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	145952	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-BEARDSTOWN	8306 ST LUKES DRIVE BEARDSTOWN, IL 62618

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F 000	INITIAL COMMENTS	F 000		
F 280 SS=D	Annual Certification 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to revise care plans addressing weight loss for two residents (R4, R11) reviewed for care plan accuracy in a sample of 15. Findings include: 1. The facility's Care Plan Process policy (dated 8/1/12) documents, "Care Plan Development...	F 280		

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

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F 280	Continued From page 1 Each discipline assigned a section of the (Minimum Data Set) will be responsible for that sections triggered (Care Area Assessments) and associated care planning goal and/or approaches." The facility's Monthly Weight Report (dated 5/18/15) documents the following weights for R4: 11/2014, 157 pounds; 12/2014, 145 pounds; 1/2015, 137 pounds; 2/2015, 140 pounds; 3/2015, 141 pounds; 4/2015, 133 pounds; and 5/2015, 127 pounds. R4's current care plan documents the following: "Nutrition/Hydration. (R4) is at risk for impaired nutritional status (related to) (diagnosis) of dementia, refusal to participate in (activities of daily living) to (R4's) ability, and decreased mobility." R4's current care plan does not document R4's weight loss from 11/2014 to 5/2015 as a documented problem with goals and interventions. On 5/19/15 at 12:00 PM, E1 (Administrator) stated that each department head is assigned certain sections of the care plan and is responsible for adding new changes and interventions to those sections of the resident's care plan. E1 also stated that E4 (Dietary Manager) would be responsible for updating the care plan with any dietary changes or recommendations. 2 .The facilities Monthly Weight Report (dated 5/18/15) documents the following wieghts for R11; 10/7/14, 151.6 pounds; 11/7/14, 142 pounds; 12/8/14 144 pounds, 1/5/15 144 pounds; 2/9/15, 140 pounds; 3/6/15, 134 pounds; 4/8/15 137 pounds; and 5/5/15 138 pounds.	F 280		

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F 280	Continued From page 2 R11's current care plan documents the following "Nutrition/Hydration (R11) is at risk for nutrittional problems (related to) (diagnosis) of Azlheimer's disease." R11's current care plan does not document R11's weight loss from 11/17/14 to 5/5/15 as a documented problem with goals and interventions.. On 5/19/15 at 9:50 AM, E4 (Dietary Manager) confirmed that E4 did not update R4's and R11's care plan to reflect R4's and R11's weight loss and address R4's and R11's weight loss as a problem with goals and interventions on their care plans.	F 280		
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 identify a pressure ulcer for one of four residents (R16) reviewed for pressure ulcers in the sample of 15. Findings include:	F 314		

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F 314	Continued From page 3 The Facility's Ulcer Definitions Policy, dated 10/20/14, states, "A pressure ulcer is localized injury to the skin and/or underlying tissue usually over a bony prominence, as result of pressure, or pressure in combination with shear...Stage II Partial Thickness Skin loss-Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed (without bruising or slough), or as an intact or open/ruptured serum-filled blister." R16's Wound Care Treatment Plan documents that on 4/25/15 a shearing wound was discovered to the right buttock measuring 3.5 cm (centimeters) x 2.5 cm x 0.1 cm. R16's Minimum Data Set (MDS), dated 5/5/15, documents that R16 did not have any pressure ulcers. On 5/18/15 at 10:42 a.m., R16 had an open area to R16's right buttock. The open area has a shallow depth and a red wound bed. E3 (Licensed Practical Nurse) measured R16's pressure ulcer at 2 cm (centimeters) x 1.2 cm x 0.2 cm. R16 stated, "The right side of (R16's) buttock I would consider a pressure ulcer because it's deeper. I would stage it a stage II."	F 314		
F 315 SS=D	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	F 315		

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F 315	Continued From page 4 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 observation, interview, and record review the facility failed to assess the continued need for an indwelling urinary catheter, failed to monitor the functioning of catheter by not consistently documenting intake and output, and failed to secure an indwelling catheter to prevent pulling of the tubing for one of one residents (R2) reviewed for indwelling urinary catheters in the sample of 15. Findings include: R2's Minimum Data Set (MDS) dated 4/21/15 documents that R2 is cognitively intact. R2's Order Summary Report dated 5/20/2015 documents that R2 has an order for an indwelling catheter. On 5/20/15 at 10:00 AM, R2 stated that the catheter was placed due to frequent incontinent episodes at home. R2 stated that R2's prostate is enlarged but it didn't affect the ability to urinate. R2 stated that R2 would rather not have the catheter...and the catheter pulls sometimes at night causing R2 to wake up. R2 stated that during the day a leg bag is worn and at night it is connected to a drainage bag. R2 stated that the catheter is not secured at night to prevent the catheter from pulling. R2 stated that no one in the facility has talked to him about discontinuing the catheter.	F 315		

