STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145243	A. BUILDING _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH LOGAN HEALTHCARE CENTER	801 NORTH LOGAN AVENUE DANVILLE, IL 61832

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F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Annual Certification Survey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

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F 157	Continued From page 1	F 157		

by:
Based on interview and record review the facility failed to notify the physician of a resident's change in mental status for one of three residents (R13) reviewed for urinary tract infections in the sample of 16.

Findings include:

The Physician's Order Sheet dated 4/1/16 through 4/30/16 documents that R13 has diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure. The Minimum Data Set dated 1/20/16 documents R13 is cognitively intact.

The Discharge Instructions Sheet dated 1/29/16 documents that R13 was readmitted to the facility after being hospitalized for Acute COPD Exacerbation, Congestive Heart Failure, Confusion, Hypoxia and Urinary Tract Infection (UTI). E16's (Registered Nurse) unsigned Nurses Note (telephone report from hospital nurse) dated 1/29/16 at 11:35 am documents " (R13) no confusion at this time".

E20's (Registered Nurse) Nurses Note dated 1/30/16 documents "Resident (R13) is alert but has been confused off and on all day.....(R13) states I know I am confused but I don't want to go back to the hospital....."

E20's Nurses Notes dated 1/31/16 documents "Resident is alert but still shows increased confusion.....continues on antibiotic for UTI....."

E16's Nurses Note dated 2/1/16 at 1:23 PM documents "(R13) talks of being confused, clearly speaking at this time....."

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F 157	Continued From page 2 E16's Nurses Note dated 2/1/16 at 2:05 PM documents "(R13) up in bathroom without oxygen in place. Attempted to explain the importance of keeping (R13's) oxygen on at all times.....cont (continue) to state she is not thinking right now. When asked to define this (R13) states I can't....." The Nurses Note dated 2/1/16 at 4:00 PM states "Family would like resident to go to ER (emergency room). Family stated that something with resident isn't right. (R13) states "I just don't feel right" ....." The Nurses Note dated 2/2/16 at 2:44 AM states "(R13) removes O2 (oxygen) per self to go to bathroom.....oxygen sats (saturation) decrease to 85-88% on room air.....resident confused at times." The Nurses Note dated 2/2/16 at 5:51 am states "(R13) again removed O2 to go to BR (bathroom) after this nurse demonstrated that there was enough tubing for (R13) to leave it on and reach BR. O2 sat was down to 78% when this nurse happened to walk by and saw resident stumbling back to bed almost falling.....resident was confused, disoriented and garbled speech when O2 was reapplied, which mostly cleared these symptoms....." The Nurses Note dated 2/2/16 at 7:30 AM documents "(R13) having increased AMS (altered mental status).....Resident v/s (vital signs) 101.1 (temperature), 80/64 (blood pressure).....skin warm to touch. Confused, speech slurred at times and not making sense.....balance unsteady.....unusual body jerking.....call to MD (medical doctor). (Transport) called....."	F 157		

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F 157	Continued From page 3 The Nurses Note dated 2/2/16 at 7:40 am documents "(R13) transferred to (emergency room)....." The Hospital History and Physical dated 2/2/16 documents an assessment of Septic Shock, Acute Kidney Injury and Altered Mental Status, probably secondary to sepsis for R13. On 4/20/16 at 11:25 AM E20 stated that E20 did not notify Z2 Physician of R11's confusion on 1/30/16 and 1/31/16. On 4/20/16 at 12:30 pm E16 stated E16 did not notify Z2 on R13's confusion on 2/1/16. On 4/21/16 at 11:55 AM E2 Director of Nurses could not provide documentation that Z2 was notified of R13's change in mental status before 2/2/16 at 7:30 AM. On 4/21/16 at 9:15 AM Z2 stated he does not remember being notified of R13's confusion after R13 was readmitted to the facility on 1/29/16. Z2 stated when R13's confusion did not resolve after one or two days staff should have notified Z2. The Change in a Resident's Condition of Status policy dated 4/2012 states "notify the residents Attending Physician.....when there has been.....a significant change in the residents physical/emotional/mental condition....."	F 157		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250		

