STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145334	A. BUILDING _____ B. WING _____	08/14/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BALLARD NURSING CENTER	**9300 BALLARD ROAD DES PLAINES, IL 60016**

(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 Certification Survey. No extended survey was conducted.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services,	F 156		

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 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These	F 156		

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F 156	Continued From page 2 requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observations on 3 of 3 resident floors and the facility basement the facility failed to post the medicare and medicaid information. Findings Include: On 3 of 4 days of the survey the medicare and medicaid information was not observed posted on any of the resident floors or in the facility basement. Interview with E2 (Assistant Administrator) on 8/14/09 stated the medicare and medicaid information was not posted prior to surveyor prompting.	F 156		

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F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation during the environmental tour the facility failed to have survey results accessible without having to ask to view this information. Findings Include: During the environmental tour surveyor was told signs were removed stating the survey results were available at the reception desk. When surveyor went to the reception desk the binder was kept behind the desk. To view the survey results you had to ask the receptionist to retrieve the binder from behind the receptionist desk.	F 167		
F 309 SS=D	483.25 QUALITY OF CARE 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.	F 309		

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F 309	Continued From page 4 This REQUIREMENT is not met as evidenced by: A) Based on observation, record review and interview, the facility failed to reassess the pain and relieve the pain within a reasonable time-frame for 2 (R15, R16) of 24 sampled residents within the sample. This failure to reassess and relieve the pain caused R15 to be in severe pain for 20.5 hours. This failure has the potential to affect 68 residents that are on pain management per the federal form 672. The finding include: 1) On 8/11/09 at 11:42 a.m. during the initial tour with E2 (Assistant Administrator), R15 stated that she was having severe pain in her knee. R15 was asked to rate her pain between zero to 10, 10 being the worst pain and R15 responded that it was a "8". R15 stated that she has been in pain all night. R15 stated that she received Tylenol 45 minutes ago and it was not working. R15 stated the Tylenol never works for her. Review of the pain assessment dated 8/1/09 documents that R15 has nauseating pain after she eats. At that point in time, R15 was still on the Fentyl patch for pain. The fentanyl patch was discontinued on 8/2/09 per physician's order. The pain assessment dated 8/11/09 documents at 12:30 a.m. that R15 was having terrible pain in the knee. R15 rated it at "5". The scale is zero to 5, 5 being the worst pain. R15 is re-assessed one hour later and she has no relief from the pain. The documentation documents that cold compress was put on the knee and legs elevated but has no relief. The pain assessment dated 8/11/09 at 10 a.m., documents left knee pain at a	F 309		

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F 309	Continued From page 5 "3" and is given 2 tablets of 325 mg (milligrams) of Tylenol and the Lidocaine patch is repositioned. One hour later, the pain is still there with minimal relief. On 8/13/09 at 2:30 p.m., E6 (nurse) stated that the Tylenol was given at 10 a.m. along with the lidocaine patch. E6 stated she was delayed in applying the patch by one hour. Per the physician order, the lidocaine patch should have been applied at 9 a.m. E6 stated she was informed that R15 was still in pain and the Tylenol was not working so the physician was notified and she received an order for Ultram 50 mg. Review of the nurses' notes dated 8/11/09 at 1 p.m. documents that the physician was contacted for a stronger pain medication. The nurses' notes and the Medication Administration Review (MAR) dated 8/11/09 at 9 p.m. documents R15 received the Ultram. The MAR documents the result of receiving the Ultram was good. This was 20.5 hours from when the resident stated she was in pain and the pain was relieved. On 8/14/09 at 11 a.m., E6 stated that the Ultram was not delivered from pharmacy until 9 p.m. R15 is 70 year old female who was admitted on 7/18/09 and re-admitted on 8/1/09 with a diagnosis that includes Chest pain and Atrial Fibrillation per the physician order sheet (POS). On the 7/18/09 admission, R15 had recent surgery on her left thigh and was admitted with a non-healing surgical wound. The nurses' note date 8/12/09 and the current minimum data set (MDS) dated 7/22/09 documents no cognition loss and she is orient times three. The August '09 POS documents that	F 309		

