STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 000	INITIAL COMMENTS	F 000		
F 176 SS=D	Annual Licensure and Certification Survey 483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assess and determine safety of self administration of medications for two of 12 residents (R16, R19) reviewed for assessments in the sample of 14. Findings Include: 1. R16's POS (Physician Order Sheet) dated 6/2016 documents an order for "Symbicort 160-4.5 mcg (micrograms) inhaler - Inhale 2 puffs twice a day. RINSE MOUTH AFTER EACH USE." On 6/20/16 at 4:28 pm, E7 LPN (Licensed Practical Nurse) entered R16's room and handed R16, R16's Symbicort {Bronchodilator} inhaler. E7 stated, take one puff, then E7 will do your blood sugar then you can take the other puff. E7 did not instruct R16 to rinse out R16's mouth when finished. R16 shook the inhaler, expressed one puff into the air, then administered one puff to self. R16 waited 15 seconds, then administered the second puff. R16 did not rinse mouth out after administrating the inhaler.	F 176		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 176	Continued From page 1	F 176		

On 6/20/16 at 4:32 pm, E7 stated, R16 does R16's own inhalers. "We give (R16) instructions but (R16) doesn't wait. (R16) always does the puffs back to back. Sometimes (R16) rinses (R16's) mouth, other times (R16) doesn't."

The Symbicort package insert dated 2/16 documents, "rinse your mouth with water and spit the water out after each dose of Symbicort. Do not swallow the water. This will help to lessen the chance of getting a fungus infection (thrush) in the mouth and throat."

There was no Medication Self Administration Assessment in R16's clinical record.

2. R19's POS (Physician Order Sheet) dated 6/16 documents an order for Ipratropium - Albuterol 0.5 mg (milligrams) - 2.5 mg per ml (milliliter), take three ml's by nebulizer QID (four times a day). This POS documents a Diagnosis of COPD (Chronic Obstructive Pulmonary Disease) with Acute Exacerbation.

On 6/21/16 at 10:30 am, E8 RN (Registered Nurse) put the above medication in an uncovered nebulizer cup, which was already hooked up to the nebulizer machine and had droplets of liquid in it, reattached the nebulizer mask to the cup, started the machine, put the face mask on R19 and left the room. E8 stated, "(R19) is real independent with doing the nebulizer and will remove the mask when it is complete."

There was no Medication Self Administration Assessment in R19's clinical record.

On 6/21/16 at 12:50 pm, E2 DON (Director of Nursing) stated, "we do not do Medication Self

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 176	Continued From page 2 Administration Assessments, we don't have anything like that here." At 1:55pm, E2 stated, "staff should remain with a resident while administrating a nebulizer treatment, it is a medication and the resident needs monitoring during the process in case something happens."	F 176		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to follow the plan of care for one of 12 residents (R6) reviewed for plans of care in the sample of 14. Findings Include: R6's Physician Order Sheet (POS) dated 6/2016 lists the following Diagnoses: Muscle Wasting, Parkinson's and Alzheimers. This POS documents an order for, "general diet, avoid high sodium...magic cup at 12:00pm" and to be admitted to Hospice on 3/28/16. R6's Care Plan dated 4/16/16 documents, "Potential for weight loss related to decreased intake, refuses meals at times, difficulty making needs/wants known...provide supplements as ordered...magic cup at lunch." The facility's ongoing weight log documents R6's	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 282	Continued From page 3 monthly weight as: 1/16 - 163 pounds (lbs), 2/16 - 162.4 lbs, 3/16 - 158.8 lbs, 4/16 - 152.5 lbs, 5/16 - 150.8 lbs, and 6/16 - 149.2 lbs. On 6/20/16 at 11:50 am, R6 at less than 25% of the pureed beef over noodles and 50% of the carrots, which were served. On 6/21/16 at 11:55am, R6 ate less than 25% of the turkey cutlet and mashed potatoes that was served. R6 did not eat any of the apple dessert, apricots or corn that was served. R6 did not get served the ordered magic cup (dietary supplement) on 6/20/16 and 6/21/16 during the lunch meal. On 6/21/16 at 12:00 pm, E6 Dietary Manager stated, R6 doesn't get the magic cup anymore because R6 is on hospice and hospice patients can have whatever they want, it's their right. E6 stated, R6 "didn't eat it anyway." E6 confirmed that the magic cup was a physician order and that the facility should have still been serving it to R6, until the order could be discontinued by Z1, R6's physician.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to provide showers as scheduled for residents dependent on staff for bathing, for two	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 312	Continued From page 4	F 312		