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F 250	Continued From page 4 practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide Podiatry services for one of one resident (R14) reviewed for Podiatry services in the sample of 16. Findings include: On 4/21/16 at 2:25PM, E1 Administrator stated the facility does not have a policy regarding podiatry services. R14's Physician Order Sheet (POS) dated 4/1/16 to 4/30/16 documents the diagnoses of Dementia and Diabetes Mellitus. R14's Minimum Data Set (MDS) dated 3/9/16 documents a Brief Interview for Mental Status (BIMS) score of five out of 15. R14's Care Plan dated 12/30/15 documents the BIMS score of five indicates severely impaired cognition. R14's Care Plan dated 3/16/16 documents R14 is totally dependent on staff for bathing and requires extensive assistance for personal hygiene. On 4/18/16 at 1:06PM, E18 Certified Nursing Assistant (CNA) removed R14's left slipper and R14's left big toe nail was thick and discolored and over 1/2 inch long. On 4/20/16 at 3:10PM, E3 Assistant Director of Nursing (ADON) confirmed R14 has Diabetes and confirmed R14's medical record has no	F 250		

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F 250	Continued From page 5 documentation of being seen by the Podiatrist. On 4/21/16 at 9:00AM, E3 confirmed R14 has not seen a Podiatrist since R14 was admitted on 4/10/15. On 4/21/16 at 2:11PM, E8 Registered Nurse removed R14's slipper and confirmed that the left big toe nail has not been cut. E8 stated R14 is on the list to see the Podiatrist this month and is unsure why R14 hasn't been seen by the Podiatrist before now.	F 250		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure a resident received prompt diagnosis and treatment for a worsening infection by failing to notify the physician of a resident's change in mental status for one of three residents (R13) reviewed for urinary tract infections in the sample of 16. Findings include: The Physician's Order Sheet dated 4/1/16 through 4/30/16 documents that R13 has	F 309		

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F 309	Continued From page 6	F 309		

diagnoses of Chronic Obstructive Pulmonary Disease (COPD) and Congestive Heart Failure. The Minimum Data Set dated 1/20/16 documents R13 is cognitively intact.

The Discharge Instructions Sheet dated 1/29/16 documents that R13 was readmitted to the facility after being hospitalized for Acute COPD Exacerbation, Congestive Heart Failure, Confusion, Hypoxia and Urinary Tract Infection (UTI). E16's (Registered Nurse) unsigned Nurses Note (telephone report from hospital nurse) dated 1/29/16 at 11:35 am documents " (R13) no confusion at this time".

E20's (Registered Nurse) Nurses Note dated 1/30/16 documents "Resident is alert but has been confused off and on all day.....(R13) states I know I am confused but I don't want to go back to the hospital....."

E20's Nurses Notes dated 1/31/16 documents "Resident is alert but still shows increased confusion.....continues on antibiotic for UTI....."

E16's (Registered Nurses) Nurses Note dated 2/1/16 at 1:23 PM documents "(R13) talks of being confused clearly speaking at this time....."

E16's Nurses Note dated 2/1/16 at 2:05 PM documents "(R13) up in bathroom without oxygen in place. Attempted to explain the importance of keeping (R13's) oxygen on at all times.....cont (continue) to state(R13) is not thinking right now. When asked to define this (R13) states I can't....."

The Nurses Note dated 2/1/16 at 4:00 PM states "Family would like resident to go to ER (emergency room). Family stated that something

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F 309	Continued From page 7	F 309		

with resident isn't right. (R13) states "I just don't feel right".

The Nurses Note dated 2/2/16 at 2:44 AM states "(R13) removes O2 (oxygen) per self to go to bathroom.....oxygen sats (saturation) decrease to 85-88% on room air.....resident confused at times."

The Nurses Note dated 2/2/16 at 5:51 am states "(R13) again removed O2 to go to BR (bathroom) after this nurse demonstrated that there was enough tubing for (R13) to leave it on and reach BR. O2 sat was down to 78% when this nurse happened to walk by and saw resident stumbling back to bed almost falling.....resident was confused, disoriented and garbled speech when O2 was reapplied, which mostly cleared these symptoms....."

The Nurses Note dated 2/2/16 at 7:30 AM documents "(R13) having increased AMS (altered mental status).....Resident v/s (vital signs) 101.1 (temperature), 80/64 (blood pressure).....skin warm to touch. Confused speech slurred at times and not making sense.....balance unsteady.....unusual body jerking.....call to MD (medical doctor). (Transport) called....."

