STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145776	A. BUILDING _____ B. WING _____	11/06/2015

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BRIGHTVIEW HEALTHCARE & REHAB	**4538 NORTH BEACON CHICAGO, IL 60640**

(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 Licensure & Certification Survey Complaint Investigations: 1585355/IL80465-F-314 1585146/IL80235-No deficiency 1585788/IL80979- No deficiency 1585990/IL81200-No deficiency	F 000		
F 309 SS=D	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 interview and record review, the facility failed to evaluate and manage pain for one of four residents (R3) reviewed for pain, in a sample of 24 and Based on observation, interview and record review, the facility failed to follow physician orders regarding splint application for one of four residents(R4), reviewed for physician orders, in the sample of 24. These failures resulted in uncontrolled pain for (R3) and development of an acquired pressure ulcer for (R4). Findings include: On 11/5/15 at 9:49am, R3 stated " I feel like I am being held hostage in my bed, in the corner of the room by my pain. I had a new nurse on 11/4/15 during the day who took off my pain patch though it was not supposed to be changed until the next	F 309		

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

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day. I know the patch stays on for three days. E3 (Licensed Practical Nurse) realized it was a day too soon to take it off and stated she could not put another one on until the next day, so I had to wait until the next day. I went the whole day without it and in pain. I only got something for pain in the evening but I said I was in pain all day. "

On 11/6/15 at 9:50am, E3 (Licensed Practical Nurse) stated, " I remember that I gave R3 pain medication during the day. I cannot find that I charted it; all I see is the pain medication I gave her at 6pm. I removed the Fentanyl patch because I thought it had to be removed. I realized it wasn't supposed to be removed and was due to be changed the next day. I apologized and explained to R3 we had to wait until the next day to put it back on. I gave R3 Oxycodone 5 mg once at 6pm during my shift but I did not complete the pain assessment that day as ordered. "

Review of R3 ' S Physician Order Sheet (POS) dated 11/1/15 through 11/30/15 denotes; Fentanyl 25 micrograms (mcg) per hour patch every 72 hours, last signed out as given on 11/2/15. Oxycodone 5 milligrams (mg) tablet every four hours as needed for pain.

Review of R3 ' s Controlled Drug Record on 11/4/15 denotes Oxycodone 5mg tablet given at 6pm by E3.

Review of R3 ' s nursing progress notes dated 11/04/15 by E3, does not mention pain patch being removed or mention of residents complaints of pain. Review of R3 ' s Physician Order Sheet dated 11/1/15 through 11/30/15 denotes; Pain Assessment every shift on scale of one to ten; Record pain level: was left blank on 11/4/15 during the day shift.

Policy labeled Pain Assessment and

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Management, Revised October 2010 denotes in part; 1. Assess the resident ' s pain and consequences of pain at least each shift for acute pain or signification changes in levels of chronic pain.

Review of R4 ' s Treatment Administration Record (TAR) dated 11/1/15 through 11/30/15 denotes; Splint to be worn during the day, on at 6am and off at 9pm. Review of R4 ' s Physician Order sheet (POS) dated 9/24/15 denotes; Splint to be worn during the day, on at 6am and off at 9pm.
On 11/5/15 at 11:20 am, R4 observed in dining room without splint on his right hand.
On 11/5/15 at 11:20 am, E9 (Wound Care Nurse) stated, " The wound is from the thumb nail digging into the next index finger. "
On 11/5/15 at 11:20am, R4 stated, " I am supposed to have a splint on all the time, but they never put it on me. "
On 11/5/15 at 11:22 am, E9 found the splint in the top drawer of bedside table underneath clothes and set it on the bed, then escorted R4 to dining room.
On 11/5/15 at 2:20 pm, R4 observed in dining room without splint on right hand. Splint was sitting on bedside table.
On 11/5/15 at 2:20 pm, E10 (Restorative Nurse) stated, " I believe the resident has the splint off until the wound is healed. "
Review of R4 ' s TAR provided on 11/5/15 at 3:15pm denotes no signature that splint was applied on 11/5/15 and no documentation that resident refused.
On 11/6/15 at 9:35 am, E1 (Administrator) stated, " The splint was removed because the hand is too contracted and I am having someone come in today to fit resident for a new splint. "
On 11/6/15 at 10:40 am, E11 (Licensed Practical

