PRINTED: 02/17/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145987	A. BUILDING ______ B. WING ______	01/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER CROSSING REHAB	**1145 FRANK STREET GALESBURG, IL 61401**

(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 and Licensure Certification Validation Survey for Subpart S	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to provide quarterly assessments for the continued use of physical restraints without medical justification for one of one residents (R15) on a sample of 15 residents. Findings Include: Facility Policy for Resident Restraints reviewed: 3/18/13 documents"Convenience is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest. Facility Policy for Resident Restraints reviewed 3/18/13 documents, "Procedure: #2. The use of restraints will be reviewed by the Interdisciplinary Team periodically and at least Quarterly thereafter. Restraint use data will be provided to the physician for review and prior to ordering/re-ordering restraint use." Facility Policy for Residents Restraints reviewed	F 221		

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 221	Continued From page 1 3/18/13 documents, "Procedure: #9. Physician orders for restraints shall be complete and specifically define the Type, Reason, Duration, and Justification of use." 1. R15 has diagnoses including Chronic Airway Obstruction and Mild Mental Retardation found on the Team Care hospice plan as of 1/15/15 which indicates "up as tolerated with activities permitted-walker" Physician telephone orders for 5/11/14 documents "Trial times three days for Reclining wheelchair with table as needed for positioning. Release every two hours when in use for Diagnosis of Dementia with Psychosis." and a following order on 5/13/14 documented, "OK for Reclining chair with table as needed for positioning Release every two hours when in use for Diagnosis of Dementia with Psychosis." There was no medical justification for the restraint documented on the physicians order. On 5/13/14 R15's record included a "Physical Restraint Informed Consent" for a "chair table" restraint with the reason for the restraint documented as "Repeated Falls, Slipped out of chair" with only a "verbal consent obtained" from the Power of Attorney by E16, Licensed Practical Nurse. On 1/15/15 at 10:00 am, R15's "Interdisciplinary Physical Restraint Assessment" was reviewed with Administrator, E1 and Director of Nurses, E2. Both stated that R15's last quarterly assessment documented was on 8/7/14. Instructions on the form documented, "Restrained residents should be assessed by the Interdisciplinary Team on	F 221		

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admission and at least quarterly to determine whether or not a resident is appropriate for restraint reduction, less restrictive restraint measures, or total restraint elimination. Each question should be discussed and completed by the Interdisciplinary Team." This form identified the medical reason for use of the restraint as "Repeated falls, slid out of chair, leans forward in wheelchair."

During the initial tour on 1/12/15 at 6:00 am through 6:15 am, R15 was sitting at a dining room table in a reclining wheelchair with a laptray in place. R15 was yelling out and cursing outloud with no one in attendance of R15.

On 1/14/15 at 3:20 pm, R15 was sitting at the dining room table with a laptray on a reclining wheelchair as previously noted. R15 was quietly sitting. E3, Assistant Director of Nursing, stated during this observation that "resident does not need the laptray on if no behaviors." E3, ADON, stated "remove restraints from R15 when no behaviors without deleterious effect on resident while at dining room table."

F 226 SS=C — 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES — F 226

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility

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F 226	Continued From page 3 failed to operationalize their Abuse Prevention Policy for screening new employees by failing to complete a Illinois Health Care Worker Registry check prior to hiring potential employees. This failure has the potential to affect all 73 residents living at the facility. Findings include: The Resident Census and Conditions of Residents Centers for Medicare and Medicaid Services (CMS) form dated 1/12/15 documents that 73 residents currently reside at the facility. The facility's "Abuse Prevention Program, Facility Procedures" (December 2013) documents "Prior to a new employee starting a work schedule, this facility will...Check the Illinois Health Care Worker Registry on any individual being hired..." On 1/13/15 at 11:00am, E1, Administrator, provided E17's, Licensed Practical Nurse (LPN), personnel file. E17's personnel file did not contain evidence that the Illinois Health Care Worker Registry was checked prior to hiring E17. On 1/13/15 at 11:08am, E1 stated "It (E17's Illinois Health Care Worker Registry check) was overlooked." On 1/12/15 E1 provided a list of new employees hired within the last four months which documents E17's date of hire as 12/23/14. The Nursing Schedule for 12/11/14-1/1/15 documents that E17 began working on 12/26/14. The Nursing Schedules dated 12/11/14-1/1/15 and 1/1/15-1/21/15 document that E17 works in all resident areas of the facility. On 1/15/15 at 3:00pm, E1, Administrator, stated that E17 works in all resident areas of the facility and has access to all residents.	F 226		
F 246	483.15(e)(1) REASONABLE ACCOMMODATION	F 246		

