it is an accelerant. The facility "Oxygen Therapy" policy dated 1/29/14 states "Oxygen concentrators and tanks are not allowed inside the beauty shop." 2. On 10/23/14 at 9:30 am, two of the free standing hair dryers in the beauty shop were missing filters to prevent lint accumulation inside the dryers which could be a fire hazard. Beautician E3 stated she needs to have the those dryers replaced because they are so old. On 10/23/14 at 9:40 am Maintenance Director E5 stated he was not aware the dryers did not have filters and they should be removed from the shop. 3. On 10/21/14 at 3:35 pm, one aerosol can of disinfectant and one can of aerosol air freshener, were on a small table just outside the R23's bathroom door. R23 was seated in a recliner chair in the bedroom and was not able to state if the items were hers. R8, a cognitively impaired resident (per 8/29/14 Minimum Data Set /MDS) was independently propelling herself in the hallway at that time. On 10/22/14 at 3:55 pm, the aerosol spray cans were still on the table in R23's room and the door was open. The labels on the disinfectants had warning to keep out of reach of children and to	S9999		

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S9999	Continued From page 5 avoid contact with skin, eyes, and avoid inhalation. R20 was independently ambulating with a walker down the hall towards the room at the time of the observation R20 was not able to state his name or where he was going. R8's 8/29/14 Minimum Data Set identified R8 with severe cognitive impairment. R8's Care Area Assessment dated 8/27/14 stated (R8) has been known to get into others things and has to be monitored. R20's MDS dated 9/17/14 states R20 has severe cognitive impairment. R20's Care Plan dated 9/23/14 states R20 is at the facility "due to his senile dementia and is at risk for wandering behavior". R23's MDS dated 9/03/14 stated R23 has moderate cognitive impairment and requires assistance of one staff for transfers and ambulation. 4. On 10/21/14 at 10:30 am, the first floor kitchenette door was unlocked. The door had a punch entry pad however the door could be opened without putting in a code. There was a spray bottle of quaternary ammonium sanitizer that measured 300 parts per million (ppm) on the counter just inside the door. There was a 32 ounce bottle of concentrated floor cleaner stored under the sink in an unlocked cabinet. There were warnings on the label to avoid ingestion, and eye, skin contact. The kitchenette remained unlocked with chemicals in view during a subsequent observation made on 10/22/14 at 2:50 pm. E5 Maintenance Director who was present during the observation, stated the kitchenette should be	S9999		

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S9999	Continued From page 6 locked. E5 stated that no one had reported the door was not locking. E5 stated at that time that staff should make sure the door is locked when they close the door. On 10/22/14 at 3:10 pm the Second Floor Kitchenette door was unlocked. There was a spray container of quaternary ammonium sanitizer on the counter in the kitchenette. R8 was propelling herself in her wheelchair in the hallway outside of the kitchenette. E5 who was present at the time stated no one had reported that the door lock was not functioning. E5 again found the lock did function when properly closed. On 10/23/14 at 4:10 pm E5 stated the locksmith found that the strike plates for both locks were loose which is why the locks did not always latch. R8's 8/29/14 Minimum Data Set identified R8 with severe cognitive impairment. R8's Care Area Assessment dated 8/27/14 stated "(R8) has been known to get into others things and has to be monitored." E5 stated on 10/23/14 at 3:40 pm that they do not have any written policies that address locked chemical storage however it is their practice not to leave any chemical out. (B)	S9999		