STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14A383	A. BUILDING _____ B. WING _____	07/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
APOSTOLIC CHRISTIAN RESTHAVEN	2750 WEST HIGHLAND AVENUE ELGIN, IL 60123

(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 Annual Licensure and Certification survey.	F 000		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to: Analyze the contributing factors for residents identified with urinary incontinence, Complete a thorough assessment of factors that may predispose one resident (R2) to having urinary incontinence with resulting moisture associated skin disorder contributing to a stage III pressure sore. Develop individualized goals & implement specific plans or interventions in order to prevent or minimize decline, including whether the causes of residents' incontinence are reversible or irreversible. This is for 1 resident (R2) in the sample of 11 but has the potential to affect all 39 incontinent residents in the facility. Findings include:	F 315		

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

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F 315	Continued From page 1 R2's most recent Minimum Data Set dated 6/27/12 shows R2 is 85 years old with moderately impaired cognition. R2 ' s most recent urinary incontinence assessment dated 7/20/11 shows R2 can identify urinary urge sensation and is cooperative with attempts at toileting. A " monthly resident data collection " document dated 6/22/12 shows R2 is incontinent daily but some control is present. E 12 (nurse) stated on 7/18/12 at 11:00am R2 ambulates frequently and R2 will ask to use the bathroom at times and often appears anxious when she has to go to the bathroom. E12 stated R2 has a recurring pressure sore on her coccyx from friction and from being incontinent. There is a three day voiding diary from 6/12/ -6/14/12 in R2's medical record. E3 stated on 7/18/12 at 11:10am there has not been an analysis of this documentation to assist in determining a pattern nor has there been any diagnostic evaluation to determine if there are reversible causes of R2's incontinence. R2's incontinence care plan initially dated 1/1/12 states "I have multiple episodes of incontinence daily and wear pullups with two pads inside-one in front and one in back for containment and dignity." There are no individualized interventions for toileting programming or revised approaches to help R2 from developing her recurring pressure sores due to incontinence. Nurse's note dated 5/6/12 states "coccyx excoriated and red with maceration in the middle by opening." A 7/11/12 narrative wound assessment states "openings to top of gluteal crease continues. Site A measures .5 x .3 x .1 cm. Serous drainage noted. ...Wound edges irregular. Skin surrounding wound extends .5 cm all the way around with macerated tissue.	F 315		

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F 315	Continued From page 2 Complains of pain with dressing change. Site B is below site A ....maceration surrounds wound on all sides." A consulting wound document dated 7/12/12 assesses the coccyx wound as a stage III measuring .5 x .3 x < .2 cm. R2 was observed along with E11 (cna) and E12 (nurse) on 7/20/12 at 11:40am. E11 stated the last time she (E11) toileted R2 was at about 9:30am. R2 was observed to be taken into the bathroom where her diaper was removed and observed to have two thick pads inside the diaper, both of which were heavily wet. The dressing on the coccyx was removed and the pressure ulcer was observed to be inside buttock cheeks on coccyx bone. The entire surrounding area was observed to be macerated, indicating moisture involvement from incontinence. E12 stated at 11:55am R2 was placed on isolation yesterday (7/19/12) for ESBL (Extended Spectrum Beta Lactamase) urinary tract infection. Review of CMS 672 shows of the 43 residents residing in the facility, 39 are frequently occasionally incontinent of bladder and 25 of bowel. This form also shows that none of these incontinent residents are on individual bladder or bowel programs. E2 (director of nursing) stated on 7/18/12 at 10:25am because most of the facility's residents have a diagnosis of dementia, the facility only has a scheduled bladder and bowel program, meaning all of the incontinent residents are on a scheduled toileting program: upon rising, before bed and before and after meals in addition to prompting every two hours. E 3 (restorative nurse) stated on 7/18/12 at 1:20pm after reading F315, she realizes the facility does not have individualized incontinent plans of care based on	F 315		

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F 315	Continued From page 3 comprehensive bladder and bowel assessments for the incontinent residents. E3 said the facility plans on improving the incontinent assessments to better reflect the factors leading to each residents' incontinence episodes.	F 315		
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 direct observation, staff interviews and review of facility records, the facility failed to provide a baseline range of motion assessment and failed to provide Passive Range of Motion (PROM) as ordered for one of 11 sampled residents (R3). Findings include: R3 was observed on all days of the survey to have contracted fingers of the right hand. Record review shows R3 was admitted 2/15/2010. The Nursing Admission and Evaluation, dated 2/15/10 indicated R3 had " hand grasps strong/equal." On 3/2/10 an order was written for R3 to wear a right hand splint on HS (hour of sleep) and off in AM. There was no baseline evaluation conducted to address the	F 318		