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R2's Urology Office Visit report dated 6/10/14, documents that R2 has a diagnosis of Urinary Incontinence, Weak Stream, and Nocturia. R2's Toileting Care Plan dated 6/5/14 documents an intervention to monitor and document intake and output per facility policy. R2's Care Plan does not include a documented medical need for the indwelling urinary catheter and does not document a goal related to the indwelling urinary catheter.

On 5/20/15 at 10:30 AM, E8 (Restorative Nurse) stated that R2 was admitted to the facility with an indwelling catheter. E8 stated that E8 is responsible for completing the continence assessment. E8 stated that need for the continued use of the catheter has not been assessed due to R2 being admitted with the catheter. E8 stated that R2 has a medical diagnosis for the catheter but is unsure of the diagnosis. R2's Continence Assessment dated 3/31/15 documents that, "R2 has an indwelling (urinary) catheter that nursing staff changes monthly and provides care."

On 5/21/15 at 10:00 AM, E2 (Director of Nursing/DON) stated that R2's Care Plan should document the reason for the catheter.

R2's Intake and Output records dated 5/28/14 through 5/12/15 had multiple missing entries including no entries for 5-15-15 through 5-20-15 for oral intake, catheter output, and totals for each shift. On 5/20/15 at 11:15 AM, E11 Licensed Practical Nurse (LPN) stated that documentation of R2's intake and output is completed on the Intake and Output records. E11 stated that the Certified Nurses Assistants (CNAs) document the intake and outputs. E11

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confirmed that R2's Intake and Output records contained multiple missing entries and that R2's intake and output could not be assessed accurately due to the missing entries.

On 5/20/15 at 11:30 AM, E2 Director of Nursing stated that R2's intake and output is necessary to ensure that R2's catheter is draining properly. E2 stated that R2 has had issues in the past. E2 stated that R2 has had low output due to the catheter being clogged and sometimes needs changed early. E2 stated that the CNAs document R2's output and that the nurses monitor the intake and output and act appropriately. E2 stated that the documentation of R2's intake and output is unacceptable and that the nurses would not be able to effectively evaluate if R2's catheter was draining properly.

On 5/21/15 at 8:00 AM, R2's catheter tubing was connected to a drainage bag located on the side of R2's bed. R2's catheter tubing was not secured to R2's leg. At that time E16 (CNA) stated that R2's catheter tubing is never secured. On 5/21/15 at 10:00 AM, E2 (DON) stated that it is expected that a leg band is used to secure catheter tubing. E2 stated that leg bands are used to prevent the catheter from pulling.

The facility's Catheter Protocol dated 2/1/10 documents that , "The care plan will reflect the resident's need for a catheter and information regarding the catheter ordered....When monitoring for accurate intake and output the clinical record shall reflect the intake and output for each 24 hour period...A continence assessment shall be completed for restorative candidates and determined by the interdisciplinary team as appropriate for the

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F 315	Continued From page 7 individual resident."	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to document a clinical indication for duplicate antipsychotic medications for one of three residents (R20), and failed to document a medical diagnosis and behaviors for the use of an antipsychotic for two of three	F 329		

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residents (R7, R20) reviewed for antipsychotic's in a sample of 15.

Findings include:

The facility's policy titled Antipsychotic's, last revised 4/2015 documents Criteria for use: diagnosis alone does not warrant the use of antipsychotic medications. The following criteria also needs to be met: a) The behavioral symptoms must present a danger to the resident or others and one or both of the following: b) The symptoms are due to mania or psychosis (ex. auditory, visual or other hallucinations, delusions, paranoia or grandiosity.)...

1. R20's Psych Med Evaluation (Psychiatric Medication Evaluation) dated 3/24/15 documents R20 is receiving Haldol 0.25mg (Milligrams) TID (three times a day) for a diagnosis of Anxiety. The same form documents "indicate behaviors warranting the use of the medication: restless, agitation." The same form also documents R20 is receiving Seroquel 12.5 mg (Milligrams) TID for a diagnosis of unspecified psychosis. The same form documents "indicate behaviors warranting the use of medication; agitation." There is no consistent pattern of adverse behaviors being monitored in R20's medical record.