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F 246 SS=D	Continued From page 4 OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to make sure call lights were in reach for one of 15 residents (R27) reviewed for resident care in a sample of 15. Findings include: On 1/12/15 at 9:30AM, R27's soft touch call light (a specialized sensor for individuals who have difficulty using a regular call light due to mobility issues) was behind (R27) head hanging over the headboard and not in (R27) reach. On 1/13/15 at 11:35AM, R27's soft touch call light was on (R27) left side between (R27) bed and siderail touching the floor and not in (R27) reach. R27's care plan dated 11/12/14, states to place R27's call light within accessible reach, and R27 is dependent upon staff.	F 246		
F 271 SS=D	483.20(a) ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE At the time each resident is admitted, the facility must have physician orders for the resident's	F 271		

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F 271	Continued From page 5 immediate care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to obtain complete admission orders for one of one residents (R14) reviewed for admission orders in a sample of 15. Findings include: R14's hospital transfer sheet from 1/5/15 does not include R14's orders for diet of NPO (nothing by mouth), artificial tube feeding times, urinary catheter cares, colostomy care, skin checks, respiratory treatment orders including ventilator settings and tracheostomy care and current treatment orders for R14's right side of neck, right lateral ankle, sacral wound, right lateral thigh, and barrier cream. On 1/14/15 at 10:50AM, E2 DON (Director of Nursing) confirmed that as of that date and time, R14 ' s medical contained no orders for a diet, gastric tube feedings, catheter care, colostomy care, ventilator settings, or tracheostomy care. E2 stated that (E2) would expect all orders to be completed at the time the resident was admitted to the facility.	F 271		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough	F 322		

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F 322	Continued From page 6 alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on interview, record review and observation, the facility failed to check gastric tube placement before medication administration for two residents reviewed for feeding tubes (R17 and R27) in the supplemental sample. Findings include: On 1/13/15, at 11:45 am, E5 (Licensed Practical Nurse/LPN) administered 10 milliliters of Metoclopramide to R17 through R17's gastric tube. After the medication was administered, E5 checked placement of the gastric tube. On 1/13/15, at 12:00 pm, E5 (LPN) administered 20 milliliters of Valproic Acid to R27 through R27's gastric tube. After the medication was administered, E5 checked placement of the gastric tube.	F 322		

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F 322	Continued From page 7 Tube Feeding-Infusion Pump Method (Closed Container Method) Policy, dated 3/8/13, documents that tube placement should be confirmed before medication administration. On 1/14/15, E2 (Director of Nursing) stated that staff would be expected to check placement before medication administration.	F 322		
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 follow the manufacturer's operation instructions for use of a mechanical lift for two of five residents (R6 and R14) reviewed for transfer with mechanical lift in a sample of 15. Findings include: 1. On 1/13/15 at 1:15 PM, E18/CNA (Certified Nursing Assistant) did not lock the wheels on the mechanical lift while lifting R6 out of (R6)'s wheelchair and lowering (R6) to the bed. On 1/13/15 at 1:20 PM, E18/CNA (Certified	F 323		

