STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146066	A. BUILDING _____ B. WING _____	10/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPINE FIRESIDE HEALTH CENTER	**3650 NORTH ALPINE ROAD LOVES PARK, IL 61111**

(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 225 SS=E	Annual Licensure and Certification Survey. 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working	F 225		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 225	Continued From page 1 days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to conduct a thorough investigation when a Certified Nursing Assistant (E15) alleged E16 & E17 (Certified Nursing Assistants) were abusive to two residents (R50 & 51). This has the potential to affect 6 residents (R7, 8, 11, 15, 20, 23) reviewed for abuse in the sample of 12 residents and 24 residents (R1-6, 9, 10, 12-14, 16-19, 21 & 22, 24-28,50 & 51) in the supplemental sample who reside or have resided on the 100 wing. The finding includes: The facility's abuse investigations were reviewed. On 1/12/2011, E15 (Certified Nursing Assistant), reported to E2 (Director of Nursing) allegations of abusive behavior involving E16 & E17, toward R50 & 51. E16 allegedly told R50 she was crazy and "threw" the resident into her wheelchair. She allegedly told R50 she did not want to look at her the rest of the night. E16 allegedly yelled at R51 for wetting his bed. On 1/12/2011, E5 (Social Service Designee) interviewed R50 and R51. The written interview for R50 states, "...a woman on the night shift was not very friendly to her...the woman does not chat with her and is 'short' when speaking with her	F 225		

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F 225	Continued From page 2 during care." E5's interview with R51 documents the resident felt that some staff were short with him. He said staff get mad at him if he does not use the toilet. The resident stated,"...she was mad and that everyone here is always mad at him." E5 did not interview any of the other residents residing on the same wing as R50 and R51 or any residents who may have come in contact with E15 and E16. On 10/5/2011 at 9:50 AM E5 and E2 (Director of Nursing) verified more residents should have been interviewed to see if any one else felt the same way R50 & R51 did. On 10/6/2011 at 1:45 PM, E1 (Administrator) said that R50 and 51 no longer reside in the facility. When they did live in the facility they resided on the 100 Wing. The facility's roster,on 10/5/2011, showed R1-28 currently reside on the 100 wing. The facility's undated Abuse Investigations Policy and Procedure states, "All reports of resident abuse, neglect, and injuries of an unknown source shall be promptly and thoroughly investigated by facility management." Under Policy Interpretation and Implementation it states: #3 f. "Interview other residents to whom the accused person had contact with..."	F 225		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY	F 241		

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F 241	Continued From page 3 The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to safeguard a resident's bathing and dressing schedule from public view. This applies to 1 of 12 residents (R23) reviewed for dignity in the sample of 12. The finding includes: On 10/4/2011 at 12:30 PM and on 10/5/2011 at 9:30 AM a sign was observed posted on the outside of R23's closet door, within the view of anyone entering R23's room. The sign said R23 was to remain in bed on Tuesday and Friday mornings for a bed-bath and dressing. The sign had R23's name written on it. The facility's Residents' Rights for People in Long Term Care Facilities states, "Your medical and personal care are private...Your facility may not give information about you or your care to unauthorized persons without your permission..." On 10/6/2011 at 9:30 AM, E1 (Administrator) said the hospice staff posted the sign on the resident's door.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		

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F 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under o483.25; and any services that would otherwise be required under o483.25 but are not provided due to the resident's exercise of rights under o483.10, including the right to refuse treatment under o483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure nutritional care plans were developed and implemented for residents with a history of weight loss and/or pressure ulcers. This applies to 3 residents (R11, R20 and R23) of 12 reviewed for nutritional care plans in the sample of 12. The findings include: 1. The weight record for R23 shows the resident has lost 27 pounds since April 2011. R23's	F 279		

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weight in April 2011 was 154 pounds (#'s) and his September weight is 127 #'s. The resident receives 1 on 1 assistance with feeding. On 10/4/2011 and 10/5/2011, R23 was observed from 12:00 noon to 1:30 PM, during the noon meal. R23 ate very poorly. The resident required encouragement to take each bite of food.

R23's dietary tray card shows the resident receives a general diet with ground meat. He is given super cereal with 2 pats of butter for breakfast. He is given whole milk for all 3 meals.