The Nurses Note dated 2/2/16 at 7:40 am documents "(R13) transferred to (emergency room)....."

The Emergency Department Physician (Z3) Report dated 2/2/16 documents an impression of Pneumonia and Sepsis with an elevated Partial Pressure of Carbon Dioxide (PCO2) for R13.
The Hospital History and Physical dated 2/2/16 documents an assessment of "Septic Shock,

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most likely secondary to pneumonia versus urinary tract infection , or both.....acute kidney injury.....altered mental status, probably secondary to sepsis" for R13. The Hospital History and Physical documents R13 was admitted to the intensive care unit and treated with intravenous fluid and antibiotics.

On 4/20/16 at 11:25 AM E20 stated that E20 did not notify Z2 Physician of R11's confusion on 1/30/16 and 1/31/16.

On 4/20/16 at 12:30 pm E16 stated E16 did not notify Z2 on R13's confusion on 2/1/16.

On 4/21/16 at 11:55 AM E2 Director of Nurses could not provide documentation that Z2 was notified of R13's change in mental status before 2/2/16 at 7:30 AM.

On 4/21/16 at 9:15 AM Z2 stated Z2 does not remember being notified of R13's confusion after R13 was readmitted to the facility on 1/29/16. Z2 stated when R13's confusion did not resolve after one or two days staff should have notified Z2. Z2 stated R13 has a history of becoming disoriented due to increased PCO2 (blood gas) during exacerbations of R13's COPD. Z2 stated R13's urinary tract and lung infection probably caused an exacerbation of R13's COPD resulting in an increased PCO2 level and confusion. Z2 stated Z2 would have checked R13's blood gas levels if facility staff had notified Z2 of R13's confusion. Z2 stated failing to notify Z2 of R13's continued confusion resulted in a delay in diagnosis and treatment.

The Change in a Resident's Condition of Status policy dated 4/2012 states "notify the residents

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F 309	Continued From page 9 Attending Physician.....when there has been.....a significant change in the residents physical/emotional/mental condition....."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide a pressure reducing device for one of three residents (R17) reviewed for pressure sores in the sample of 16. Findings include: The facility's undated Pressure Ulcer Prevention Policy documents, "....General Preventive Measures.....All residents identified to be at risk for pressure ulcer development should have a pressure reduction chair cushion...." R17's Care Plan dated 4/13/16 documents diagnoses of Cerebral Palsy, Anorexia, Pressure Ulcer of Right Heel, Unstageable. The same Care Plan documents an intervention, "....to have w/c (wheelchair) leg cushion/leg separator applied to w/c...."	F 314		

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R17's Minimum Data Set (MDS) dated 4/6/16 documents R17 requires extensive assistance of two people for bed mobility and R17 is totally dependent on two people for transfers. R17's balance during transitions on this same MDS documents R17 is not steady , only able to stabilize with staff assistance for a surface to surface transfer. The same MDS documents that R17's range of motion is impaired on both sides of the upper and both sides of the lower extremities.

The same MDS documents R17 has one unhealed pressure ulcer at stage 1 or higher and is at risk for developing pressure ulcers. This same MDS documents R17 has a pressure reducing device for the bed and chair. This MDS documents R17 is frequently incontinent of urine and always incontinent of bowel.

R17's Pressure Ulcer Risk Assessment dated 4/6/16 documents a score of 15 that documents R17 is at risk for pressure ulcers.

On 4/18/16 at 1:23PM R17 was transferred out of her wheelchair to the bed and there was no cushion in the sling bottom wheelchair. At this time R17 complained of back pain.

On 4/19/16 R17 was in her wheelchair without a cushion at 9:29AM, 9:52AM, 10:08AM, 10:27AM, 10:45AM, 10:55AM, 11:30AM, 11:46AM. On 4/19/16 at 12:41PM, R17 was transferred back to her bed by E18 and E19, Certified Nursing Assistants (CNA) and there was no cushion in R17's wheelchair.