of four residents (R16, R20) reviewed for bathing from a sample of 14, and one resident (R22) from the supplemental sample.

Findings include:

1. According to the Minimum Data Set (MDS) dated 5/9/16, R20 is cognitively intact, and requires extensive assist of one staff for bathing.

On 6/21/16 at 12:00pm, R20 stated he often does not receive showers as planned. E20 stated he is supposed to get two showers a week and says he often does not get even one shower a week. R20 says he is told the facility does not have enough Certified Nurse Aides (CNA).

According to R20's Hall Day Shower list, R20 is scheduled to receive showers on Wednesdays and Saturdays, on the day shift.

R20's Bath sheets document the following: R20 had only four showers of 9 planned in March 2016, on 3/10, 3/13. 3/16 and 3/26/16; May 2016 bathsheet had four of 8 planned, R20 had showers documented on 5/4, 5/7, 5/21 and 5/25/16 - R20 was offered a shower on 5/22/16 but R20 refused; June 2016 bathsheet had three of 6 planned, R20 has showers documented on 6/2, 6/8 and 6/18/16. R20 was offered a shower on 6/4/16, but R20 refused, due to it being after 7:00pm.

2. According to the MDS dated 6/6/16, R16 is cognitively intact and is totally dependent on on one staff for bathing.

On 6/21/16 at 11:05am, R16 stated R16 usually

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 312	Continued From page 5	F 312		

gets a shower one time a week.

According to Day Shower List, R16 is scheduled for showers on Wednesdays and Sundays.

Bath Sheets for R16 document the following: five showers of 9 planned in March 2016, on 3/8, 3/15, 3/18, 3/24 and 3/29/16; Bath sheets for April, 2016 document only four of 8 planned showers, on 4/5, 4/9, 4/13 and 4/25/16; May 2015 Bath Sheets document three of 9 planned showers, on 5/19, 5/25 and 5/27. According to E2 (Director of Nursing) on 6/23/16 at 2:35, R16 was in the hospital from 5/4 - 5/9/16. Showers for June 2016 so far were on 6/11, 6/12 and 6/19/16, three of 6 planned.

3. According the the MDS dated 4/11/16, R22 is cognitively intact and is totally dependent on two staff for bathing.

On 6/21/16 at 3:05pm, R22 stated residents are supposed to have two showers a week. R22 stated that R22 has been lucky to get one shower a week. R22 stated sometimes 2 weeks have passed without R22 getting a shower. R22 stated the "shower issue" is a, "regular issue."

According to the Day Shower List, R22 is scheduled for showers on Wednesdays and Saturdays.

Bath Sheets for R22 document the following: five of 9 planned showers in March on 3/9, 3/12, 3/16, 3/26 and 3/30/16; bath sheets for April 2016 document two of 9 planned showers, on 4/24 and 4/27/16; bath sheets for June 2016 document one of 6 planned showers only on 6/12/16, and then another on 6/26/16 which has not occurred

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 312	Continued From page 6 yet. Resident Council Meeting Minutes dated 1/8/16 and 3/4/16 document a resident was concerned that they (residents) are not getting enough showers. On 6/21/16 at 10:40am, E21 (CNA) stated that the aides rotate being shower aides, about every four to six weeks. E21 stated that when an aide calls off then the shower aide is taken off shower aide duty and works the floor. On 6/23/16 at 2:00pm, E3 (Assistant Director of Nursing) stated that showers are to be given twice a week as per Hall Shower List schedule. The facility's Personal Hygiene policy dated 3/21/16 documents, "It is the policy... that personal hygiene will be performed daily and as needed... Personal Hygiene includes all of the following: 1. Bathing 2. Showering..."	F 312		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 323	Continued From page 7	F 323		

interview, the facility failed to ensure supervision and use of assistive devices to prevent injury for one of 14 residents (R2) reviewed for accidents on the sample of 14. This failure resulted in a large laceration on the leg requiring hospital treatment with sutures.

