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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 164 SS=E | Annual Certification Survey<br>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS<br><br>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.<br><br>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.<br><br>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.<br><br>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.<br><br>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the Facility failed to provide privacy during | F 164 | | |

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

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care for 3 of 13 residents (R2, R10 and R12) reviewed for privacy in the sample of 15 and two residents (R16 and R17) in the supplemental sample.

Finding include:

1. On 7/26/16 at 11:25 AM, E6 Registered Nurse (RN), entered R10's room, performed a blood glucose fingerstick test and gave a Novolog insulin subcutaneous injection in the left lower abdomen with no privacy curtain pulled, the door open and R16 sitting next to R10 in an armchair.

2. On 7/26/16 at 11:27 AM, E6, entered R16's room, performed a blood glucose fingerstick test and gave a Humalog insulin subcutaneous injection in the right lower abdomen with no privacy curtain pulled, the door open and R10 sitting next to R16 in an armchair.

3. On 7/26/16 at 11:35 AM, E6, entered R17's room, performed a blood glucose fingerstick test and gave a Humalog insulin subcutaneous injection in the left lower abdomen with no privacy curtain pulled and the door open.

4. On 7/26/16 at 11:40 AM, E6, entered R12's room, performed a blood glucose fingerstick test with no privacy curtain pulled and the door open.

5. On 7/26/16 at 9:46 AM, E7 Certified Nurse's Aide (CNA) and E9 CNA, assisted R2 with toileting in the North Hall bathroom. During this care, E12 CNA, opened the door to the bathroom and removed a linen cart.

On 7/26/16 at 3:45 PM, E2 Director of Nurses (DON), stated, "I expect staff to provide privacy

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| F 164 | Continued From page 2<br>while giving care."<br><br>The "Residents' Rights for People in Long Term Care Facilities" dated 11/01 documents, in part, "Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care." | F 164 | | |
| F 225 SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.<br><br>The results of all investigations must be reported | F 225 | | |

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| F 225 | Continued From page 3 | F 225 | | |

to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the Facility failed to investigate an allegation of abuse for 1 of 6 residents (R1) reviewed for abuse in the sample of 15.

Findings include:

R1's Skin Occurrence report dated 7/11/16 documents, in part, "Bruise: right finger 2 and right finger 3. Summary Notes: 7/11/16 Certified Nurse's Aides (CNA's) were laying resident down when this nurse heard resident yelling loudly. As this nurse entered the room, resident was hitting and cursing at staff. After CNA's got resident in bed and removed (mechanical lift), (E13 CNA), placed her hands to prevent resident from hitting at other CNA. Resident continued to curse and try to hit at staff. CNA's finished up and the three of us left the room. Afterwards, daughter came in and resident stated "Them b*****s squeezed my hand." From when this nurse entered the room till we left the CNA's did not squeeze residents hand. Resident did have swelling and bruising to 1st and 2nd knuckle of right hand. X-ray ordered to rule out fracture. 7/11/16 X-ray negative for fractures or problems."

On 7/27/16 at 11:45 AM, E1 Administrator, stated,

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| F 225 | Continued From page 4<br>"I did not investigate this allegation as abuse. I know my girls would never abuse residents. (R1) hurt her hand because she was hitting at staff." | F 225 | | |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to have an accurate employee background check policy for 10 of 5 employees (E5) and failed to operationalize their abuse policy by not investigating an allegation of abuse for 1 of 6 residents (R1) reviewed for abuse in the sample of 15.<br><br>Findings include:<br><br>1. On 7/27/16 at 1:00 PM, five employees who were hired within the last year were reviewed for health care worker background checks and the following were documented:<br><br>E5 was hired on 3/29/16 as Maintenance Director and no fingerprint-based criminal history records check was done or initiated.<br><br>On 7/27/16, at 2:00 PM, E14, Bookkeeper stated that they did not fingerprint E5 they only did a name check. E14 then stated they only fingerprint Certified Nursing Assistants (CNAs) and only do a | F 226 | | |

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| F 226 | Continued From page 5 | F 226 | | |

name check for anyone else hired. E14 stated that she was unsure if they had a policy but followed the current regulations.