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F 323	Continued From page 8 Nursing Assistant) verified she did not lock the wheels on the mechanical lift. 2. On 1/14/15 at 10:30AM, E19 CNA and E20 CNA finished using the mechanical lift on R14 and did not lock the wheels and open the mechanical lifts legs before lifting R14 from R14's bed and lock the wheels on the mechanical lift before lowering R14 into R14's recliner chair. On 1/14/15 at 4:00 PM, Z3/Customer Service representative from the mechanical lift manufacturer verified the wheels should be locked on the mechanical lift at the lift point. Facility document titled, "Owner's Installation and Operating Instructions" for the mechanical lift state, "When using an adjustable base lift, the legs must be in the maximum opened/locked position before lifting the patient."	F 323		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to administer seizure medications as ordered for 34 days for one (R22) of 15 residents reviewed for medication orders in a sample of 15. Findings include: Psychiatric Evaluation for R22, dated 11-20-14, documents that R22 has a "hx (history) of a	F 333		

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F 333	Continued From page 9 seizure disorder." The hospital Medication List, dated 12-11-14, documents that R22 should be administered divalproex sodium 750 milligram Enteric Coated by mouth at bedtime. R22's POS (Physician's Order Sheets) for New Admission, dated 12/12/14, and POS for January 2015 do not include any orders for divalproex sodium. Medication Administration Record (MAR) dated 12/12/14 through 12/31/14 does not document any doses of divalproex sodium being administered to R22. The MAR for January 2015 also does not include any documentation that divalproex sodium was ever administered to R22. On 1/14/15, at 9:50 am, E2/DON (Director of Nursing) confirmed that R22 had not received any divalproex sodium since being admitted on 12-12-14. On 1/15/14, at 8:50 am, Z1 (R22's Physician) stated that the facility would be expected to follow through on admission orders from the hospital, especially the divalproex sodium that was prescribed for seizures.	F 333		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		

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immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:

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(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to administer required vaccines for four of fifteen residents (R1, R6, R14 and R25) reviewed for influenza and pneumococcal immunizations in a sample of 15 and four residents (R15, R19, R27 and R42) in the supplemental sample.

Findings include:

1. Signed influenza/pneumonia consent for R1, dated 12-15-14, documents R1's wish to receive the vaccines. As of 1/13/15, there was no documentation in R1's record that they had been administered.

2. Signed influenza/pneumonia consent for R6, dated 12-24-14, documents R6's wish to receive the vaccines. As of 1/13/15, there was no

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F 334	Continued From page 12 documentation in R6's record that they had been administered. On 1/13/15 R6's Influenza vaccine record documented that the last administration of the vaccine was on 10/23/12. 3. Signed influenza/pneumonia consent for R14, dated 12-20-14, documents R14's Power of Attorney chose for R14 to receive the vaccine. As of 1/13/15, there was no documentation in R14's record that they had been administered. On 1/13/15 R14's Influenza vaccine record documented that the last administration of the vaccine was on 10/24/12. 4. On 1/14/15 at 9:50 am, E2, Director of Nurses stated, " I sent out the flu and pneumonia consents for (R15) but have not heard from the Power of Attorney, I will need to contact them again." E2 confirmed at that time that R15 had not received the flu vaccine since 2013. 5. Signed influenza/pneumonia consent for R19, dated 12-15-14, documents R19's wish to receive the vaccines. As of 1/13/15, there was no documentation in R19's record that they had been administered. 6. 01/15/2015 R25's chart does not contain any consents for influenza/pneumococcal vaccinations. R25's chart review does not contain information that the vaccinations were administered. 7. R27's Influenza vaccine record had a date of 1/8/12 and Pneumo-vaccine record had a date of 5/21/10. No documentation found for 2014	F 334		