Findings include:

According to the current Physician's Order Sheet (POS) for 6/2016, R2 has multiple diagnoses including Congestive Heart Failure, Ascorbic Acid Deficiency, Anxiety, and history of Fractured Femur. This POS also lists an order for Coumadin (anticoagulant) daily. R2's Minimum Data Set (MDS) dated 3/28/16 assesses R2 as moderately cognitively impaired, and requiring extensive assist of two staff for transfers. On 6/20/16 at 10:00am, R2 was identified by E3 (Assistant Director of Nursing) as interviewable. R2's careplan dated 4/6/16 states that R2 "does not ambulate.. . .transfer with mechanical lift for safety."

The Resident Incident Report dated 5/1/16 states the following: "CNA (Certified Nurse Aide) reported large laceration to resident's (R2) leg stated happened during transfer from wheelchair to bed. Laceration to right lower leg on outer aspect measuring 12 x 5.5 cm (centimeters) with unknown depth; noted fatty tissue attached to lacerated skin and muscle tissue visible. Site cleansed and covered with {non-stick} dressing . . . .hospital transfer."

Hospital discharge instructions dated 5/1/16 at 10:52pm note the repair of the laceration on the right lower leg. The POS documents continuing treatment with antibiotic ointment and dressing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 323	Continued From page 8	F 323		

until suture removal on 5/14/16. The Final Report of the incident completed on 5/5/16 documents R2 returning from the hospital with 20 sutures.

The dictated statement by Z2 (agency CNA) dated 5/1/16 states that Z2 had removed the footrests and heel boots prior to positioning R2's wheelchair next to the bed. "I (Z2) asked {R2} to give me a hug. Then I (Z2) stood {R2} and pivoted to the left on to the bed. I noticed leg was bleeding. I cleaned the blood on the floor. I lifted {R2's} legs into the bed so {R2} was in a laying position. I applied pressure to {R2's} legs with tissue and my hand to stop the bleeding then I (Z2) reported to the nurse {R2's} injury." No mention is in the statement regarding use of gait belt, mechanical lift, or assistance from another staff person.

Dictated statements by E16, E17, E18 and E19 (CNAs) all stated that Z2 did not ask for assistance with transfers from any of them throughout the evening. The written Witness Statement signed by E15 (CNA) on 5/3/16 states, "I have worked with {Z2} before and I have told her multiple times how {R2} transferred." On 6/23/16 at 3:15pm, E15 confirmed the written statement, and stated E15 told Z2 that R2 was to be a sit-to-stand lift with two assist. E15 stated there are to be two assist with all mechanical lifts.

The statement by E7 (Licensed Practical Nurse/LPN) dated 5/1/16 stated that Z2 entered the charting room on 5/1/16 about 7:55pm and reported a laceration to R2's leg. Along with E14 (LPN), E7 assessed the large laceration to the right lower leg, noting fatty tissue and white muscle tissue visible with "no active bleeding present." E7 noted a blood smear on the floor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 323	Continued From page 9	F 323		

The statement documented that R2 stated at that time that the cut happened during the transfer but did not know what R2 cut her leg on. R2 also stated at that time that she had told Z2 to use a mechanical lift, but did not recall whether it was before or after the transfer and injury. E7's statement states that Z2 gave multiple versions of sequence of events, including when Z2 noticed the injury, cleaning up the blood, putting pressure on the wound, placement of bed rails, wheelchair, bedside table, etc. E7 also noted in the statement that the room had been re-arranged from the time of the transfer, including the wheelchair in the hallway, and the bedside table next to the bed. R2 complained of pain at that time. The wound was cleansed and covered, R2 was medicated for pain, and transferred per ambulance to the hospital as per physician's orders. This statement also stated that Z2 was asked to leave the facility, following completion of Z2's statement.