A 1/29/2011 Dietary note written by Z2 (Licensed Nutritionist) states the resident has potential for nutritional deficit. On 8/13/2011, Z2 writes, "...male on comfort care with 'worsening condition due to Parkinson's (as MD noted)'...Nutrition diagnosis: Unintended weight losses related to worsening condition secondary to Parkinson's and other medical conditions likely affecting appetite and feeding skills including Depression, Dementia evidenced by low albumin, low total protein per most recent Complete Metabolic Profile. Multiple nutritional supplementation, diet liberalization and feeding assist appropriate at this time. Weight loss may be unavoidable due to reported overall decline."

On 10/5/2011 at 1:40 PM, E6 said R23 was on Comfort Care Only. He said residents receiving Comfort Care may not necessarily receive aggressive attempts to encourage weight gain. E6 said the resident's house supplement was increased to 120 cc, 4 times daily and his diet was liberalized to no concentrated sweets. E6 was asked what R23's food likes are. E6 said he

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remembered that the resident liked peanut butter and jelly sandwiches, but this had not recently been tried. The resident was not offered a peanut butter and jelly sandwich during the meals observed. There are no careplans and it is not written on the dietary card to offer R23 a peanut butter and jelly sandwich when appetite is poor. E6 said he had no assessments showing he asked the resident or his family what kinds of foods the resident may enjoy eating.

R23's careplans were reviewed. R23 did not have a careplan addressing his weight loss or "Comfort Care" measures.

On 10/5/2011 at 2:45 PM, E3 (Assistant Director of Nursing) was asked what interventions are in place to try to stabilize, slow, or stop R23's weight loss. E3 said the only place interventions are written are on the care plans. E2 said R23 does not have a nutrition care plan.

The facility's undated Comfort Care Policy and Procedure states, "It is the policy of Alpine Fireside Health Center to offer Comfort Care to residents when it has been determined by a consensus of the resident and/or resident's decision maker; in consultation with the primary care physician and staff caring for the resident, that further aggressive treatment will provide more of a burden to the resident than it will benefit him or her...Supplementation will be offered to ensure comfort such as offsetting severe weight loss, promoting wound maintenance (not healing), and pleasure of the resident to relieve hunger. Supplementation will not be offered for the purpose of maintaining weight stability or baseline lab values.

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F 279	Continued From page 7 On 10/6/2011 at 10:00 AM, Z1 (R23's physician) said he was aware of the resident's weight loss. He said he hesitated to give the diagnosis of Failure to Thrive, however, the weight loss may be unavoidable. The facility's undated Care Plan Policy states, "Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care...Staff approaches are to be developed for each problem or need. When possible more than one discipline per approach is to be documented on the Care Plan or all disciplines are responsible for that approach..." 2. R11 is a 90 year old male resident with diagnoses to include Acute Renal Failure (ARF), Acquired Hypothyroidism, Alzheimer's Disease, Dementia with Delusions, Chronic Pain Syndrome and Anemia according to the Physician Order Sheet (POS) dated 10/2011. The Diet Order Sheet dated/signed 1/14/11 identifies R11 has having a General Mechanical Soft Diet with cut up meats. The Braden Scale dated 9/24/11 scores R11 at a 13 (Moderate Risk for Development of Pressure Ulcers). The Nursing Progress Note dated 9/24/11 under Mood identified R11 as "Refuses food" and under Nutrition as "Requires assist" with feeding. The 1/13/11 Initial Nutritional Assessment identified R11's overall nutritional risk as 12 (> or = 8 points: High Risk). An Initial Nutritional Assessment dated 1/17/11 identified R11 with	F 279		

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F 279	Continued From page 8 two Stage II pressure areas and weight declines as follows: 10/2010 = 162 pounds; 12/2010 = 155 pounds; and 01/2011 = 150 pounds. The Month Weight Log presented by the facility identified R11's weights as follows: 10/2010 = 162 pounds; 11/2010 = 159 pounds; 12/2010 = 155 pounds; 01/2011 = 150 pounds; 02/2011 = 144 pounds; and 03/2011 = 139 pounds. On 10/5/11 at 2:45 PM, E3 (Assistant Director of Nursing) verified R11 had no nutritional care plan. 3. R20 is a 90 year old female resident with diagnoses to include Traumatic Amputation of Toes, Neuropathy, Cellulitis, Ulcerative Colitis, Anemia and Chronic Renal Failure according to the POS of 10/11. The nursing progress note dated 9/15/11 documents R20 with "2 L (left) toes amputated. Edema at BLE (bilateral lower extremities). Suspected deep tissue injury at buttocks. The Braden Scale for R20 dated 9/15/11 writes "Two amputated toes at L foot. Blanchable redden area at bilateral buttocks and upper thigh. Txs: (treatments) Barrier cream to buttock q (every) shift and as needed after incontinent episodes. Scattered bruises throughout lower legs. Refer to naked man assessment." The scale documents R20 as scoring 13 (moderate risk for development of pressure ulcers.) The Body	F 279		