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F 309	Continued From page 6 R15 is to receive the Lidocaine patch (on at 9 a.m. and off at 9p.m.) and Tylenol as needed for pain. R15 also takes a low dose aspirin (81 mg) for her Atrial Fibrillation. There was no other pain medications ordered on the August '09 P.O.S. prior to surveyor's intervention. Review of the facility's pain policy does not reflect the same information as the pain assessment form. The policy reflects the pain scale from 1 to 10 and the assessment form has a pain scale of zero to 5. When the pain assessment was taken to the floor, the floor nurses claimed that the pain policy is old, not current. The pain policy does document when a patient is assessed for pain, the assessment will include type of pain, location of pain, duration of pain, frequency of pain, current relief factors, rate of pain (based on 1 - 10 scale), and the psychological and/or behavioral manifestation of pain. 2) On 8/13/09 at 2 pm. and again on 8/14/09 at 11 a.m., R16 was observed in her room, in the bed, crying out and moaning which could be heard down the hall from the nurses' station. R16 was observed to have her wrist and fingers curled up and retracted. There were no splints or devices in place to prevent further contractures. R16 is a 48 year old female, who suffered a traumatic brain injury and is in a vegetative state and can not communicate. She is total care and dependent on staff for all her needs. The current MDS concurs with observation. R16 has been in the facility since 3/20/07 and re-admitted on 3/26/09. Review of the clinical chart on 8/13/09 showed no current pain assessment. On 8/14/09 at 1pm. ,	F 309		

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F 309	Continued From page 7 E8 (MDS coordinator) stated that the last pain assessment was done on 6/26/09 and was found in the thinned record. E8 stated that there is no current pain assessment and she noticed that the Norco schedule was increased from twice a day to three times a day on 8/13/09 . E8 stated that she was currently doing the assessment and dated it 8/14/09. The pain assessments documents that R16 will cry out, moan out loud and retract where there is pain. On 8/14/09 at 11a.m., surveyor asked why R16 was crying out and E6 stated maybe it is from being wet and sometimes she does not know why she is moaning. E6 stated she gave R16 a Norco, 1 tablet (5/325 mg) at 6 a.m. and the next dosage is at 2 p.m., E6 stated that the pain medication was just increased from twice a day to three times a day. Review of the POS documents that the Norco frequency was increased on 8/13/09 (at 5:30 p.m. which was confirmed by E6). On 8/14/09 at 11:02 a.m., E9 (certified nurse aide) stated that she changed and cleaned R16 one hour ago and does not know why she is crying out. E9 stated that sometimes she cries out and doesn't know why. On the morning of the 8/14/09, R16 was fitted for bilateral hand/wrist/finger splints by the therapist. The splints were off at 11 a.m. on 8/14/09 and the morning of 8/11/09 during the initial tour. On 8/14/09 at 1 p.m., E10 (Director of Rehabilitation) confirmed that the splints were put on, taken off and put on again in-order to take the picture R16's hands with the splints. The facility staff failed to recognize or anticipate the potential for pain to R16.	F 309		

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F 309	Continued From page 8 Review of R16's current care plan documents pain as a problem and the approaches are generic. The approaches do not use the same information from the pain assessment. R16 can not communicate and staff need to anticipate R16's need for pain medication. Based on observation, interview and record review the facility failed to properly position 1 (R7) of 24 sampled residents resulting in development of hemorraghic blister in the sole of the left foot. Findings include: Review of R7 M.D.S (medical data sheet) dated 6/8/09 indicates R7 is unable to transfer, ambulate or perform activities of daily living. R7 is totally dependent for all care. On 8/12/09 at 9:15 am during observation of wound care, R7 noted to have bluish, purplish discoloration of left foot sole extending under the 3rd and 4th toe. E4 (wound care nurse) stated, "foot was pushing because of pressure. It was blister." On 8/12/09 at 10:30am Z1 (podiatrist for R7) stated with regards to the left foot discoloration, "Left foot had a hemorrhagic blister. Resident put foot end of bed. We ordered bed extension. Probably happened in a few hours." On 8/13/09 at 7:30am E5 (Certified Nurse Aide) stated, "Taken care of (R7) since admission. He hasn't moved his lower body since admission. He doesn't scoot by himself." Record review of nurses notes from 5/7/09 to present does not contain any reference to left foot hemorrhagic blister." Review of wound assessment flow sheet documents "L (left) plantar foot purple on 8/4/09." On 8/13/09 during daily status, incident report for	F 309		

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F 309	Continued From page 9 development of left foot blister was requested. On 8/14/09 E2 (Assistant Administrator) reported no incident report existed for the left foot blister.	F 309		
F 318 SS=D	483.25(e)(2) 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 observations, record review and interview, the facility failed to provide device or documentation to support the rationale for no device in place for 2 (R3, R16) out of 17 residents identified with contractures/range of motion deficits within the sample of 24 residents. This has the potential to affect 5 resident identified with contractures in the facility per the 672 federal form. The findings include: 1) During the initial tour on 8/11/09 between 10 a.m to 11:55 a.m. with E3 (Director of Nursing) and E2 (Assistant Administrator), R3 and R16 were noted to have contractures and no device in place. R16 was observed in the bed, in a vegetative state, her bilateral wrists and fingers curled and contracted. There was no device in place. 2) R16 was observed on 8/13/09 at 9:50 a.m. to have bilateral hand/wrist splints on. The fingers on the right hand were curled up in the splint.	F 318		