The written statement by E14 LPN concurred with the assessment of the laceration, and that R2 had said "I told her (Z2) to use the machine," E14's statement also included that Z2 was told she should not have touched the wound or tried to clean up, "to come and get the nurse directly." E14's statement noted that the bed and wheelchair were inspected with no sharp edges and no blood noted. "{R2} does receive Coumadin. When entering room wound was not actively bleeding."

On 6/21/16 at 9:45am, E12 and E13 (CNAs) transferred R2 for incontinence care, using a sit to stand lift. E12 and E13 stated at that time that R2 had always been either a mechanical or sit to stand lift for transfers.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 323	Continued From page 10	F 323		

On 6/21/16 at 10:00am, E11 (Registered Nurse/Wound Nurse) cleansed and applied Skin Prep to the large, curved healing scar on R2's right lower leg. Upon completion of the treatment, R2 stated she "didn't see anything in her (Z2's) hand, but somehow she sliced me and there was blood. The nurse came in and said she couldn't do anything for me, that I would have to go to the hospital and get stitches." R2 did not recall anything else regarding the incident, i.e. with the transfer, when the cut occurred, or if she told Z2 to get a lift.

On 6/21/16 at 3:20pm, E7 LPN confirmed information in the written statement. E7 stated what caused E7 and E14 to be "suspicious" right away was, with the seriousness of the laceration, there was no active bleeding, and that Z2 had cleaned up, put pressure on the wound and rearranged the room prior to getting the nurse. E7 stated Z2 "had to have been putting pressure on it for a while - {R2} is on Coumadin." E7 stated she saw a large blood smear on the floor where Z2 had apparently tried to clean it up, but did not see blood on anything else. E7 stated R2 said that R2 had told Z2 to get a lift and another person, but did not know when the cut occurred. E7 confirmed that Z2 transferred R2 by herself, without a lift or another person. E7 also stated that at that time the CNA worksheet had R2 down as a mechanical lift. E7 also confirmed that Z2 had worked at the facility multiple times.

On 6/22/16 at 2:30pm, E14 LPN also confirmed information in the written statement. E14 stated Z2 was "very sketchy" as to how the laceration happened and versions of the reports "didn't jive." E14 also stated that R2 said she had told Z2 that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 323	Continued From page 11	F 323		

Z2 needed to use a lift. E14 stated that R2 was a mechanical or sit to stand lift at that time and the two people are used even with a lift. E14 stated agency staff are given sheets as what kind of transfer or lifts are to be used. E14 also stated that Z2 had worked at the facility and assumed had cared for R2 prior to the incident.

On 6/22/16 at 11:15am, E2 (Director of Nursing) stated that agency staff read and sign the abuse policy, are paired up with facility staff, and given worksheets for the halls they are assigned to that gives resident information, including transfers and special instructions. E2 provided examples of same. E2 stated that Z2 had worked at the facility a lot prior to 5/1/16. E2 stated that Z2 will not be returning to the facility.

On 6/23/16 at 11:40am, Z2 confirmed information in the written statement, that footrests were off, Z2 asked R2 to "give her a hug" and transferred R2. Z2 stated she noticed the blood after placing R2's legs on the bed. Z2 stated she did not use a gait belt because R2 "didn't need it," and that Z2 had transferred R2 the same way that week prior to the incident. Z2 stated she did not know that R2 was to be a mechanical lift, nor did R2 say anything about using a lift. Z2 also stated she did not have a worksheet with instructions for residents. Z2 stated they do a walk-through on the halls at the beginning of the shift. Z2 stated she wanted to stop the bleeding and clean up the blood before getting the nurse, and Z2 "couldn't reach the call light" to get help.