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F 318	Continued From page 4 degree of the right hand's range of motion (ROM) before the initial application of the splint. R3's physician's orders dated March, 2012 through July, 2012 show the resident has a physician's order for PROM to be done twice daily, in AM and PM. Review of Treatment Records for the same time periods showed no documentation of the PROM being done as ordered. Staff interviewed were unable to provide documentation of the PROM having been done for R3. On 7/19/12 at approximately 4:00PM E2 (Director of Nurses) verified there was no documentation of PROM having been done for R3. On 7/20/12 at 1:05PM E2 verified there had not been any detailed assessment done that would indicate the degree of contracture of R3's right hand and there had not been any such assessment done by the physical therapy company used by the facility.	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 by: Based on record review and interview the facility failed to assist residents during transfer /	F 323		

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F 323	Continued From page 5 ambulation activities in a safe manner to prevent fall incidents. This was evidenced in 1 of 11 sampled residents (R10) and 5 residents in supplemental sample (R12, R13, R14, R15 and R16). Findings include: Facility incident reports included 7 incidents, between 02/07/12 and 6/25/12, of residents falling while being assisted by facility staff during transfer activities. 1)) On 02/07/12 at 7:05PM, while E7 (CNA), was assisting R15 to ambulate out of the bathroom, R15 said "I can't go anymore". The residents knees buckled and she fell to the floor. This incident report includes E7 was unable to assist R15 down to the floor due to the resident being "Obese". R15's February 2012 weight record document 204 pounds. R15 transferred off the floor to bed using a mechanical lift and complained of severe pain in her left ankle. R15 was sent to the hospital and was admitted with diagnosis of re-fractured left ankle. R15's 02/07/12 hospital records include presence of acute left ankle fracture dislocation. R15 required surgical intervention to reduce and stabilized fracture. R15's 02/07/12 incident report shows in December 2011, R15 sustained a left ankle stress fracture and utilized a brace to the left lower extremity during ambulation activities up until 02/02/12.	F 323		

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F 323	Continued From page 6 R15's 02/02/12 Orthopedic report documents the left ankle fracture was healing well and the left lower extremity brace could be discontinued. R15's medical record include diagnosis of Insulin Dependent Diabetes, Vertigo, Hypertension and Dementia. R15's 12/27/11 and 3/02/12 care plan include decreased bilateral lower extremity muscle strength, un-steady gait, decreased balance. High risk for falls. R15's 12/19/11 fall assessment scored 19 (High Risk). R15 has intermittent confusion, chair bound, poor vision, gait problems while standing and walking. Decreased muscular coordination, un-stable / jerking movements when making turns while ambulating. R15's 02/08/12 Minimum Data Set Assessment (MDS), includes: severe impaired cognition, low energy, feeling tired, requires extensive assistance with transfer and ambulation activities. Is totally dependent on staff with toileting and dressing activities. Decreased range of motion (ROM), to bilateral upper extremities. 2) On 02/08/12 at 9:15AM, R14's knees buckled while being ambulated into the activity room by E9 (activity aide). R14 fell to the floor. This incident report includes: R14 drags her left foot and stumbles when ambulating, has left lower extremity weakness and requires reminders to pick up foot when walking. Intervention listed post fall include only nursing staff will assist R4 with ambulation for safety and use wheel chair to go to activities.	F 323		

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F 323	Continued From page 7 3) On 3/19/12 at 9:05PM, while E6 (CNA), was assisting R14 ambulating out of the bathroom, R14's legs became twisted and causing the resident to fall to the floor. R14 complained of pain in the buttocks after this fall. The incident report post fall intervention documented included staff was inserviced to monitor residents feet when ambulating and if problems noted, use a wheel chair. E6's inservice records included no transfer / ambulation training program prior to 3/19/12. R14's medical record included: - 12/21/11 Minimum Data Set Assessment (MDS). This MDS documented R14 with moderate impaired cognition, requiring extensive assistance with ambulation, toilet and transfer activity. - R14's 12/26/12 restorative care plan documents presence of decreased balance and endurance. - R14's 12/27/12 fall care plan document High Risk for recurrent falls. R14 has history of numerous falls, including hip fracture injury and peripheral neuropathy in bilateral feet. R14 has diagnosis to include Parkinson Disease. R14's fall care plan also included an additional fall incident, dated 6/03/12. While attempting to stand up from a chair, R14 lost her balance and fell to the floor - R14's 12/19/11 and 02/09/12 fall assessments that document score of 16 - 17 (High risk if greater than 10). R14's fall assessments include disoriented, decreased balance while standing and walking, decreased muscular coordination and decreased gait pattern.	F 323		

