STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	145567		12/03/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARE CENTER OF ABINGDON	801 WEST MARTIN STREET ABINGDON, IL 61410

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F 000	INITIAL COMMENTS	F 000		
	Annual Licensure and Certification Survey. Validation Survey for Subpart U: Alzheimer Unit. Care Center of Abingdon is in substantial compliance with Subpart U, 77 Illinois Aministrative Code 300.7000.			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to assess, document alternatives tried, care plan the use of, and obtain a physician's order and informed consent for the the use of a restraint for one of one resident (R8) reviewed for the use of restraints in a sample of 13. FINDINGS INCLUDE: The facility policy titled "Restraints", dated (Revised) 03/03 instructs staff, "It is the policy of the facility to strictly limit the use of restraints in the facility and to promote the least restrictive environment for the resident. Physical restraints shall not be used on a resident for the purpose of discipline or convenience. An assessment done by licensed staff and reassessment done at least every 90 days with the least restrictive restraint method to be used. Must have signed consent by	F 221		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 resident or resident's family for the use of restraints. Must have a physician's order. The care plan shall include the reason for the use of the restraint, types of restraints tried, duration of restraint and location of resident when restrained." The facility form titled, "Final Abuse Allegation" dated 2/24/15 documents, "This is a follow-up to the abuse allegation from 2/22/15. Upon my further investigation it was determined that only one CNA (Certified Nursing Assistant) was involved and one resident. CNA had put gait belt around wheel chair while CNA was sitting at nurse's station with the resident. Staff member was suspended immediately pending investigation and terminated for restraining resident." R8's Physician Order Sheet, dated 2/1/15 includes the following diagnoses: Alzheimer's disease, Anxiety disorder and Depression, and the following activity orders: "May go on therapeutic pass with medications. May go on outings with staff as desired. May participate in activity program as tolerated. May participate in restorative program as tolerated." No physician order for restraints is noted. R8's Minimum Data Set, dated 2/1/15 documents, "Physical Restraints- not used." R8's Care Plan, dated 2/21/15 includes the following approaches to be used when (R8) is anxious: "Provide support when needed. Talk to resident at eye level and quietly ask (resident) what is bothering (resident). Assist with any needs at that time. Give resident space and reapproach at a later time with a different Aide."	F 221		

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F 221	Continued From page 2 R8's "Resident Progress Notes" dated 2/20/15 at 2:31 P.M. document, "Resident noted to have an increase in behaviors. resident is easily agitated, increased confusion and not easily redirected. MD (Medical Doctor) notified." R8's "Resident Progress Notes" dated 2/21/15 at 5:49 P.M. document, "Per another resident, (R8) asked another resident to help (R8) stand. Before staff could reach (R8), (R8) stood and fell on bottom...Fall huddle done. Check for needs often. Keep resident in eye sight while awake (instituted)." On 12/2/15 at 2:03 P.M., E8/CNA (Certified Nursing Assistant) stated, "I came into work between 10:08 P.M. and 10:15 P.M. on 2/21/15. When I came on, I saw (R8) sitting in (R8)'s wheel chair, moving (R8)'s feet. (R8)'s chair wasn't moving. I hung my coat up and turned and saw something shiny. I saw a gait belt around (R8)'s wheel chair, attached to a wooden chair. The chair was beside the desk. (E5) CNA was sitting on the desk, beside the chair. I asked what was going on, (E5) CNA said that was her way of not chasing (R8) up and down the hall." On 12/3/15 at 8:40 A.M., E9/CNA (Certified Nursing Assistant) stated, "On 2/21/15, I came into work around 10:15 P.M. When I came to the unit (secured dementia unit), I saw (E5) sitting on the desk with a gait belt in her hand. (R8) was sitting in a wheel chair and the gait belt was tied around it, preventing (R8) from leaving. (E5) said she was tired of chasing (R8)." On 12/3/15 at 10:10 A.M., E10/CNA (Certified Nursing Assistant) stated, "I was working second	F 221		

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F 221	Continued From page 3 shift the night of 2/21/15. R8 was having some behaviors. (R8) was very antsy, getting up and down all night. Around 9:30 P.M., I saw (E5) put her gait belt through (R8)'s wheel chair so (R8) couldn't move (R8)'s chair." On 12/3/15 at 8:00 A.M., E2 (Director of Nurses) stated, "(R8) did not have a (physician's) order for a restraint (on 2/21/15)."	F 221		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to implement fall precaution interventions for one of seven residents (R1) reviewed for falls in the sample of 13. Findings include: The facility's Care Plan Policy & Procedure form (revised 11/2013) documents the following: "Care plans are available to clinical staff online in the (Electronic Health Record)..." R1's electronic Physician's Orders Sheet (dated 12/1/15- 12/31/15) documents that R1 has a	F 323		