The facility policy for Safe Patient/Resident Handling and Movement dated 1/7/13 "provides a process for all caregiver assisting inpatient movement to be protected for patient handling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 323	Continued From page 12 injuries while caring for patients/residents safely within an environment of dignity and respect. . . Staff should utilize the proper techniques, lifting devices, etc., to match the identified task. . . Avoid manual lifting unless identified as a qualifying manual lift in Section 3b. . . .Use mechanical lifts, devices and other approved aids in accordance with instructions and training. . ."	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to administer medications according to Physician Orders, Manufacture's Specifications, and Facility Policy for one sampled resident (R16) and one supplemental resident (R21). This applies to three of the 12 residents observed in the medication pass. 25 opportunities were observed with four errors, for a medication error rate of 16%. Findings Include: 1. R16's POS (Physician Order Sheet) dated 6/2016 documents an order for "Symbicort 160-4.5 mcg (micrograms) inhaler - Inhale 2 puffs twice a day. RINSE MOUTH AFTER EACH USE." On 6/20/16 at 4:28 pm, E7 LPN (Licensed Practical Nurse) entered R16's room and handed	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 332	Continued From page 13	F 332		

R16 the Symbicort {Bronchodilator} inhaler. E7 stated, take one puff, then E7 will do your blood sugar then you can take the other puff. E7 did not instruct R16 to rinse out R16's mouth when finished. R16 shook the inhaler, expressed one puff into the air, then administered one puff to self. R16 waited 15 seconds, then administered the second puff. R16 did not rinse mouth out after administrating the inhaler.

On 6/20/16 at 4:32 pm, E7 stated, R16 does R16's own inhalers. "We give (R16) instructions but (R16) doesn't wait. (R16) always does the puffs back to back. Sometimes (R16) rinses (R16's) mouth, other times (R16) doesn't."

The Symbicort package insert dated 2/16 documents, "rinse your mouth with water and spit the water out after each dose of Symbicort. Do not swallow the water. This will help to lessen the chance of getting a fungus infection (thrush) in the mouth and throat."

The facility's Oral Inhalation Administration Policy dated 2/12/15 documents, "The purpose of this policy is to allow for safe, accurate, and effective administration of medication using an oral inhaler....press down on inhaler once to release medication...if another puff of the same or different medication is required, wait at least one minute between, then repeat..."

2. R16's POS dated 6/2016 documents an order for "Novolog {fast acting insulin} 100 units/ml (milliliter) Flexpen - inject 10 units subcutaneously three times daily with meals." This POS also documents an order for "Novolog 100 units/ml Flexpen - inject by subcutaneous route four times daily per sliding scale 150 - 199 = 2 units, 200 -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 332	Continued From page 14	F 332		

249 = 4 units, 250 - 299 = 6 units, 300 - 349 = 8 units, greater than 350 = 10 units", which is scheduled for 6:00 am, 11:00 am, 5:00 pm, and 9:00 pm.

On 6/20/16 at 4:28 pm, E7 LPN checked R16's blood glucose level, which was 159. E7 stated, R16 would receive the scheduled Novolog with an additional 2 units due to his blood glucose being over 150. At 4:33pm, E7 injected R16 with 12 units of Novolog. R16 stated, "the last time I ate anything was at noon." R16 was served supper at 5:17 pm, 44 minutes after receiving the insulin.

3. R16's POS dated 6/2016 documents an order for "Novolog {fast acting insulin} 100 units/ml (milliliter) Flexpen - inject 10 units subcutaneously three times daily with meals." This POS also documents an order for "Novolog 100 units/ml Flexpen - inject by subcutaneous route four times daily per sliding scale 150 - 199 = 2 units, 200 - 249 = 4 units, 250 - 299 = 6 units, 300 - 349 = 8 units, greater than 350 = 10 units", which is scheduled for 6:00 am, 11:00 am, 5:00 pm, and 9:00 pm.

On 6/21/16 at 10:12 am, E8 RN (Registered Nurse) checked R16's blood glucose level, which was 133. E8 asked R16 if R16 had eaten that morning, since the level was low. R16 stated, "yes, last time I ate was around 7:30 am. That scares me when it gets that low." At 10:15 am, E8 injected R16 with the scheduled 10 units of Novolog. R16 was served lunch at 11:25 am, 70 minutes after receiving the insulin.