The Facility's Employee Background Check Policy undated documents in part, "The Facility checks the Illinois healthcare Worker Registry at time of hire to ensure that a CNA has a clear Fee_APP background check listed on the registry. If the CNA has not had a Fee_APP background check completed, the facility will initiate the Fee_App through the livescan vendor. All other staff (excluding CNA's) have a UCIA Name background check initiated at the time of hire, and then conducted annually by hire date. all staff, including CNA's , must have a clear background check according to the standards set by the Illinois Healthcare Worker Registry to be employed at the Facility."

2. The facility "Abuse Prevention Program Facility Procedures" undated documents, in part, "Final Abuse Investigation Report. The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident. The final investigation report shall contain the following:
Name, age, diagnosis and mental status of the resident allegedly abused and neglected
Facts determined during the process of the investigation, review of medical record and interview of witnesses . Conclusion of the investigation based on know facts
Attach a summary of all interviews conducted, with the names, addresses, phone numbers and willingness to testify of all witnesses."

R1's Skin Occurrence report dated 7/11/16 documents, in part, "Bruise: right finger 2 and

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| F 226 | Continued From page 6<br>right finger 3. Summary Notes: Daughter came in and resident stated 'Them b*****s squeezed my hand.' From when this nurse entered the room till we left the CNA's (Certified Nurse's Aides) did not squeeze residents hand. Resident did have swelling and bruising to 1st and 2nd knuckle of right hand. X-ray ordered to rule out fracture. 7/11/16 X-ray negative for fractures or problems."<br><br>On 7/27/16 at 11:45 AM, E1 Administrator, stated, "I did not investigate this allegation as abuse. I know my girls would never abuse residents. (R1) hurt her hand because she was hitting at staff." | F 226 | | |
| F 241 SS=D | 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the Facility failed to promote dignity during dining services for 1 of 13 residents (R2) reviewed for dining services in the sample of 15.<br><br>Findings include:<br><br>R2's Physician's Order Sheet, dated July 2016, documents R2's diagnoses, in part, "Alzheimer's and Dementia with Psychosis."<br><br>R2's Minimum Data Set (MDS) dated 5/24/16 documents R2 requires extensive assistance of 1 staff member for dining. | F 241 | | |

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| F 241 | Continued From page 7 | F 241 | | |

On 7/26/16 at 8:18 AM, R2 was served a breakfast tray which had toast, scrambled eggs, ground sausage covered with gravy and a bowl of oatmeal. R2 consumed 100% of the meal with her fingers. During breakfast, R2 dropped her fork on the ground while attempting to use it. E7, Certified Nurse's Aide (CNA) was sitting at R2's table assisting other residents with the meal. E7 would watch R2 eat with her fingers and did not cue R2 to use utensils. E7 served R2 a second serving of scrambled eggs and did not realize R2's fork was on the ground. R2 ate the second serving of scrambled eggs with her fingers.

On 7/26/16 at 12:28 PM, R2 was served ground beef tips, noodles, sliced carrots and pineapple bits. R2 ate 90% of the meal. R2 ate the meal with her fingers. Staff did not cue R2 to use utensils during this meal.

On 7/27/16 at 8:15 AM, R2 was served cut up biscuits with gravy on top, scrambled eggs, a bowl of oatmeal. E10 CNA came and assisted R2 with the meal. E10 would load the fork with large amounts of food and feed R2. The amount of food on the fork was too large to fit into R2's mouth. E10 would force the large bite into R2's mouth causing the excess food to go all over her mouth and chin. During the meal with E10 present R2 would eat food with her fingers and E10 did not cue R2 to use utensils. At one point R2 grabbed a large amount of oatmeal with her hand and began to eat it and E10 stated, "What, I wasn't feeding you fast enough?"