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F 279	Continued From page 9 Check Form (naked man assessment) dated 7/30/11 identified a scabbed area to R20's left heel, reddened buttocks, surgical areas related to amputation of toes on the left foot. The 9/12/11 Body Check Form identified R20 as having a "boggy" right heel and "boggy" skin at calf and heal areas. There is a box drawn on the form which encompassed the posterior portion of both of R20's legs. R20 had no nutritional care plan in place to assist in promoting heeling of her wounds. On 10/5/11 at 2:45 PM, E3 (Assistant Director of Nursing) verified R20 had no nutritional care plan.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to update a resident's (R23) care plan with new interventions after each fall.

This is for 1 of 12 residents (R23) reviewed for falls.

The findings include:

R23's 10/2011 Physician Order Sheet shows the resident's diagnoses include: Parkinson's Disease, Dementia, Diabetes Type II, Depressive Disorder, and Coronary Artery Disease.

On 10/4/2011 at 12:30 PM , R23 was observed to be in a low bed with a mat on the floor. A Falls Assessment, dated 8/23/2011, shows R23 has had 3 or more falls in the past 3 months. A facsimile note sent to Z1 (Resident's physician) on 4/12/2011 documents the resident has had 9 falls since 3/1/2011. The note states the resident has had a significant decline in gait and ambulation in 1 month. A 5/18/2011 facsimile to Z1 documents R23 was found on the floor beside his bed. Another transmission to Z1 on 7/17/2011 documents R23 stood up from his wheel chair and fell. A transmission of 8/23/2011 documents the resident fell in the dining room, from his chair. On 9/6/2011 a facsimile was sent to Z1 stating the resident was found on the floor and sustained a skin tear to his left hand.

R23 has fallen a documented 13 times since

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3/1/2011. The resident's care plan, at risk for falls, dated 1/19/2011, has never been updated. The goal of the plan is the resident will have no falls or signs of injury from falls. The interventions on the care plan are as follows: monitor for a steady gait, use assist of 1 when transferring, use assist of 1 when walking, use gait belt when ambulating for safety, monitor for side effects of medications that may contribute to falls, monitor for the need to use the toilet, and monitor to make sure pathway is clear.

On 10/4/2011 at 12:30, E7 & E8 (Certified Nursing Assistants) were observed getting the resident out of bed and taking him to the bathroom. They said the resident no longer ambulates. He requires the assistance of 2 staff to transfer him from one surface to another.

On 10/5/2011 at 2:45 PM, E3 (Assistant Director of Nursing) was asked where ongoing interventions would be written to protect R23 from further falls. E3 said the only place interventions are written are on the care plans.

R23's Minimum Data Sets dated 8/15/2011 and 9/15/2011 shows the resident has experienced 2 significant changes in 30 days.

The facility's undated Care Plan Policy states, "Each resident will have a plan of care to identify problems, needs and strengths that will identify how the interdisciplinary team will provide care...Staff approaches are to be developed for each problem or need. When possible more than one discipline per approach is to be documented on the Care Plan or all disciplines are responsible for that approach...All goals and

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F 280	Continued From page 12 approaches are to be reviewed by the appropriate disciplines every quarter and upon significant change of condition. Each department's notes are to reflect a review of all appropriate Care Plan goals and approaches.	F 280		
F 323 SS=D	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, interview, and record review the facility failed to provide leg rests for resident wheel chairs, to protect their feet and legs from injury, when being pushed in their wheel chairs. This applies to 2 of 12 (R7 & R30) reviewed for accidents and injuries. The findings include: 1. R7's 10/2011 Physician Order Sheet documents the resident has a fractured ankle. On 10/4/2011 at 12:20 PM, R7 was observed to have a lower leg boot cast on her right leg. E7 (Certified Nursing Assistant) was observed pushing the resident down the corridor. E7 told R7 to keep her feet up off of the floor while she was being pushed. E7 was asked if the resident	F 323		