4. R21's POS dated 6/2016 documents an order for "Novolog {fast acting insulin} 100 units/ml (milliliter) Flexpen - give per sliding scale: 70 -

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 332	Continued From page 15 149 = 0 units, 150 - 199 = 4 units, 200 - 249 = 6 units, 250 - 299 = 8 units, 300 - 349 = 10 units, over 350 = 12 units", which is scheduled for 6:00 am, 11:00 am, 5:00 pm, and 9:00 pm. On 6/21/16 at 10:50 am, E8 RN checked R21's blood glucose level, which was 212. E8 stated, with a sugar level of 212, R21 would receive 6 units of insulin. At 10:56 am, E8 injected R21 with 6 units of Novolog insulin. R21 stated, "I have not eaten since around 7:30 this morning." R21 was served lunch at 11:38 am, 42 minutes after receiving the insulin. On 6/21/16 at 2:00 pm, E2 DON (Director of Nursing) stated, Novolog acts quickly, I would say residents should eat within 15 - 30 minutes after receiving it. The Novolog Drug Knowledge booklet dated 7/2014 documents, "Novolog is fast-acting. Eat meals within 5 to 10 minutes after taking it."	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 431	Continued From page 16	F 431		

instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow their policy for disposal of a controlled substance for one resident (R24) on the supplemental sample.

Findings Include:

The facility Destroying Drugs Policy dated 4/17/2002 documents, "The purpose of this policy is to ensure safe destruction of controlled and non-controlled substances....all controlled schedules II, III, IV and V medications must be destroyed in the presence of two nurses (one of which must be an RN (Registered Nurse))..."

On 6/21/16 at 10:38 am, E8 RN prepared R24's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 431	Continued From page 17 medication: Tylenol {Analgesic} 500 mg (milligrams) one tablet and Alprozolam {Antianxiety/Scheduled II} by crushing them and adding a few drops of water to the mixture. E8 proceeded to spoon the medication into R24's mouth. R24 did not swallow the medication and it ran back out of R24's mouth and into the medication cup. On 6/21/16 at 10:46 am, E8 dropped this medication cup into a locked box on the wall in the treatment room, without a witness, and explained, "anytime a medication is wasted, we put it in here and document in the record that it was refused or whatever." On 6/21/16 at 1:50 am, E2 DON (Director of Nursing) confirmed that two nurses are needed for any controlled medication destruction, no matter what schedule class it is.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 441	Continued From page 18 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: A. Based on interview and record review, the facility failed to investigate and provide corrective actions related to resident infections. This failure has the potential to affect all 53 residents who reside in the facility. B. Based on observation, interview and record review, the facility failed to use sterile technique when performing tracheostomy care for one resident (R18). The facility also failed to ensure that respiratory equipment is maintained in a sanitary condition to prevent potential infections for two of three residents (R16 and R19) reviewed for infections in the sample of 14.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 441	Continued From page 19	F 441		

Findings include:

a. The facility provided Resident Focus-Infection/Antibiotic Monitoring sheets dated June 2015- June 2016. These sheets document name, infection and treatment but do not document trending or analysis of the infections. These sheets do not document methods used to investigate infections.

On 6/23/16 at 1:55pm, E3, Assistant Director of Nursing stated she was not sure of analysis or tracking of infections. E3 stated it was E20, former Director of Nursing who was responsible for infection control.

On 6/23/16 at 2:30pm, E1, Administrator stated E20 should have been trending and analyzing the infections of the residents for the facility.

The facility's Infection Control Program policy dated 6/20/13 documents, "The infection control program is identified to identify and reduce the risk of acquiring and transmitting infections... The program incorporates a broad range of... surveillance, prevention and infection control practices... is managed by the designated infection control nurse... The infection control program consists of... Surveillance methods used to identify, document and investigate nosocomial/healthcare-associated (HAI) infections and communicable diseases..."

The Resident Census and Condition Report dated 6/20/16 documents 53 residents reside in the facility.

b. 1. R18's Physician Orders dated June 2016 document diagnoses including Asthma. These

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 441	Continued From page 20	F 441		

orders also document orders for tracheostomy care daily.