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F 323	Continued From page 8 4) On 6/23/12 at 6:25AM, R12 fell to the floor while ambulating from the living room to the bathroom. R12's 6/23/12 incident report and nurses notes document that E4 (CNA), was with R12 at the time of this fall incident. E4 did not use a gait belt on R12 and was walking ahead of R12 instead of next to her. E4 turned around and observed R12 trip over her own feet and fall to the floor on the right side. R12 sustained a 2cm x 1.5cm abrasion to right elbow. R12's 4/30/12 fall assessment and 02/07/12 fall care plan include "High Risk" for falls. Care plan documents tends to lose her balance when ambulating. Requires gait belt, walker and assistance with ambulation. R12's 5/02/12 MDS document: decreased cognition, requires extensive assist with transfers, ambulation, dressing, toileting and hygiene. Unsteady balance with moving from seat to stand, walking, turning, moving on and off toilet and when moving surface to surface. E4 was given a written counseling for failing to apply gait belt on resident and failing to safely walk with resident, instead of in front of R12 on 6/23/12. 5) On 4/13/12 at 6:20PM, while transferring with E5 (CNA), from wheel chair to toilet, R13 stated "I can't" and went down to the floor. R13 said that her feet got caught on the over toilet commode. E5 said that R13's knees gave out. R13's medical record includes presence of chronic knee pain.	F 323		

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F 323	Continued From page 9 R13's 3/21/12 MDS and 3/14/12 care plan include: requires extensive assistance with transfer and toileting activities and is totally dependent with ambulation activities. R13's 3/14/12 fall assessment and care plan document decreased standing and walking balance and gait problems. Only able to ambulate short distances due to pain in bilateral knees, decreased endurance and knees give out. R13's 3/28/12 rehab care plan document presence of lots of pain in bilateral knees with decreased ability to stand and ambulate. Received steroid injection in left knee in March 2012. R13's 6/19/12 care plan up-date includes : decreased endurance, pain in left leg, history of pain in knees. Needs extensive assist of 2 people with gait belt and wheeled walker for safe ambulation. This care plan also documents "Be aware", when resident becomes fatigued, sometimes her knees give out without warning. 6) On 02/14/12 at 9:40PM, R16 was exhibiting restlessness and attempting to get up from wheel chair without assistance. When questioned by staff where she was going or if she needed something, R16 was un-able to answer. R16 was seated at the nurses station with E8 (nurse), present. R16 stood up from her un-locked wheel chair, the chair rolled backward and R16 fell to the floor. R16's incident report included the resident had been toileted last 2 hours and 25 minutes prior to the fall (7:15PM), at which time she voided.	F 323		

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F 323	Continued From page 10 R16 was taking diuretics and anti-hypertensives, had a recent medical condition change with un-steady gait and back pain. R16 has diagnosis of dementia with psychosis and anxiety. R16's 12/07/12 MDS document: moderate impaired cognition and frequently incontinent of bladder. R16's 02/13/12 fall assessment scored resident as high risk 20 (greater than 10 high risk). 7) On 5/14/12 at 6:445PM, while ambulating in hallway with E4 (CNA), R10 lost her strength and fell to the floor onto her knees. R10 sustained 1.5cm x .4cm abrasion to left knee. R10's 5/14/12 nurses notes and incident report include presence of an upper respiratory infection and receiving anti-biotics. Incident report vital signs documented include temperature of 103.1 degrees Fahrenheit, pulse 124, blood pressure 176/96. This incident report failed to include any follow-up interventions. E4's inservice records reviewed. E4 had no documented transfer / ambulation training. During 7/19/12 10:30AM individual interview in facility conference room, E3 (assistance director of nurse / restorative nurse), said that as of 2012, E3 initiated return demonstration for transfer / ambulation skills being done on all nursing staff when their annual reviews are due.	F 323		

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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 and interview the facility failed to provide adequate lighting in the walk-in refrigerator and adequate sanitizing solution in the three compartment sink. Findings include: On 7/18/12 three compartment sink sanitizing solution was tested. The quaternary ammonia test strip did not turn color indicating not enough sanitizing solution was being used. R10 stated, "The automatic dispenser is broken. We are adding the solution by hand." R10 added more sanitizer. The strip turned the appropriate shade of green indicating the equivalent to 50 parts per million of chlorine was reached. The walk in refrigerator's light is not located to allow the light to shine into the refrigerator. The light is above the door. The storage space in the refrigerator turns left when entering through the door. The shelving keeps the light from shining	F 371		

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F 371	Continued From page 12 to the left. to illuminate what food is on the shelves at the end of the walk-in. The labels on the boxes and dates could not be read. E1 said "We changed the 60 watt bulb to the maximum 75 watts bulb that the fixture allows." Because of the lights location the illumination was still blocked from shining on the shelves at the end of the refrigerator.	F 371		
F 441 SS=D	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 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	F 441		

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F 441	Continued From page 13 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 observation, record review and interview the facility failed to provide 160 degree F.for washing isolation linen for one of one resident (R2) on contact isolation. Findings include: On 7/20/12 hot water temperatures were taken in the laundry. Hot water was 110 degrees F. Thermometer used to test the water was calibrated the day of the survey. E2 stated, "We have one resident (R2) on contact isolation." E14 stated, "Isolation linen is washed separately from the other linen." R2's laboratory report for 7/19/12 indicates R2 has ESBL (Extended Spectrum Beta Lactamase) The facility's policy and procedure for isolation linen calls for 160 degree F. water to be used..	F 441		