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F 323	Continued From page 13 had foot rests for her wheel chair. E7 said she did not have any. R7's care plans were reviewed. She has the following plans: At risk for skin breakdown related to incontinence, at risk for falls related to history of falls and unsteady gait, needs assistance with brace to right ankle, at risk for skin breakdown, limited assistance for dressing due to weakness, acut pain related to knee pain, active range of motion related to decrease in mobility and muscle weakness and needs easy lift chair due to poor transfers. None of the careplans address the resident's ankle fracture or how staff should protect the ankle from further injury. 2. R30 was observed on 10/5/2011 at 12:46PM, sitting in a wheel chair being wheeled by staff from the dining area to his room. R30's ace wrapped legs were positioned straight out, feet barely skimming the floor, with staff reminding R30 to keep his legs up. There were no foot or leg rest on the wheel chair. On 10/4/2011 at 9:40AM E14 (Registered Nurse, wound nurse) stated R30 was on isolation because of having MRSA infection in his legs. Interdisciplinary Progress Notes dated 10/5/2011, 10:00PM, Dressings to bilateral leg as with ace wraps intact. Isolation maintained for MRSA of wounds. Transports per wheel chair. On 10/5/2011 at 12:45PM a line of wheel chairs were observed along the wall in the common area, outside the dining room. All but one wheel chair was observed to be without foot and leg rest. On 10/6/2011 at 9:15AM, E2 (Director of	F 323		

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F 323	Continued From page 14 Nursing) stated, "The wheel chairs do not have leg and foot rests because they are in the storage shed outside the building.	F 323		
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure that chicken was palatable and cooked in an manor which is acceptable to residents. The facility failed to ensure milk was served at a palatable temperature. This applies 46 of 46 residents. The findings include: The facility's census and condition sheet completed on 10/04/11 shows a census of 46 residents. 1. On 10/04/11 at 1:15 PM, twenty six residents either did not eat any of their noodles or only ate bites of their noodles. Thirteen residents either did not eat any of their meat or only ate bites of their meat. The following comments were made during three confidential interviews: The facility serves noodles too often, the meat is tough and	F 364		

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F 364	Continued From page 15 overcooked. The meat used to be tender here, and now I can't cut the pork or chicken. On 10/05/11 at 2:10 PM, during the group meeting residents stated, the meat is tough and difficult to chew. 2. On 10/04/11 at 12:00 PM, dietary staff placed milk on the tables in the resident dinning room. At 12:15 PM, there were residents being brought into the dinning room and seated. The temperature of the milk was between 48 and 50 degrees Fahrenheit (F) when the residents were seated for lunch. On 10/04/11 at 12:15 PM, E6 (Dietary Manager) calibrated his thermometer and confirmed the milk sitting on the table was between 48 and 50 degrees F. E6 stated, "It should be below 41 degrees when served." On 10/05/11 at 2:10 PM, during the group meeting residents stated, the milk is served lukewarm.	F 364		
F 368 SS=F	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily.	F 368		

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F 368	Continued From page 16 When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all 46 residents in the building were offered bedtime snacks. The findings include: On 10/4/2011 the facility identified on Federal Form 672 that 46 residents reside in certified beds. During the resident meeting on 10/5/2011 at 2:10PM, all residents stated, "We are not offered anything to eat before we go to bed." On 10/6/2011 at 1:45PM R30 stated, "Last night was the first time I got something to eat before I went to bed. They gave me juice and a cookie. I was very hungry and am glad they gave me something. It would have been worse if I hadn't gotten anything." Review of R30's face sheet identifies the admission date of 9/30/2011. R30's Physician Order Sheet dated 9/2011 identifies R30's diagnoses as Diabetes Mellitus. The policy and procedure undated titled Nourishments documents, 'Policy: Nourishment will be provided to the residents at approximately bedtime. Procedure: Dietary department will deliver the bed time nourishment (snacks) as planned on the current menu. Nursing will	F 368		

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F 368	Continued From page 17 distribute the bed time snack.' On 10/5/2011 at 2:50PM E6 (Food Service Supervisor) stated, "All the residents should get the snack that follows their diets. The cart goes out around 8PM with the snacks on it." E6 confirmed at the time of the interview, residents having diabetes have a planned snack. Review of the Menu titled, Options Fall/Winter 00 Wk-1 Day 3 and Day 4, Day 5, dated Oct. 4, 2011, 9:45AM identifies all diets getting the same bedtime snack. (Regular, Mech. Soft, Pureed, Low Fat/Low Chol, No Conc. Sweets) Day 3- Cheese-Nip crackers 1pkg and 6 oz. of grape juice. Day 4- One oatmeal cookie, 6 oz. of lemonade Day 5- One sandwich cream cookie, 6 oz. Fresh Cranberry Cocktail.	F 368		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure raw poultry was stored in a manor to prevent cross	F 371		

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F 371	Continued From page 18	F 371		

contamination of ready-to-eat foods. The facility failed to ensure food preparations surfaces were not contaminated.