On 5/20/15 at 2:45 p.m. R20 was lying in bed sleeping. On 5/21/15 at 10 a.m. R20 was quietly sitting in wheelchair in activities.

On 5/21/15 at 9:10 a.m. E15 SSD (Social Service Director) stated E15 monitors behaviors for residents on antipsychotic's. E15 stated R20's behaviors are "standing up and sitting down, but a lot of it is R20's dementia." E15 stated R20

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"knows what R20 is doing because R20 watches staff walk away then tries to get up but as soon as staff turns around R20 sits right back down." E15 stated R20 has not had behaviors in approximately a month. E15 stated R20 does not see a psychiatrist.

On 5/21/15 at 9:30 a.m. E14 MDS Coordinator (Minimum Data Set coordinator) stated R20 is receiving Seroquel for Psychosis and Haldol for Anxiety. R20 stated the facility is monitoring R20 for anxiety and restlessness.

The facility was unable to provide rationale for the use of dual antipsychotic's.

2. R7's Psychiatric Medication Evaluation Form dated 2/26/15 documents R7 is receiving Seroquel 25 mg (Milligrams) in the morning and 75 mg in the evening for Dementia with Behavioral Disturbances. The same form documents the behaviors warranting the use of the medication are agitation, history of paranoia, verbal outbursts towards staff, combative and resists ADL's (activity of daily living).

R7's Behavior/Intervention Monthly flow records from 1/2015 through 5/2015 document the behaviors the facility is tracking for R7 are sad mood, sexual behaviors towards staff/grabbing, and physical behaviors towards staff/resisting ADL's. R7's Social Service Notes dated 2/26/15 documents R7 exhibited one episode of sexual behaviors towards staff/grabbing and one episode of resisting ADL's/physical aggression towards staff. R7's social service note dated 12/4/14 document R7 exhibited four episodes of sexual behaviors towards staff/grabbing and five episodes of resisting ADL's/physical aggression

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F 329	Continued From page 10 towards staff. There is no consistent pattern of adverse behaviors being monitored in R7's medical record. On 5/21/15 at 9 a.m. E6 and E13 CNA's (Certified Nursing Assistants) transferred R7 with a mechanical lift from the chair to the bed without any concerns. R7 was cooperative. E13 stated R7 wants to touch young girls and pinch them but does not bother all of the staff. E6 and E13 stated never witnessing R7 exhibiting adverse behaviors towards other residents. On 5/21/15 at 9:10 a.m. E15 SSD (social service director) stated R7 has physical behaviors towards staff during cares, and resists cares. E15 stated the majority of the time R7's behaviors are sexual behaviors and grabbing staff during cares. E15 stated R7 never exhibits negative behaviors towards other residents.	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to provide ordered nectar thick liquids for one of 13 residents (R4) reviewed for Physician ordered diets in the sample of 15. Findings include:	F 367		

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F 367	Continued From page 11 The facility's Diet Order Protocols policy (dated 10/2013) documents the following: "According to (State Agency) regulations a written diet order is needed for each resident... Sign and date all diet orders to ensure that the resident receives the most current diet ordered by the (Physician)." R4's current Physician's Order Sheet documents a diet order (dated 4/27/15) for a regular diet, pureed texture and nectar consistency (liquids). On 5/19/15 at 11:45 AM, E8 (Licensed Practical Nurse/Restorative Nurse) was assisting R4 with eating and drinking R4's lunch. E8 provided R4 with oral liquids which appeared to be normal consistency thin liquids. On 5/19/15 at 12:05 PM, E8 confirmed that R4 was eating a puree texture diet with thin liquids for lunch. On 5/19/15 at 12:50 PM, E9 (Registered Nurse) stated that R4 does not have a current diet order for thin liquids. A recommendation was made to change R4's liquids from nectar consistency to thin liquids but an order has not been received from Z1 (R4's Physician). E9 also stated that R4 should still be receiving nectar thick liquids while waiting for Z1 to provide an order for diet change.	F 367		
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.	F 441		

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F 441	Continued From page 12 (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 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 prevent cross contamination during pressure ulcer care for one resident (R19) and during perineal/incontinence care for three residents (R11, R13 and R17)	F 441		