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F 309	Continued From page 3 Nurse) stated, " I was working yesterday and the resident refused the splint. I charted that on the TAR. " Review of TAR provided on 11/6/15 at 11:40am by E2 (Director of Nursing) now denotes documentation from E11 that R4 had refused splint at 6am and was applied at 2pm. On 11/6/15 at 11:40 am, surveyor informed E2 (Director of Nursing) again that R4 was observed on 11/5/15 at 2:20pm with no splint on. E2 (Director of Nursing) stated, " E11 remembered putting the splint on around 2pm, she just charted it today. She had not charted that yesterday. "	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 apply interventions to prevent a pressure sore for one of three residents (R4) reviewed for pressure sores in a total sample of 24 residents. This failure resulted in an avoidable, facility acquired pressure wound on R4 ' s right index finger. Findings include: Review of R4's recent Minimum Date Set (MDS)	F 314		

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F 314	Continued From page 4 dated 8/20/15, Section M0150 denotes, Resident is at risk of developing pressure ulcer and on this date Resident did not have a pressure ulcer. Review of R4 ' s Treatment Administration Record (TAR) dated 11/1/15 through 11/30/15 denotes; Splint to be worn during the day, on at 6am and off at 9pm. Review of R4 ' s Physician Order sheet (POS) dated 9/24/15 denotes; Splint to be worn during the day, on at 6am and off at 9pm. On 11/5/15 at 11:20 am, R4 observed in dining room without splint on his right hand. On 11/5/15 at 11:20 am, E9 stated, " The wound is probably from the thumb nail digging into the next index finger. " On 11/5/15 at 11:20am, R4 stated, " I am supposed to have a splint on all the time, but they never put it on me. " On 11/5/15 at 11:22 am, E9 found the splint in the top drawer of bedside table underneath clothes and set it on the bed, then escorted R4 to dining room. On 11/5/15 at 2:20 pm, R4 observed in dining room without splint on right hand. Splint was sitting on bedside table. On 11/5/15 at 2:20 pm, E10 (Restorative Nurse) stated, " I believe the resident has the splint off until the wound is healed. " Review of R4 ' s TAR provided on 11/5/15 at 3:15pm denotes no signature that splint was applied on 11/5/15 and no documentation that resident refused. On 11/6/15 at 9:35 am, E1 (Administrator) stated, " The splint was removed because the hand is too contracted and I am having someone come in today to fit resident for a new splint. " On 11/6/15 at 10:40 am, E11 (Licensed Practical Nurse) stated, " I was working yesterday and the resident refused the splint. I charted that on the TAR. "	F 314		

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F 314	Continued From page 5 Review of TAR provided on 11/6/15 at 11:40am by E2 (Director of Nursing) now denotes documentation from E11 that R4 had refused splint at 6am and was applied at 2pm. On 11/6/15 at 11:40 am, surveyor informed E2 (Director of Nursing) again that R4 was observed on 11/5/15 at 2:20pm with no splint on. E2 (Director of Nursing) stated, " E11 remembered putting the splint on around 2pm, she just charted it today. She had not charted that yesterday. " Review of R4's initial wound care note, provided by E9 (Wound Care Nurse) on 11/5/15 denotes; Initial Assessment 9/22/15, Stage 4, Acquired at the facility on 9/22/15, hand splint to be worn during the day. Review of R4's Wound Care Consultation note by Z1 (Wound Care Specialist) dated 10/07/15 denotes in part; New onset, Stage 4 pressure ulcer to Right index finger, Place of initial wound onset was faciliy and is pressure related.	F 314		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to give insulin as ordered for one of three residents(R25), reviewed for significant medication errors, from the supplemental sample. Findings include: On 11-03-2015 at 1:30 pm E3 (RN) was observed preparing insulin for R25. R25 received 12 units	F 333		

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F 333	Continued From page 6 of insulin at this time. E3 was asked after E3 administered R25 insulin if R25 has eaten. E3 asked R25 if she has eaten already. R25 stated yes. E3 was asked should the insulin be giving before meals or after meals. E3 stated before meals. On 11-04-2015 reviewed physician order sheet for insulin order and instruction. Novolin R 100 units/ML vial inject 12 units subcutaneous three times daily right before meals 12:30P. Policy: Administering Medication (Revised December 2012) Policy Statement Medication shall be administered in a safe and timely manner, and as prescribed. Policy Interpretation and Implementation Number 4 Medications must be administered within one (1) hour of their prescribed time, unless otherwise specified (for example, before and after meals order) Number 7 The individual administering the medication must check the label THREE (3) times to verify the right resident, right medication, right dose, right time and right method (route)of administration.	F 333		
F 367 SS=E	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, interview and record review, the facility failed to follow facility standardized recipe in preparing pureed fish. This	F 367		

