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F 000	INITIAL COMMENTS	F 000		
F 309 SS=D	Annual Licensure and Certification 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess, monitor and effectively treat pain. This applies to 2 resident out of 9 (R10 and R16) reviewed for pain from a total sample of 19. The findings include: 1) R10 was admitted to the facility on February 12, 2016 per the admission face sheet. The POS (physician order sheet) shows that R10 has diagnoses of Myasthenia Gravis, Dysphasia, and Cerebral Vascular Accident. On March 28, 2016 at 4:10PM, R10 was observed in her bed moaning and crying out in pain. E3(Licensed Practical Nurse) administered 650 milligrams of Acetaminophen to R10. R3 did not assess R10's pain or obtain the location of the pain prior to administration of the medication. E3 stated, " I don't usually work this hall. I am not sure but I think this behavior is normal for R10. I will check back on R10 later. " E3 then walked out of R10's room to continue passing medications to other residents. R10 continued with the moaning and	F 309		4/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/18/2016

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crying out. E3 stated that vital signs were only done if the resident were to have pain that was not the normal for that resident.
At 4:30pm, E2 (Director of Nursing) came to assess R10 and stated, " This is not usual for R10. I will notify the physician. " E2 said that the nurse should fully assess a resident with pain and notify the physician if there is a no relief given by the medication.
On March 29th, 2016 at 10:20 am, E6(Registered Nurse) was stated, " That is not normal for R10. R10 does not moan and cry out like that. R10 only had Acetaminophen ordered for pain now we added Ultram to see if that helps. When a resident has a change of condition the nurse should call the physician and take vital signs. "
2) R16 was admitted to the facility on August 31st, 2010 per the admission face sheet. The current physician orders showed that R16 had diagnoses of Polyarthritis, Osteoarthritis, Osteoporosis, Anxiety and Depression. R16 was observed sitting in a chair in the bedroom on March 30, 2016 at 11:50AM, and stated, " It hurts more on my left side. My nurse gave me pain medicine this morning but it does not seem to work very well. "
The MAR (Medication Administration Record) for R10 and R16 showed that each resident had pain medication ordered to be given as needed for pain. R10 ' s MAR showed that R10 could receive 650 milligrams of Acetaminophen every four hours as needed for pain. The record showed that R10 received the drug on March 22, 23, 25, 27, and 28, 2016. The record showed that on March 28, 2016, R10 received the medication at 7:00 AM and at 4:00PM. The medications given were not evaluated for effectiveness on the monitoring form on the back of the MAR.

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F 309	Continued From page 2 R16 ' s MAR showed that R16 received Acetaminophen 650 mg on March 23, 24, 25, 28, and 30, 2016. The monitoring for effectiveness area on the MAR showed no assessment from the nurse to show if the medication was effective in relieving R16 ' s pain. The facility policy for Pain Management dated May 2015 showed that staff were to have the resident rate the pain using a numeric scale or the verbal descriptor rating scale. The policy also instructs staff to observe for behaviors that could signify pain, facial expressions, vocal behaviors, body movements, routines and mental status. The policy also directs staff to assess for the effectiveness of the as needed medication one to two hours after administration. The facility policy for pressure ulcer treatment dated November 2013 directs staff to monitor the resident ' s pain and provide analgesics as ordered before wound care.	F 309		
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 clarify and transcribe	F 314		4/18/16

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F 314	Continued From page 3	F 314		

recommendation for wound cleansing and failed to ensure that pressure ulcer treatments are followed as ordered by the physician.
This applies to 2 of 5 residents (R 1 and R9) observed for pressure ulcer treatments in the sample of 19.

The findings include:
1. R9 has multiple diagnoses to include DM (diabetes Mellitus), Dementia and Alzheimer's disease based on the face sheet.
R9's significant MDS (minimum data set) dated March 11, 2016 showed that the resident is severely impaired with cognition and would require extensive assistance with most of her ADL's (activities of daily living).
On March 29, 2016 at 9:15 AM, E4 (Treatment Nurse) prepared and administered pressure ulcer treatment to R9's left elbow. E4 cleaned R9's left elbow pressure ulcer with Betadine solution, applied Santyl ointment on the base of the wound then covered it with Calcium Alginate which was sprinkled with Nystatin powder and protected it with a comfort foam and adherent dressing.
R9's POS (physician order sheet) dated March 20 through April 19, 2016 showed an order dated March 10, 2016, "Left elbow: Dakin's F.S. (full strength) cleanse. Apply Santyl ointment to wound base, cover with Calcium Alginate\foam and gauze, to change BID (twice a day)."
R9's wound physician assessment dated March 17, 2016 showed under recommended treatment, to clean the left elbow with Betadine. The same wound assessment showed under additional orders, "Left elbow ulcer - Santyl/Alginate/foam change BID."
On March 30, 2016 at 11:30 AM, E4 stated that she applied the Nystatin powder on R9's left elbow pressure ulcer without the physician order.