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F 334	Continued From page 13 consents or follow up. 8. R42's Influenza vaccine record had a date of 10/23/12 and Pneumo-vaccine record had a date of 8/21/11. No documentation found for 2014 consents or follow up. 1/15/2015, at 3:30 p.m., E3 (Assistant Director of Nursing) stated that consents nor proof that the influenza/pneumococcal vaccinations were administered, could not be found for R15, R25, R27, or R42. On 1/13/15 at 8:50 am, E2, Director of Nurses, stated, "The vaccines are not here from the pharmacy. A phone call was made to the pharmacy and 19 doses of pneumonia vaccine are to arrive on the evening of 1/13/15. The person before me did not order vaccines so I am trying to get caught up." E2 confirmed at that time that R1, R6, R14 and R19 had not yet received the influenza or pneumonia vaccines. On 1/13/15 at 12:25PM, E2 DON (Director of Nursing) stated (E2) needed to follow up with the residents families who did not have consents returned.	F 334		
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:	F 356		

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- 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, interview, and record review, the facility failed to include the facility name on the staffing posting form and failed to post it on weekends and holidays.
This failure has the potential to affect all 73 residents in the facility.

Findings include:

On 1/12/15 at 7:30AM the staffing posting, dated 1/12/15, did not have the facility name on the posting paper.

Staffing records from October 2014 through

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F 356	Continued From page 15 January 2015 did not include the facility name on the postings and the postings were missing for the following dates: 1/10/15 and 1/11/15, 1/3/15 and 1/4/15, 12/30/14, 12/27/14 and 12/28/14, 12/25/14, 12/6/14 and 12/7/14, 12/2/14, 11/27 through 11/30/14, 11/21/14 through 11/23/14, 11/15/14 through 11/17/14, 11/8/14 and 11/9/14, 11/1/14 and 11/2/14, 10/25/14 and 10/26/14, 10/18/14 and 10/19/14, 10/11/14 and 10/12/14, and 10/4/14 and 10/5/14. On 1/15/15 at 12:10PM, E2 DON (Director of Nursing) confirmed that the positing form does not include the name of the facility and stated that the staffing was not posted on holidays or weekends. Resident Census and Conditions Report, dated 1/12/15, states there are 73 residents in the facility.	F 356		
F 371 SS=E	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, record review, and interview, the facility failed to ensure the	F 371		

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dishwasher rinse reached the required temperature for sanitation. This failure has the potential to affect 9 residents who receive meal trays (R1, R6, R12, R13, R15, and R20-R23) in a sample of 15 and 47 residents (R3-R5, R7-R9, R11, R19, R27-R29, R30-R46, and R48-R77) in a supplemental.

F 371

Findings include:

On 1/13/15 at 12:45 p.m., E11 (Dietary Manager) reported the facility dishwashing machine is a high temperature dishwasher. E11 then ran the dishwasher through one cycle before placing a heat sensor test strip on a dish and running it through the dishwashing cycle. The outside gauge on the dishwasher indicated the water temperature for the rinse cycle reached only 160 degrees (Fahrenheit). E11 stated the dishwasher must be ran through a cycle, two to three times, before it will reach 180 degree rinse temperature. The test strip, which E11 stated is designed to turn black when the stated temperature (160 degrees Fahrenheit) is reach, was black only around the edges. E11 repeated the wash cycles monitoring the outside temperature gauge four more times with the following temperature results: 174 degrees, 172 degrees, 174 degrees, and 176 degrees. E11 then placed another heat sensor test strip on a dish and ran it through the dishwasher once again. The second test strip turned black but a small section in the center of the strip remained white. The outside temperature gauge indicated the rinse temperature reached 176 degrees. E11 stated, E11 would have to call (the dishwasher manufacturer) and report the problem.

An undated policy titled Equipment and Utensil

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F 371	Continued From page 17 Cleanliness and Sanitation states, "If high temperature model, the temperature will be maintained as follows: Final rinse 180 - 195 degrees (Fahrenheit)." The manufacturer manual for the dishwashing machine states, "Verify that the rinse temperature is between 180 (degrees Fahrenheit) and 195 (degrees Fahrenheit) for the entire rinse sequence."	F 371		
F 441 SS=E	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 hands after each direct resident contact for which	F 441		

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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:
Facility failures resulted in two deficient practices:

A. Based on observation, interview and record review, the facility failed to perform hygiene as required by facility policy for two of 15 residents (R6 and R14) reviewed for infection control practices in a sample of 15 and five residents (R8, R17, R27, R28, and R29) in the supplemental sample.