On 6/22/16 at 1:50pm, E10, Registered Nurse (RN) performed tracheostomy care on R18. E10 washed her hands, donned non-sterile gloves and opened the tracheostomy care kit package. E10 removed the inner cannula from R18's tracheostomy. E10 removed the non sterile gloves, washed her hands and applied sterile gloves. E10 used her right and left hands with sterile gloves to touch the non sterile bottles of Normal Saline (cleansing solution) and pour the Normal Saline in to the sterile tracheostomy care tray. E10 then removed the speaking valve and cleaned R18's inner cannula. E10 picked up the non sterile bottle of Normal Saline with her right hand and poured an unidentified amount on to gauze that was in her left hand. E10 wiped around R18's tracheostomy with this potentially contaminated gauze. E10 picked up the inner cannula by the clear tubing, dried the clear tubing with gauze and reinserted the inner cannula in to R18's tracheostomy. E10 verified the two bottles of Normal Saline were not sterile and that she had touched them with her sterile gloved hands. E10 did not change her potentially contaminated sterile gloves throughout the procedure.

The facility's Clinical Skills, Tracheostomy Care document dated August 2011 documents, "... To reduce the risk of infection, tracheostomy care is performed using sterile technique... Don sterile gloves. Keep dominant hand sterile throughout the procedure... Clean inner cannula... While touching only the outer aspect of the tube, unlock and remove the inner cannula with nondominant hand... "

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 441	Continued From page 21	F 441		

2. R16's Physician Orders dated June 2016 document R16's diagnoses including Chronic Obstructive Pulmonary Disease (COPD) with acute exacerbation and Bacterial Pneumonia. These orders also document R16's orders for Oxygen (O2) at four liters per minute per nasal cannula.

On 6/20/16 at 11:57am, 6/21/16 at 9:20am R16's O2 nasal cannula tubing attached to the concentrator was dated 5/29/16. This tubing was hanging on the concentrator and not in a bag. R16's nebulizer machine was located on shelves next to R16's bed with tubing and mask dated 4/22/16. The surface of the nebulizer machine was covered with dusty residue and the tubing and mask were laying on the shelving not in a bag.

On 6/21/16 at 9:20am, R16's O2 tubing attached to the portable O2 device on R16's wheelchair was dated 6/12/16.

On 6/22/16 at 2:20pm, R16's O2 tubing attached to the concentrator was hanging and touching the floor while in use by R16.

On 6/22/16 at 2:20pm, E2, Director of Nursing (DON) verified the dates of R16's nasal cannula tubing of 5/29/16 attached to the concentrator and the nebulizer machine tubing and mask of 4/22/16. E2, DON, stated O2 nasal cannula tubing and nebulizer tubing should be changed every week. E2 stated that she had obtained bags to store the O2 and nebulizer tubing and masks in but that the facility is not using the bags yet. E2 stated the tubing should be placed in bags when not in use. E2 stated tubing changes are documented on the Treatment Administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 441	Continued From page 22	F 441		

Record (TAR) but may be documented on the Medication Administration Record (MAR).

The facility was unable to provide documentation of the Oxygen nasal cannula and nebulizer machine tubing changes for R16.

The facility's Oxygen Administration via Nasal Cannula policy dated 6/11/16 documents, "... Oxygen tubing must be kept off the floor... nasal cannula shall be changed once a week and when needed.
3. R19's POS (Physician Order Sheet) dated 6/16 documents an order for Ipratropium - Albuterol 0.5 mg (milligrams) - 2.5 mg per ml (milliliter), take three ml's by nebulizer QID (four times a day). This POS documents a Diagnosis of COPD (Chronic Obstructive Pulmonary Disease) with Acute Exacerbation.

On 6/21/16 at 10:30 am, E8 RN (Registered Nurse) put the above medication in an uncovered nebulizer cup, which was already hooked up to the nebulizer machine and had droplets of liquid in it, reattached the nebulizer mask to the cup, started the machine, put the face mask on R19 and left the room. E8 continued passing medications to other resident's until 11:03 am. At that time, E8 stated, E8 does not take apart and clean the nebulizer equipment (cup and mask) after the nebulizer treatment is completed.