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F 367	Continued From page 7 failure affects one of twelve residents (R15),reviewed for therapeutic diets, from the sample of 24 and eleven residents(R26, R27, R28, R29, R30, R31, R32, R33, R34, R35, R36), in the supplemental samples. Findings include: On 11-4-15 at 10:30 am , during an observation of puree fish preparation with E8 (Dietary Director), E6 (cook) added an unknown amount of white color liquid without using a measure cup into a blender with 12 portions of grounded crunchy baked fish in the blender. E6 turned the blender on for a few minutes and proceeded to transfer the pureed fish into a serving pan for lunch. E6 stated the white color liquid is a mixture of water and food thickener and was added to the ground fish to prepare the pureed fish. When asked on 11/4/15 at 10:45am, what should be the consistency of the pureed fish and how much liquid should be used? E6 stated the consistency of puree food should be creamy but was unable to provide information on the amount of water and thickener mixture used to prepare the pureed fish. When asked E8 on 11/4/15 at 10:50am ,about why the consistency of the pureed fish is runny, E8 stated that the consistency of pureed food should be between mashed potatoes and pudding and once the product is reheated it will become thicker. E8 also stated that slurry is used to prepare pureed fish by mixing water and food thickener, the amount of slurry used to prepare pureed fish for lunch on 11-4-15 is a mixture of 2 quart (equivalent to 4 cups) water and ¼ cup food thickener. Facility recipe for pureed fish indicates to prepare required amount of slurry by blending instant food thickener into milk, broth or stock. The amount of slurry to add per 10-2oz servings fish is ¾ cup of	F 367		

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F 367	Continued From page 8 milk, broth or stock and 1 1/2 Tbsp instant food thickener. Facility policy entitled " Standardized Recipes " indicates in part, the facility uses standardized recipes to assure: 1. Accurate nutrient content, 2. Consistent food quality, 3. Predictable yield. Facility policy entitled " Pureed Food Preparation " indicates in part, food is pureed to a texture similar to the texture of applesauce, mashed potatoes or pudding.	F 367		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to follow its policies in labeling and storing food, on hand washing and safe food handling to prevent cross-contamination and food-borne illness. This has the potential to affecting all 124 residents receiving oral diets from the facility kitchen. Findings include- On 11-3-15 at 9:45 am, during an initial tour of the kitchen with E5 (cook), the following expired products were identified: In the reach-in refrigerators: three 5-lb (pound) containers of	F 371		

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cottage cheese dated 9-21, best to use by date 10-12-15. One 5-lb container of grated parmesan cheese dated 6-22-15, no used- by date. Eleven half sandwiches dated 11-1, used- by date 11-2, no label of names of sandwiches. ¼ serving pan of tuna dated 10-31-15, no used- by date. ¼ serving pan of brown color substance dated 10-2-15, no label of name of product. In the reach-in freezer: one 5-lb container of grated parmesan cheese dated 9-14-15, used-by date 10-30-15. ½ serving pan black eye peas dated 9-3-15, used-by date 9-18-15. In the dry food storage room, one 11-oz (ounce) container of ground thyme with used-by date of 5-22-15, one 11-oz container of red chili pepper flakes with used-by date of 9-31-15, one 11 oz container of celery salt with used- by date of 9-12-15, on 12-oz container of basil with used- by date of 5-23-15, one 12oz container of ground cumin with used- by date of 5-27-15, one 12-oz container of dill weed with used- by date of 5-27-15, one 12oz container of bay leaves with used-by date of 5-22-15.

The following products were identified with no product names and/or no dates: In the reach-in refrigerator, one 3- lb bag of loose, sliced yellow cheese with no product name and date. One sandwich wrapped in plastic with no name and date. In the reach-in freezer, no names and dates on the following items: one 10-lb bag of chicken nuggets, one 10-lb bag of chicken drumsticks, one 15-lb bag of chicken breast, one 5- lb bag of chicken wings.