On 4/20/16 at 3:03PM, E3 Assistant Director of

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F 314	Continued From page 11 Nursing (ADON) stated, "(E3) can't remember if (R17) has ever had a cushion in (R17's) wheelchair...(R17) has never had breakdown on (R17's) bottom so they haven't recommended a wheelchair cushion..."	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview, record review and observation the facility failed to apply hand splints for one of four residents (R11) reviewed for contractures in the sample of 16. Findings include: The Physician's Order Sheet dated 4/1/16 through 4/30/16 documents that R11 has a diagnosis of Spastic Cerebral Palsy and includes an order for R11 to have bilateral hand splints during the day and remove at night. On 4/18/16 at 2:45 PM R11 was not wearing hand splints. On 4/19/16 at 8:40 AM and 12:00 PM R11 was not wearing hand splints. On 4/19/16 at 12:30 PM E12 Certified Nurses Aide (CNA) stated E12 assisted R11 out of bed	F 318		

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F 318	Continued From page 12 and into the wheel chair this morning. E12 stated E12 did not apply R11's hand splints because E12 thought the splits had been discontinued. E12 stated R11 had not worn the splints for a few weeks. On 4/19/16 at 1:30 PM E13 Licensed Practical Nurse stated that R11 does not like to wear the splints but R11 will wear them for part of the day. E13 stated the CNAs should be offering and encouraging R11 to wear the splints. On 4/19/16 Z1 Occupational Therapist stated Z1 worked with R11 and the hand splints during February 2016. Z1 stated that R11 did not like wearing the splints but once R11's wrists were passively stretched R11 could tolerate wearing them. Z1 stated if Z1 had known R11 was not wearing the splints Z1 would have reevaluated R11. On 4/20/16 at 1:50 PM E2 Director of Nurses stated staff should have notified Z1 if they were having trouble getting R11 to wear the hand splints.	F 318		
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	F 323		

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F 323	Continued From page 13	F 323		

by:
Based on observation, interview and record review the facility failed to follow manufacture's recommendation for mechanical lift sling placement to ensure a safe transfer for one of five residents (R11) reviewed for assistive devices in the sample of 16.

Findings include:

The Physician's Order Sheet dated 4/1/16 through 4/30/16 documents that R11 has a diagnosis of Spastic Cerebral Palsy. The Minimum Data Set dated 2/4/16 documents that R11 requires total assistance of two people for transfers and that R11 has impaired range of motion of R11's upper and lower extremities.

On 4/18/16 at 2:45 PM E15 Certified Nurses Aide (CNA) and E6 Restorative CNA transferred R11 from the geriatric chair to the bed using a mechanical lift with a full body sling. During the transfer the top edge of the mechanical lift sling was over R11s head and resting on R11's face. The lower edge on the sling was positioned at R11's upper thigh just under R11's hip area.

On 4/18/16 at 3:05 PM E6 confirmed that R11 was not positioned safely on the sling during the transfer and that R11 was at risk of sliding out of the sling. E6 stated the lower edge of the sling should be positioned under the residents' knees.

The undated Patient Slings Owner's Operator and Maintenance Manual states "Positioning the Full Body Slings.....The top edge of the sling fabric should be slightly above the patient's head. The bottom edge of the sling fabric should be a few inches above the back of the patient's knees."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145243	A. BUILDING _____ B. WING _____	04/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH LOGAN HEALTHCARE CENTER	801 NORTH LOGAN AVENUE DANVILLE, IL 61832

(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 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to prominently display the daily nurse staffing data sheet and failed to record the facility's name on the staffing sheet.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356	Continued From page 15 These failures have the potential to affect all 80 residents that reside in the facility. Findings include: On 4/20/16 at 9:50 am the facility's posted staffing was not posted in a prominent location for residents or visitors to review. The posted staffing was located on the wall near the employee time clock in a hallway near an emergency exit door. The daily staffing sheet dated 4/20/16 did not document the facility's name. At this time E1, Administrator stated the posted staffing was in a hallway that employees used to access the time clock. E1 stated the daily staffing was not posted in a main entrance or common area. E1 stated that the area is an emergency exit only and that "no one uses that door." On 4/20/16 at 3:30 pm E1 provided 18 months of daily staffing sheets dated 1/1/14 through 4/20/16. E1 stated the daily staffing sheets did not identify the name of the facility. On 4/21/16 at 11:37 am E1 stated "We do not have a policy" for the daily nurse staffing data. The Resident Census and Conditions of Residents dated 4/18/16 documents that 80 residents reside in the facility.	F 356		