On 6/21/16 at 11:05 am, R19's nebulizer mask and cup were sitting on the nebulizer machine intact and uncovered. The cup had droplets of liquid in it.

On 6/21/16 at 11:14 am, R19 stated, "they {staff} are suppose to clean it {nebulizer mask and cup}

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 441	Continued From page 23 after each use but they don't, never have. I know they are suppose to do it though because when I was at home and doing it {treatments} myself, I was told to make sure and clean it after each use to prevent bacteria from growing." On 6/21/16 at 1:55 pm, E2 DON (Director of Nursing) stated, the nebulizer equipment {mask and cup} should be cleaned after each use. The facility Nebulizer Cleaning Policy dated 10/13/13 documents, the purpose of this policy is "to insure that the nebulizer is properly cleaned after each use...After each treatment, rinse the nebulizer cup with warm water. Shake off excess water and allow to dry. After the last dose at the end of the day, wash the nebulizer cup, mask, or mouthpiece in warm soapy water. Rinse and allow to air dry overnight...Every week, was the equipment as described above, then disinfect following the manufactures directions...Once completely dry, place in re-sealable, plastic bag to store."	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that hot water accessible to residents, was at a safe temperature so as not to pose a burn hazard.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 465	Continued From page 24	F 465		

This failure creates a hazard to 53 residents.

The finding includes:

During resident room reviews on 6-20-16, hot water temperatures were taken and hot to the touch. The hot water at R2's resident room lavatory (sink) hot water temperature was 118 degrees Fahrenheit (F.) at 11:32 A.M. R15's resident room lavatory hot water temperature was 115 degrees F. at 11:40 A.M. R11's resident room lavatory hot water temperature was 116 degrees F. at 11:43 A.M.

E9, Environmental Services Director stated on 6-20-16 at 12:00 P.M., the facility has one hot water distribution system for the residential domestic water. The system includes a boiler, hot water holding tanks, circulation pumps and a mixing valve. E9 stated that the hot water temperature are recorded weekly and in the mornings. E9 stated that the temperatures are taken at the lavatory in the training toilet rooms located at the beginning of each of the four resident room wings. The resident wings meets at the center core nurses station.

The D wing General Bath hot water temperature recorded 120 degrees F. at 12:01 P.M. on 6-20-16. The C wing General Bath hot water temperature recorded 118 degrees F. at 12:04 P.M. on 6-20-16. The B wing General Bath hot water temperature recorded 116 degrees F. at 1:10 P.M. The A wing General Bath hot water temperature recorded 115 degrees F. at 1:16 P.M. The boiler inline hot water discharge thermometer recorded 140 degrees F. and the inline mixing valve thermometer recorded 128 degrees F. at 12:22 P.M. on 6-20-16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146085	A. BUILDING _____ B. WING _____	06/23/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A MERKLE C KNIPPRATH N H	1190 E 2900 NORTH ROAD CLIFTON, IL 60927

(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 465	Continued From page 25 According to the facility's residential hot water temperature log, the last time the hot water temperatures were recorded was on 6-13-16. The temperatures were 111.7 degrees F. on A wing, 112.7 degrees F. on B wing, 114.3 degrees F. on C wing and 115.2 degrees F. on D wing. E9 stated on 6-20-16 at 12:22 P.M. , A new replacement boiler was installed and that E9 would have to adjust the hot water temperature. E9 stated on 6-23-16 at 9:30 A.M., that after making the adjustments the hot water temperature did not remain stable. E9 stated a mechanical contractor has determined that the mixing valve needs to be serviced or replaced and parts have been ordered. E2, Director of Nurses stated on 6-23-16 at 9:35 A.M. that all residents have the potential to be bathed in the General Baths. According to the facility's "Resident Census and Conditions of Residents" report dated 6-20-16, 53 residents reside at the facility.	F 465		