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F 314	Continued From page 4 R9's skin integrity care plan related to the left elbow initiated on February 16, 2016 showed multiple interventions which included, administering treatments as orders by the physician. R9's POS and the wound physician assessment report dated March 17, 2016 showed that the facility did not clarify and transcribe the recommended wound cleanser for the resident ' s left elbow pressure ulcer. 2. R1 has multiple diagnoses to include DM, Hemiplegia & Hemiparesis post cerebrovascular disease affecting right dominant side, PVD (peripheral vascular disease), Colostomy and Gastrostomy based on the face sheet. R1's significant MDS dated February 29, 2016 showed that the resident has a BIMS (brief interview for mental status) score of "05," indicating that the resident is severely impaired with cognition and would require extensive assistance with most of his ADL's. On March 30, 2016 at 10:55 AM, E4 prepared and administered pressure ulcer treatment to R1's Stage III bilateral ischial and midsacral pressure ulcers. E4 also cleaned R1's Stage III perisacral pressure ulcer but no treatment was applied. During the same observation, E4 started covering R1's pressure ulcers (consisting of bilateral ischial, midsacral and perisacral areas) with alginate pads. E4 was asked, if she was finished with the pressure ulcer treatments to which E4 responded, "Yes." E4 was asked, why R1's perisacral pressure ulcer did not receive any treatment after it was cleansed. E4 stated that she forgot and then, proceeded to get more Santyl ointment which she placed inside a medication cup. E4 started applying the Nystatin powder then, applied the Santyl ointment on top	F 314		

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F 314	Continued From page 5 of the Nystatin powder on R1's perisacral pressure ulcer. During this time, E4 stated that she should have applied the Santyl ointment first on the base of the perisacral pressure ulcer before putting the Nystatin powder on the said area. R1's POS dated March 17, 2016, showed an order to apply, "Santyl ointment/Nystatin powder/Alginate, non-adherent dressing, change BID, Dakin's cleanse," to bilateral ischial, sacrum and perisacrum areas. R1's wound physician assessment dated March 17, 2016 showed that the physician identified the pressure ulcers on R1's bilateral ischial, midsacrum and perisacrum as Stage III pressure ulcers. R1's skin integrity care plan related to the perisacral pressure ulcer initiated on June 10, 2015 showed multiple interventions which included, administering treatments as orders by the physician.	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 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:	F 315		4/18/16

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Based on observation, interview and record review the facility failed to thoroughly clean the resident's genital area after an incontinent episode, in a manner that would prevent the potential development of infection and to maintain hygiene.
This applies to 2 of 15 residents (R2 and R9) reviewed for incontinence in the sample of 19.
The findings include:
1. R9 has multiple diagnoses to include DM (diabetes Mellitus), dementia, Alzheimer's disease and history of cystitis without hematuria and UTI (urinary tract infection) based on the face sheet.
R9's significant MDS (minimum data set) dated March 11, 2016 showed that the resident is severely impaired with cognition and would require extensive assistance with most of her ADL's (activities of daily living) including personal hygiene and toilet use. The same MDS showed that R9 is always incontinent of both bowel and bladder functions.
On March 28, 2016 at 1:00 PM, E10 (CNA/Certified Nursing Assistant) assisted E9 (CNA) during R9's incontinent care. R9 was awake in bed. E9 and E10 removed R9's incontinent brief. R9's incontinent brief was soiled with urine. E9 with her gloved hand used a dry disposable wipes sprayed with perineal cleanser to wipe R9's bilateral inner legs/thigh area first, then from the pubic area down towards the perineum using the same side of the disposable wipes. During this observation, E9 did not separate the labia and any skin folds to clean the area to ensure that urine was removed. E9 and E10 then turned R9 on her left side to clean the resident's buttocks area. During this time, R9 was noted to have small amount of stool on her anal region. E10 with her gloved hand used dry