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F 323	Continued From page 4 history of falling diagnosis. On 11/30/15 at 1:30 PM, E3 (Certified Nursing Assistant) and E4 (Certified Nursing Assistant) transferred R1 from R1's high back wheelchair to R1's bathroom with the use of a stand aid. R1's Event Report (dated 10/15/15) documents that R1 had a fall on 10/15/15 while in R1's bathroom. This same form documents the following: "(R1) had a change of plane while being toileted at 11:15 PM. (R1) was sat down before (R1) was back far enough to reach toilet seat. CNA assisted (R1) to floor..." R1's care plan (dated 10/16/15) documents the following: "Problem start date: 10/16/15. Problem: Transfer and Mobility limited by (weakness)... Goal: Resident will transfer with (extensive) assist of 1 with stand aid... Approach start date: 10/16/15. (Transfer Program) (1) cue (R1) to scoot forward in chair, place feet on platform and reach forward pulling on grab bar of stand aid with assist as needed, place split pads under buttocks and cue (R1) to sit slowly and with control. (R1) must not let go of grab bar. Move stand aid to destination, cue (R1) to pull to stand, release pin lock mechanism and instruct (R1) to lower self slowly and with control. Needs extensive assist of 2." R1's Event Report (dated 10/17/15) documents the following: "Description: witnessed fall/change of plane... Why does resident think they fell: (R1) felt legs gave away... (R1) had a change of plane while in the bathroom with (E12, Certified Nursing Assistant). No new onsets of pain or complaints. Fall huddle was implemented upon accident. Vitals are (within normal limits). (R1) was rushing	F 323		

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F 323	Continued From page 5 to the bathroom after supper when (R1) was lowered to the floor in a state of panic when (R1) became incontinent and upset about it. (Power of attorney) and (Medical Doctor) notified..." On 12/1/15 at 10:30 AM, E2 (Director of Nursing) stated that on 10/17/15, R1 was ambulating with E12's assistance to the bathroom when R1 fell. E2 verified that R1's care plan had been updated on 10/16/15 to indicate that R1 was supposed to transfer with a stand aid, and an inservice was provided with R1's updated transfer status. E2 also verified that on 10/17/15, R1 was transferred to the bathroom without the use of a stand aid, which was listed as an intervention on R1's care plan. E2 stated that E12 did not obtain a shift report with R1's updated transfer status prior to assisting R1 to the bathroom resulting in R1's fall.	F 323		
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 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.	F 441		

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F 441	Continued From page 6 (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 perform a glove change during incontinence care for one of five residents (R1) reviewed for incontinence care in the sample of 13. Findings include: The facility's Standard Precautions policy (revised 8/2009) documents the following: "Hand hygiene should be performed immediately after gloves are removed... Utilize hand hygiene between tasks and procedures on the same resident to prevent cross- contamination of different body sites... Change gloves between tasks and procedures on the same resident after contact with material that	F 441		

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F 441	Continued From page 7 may contain infectious agent(s)... Remove gloves promptly after use, before touching noncontaminated items and environmental surfaces..." On 11/30/15 at 1:30 PM, E3 (Certified Nursing Assistant) and E4 (Certified Nursing Assistant) transferred R1 to the toilet. After E4 performed incontinence care and changed E4's gloves, E3 pulled R1's incontinence brief and pants up around R1's waist. E3 and E4 then transferred R1 back to R1's bed. E3 then removed R1's pants and contaminated incontinence brief and discarded R1's contaminated brief. E4 then rolled R1 on R1's side, and E3 applied barrier cream to R1's buttocks. E3 did not remove E3's contaminated gloves, perform hand hygiene or apply clean gloves after removing R1's contaminated brief and prior to applying barrier cream to R1's buttocks. On 11/30/15 at 1:50 PM, E3 verified that E3 did not remove E3's contaminated gloves after removing R1's contaminated incontinence brief and did not put on clean gloves prior to applying barrier cream to R1's buttocks. E3 stated that E3 should have put on clean gloves prior to applying R1's barrier cream. On 12/2/15 at 1:30 PM, E2 (Director of Nursing) stated that E2 would expect the nursing staff to remove contaminated gloves, perform hand hygiene and put on clean gloves when gloves become contaminated and prior to touching a clean surface.	F 441		