On 7/27/16 at 10:53 AM, E2, Director of Nurses (DON), stated, "(R2) has always ate with her fingers but staff should be cueing her to use

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| F 241 | Continued From page 8<br>utensils."<br><br>On 7/27/16 at 11:15 AM, E1 Administrator, stated, "I do not feel that (R2) eating with her fingers is a dignity issue. Visitors are not allowed in the dining room during meal service so outside visitors are not seeing her eat with her fingers. She sits with her back to the dining room and the residents that can see her eat with her fingers are confused so they don't know what she is doing."<br><br>On 7/28/16 at 9:45 AM, E1, stated, "We did not have a finger food diet I didn't know one existed until yesterday afternoon."<br><br>A reasonable person would not eat non-finger foods with their hands. | F 241 | | |
| F 312 SS=D | 483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS<br><br>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the Facility failed to provide assistance and cueing during dining services for 2 of 13 residents (R2, R3) reviewed for dining services in the sample of 15.<br><br>Findings include:<br><br>1. R2's Physician's Order Sheet (POS), dated | F 312 | | |

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| F 312 | Continued From page 9 | F 312 | | |

July 2016 documents R2's diagnoses in part as Alzheimer's and Dementia with Psychosis.

R2's Minimum Data Set (MDS) dated 5/24/16 documents R2 requires extensive assistance of 1 staff member for dining.

On 7/26/16 at 8:18 AM, R2 was served a breakfast tray which had toast, scrambled eggs, ground sausage covered with gravy and a bowl of oatmeal. R2 consumed 100% of the meal with her fingers. During breakfast, R2 dropped her fork on the ground while attempting to use it. E7 Certified Nurse's Aide (CNA) was sitting at R2's table assisting other residents with the meal. E7 would watch R2 eat with her fingers and did not cue R2 to use utensils. E7 served R2 a second serving of scrambled eggs and did not realize R2's fork was on the ground. R2 ate the second serving of scrambled eggs with her fingers.

On 7/26/16 at 12:28 PM, R2 was served ground beef tips, noodles, sliced carrots and pineapple bits. R2 ate 90% of the meal. R2 ate the meal with her fingers. Staff did not cue R2 to use utensils during this meal.

On 7/27/16 at 8:15 AM, R2 was served cut up biscuits with gravy on top, scrambled eggs, a bowl of oatmeal. E10 CNA came and assisted R2 with the meal. E10 would load the fork with large amounts of food and feed R2. The amount of food on the fork was too large to fit into R2's mouth. E10 would force the large bite into R2's mouth causing the excess food to go all over her mouth and chin. During the meal with E10 present R2 would eat food with her fingers and E10 did not cue R2 to use utensils. At one point R2 grabbed a large amount of oatmeal with her

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hand and began to eat it and E10 stated, "What, I wasn't feeding you fast enough?"

On 7/27/16 at 10:53 AM, E2 Director of Nurses (DON), stated, "(R2) has always ate with her fingers but staff should be cueing her to use utensils."

On 7/27/16 at 11:15 AM, E1 Administrator, stated, "I do not feel that (R2) eating with her fingers is a dignity issue. Visitors are not allowed in the dining room during meal service so outside visitors are not seeing her eat with her fingers. She sits with her back to the dining room and the residents that can see her eat with her fingers are confused so they don't know what she is doing."

On 7/28/16 at 9:45 AM, E1, stated, "We did not have a finger food diet I didn't know one existed until yesterday afternoon."

A reasonable person would not eat non-finger foods with their hands.

2. R3's MDS dated 7/8/16 documents R3 has severe cognitive impairment and requires limited assistance of one person physical assist while eating.

On 7/26/16 at 8:50 AM, R3 sat in the dining room with her breakfast in front of her. R3 was holding a glass of milk up towards her mouth with her wrist propped on the edge of the table for approximately 10 minutes. R3's oatmeal was untouched. There was no physical staff assist nor cueing provided for R3 noted at the time.