This applies to all 46 residents in the facility.

The findings include:

The facility's census and condition sheet completed on 10/04/11 shows a census of 46 residents.

1. On 10/4/11 at 9:30 AM, there were three shallow trays of raw chicken breasts directly above open boxes of produce, in the walk-in cooler.

On 06/21/11 at 10:35 AM, E4 (Certified Dietary Manager) stated, "The chicken breasts should be stored on the bottom self. That is why this area (bottom self) is left open"

2. On 10/4/11 at 12:00 PM , E11 (Cook) was serving lunch and dropped several resident-tray cards onto the floor. The cards were picked up and placed on the food preparation surface, where lunch was being plated.

On 06/21/11 at 12:00 PM, E4 picked up the cards and sanitized them. E4 said the cards should not have been placed on a food preparation surface until after the cards were sanitized.

The undated facility policy titled, Food Storage, states, "Refrigerated Storage - ... Practices to maintain safe refrigerated storage include: Separating raw animal foods (e.g., beef, fish, lamb, pork, and poultry) from each other and

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F 371	Continued From page 19 storing raw meats on shelves below fruits, vegetables or other ready-to-eat foods so that meat juices do not drip onto these foods;..." (p. 2)	F 371		
F 431 SS=F	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 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.	F 431		

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F 431	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure expired medications were removed from the facility's stock medication supply. The facility failed to store medications in a manor in which the medications with the earliest expiration date were used before mediations with a later expiration date. This applies to all 46 residents in the facility. The findings include: The facility's census and condition sheet completed on 10/04/11 shows a census of 46 residents. On 10/06/11 at 10:00 AM, the following expired medications were located in the medication room which stored resident stock medications: 2 - Fiber Tabs expired on 4/11, 2 - Fiber Tabs expired on 6/11, 1 - Ecotrin (Asprin) expired on 01/11, 1 - Vite (Multivitamin with Minerals) expired on 01/11, 4 - Vitamin E expired on 6/11, and 1 - Vitamin C expired on 5/11. On 06/11 at 10:00 AM, E12 (Registered Nurse) confirmed the medications were expired and stated, "The expired medications should have been taken out of stock. We have someone from pharmacy who normally removes expired medications." The undated facility policy titled, Expired	F 431		

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F 431	Continued From page 21 Medication, states, "Pharmacy will provide a consultant to review medication storage areas on a monthly basis. Medications closer to expiration will be placed in front for usage first. If a medication is expired it will be removed an returned to pharmacy for replacement. If the medication is expired and no longer used, it will be returned to pharmacy for destruction. The pharmacy consultant will provide the Administrator/DON (Director of Nursing) with a copy of the written report prior to leaving the facility. Nursing staff should verify expiration of all medications prior to giving the medication. If expired, return to pharmacy for either replacement or destruction."	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. (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	F 441		

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F 441	Continued From page 22 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: Based on interview and record review the facility failed to have a system in place to track and trend organisms of residents with positive laboratory cultures. The facility also failed to have a method to track staff infections. This has the potential to affect all 46 residents residing in the facility. The findings include: On 10/4/2011 the facility identified,on the Federal Form 672, that 46 residents reside in certified beds. On 10/5/2011, the facility's Monthly Infection Control Log was reviewed for the past year. From October 2010 through August 2011 the facility had 19 positive cultures requiring	F 441		

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F 441	Continued From page 23 antibiotic treatment. The log does not document what the causative organisms of the positive culture were. On 10/5/2011 at 9:30 AM, E3 (Assistant Director of Nursing) said she was the Infection Control Nurse. E3 verified she did not have a method to track and trend the organisms of positive cultures. E3 was asked how the facility monitors the infections of staff. E3 said they did not have a system in place to monitor the infections of staff until September 2011. On 9/4/2011 at 3:50 PM and on 9/5/2011 at 5:00 PM, E1 was asked for the facility Infection Control Policy. An Infection Control Policy was not received.	F 441		