Findings include:

1. On 1/14/15 at 10:00AM, E5 LPN (Licensed Practical Nurse) finished performing pressure ulcer treatment on R14, who (according to lab result collected 12/24/14) is in isolation for Proteus mirabilis, Enterococcus faecalis (Group D), and Staphylococcus aureus of the urine, failed to wash (E5) hands between glove changes, and grabbed (E5) scissors (with gloved hands after touching R14) from (E5) pants pocket, cut R14's dressing, and put (E5) scissors into (E5) pocket before wiping down with bleach wipes. E5 LPN finished R14's pressure ulcer treatment and took the supplies (wound cleanser bottle, medihoney bottle, gauze in a plastic bag,

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and calcium alginate) used to perform the treatment out of R14's room and put away in the C-Hall treatment cart before wiping down with bleach wipes. E19 CNA (Certified Nurses Aide) grabbed barrier cream (with gloved hands after touching R14's right buttock) from (E19) pants pocket and handed to E5 LPN.

On 1/14/15 at 10:30AM, E19 CNA and E20 CNA finished performing daily cares on R14, who (according to lab result collected 12/24/14) is in isolation for Proteus mirabilis, Enterococcus faecalis (Group D), and Staphylococcus aureus of the urine, failed to keep R14's urine catheter bag from touching the floor, and failed to wash hands between glove changes. E19 CNA grabbed a roll of garbage bags (with gloved hands after touching R14's bed linens) from (E19) pants pocket. E20 CNA touched R14's recliner chair and curtain without gloved hands, and touched (E20) left side of (E20) face before washing (E20) hands.

On 1/14/15 at 10:30 AM, E20 CNA stated it is their policy to wipe down supplies and equipment with bleach wipes if the resident is in an isolation room.

2. On 1/13/15, at 11:45 am, E5 (LPN) entered R17's room to administer Metoclopramide through a gastric tube and did not perform hand washing upon entering the room and before donning gloves prior to medication administration.

Immediately after leaving R17's room, on 1/13/15, at 12:00 pm, E5 (LPN) entered R27's room to administer Valproic Acid through R27's gastric tube. E5 did not perform handwashing upon entering the room, before donning gloves prior to

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medication administration.

3. On 1/12/15, at 11:30 am, E5 (Licensed Practical Nurse/LPN) did not wash or sanitize hands before or after administration of medications to R8, R28 and R29.

4. On 1/13/15 at 1:15 PM, E18/CNA (Certified Nursing Assistant) provided pericare for R6. Upon completing pericare for R6, E18/CNA removed her right glove. Leaving (E18/CNA)'s soiled left glove on and without washing (E18)'s hands, E8/CNA placed a protective boot on R6's left foot.

Hand Washing Policy dated 1/1/14 documents that staff practice handwashing with an anti-microbial agent or water-less antiseptic agent before and after resident contact and immediately after glove removal.

On 1/14/15, E2 (Director of Nursing/DON) stated that staff is expected to wash hands before and after entering/exiting resident rooms and during resident medication pass.

B. Based on observation, interview and record review, the facility failed to replace equipment used for irrigation of gastric tubes or indwelling urinary catheters as required by policy for three of eight residents (R14, R16 and R24) requiring irrigation of a gastric tube or indwelling catheter in a sample of 15 and one resident (R27) on the supplemental sample.