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F 318	Continued From page 10 On 8/14/09 at 11a.m., R16 was observed in the bed without any splints on. R16's roommate was present and confirmed that the staff were in the room all morning putting and taking off the splints and taking pictures. The pictures presented by the facility showed that R16's fingers can be manipulated to spread out in the splint. E10 concurred. On 8/14/09 at 1p.m., E10 (Director of Rehabilitation) stated that he removed the splints at 11:30 a.m. this morning because he believed that the splints had been on for 4 hours. Surveyor asked him again about the removal of the splints and E10 responded that it was 11 a.m.. and then E10 stated that when he went up to take a picture of the splints they were off. E10 stated that he re-applied the splint to the right hand to take the picture and then removed it. On 8/14/09 at 10 a.m., E2 presented a physician's order dated April '09 that documents an order for bilateral hand splints to be on 8 a.m and off 12 noon. The current physician order sheet showed no order for the splints. The care plan does not document the use of splints. 3) R3 was observed on all days of the survey to have a contracted right hand and the middle finger on the left hand was also noted to be contracted. There was no device in place. Review of the current care plan documents pain as a problem and the that the right hand is contracted. There was nothing in the care plan about use of splints. On 8/13/09, during the daily status meeting at 4 p.m. and again on 81/4/09 at 10 a.m. with	F 318		

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F 318	Continued From page 11 administration, E2 stated that R3 is always removing the splints but failed to present documentation on this behavior nor was it care planned. E2 presented a care plan dated 3/24/09, which was not seen in the chart, that documents to use hand rolls, as ordered. No order was presented or seen.	F 318		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATION 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 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 --	F 334		

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F 334	Continued From page 12 (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: (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 record review and interview the facility failed to provide evidence of flu/pneumonia vaccination and or education for 2(R2, R4) of 5	F 334		

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F 334	Continued From page 13 sampled residents. Findings include: There is no record of Pneumonia vaccination/education for 2008 in R2's chart. This information was requested of E2 (Assistant Administrator) on 8/13/09 during the daily status. R4's medical record does not contain documentation of education related to risks and benifits of flu shot administered in 2008. R3 does not appear on the facility flu/pneumonia tracking record for 2008.	F 334		
F 371 SS=F	483.35(i) SANITARY CONDITIONS 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 observations and interviews, the facility failed to ensure that food was stored and distributed under sanitary conditions. So, all residents in the facility had the potential to be effective by this practice. Findings include: During the initial tour of the kitchen on 8/11/09 at 9:45 AM with the food supervisor, surveyor	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145334	A. BUILDING _____ B. WING _____	08/14/2009

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F 371	Continued From page 14 observed the following: -In the beverage refrigerator, several cups of juice and milk on two trays. But the cups of juice and milk were not labeled with the date they were opened. E7 had accompanied the surveyor on tour. When asked, E7 told surveyor that the trays contained liquids that staff had thicken for resident's on special diets. When asked on 8/14/09, E7 told surveyor that staff mixed the thickener in the juices and milks for approximately 9 residents, who required thicken liquids. -Kitchen staff were in the process of running the dish machine and cleaning dishes used during the breakfast meal. Food debris was observed still on the dishes/plates after coming out of the machine. When surveyor asked the food supervisor why this was occurring, E7 indicated to surveyor the debris was not being effectively removed when the staff scraped the plates. -At the back of the walk-in-freezer, surveyor observed a built up of frost near gallons of ice cream. The top of the freezer was dirty with condensation of frost. On 8/12/09 at 9:30 AM, surveyor returned to the kitchen and observed the following: -The walk-in-freezer continued to have a build up of frost. -one large black bind of ladders, one large black bind of scoops, one large black bind of mixed kitchen utensils (such as roller pins and whisks) were being stored wet. -4 serving pans were observed being stored wet. On 8/12/09 during the noon meal, surveyor observed residents being served their meal on one east. The refrigerator on one east was observed to have unlabeled food, such as a	F 371		

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F 371	Continued From page 15 sandwich. During the Daily Status Meeting with administrative staff on 8/13/09, the survey team expressed concerns that staff were no labeling food in the refrigerator and other concerns in the kitchen. E1, the administrator, responded to concerns. E1 informed the survey team that staff would be inserved. But, E1 did not tell provide any evidence that staff labeled food, not stored dishes wet, or identified a method to clean debris effective from plates.	F 371		