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disposable wipes sprayed with perineal cleanser to wipe R9 from the coccyx area down towards the perineal area twice in a back and forth motion, using the same side of the disposable wipes. E10 then discarded the wipes, got more disposable wipes sprayed with perineal cleanser and repeated the same procedure.
In an interview held on March 31, 2016 at 1:00 PM, E2 (Director of Nursing) stated that for female residents, the staff should separate the labia and the perineal skin folds to thoroughly clean the area and to prevent potential infection. E2 further stated that the staff should clean from the front perineal area towards the coccyx area, one stroke and not in a back and forth motion, then change the wipes to prevent infection.
2. On March 29,2016, at 1:50 PM a.m., E7 (CNA) was observed providing incontinence care to R2 in the resident's room. R2 was observed lying on her left side in bed. E7 donned gloves and opened R2's incontinence brief. E7 stated R2's diaper was a little wet. E7 with the same gloves opened R2's dresser drawer and removed a clean diaper and disposable wipes. E7 proceeded to open R2's thighs and wiped with the disposable cloth from the front to the back towards the rectum. Upon using the disposable wipe, a small amount of feces was removed. E7 again wiped R2 with a disposable cloth and again, the disposable wipe was soiled. E7 was asked how she was taught to do incontinence care, E7 stated "we were told to wipe from front to back."

R2's face sheet shows a diagnosis includes end stage renal disease. R2's minimum data set dated January 18, 2016 assessed R2 as cognitively moderate impaired and incontinent of bowel and bladder. R2's incontinence care plan

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F 315	Continued From page 8 for incontinence shows the following interventions: Clean peri-area with each incontinence episode, wash, rinse and dry perineum. The facility perineal care policy dated October 2014 states : For a female resident: wet disposable wash cloth if not using pre moistened wipe, wash perineal area and wash area downward from front to back, separate labia and wash area downward form front to back. continue to wash the perineum from inside outward to and including thighs, alternating from side to side, and using downward strokes. Instruct or assist the resident to turn on her side with her top leg slightly bent if able, wash the rectal area thoroughly, wiping from the base of the labia toward and extending over the buttocks.	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to administer medications as ordered by the physician. There were 35 opportunities with four errors resulting in a 11.76% medication error rate. This applies to two residents (R23 and R24) out of eight residents reviewed during medication pass observations. The findings include: 1. On March 28, 2016 at 3:45pm, E3 (Licensed	F 332		4/18/16

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F 332	Continued From page 9 Practical Nurse) gave R23 five milligrams of Donepezil by mouth. The current physician order sheet showed that R23 was to receive 25 milligrams of Donepezil at night at bedtime. The Medication Administration Sheet showed that at nine o ' clock PM at bedtime R23 was to receive the Donepezil. 2. On March 29, 2016 at 11:30am, E5(Registered Nurse) administered medication to R24. R24 received Sotolol 80 milligrams, Bethenachol ten milligrams, and Ultram 50 milligrams by mouth. R24's current Physician Order sheet showed that Sotolol 80 milligrams twice daily and was scheduled to be given at 9:00am and 5:00pm. The Bethenachol 10 milligrams were to be given three times a day at 9:00am, 1:00pm and 5:00pm. The Ultram 50 milligrams were to be given three times a day at 9:00am, 1:00pm and 5:00pm. On March 30, 2016 E2 (Director of Nursing) said that the physician would be notified of the errors. E2 said that E5 had given the nine o ' clock medications late.	F 332		
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,	F 441		4/18/16

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F 441	Continued From page 10 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, interview and record review the facility failed to utilize clean technique while providing dressing change and wound treatments. This failure has the potential to impede wound healing and increases the risk of infection. This applied to four residents (R4, R10, R11 and R13) out of five residents reviewed for pressure ulcer. The findings include: 1. R4 was admitted to the facility December 25, 2015 per the admission face sheet. The current	F 441		