Findings include:

1. On 1/12/15 at 9:30 AM, R14's irrigation bottle titled "foley" had a date of 1/8/15 and R14's

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F 441	Continued From page 21 irrigation bottle titled "G-tube" had a date of 1/10; 2. R16's irrigation bottle titled "G-tube" had a date of 1/8/15 3. R24's irrigation bottle titled "G-tube" had a date of 1/8/15 4. R27's irrigation bottle titled "G-tube" had a date of 1/8/15 and R27 had two irrigation bottles titled "foley" with the dates of 12/25/14 and 1/8/15. On 1/14/15 at 10:50AM, E2 DON (Director of Nursing) stated the irrigation bottles are changed weekly and the syringes are changed nightly and as needed. Facility Policy titled "Tube Feeding-Infusion Pump Method (Closed Container System), dated 3/18/13, states, "18. Feeding tube syringes and irrigation containers are to be changed every 24 hours."	F 441		
F 456 SS=C	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain equipment in residents rooms, men's community shower/bathroom, laundry department, front entrance/dining room, and outside the facility. This has the potential to affect	F 456		

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F 456	Continued From page 22 all 73 residents in the facility. On 1/12/15 at 9:15AM, the front entrance/dining room had a large amount of dirt from the front door through the dining room to the nurses desk. On 1/14/15 at 1:30PM, observation of room D8 had upper and lower personal lights out, room A8 had the upper personal light out; the designated smoking door was missing the bar handle to open the door; room C-10's dresser was missing the front of the fourth drawer, and drawer 1,2, and 3's handles were falling off; C-hall had a 6"x 6"x 2" block of wood on the floor outside of the shower room, and another 6" x 6" x 2" block of wood on the floor outside of the therapy department; the laundry department had various spots of spackling on the walls, and pieces of the ceiling hanging down above the two washers; outside the back of the facility there were portable garbage cans, commodes, and recliner chairs sitting outside with visible snow piled up on the equipment. On 1/14/15 at 2:30PM, the men's community shower/bathroom had the hot and cold handles taken off the third sink, mirror missing from the wall above the third sink, light out above the three toilets, one of the three toilets had a bag over it stating "broken", and the shower had over 3/4 of the floor tiles broken. On 1/14/15 at 3:30PM, E23 Maintenance Supervisor stated the men's bathroom was going to be updated sometime and the wall needed to be replaced to fix the toilet but nothing was on order at this time; the smoking door has been broken a few times and nothing was on order to fix the door at this time; the laundry room is	F 456		

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hopefully going to get repaired; housekeeping mops the floors; "I will get the lights fixed in D8 and A8; I have not been able to fix broken resident equipment because I have been busy with the remodel; C-hall remodel is not completed yet that is why the blocks of wood are off the wall; and I have nowhere to put extra equipment or supplies because all the buildings are full."

Resident Census and Conditions Form dated 1/12/15 states their are 73 residents in the facility.

F 458 SS=B 483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT F 458

Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, the facility failed to provide atleast 80 square feet, per bed, in nine multi-bed rooms of 47 rooms. This failure had the potential to affect one resident (R7) on a sample of fifteen and eleven residents (R23, R29, R31, R35, R36, R40, R41, R51, R52, R53, R77) on the supplemental sample who live in those rooms.

Findings include:

On 01/12/2015, E1 (Administrator) provided a letter that the facility received, from a state agency, dated April 10, 2014, that rooms A1, A4, A8, B1, B3, B5, B7, D5, and D10 were waivered for not providing at least 80 square feet per bed.

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F 458	Continued From page 24 The facilities resident census sheet, dated 01/10/2015, indicates rooms A1, A4, A8, B1, B3, B5, and B7 have two beds each; and rooms D5 and D10 each have four beds. The resident census, for these rooms, are: A1, A8, B1, and B7, have two residents in each room; A4 and B5 have no residents; B3 has one resident; D5 has four residents; and D10 has two residents. Residents R7, R23, R29, R31, R35, R36, R40, R41, R51, R52, R53, and R77, are listed as occupants in these undersized rooms. During the initial tour, of the facility, on 01/12/2015, at 6:00 a.m., no concerns with safety [or over-crowding] were noted with the rooms. No complaints were made, during group [or individual] interviews, regarding room sizes.	F 458		