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| F 312 | Continued From page 11<br>On 7/26/16 at 12:18 PM, E7, served R3 her lunch tray without saying anything to R3. R3 had her eyes closed. At 12:21 PM, E8, CNA, told R3, "Take a bite for me." At 12:39 PM, E6, Registered Nurse (RN), told R3, "Take a bite for me." R3 drank some of her tea. At 12:41 PM, E6 fed her 2-3 spoonfuls of her lunch. At 12:42 PM, E8 assisted R3 with her meal.<br><br>On 7/26/16 at 9:40 AM, E7 stated R3 is able to feed herself and staff just need to assist R3 with the first initial bites and R3 eats without physical help.<br><br>On 7/28/16 at 11:40 AM, E2, stated it is 50/50 with R3 during meals, meaning she does feed herself first and staff will assist her the rest of the time. | F 312 | | |
| F 441 SS=F | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection | F 441 | | |

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| (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 |
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(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:
A) Based on observation, interview and record review, the facility failed to perform hand hygiene to prevent potential spread of infections for 2 of 13 residents (R1, R7) reviewed for infection control in the sample of 15.

Findings include:

1. On 7/26/16 at 9:30 AM, E11, Certified Nurse Assistant, CNA assisted R7 to the toilet. E11 wiped R7's buttocks with gloved hands after R7 was finished using the toilet. E11 then pulled up R7's pants, adjusted R7's shirt, took off the gait belt around R7's waist and put the gait belt around herself, all using the same soiled gloves used to wipe R7 buttocks. E11 discarded soiled gloves in the soiled bag that was sitting on top of

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|---|---|---|---|
| | 14E717 | A. BUILDING _____ B. WING _____ | 07/28/2016 |

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the clean glove box on the back of the toilet.

2. On 7/26/16 at 12:15 PM, E11 provide incontinent care R1. R1's incontinent brief had bowel movement in it. The brief was removed and R1 continued to have a bowel movement on the disposable pad. E11 washed, rinsed and dried R2's buttocks during which E11 changed gloves multiple times with no hand sanitation in between glove changes.

On 7/28/16 at 10:00 AM, E1, Administration, stated staff know how to do proper hand hygiene and glove changes. E1 stated "I expect them to follow the rules." E1 stated E2, Director of Nursing, DON, trains staff consistently on proper hand hygiene.

B) Based on interview and record review, the Facility failed to monitor and track employee illness and infection to adequately track and manage infections, analyze date, and identify possible staff infectious process. This has the potential to affect all 58 residents living in the facility.

Finding includes:

1. On 7/27/16 at 2:30 PM, E2, DON, stated the facility does not track employee illness and she has never been told to track employee illness. E2 stated when an employee calls off work, the call is taken and written on a slip of paper and put in employee files. The information is given to the front office and put on the attendance record.

On 7/27/16 at 2:30 PM, E14, Bookkeeper, brought in the attendance records. The records document employees by alphabetical order and

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are coded when benefit time is used. There is no indication of what type of illness when an employee calls in sick. There is no tracking and trending of any employee illness in the employee attendance records.

On 7/28/16 at 10:00 AM, E1, stated she didn't know of any regulation that employee illness had to be monitored.

The Facility's Infection Control Policy, undated, documents: "Preventing Spread of Infection, the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact with transmit with transmit the disease. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted profession practice." The Policy documents "Program Development and Oversight: Identifying the staff's roles and responsibilities for the routine implementation of the program as well as in case of an outbreak of a communicable disease, an episode of infection or the threat of bio-hazard attack, Monitoring and documenting infections, including tracking and analyzing outbreaks of infections as well as implementing and documenting actions to resolve related problems. Process Surveillance, uses appropriate hand hygiene prior to and after all procedures. Hand Hygiene, Before and after direct resident contact, before and after assisting a resident with personal care, after personal use of the toilet (hand washing with soap and water), after removing gloves or aprons, and after completing duty."

2. The Resident Census and Conditions of

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| F 441 | Continued From page 15<br>Residents, CMS 672, dated 7/25/16 documents that the facility has 58 residents living in the facility. | F 441 | | |