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F 441	Continued From page 13 reviewed for infection control in a sample of 13. Findings include: 1. On 5/20/15 at 2:40 PM, E2 (Director of Nursing) performed R19's pressure ulcer care to R19's coccyx pressure ulcer. E2 removed R19's current pressure ulcer dressing and then removed E2's soiled gloves, performed hand hygiene and placed clean gloves on E2's hands. E2 then cleansed R19's pressure ulcer with normal saline and using the same soiled gloves placed a new clean dressing on R19's pressure ulcer. On 5/21/15 at 9:05 AM, E2 stated that E2 would expect to see gloves changed when going from a dirty to clean surface. E2 confirmed that E2 did not remove E2's soiled gloves, perform hand hygiene or put on new, clean gloves after cleaning R19's pressure ulcer and prior to placing a new dressing on R19's pressure ulcer. E2 stated, "Yes, I probably should have changed my gloves after cleaning (R19's) pressure ulcer with saline and before applying (the new clean dressing)." 2. On 5/19/15 at 9:50 AM, E7 (Certified Nursing Assistant) performed Perineal/Incontinence Care to R17. E7 removed E7's soiled adult brief and cleansed E7's perineal area from front to back. E7 then placed a new adult brief on R17 and readjusted R17's shirt. E7 did not remove E7's soiled gloves, perform hand hygiene or place new, clean gloves on E7's hands after performing perineal care and prior to placing a clean adult brief on R17 and adjusting R17's shirt. On 5/19/15 at 10:10 AM, E7 confirmed that E7 did not remove E7's gloves, perform hand hygiene or put on new, clean gloves after performing R17's perineal care and prior to putting on R17's clean, adult brief and adjusting R17's shirt.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145952	A. BUILDING _____ B. WING _____	05/21/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HEALTH-BEARDSTOWN	8306 ST LUKES DRIVE BEARDSTOWN, IL 62618

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F 441	Continued From page 14	F 441		

3. On 5/18/15 at 3:10 PM, E10 CNA toileted R13. After R13 was finished using the toilet, R13 stood up and with gloved hands E10 wiped R13 with toilet paper. At that time R13 then has another loose bowel movement. E10 sat R13 back down and then stood R13 back up and wiped R13 again. With the soiled gloves still on, E10 placed a new incontinence brief on R13 and pulled up R13's pants. E10 then pushed R13 out of the bathroom and opened R13's night stand and got out a comb while still wearing the soiled gloves. E10 then combed R13's hair and put the comb back into the night stand, still wearing the soiled gloves. E10 then took a gait belt off of R13 and placed it around E10's waist. E10 then walked over to sink and removed gloves.

On 5/18/15 at 3:20 PM, E10 confirmed that R13 had a bowel movement. E10 confirmed that E10 did not wash hands or replace gloves after wiping R13. E10 stated that E10 should have probably removed gloves prior to brushing R13's hair.

On 5/20/15 at 9:55 a.m. E2 DON (Director of Nurses) stated that E2 would expect CNA's to follow facility policy regarding hand hygiene. E2 further stated E2 would expect staff to wash hands after completing pericare for the residents before providing other cares for the residents.

4. On 5/19/15 at 10:20 a.m. E6 CNA(Certified Nurses Aide) provided incontinence care for R11. After completing pericare for R11, E6 removed soiled gloves and proceeded to apply clean gloves without washing E6's hands prior to applying the clean gloves. E6 continued to provide care for R11. When E6 completed care

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F 441	Continued From page 15 for R11, E6 then removed gloves and washed E6's hands. A facilty policy titled Incontinent Care Male and Female, dated 8/27/12 states ...after cleansing and rinsing perineal area...remove gloves and complete hand hygiene.	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, interview and record review the facility failed to ensure that all hot water plumbing equipment was maintained in good repair. This failure had the potential to affect all 65 residents residing in the facility. Findings include: During the general building tour on 5/20/15 at 10:00 a.m. the hot water storage tank located in the boiler room had water dripping from the spigot at the bottom of the tank. Under the spigot was a large, thick amount of brown/orange colored substance and water. The water spread on the floor towards the wall covering an area approximately 5 foot by 2 foot. On 5/20/15 E12 (Maintenance Supervisor) provided a form dated 10/14/14 that documented monies had been requested to fix the water heater storage tank. E12 states a plan was put in place a year ago to fix the hot water storage tank. E12 stated the plan was put in the budget in 2015 to fix this year but E12 has not been given a date	F 456		

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F 456	Continued From page 16 for the repair. E12 stated the hot water storage tank has been leaking since E12 became an employee in January 2014. The CMS (Centers for Medicare and Medicaid Services) form # 672 completed by E14 (MDS Coordinator) indicated that the resident census was 65 on 5/18/15.	F 456		