In the kitchen, instant food thickener was stored in one 1-gal (gallon) labeled mashed potatoes and one 1-gal container labeled with parsley flakes. One 16-oz container of ground black pepper with no date.

In the dry food storage room, three personal

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F 371	Continued From page 10 items are found: an umbrella, a shirt and a sweater. When asked about the facility food labeling and storage policy, E5 stated food items are labeled with receiving dates. Once an item is opened, an open date and a use by date are marked on the item. E5 also stated that personal items should not be stored in food storage area. Facility policy entitled " Labeling and Date Marking Foods " indicates in part, canned food and other shelf stable items such as cake mixes will be marked with the date received. If the product does not have an expiration date, it will be marked with a discard or use by date. The policy also indicates in part, food prepared on the premises to be held cold will be marked with the date of preparation and time as required for proper cooling. This food will also be marked with the date to discard or to use by. Cold food not prepared on the premises will be marked with the dater received and if not opened, will be discarded by the manufacture ' s expiration date. If opened the cold food item will be marked with the date opened and the date by which to discard or use by. Commercially processed foods that contains a " Best If Used By " date such as sour cream, yogurt and deli salads will be marked with the date opened and with a discard/use by date which is either the 6th day after opening or the " Best If Used By " date whichever occurs first. On 11-4-15 at 10:10am during an observation in the dish room, E7 (dietary aide) was observed scraping left-over foods from soiled dishes without wearing gloves. After handling soiled dishes, E7 applied hand sanitizer to hands and proceeded to remove clean dishes from the dish machine. During an interview, E8 stated the dish washer should be wearing gloves when handling soiled dishes and clean hands thoroughly before	F 371		

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F 371	Continued From page 11 handling clean dishes. E8 also stated that in order to clean hands thoroughly, employees should washing hands with soap and water. Facility policy entitled " Dish Room Safe Food Handling " indicates in part, individuals working in the dish room loading dirty dishes into the dish machine will remove their gloves and thoroughly sanitize their hands before crossing over to the clean side of the dish machine where the clean dishes and utensils are coming out of the dish machine. Facility policy entitled " Hand Washing " indicates in part, dietary employees will thoroughly wash their hands and exposed areas of their arms with soap and water at the following times: after touching anything unsanitary (garbage, dirty dishes) and after handling soiled equipment & utensils. On 11-4-15 at 10:30 am, E5 was observed preparing lunch with hair restraint only covered part of hair. When asked what is the proper way to wear hair restraint, E5 attempted to adjust the hair restraint and continued to prepare lunch with part of hair still uncovered by the hair restraint. Facility policy entitled " Hair Restraints/Jewelry/Nail Polish " indicates in part, to reduce the spread of microorganism, employees shall use effective hair restraints.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425		

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F 425	Continued From page 12 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to label multi-dose vial located in one of three medication rooms. Findings include: On 11-05-2015 at 10:30 AM in medication room there was a multi-dose vial of Tuberculin open in the refrigerator with no open date labeled Spoke with E12 (LPN) on 11/5/15 at 10:45am regarding labeling. E12 stated I will throw it out, yes it should be labeled. On 11-06-2015 received policy by E1 (Administrator) titled Administering Medication Number 9 highlighted by facility staff; when opening a multi-dose container, the date opened shall be recorded on the container.	F 425		
F 441 SS=D	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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145776	A. BUILDING _____ B. WING _____	11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 13 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which 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 ensure that handwashing policy was followed for 2 of 4	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 14 residents (R4,R10), reviewed for infection control, in the sample of 24 and 1 resident (R37), from the supplemental sample. Findings include: On 11/4/15, beginning at 10:40am, during the medication administration task, observed E4(Registered Nurse), prepare and administer medications to R4, R10 and R37. E4 did not wash hands before and after administering medications to R4, R10 and R37. E4 on 11/4/15 at 11:00am , was asked should E4 sanitize hands in between contact with each resident ? E4 stated," yes." Policy Handwashing/Hand Hygiene (Revised April 2012) Policy Statement This facility considers hand hygiene the primary means to prevent the spread of infections. Number 6 In most situations, the preferred method of hand hygiene is with an alcohol-based hand rub. If hands are not visibly soiled, use an alcohol-based hand rub containing 60-95% ethanol or isopropanol for all the following situations: a. Before and after direct contact with residents; d. Before preparing or handling medications;	F 441		