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physician order showed that R4 had diagnoses of Hemiplegia, right and left bilateral below knee amputation, Hypertension, Peripheral Vascular Disease, Depression and contractions to right side of head to chest.
On March 29, 2016 at 11:05AM, E4 (Wound Care Nurse) took scissors out of her uniform pocket. No cleaning was observed. E4 took calcium alginate dressing out of an open package and cut smaller pieces for R4. There was no name or date as to when the package was opened. Cut pieces of foam and foam dressing with mesh adhesive edges all on top of the bedside table. The table was not observed to be cleaned or sanitized prior to use. E4 had no assistance and after removing soiled dressing from R4's right ear, neck and chest area R4's head contracted back top of right shoulder and chest area. The wound on R4's ear came in contact with the right chest and gown. After cleaning the wounds E4 left the head again come in contact with the chest and gown. E4 was holding R4 ' s head and hair to access the wound area and when retrieving dressing supplies the wound would fall back to the chest and gown area. There was no cleaning of the scissors or the bedside table when complete.
2 .R10 was admitted to the facility on February 12, 2016 per the admission face sheet. The current physician order sheet showed that R10 had diagnoses of Cerebral Vascular accident, Myasthenia Gravis, Diabetes Mellitus, Hemiplegia and Depression.
On March 30, 2016 at 8:10AM, E4 took calcium alginate material from an open package and put it on top of the package on top of the treatment cart. There was no observation of the top of the cart being cleaned or sanitized. E4 took a foam dressing with a mesh adhesive edge and put on

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top of the treatment cart. E4 continued to lay out pieces of foam dressing material on top of the package. E4 took five, four inches by four inch, gauze pads out of the treatment cart drawer and placed directly on top of the treatment cart. E4 then took scissors out of her uniform pocket and cut pieces of the calcium alginate. E4 then removed the soiled dressing from R10's right lateral leg and heel. E4 took off the soiled gloves. No hand washing was observed.
At 10:10am, E4 continued with the same procedure to the left heel. The treatment cart was brought into R10's room. The top was not observed to get cleaned or sanitized. While preparing supplies the same way as at 8:10am E4 also was not wearing any gloves and hand washing was not observed before or during treatment. The dressing supplies used for the treatment were touched by E4's bare hands.
The facility policy for Pressure Ulcers dated November 2011 showed that during dressing changes packages should be opened maintaining sterility. Hands should be washed and dried thoroughly before dressing change, after removing soiled dressing and after clean dressing applied.
3. On March 30, 2016 at 1:20PM, E4 (Treatment Nurse) was observed performing wound care on R11 in the resident's rooms. E4 was assisted by E8 (CNA) and resident was up in big backed wheelchair. E4 was noted to prepared the wound care supplies including cleansing gauze with betadine, nystatin powder and alginate product and non-adherent dressing. These items were placed on top of the treatment cart without first cleansing the surface of the cart or covering it with a protective barrier to ensure clean or sterile surface.
4. On March 30, 2016 at 10:35 AM, wound care

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146112	A. BUILDING _____ B. WING _____	03/31/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIVER NORTH OF BRADLEY H & R	650 NORTH KINZIE BRADLEY, IL 60915

(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 441	Continued From page 13	F 441		

was observed. E8, CNA (Certified Nursing Assistant) and E4 (wound nurse) put gloves on. E8 assisted R13 to his left side while E4 prepared treatment ointment and poured the Dakin's solution onto the gauze on top of the treatment cart with no barrier. E8 pulled R13's pants down. E4 removed R13's wound dressing on right buttock. The wound had moderate yellow drainage. E4 removed her dirty gloves and washed her hands for 10 seconds. E4 put new gloves on and wipe the wound with the gauze with Dakin's solutions twice. E4 removed her gloves and applied hand sanitizer. E4 put new gloves again and measured R13's wound and applied treatment on R13's wound. E4 removed her gloves again, applied hand sanitizer, put a new gloves on and wiped the treatment cart with bleach disinfectant. E4 left the room without washing her hands.

On March 31, 2016 at 11:45 AM, E3 was asked the policy and procedure for hand washing. E3 said to wash hands before and after giving care and after leaving room for about 2- 3 minutes. E3 further stated that she was not sure how long she had to wash her hands.

Facility's undated policy and procedure for Handwashing/Hand Hygiene showed:

- Employees must wash their hands for at least fifteen (15) seconds using antimicrobial and non-antimicrobial soap and water under the following conditions:
  - after removing gloves and after completing duty.

The facility staff did not follow the above policy and procedures.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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