STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145364	A. BUILDING _____ B. WING _____	10/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHAMPAIGN COUNTY NURSING HOME	**500 SOUTH ART BARTELL DRIVE URBANA, IL 61802**

(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 and Certification Survey Validation Survey for Subpart U: Alzheimer Unit - 300.7050 d)f)	F 000		
F 159 SS=E	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.	F 159		

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

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F 159	Continued From page 1 The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the resident trust fund account was reconciled. This failure has the potential to affect the seven residents (R6, R7, R8, R14, R16, R18, R25) reviewed for trust fund management in the sample of 26 and 66 residents on the supplemental sample (R4, R9, R38, R39, R40, R41, R44, R47, R48, R49 and R52 through R107). The finding includes: The "Current Balance Report" dated 10-8-15 for the Resident Trust Fund Account listed a balance of $65,815.24. Seventy- three residents (R4, R6, R7, R8, R9, R14, R16, R18, R25, R38, R39, R40, R41, R44, R47, R48, R49 and R52 through R107) have funds in the group account. E42, Facility Accountant, stated on 10-7-15 at 9:30 A.M. the Resident Trust Funds are kept in an interest bearing checking account and in a	F 159		

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F 159	Continued From page 2 Resident Trust Fund petty cash account. E42 stated the bank account and the petty cash account are reconciled. E42 stated the bank and cash accounts are not reconciled with Resident Trust Fund ledger report.	F 159		
F 160 SS=E	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to convey resident trust funds to the residents' estates within 30 days of discharge for seven (R68, R71, R87, R88, R99, R102, and R106) of seven deceased residents reviewed for resident funds on the supplemental sample. The findings include: The facility's "Current Balance Report" dated 10-8-15 lists seven deceased residents with positve cash balances in the group Resident Trust Fund Account. On 10-8-15 at 9:30 A.M., E42, Accountant, provided the dates of death for R68, R71, R87, R88, R99, R102, and R106 and E42 stated that she was aware the funds are to be conveyed within 30 days of death. R68 expired on 8-22-15 with $25.00 in the account. R71 expired on 6-6-15 with $330.01 in	F 160		

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F 160	Continued From page 3 the account. R87 expired on 2-7-13 with $30.00 in the account. R88 expired on 3-28-15 with $127.24 in the account. R99 expired on 11-18-14 with $5,883.30 in the account. R102 expired on 1-15-15 with $967.38 in the account. R106 expired on 1-22-15 with $984.03 in the account. The undated facility Admission Agreement states "Conveyance of any monies you may have on deposit with the Facility will be refunded to your Legal Representative or Responsible Party. Refunds will be made within sixty (60) days of the Resident's death, transfer or discharge."	F 160		
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the Resident Trust Fund Surety bond amount was equal to or greater than the amount of funds in the Resident Trust Fund account at anytime. This failure has the potential to affect seven residents (R6, R7, R8, R14, R16, R18, R25) reviewed for trust fund management in the sample of 26 and 66 residents on the supplemental sample (R4, R9, R38, R39, R40, R41, R44, R47, R48, R49 and R52 through R107). The finding includes:	F 161		

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F 161	Continued From page 4 E1, Administrator provided evidence that the current Resident Trust Fund Surety bond amount was $60,000.00. The Resident Trust Fund "Current Balance Report" dated 10-8-15 listed the total balance of $65,815.24. On 10-8-15 at 9:30 A.M., E42, Accountant stated the Resident Trust Funds are kept in an interest bearing checking account and in a residents' petty cash fund in the facility. E42 stated the petty cash fund balance is around $300.00. The Resident Trust Fund interest bearing checking account bank statement dated 9-30-15 lists the daily balances at $65,033.78 on 9-8-15, $64,629.91 on 9-9-15, $69,111.91 on 9-11-15, $94,681.56 on 9-16-15, $94,716.56 on 9-22-15, $95,729.56 on 9-24-15, $95,798.37 on 9-29-15 and $95,824.05 on 9-30-15. Seven-three of 173 residents in the facility (R4, R6, R7, R8, R9, R14, R16, R18, R25, R38, R39, R40, R41, R44, R47, R48, R49, and R52 through R107) have trust funds managed by the facility per the 10/08/15 Resident Trust Fund Current Balance Report. E1 stated on 10-8-15 at 1:40 P.M., she has requested an increase of the surety bond amount to $100,000.	F 161		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to operationalize their Abuse Policy by failing to check the Healthcare Worker Registry Web Portal for Finger Print Background Checks for five direct care nursing staff and conduct reference checks for 12 direct care nursing staff prior to allowing them to provide direct resident care. This failure has the potential to affect all 173 residents who reside in the facility. Findings include: The facility's Abuse Prevention Program Facility Policy documents, "... The purpose of this policy is to assure that the facility is doing all that is within its control to prevent occurrences of mistreatment, neglect or abuse... This will be done by: Conducting pre-employment screening of new employees... Procedures for Prevention I. Pre-Employment Screening of Potential Employees... Prior to a new employee starting a work schedule, this facility will: Initiate a reference check from a previous employer(s), in accordance with facility policy; ... File an Illinois State Police Healthcare Worker Background Check Application on any individual being hired for a Certified Nurse Aide position... The facility policy and procedures for conducting a Healthcare Worker Background Check will be followed." The facility's Background Screening Investigations Policy documents, "... The Personnel/Human Resources Director, or other designee, will conduct employment background checks, reference checks... Such investigation	F 226		

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F 226	Continued From page 6 will be initiated within two days of employment or offer of employment." The facility did not conduct Healthcare Worker Registry Web Portal for Finger Print Background Checks for the following CNA's (Certified Nurse Assistant): E18 was hired on 7/14/15 and check was completed on 10/6/15. E19 was hired on 7/14/15 and check was completed on 10/7/15. E20 was hired on 8/27/15 and check was completed on 10/6/15. E21 was hired on 7/14/15 and check was completed on 10/8/15. E30 was hired on 6/24/15 and check was completed on 10/7/15. There is no documentation the facility conducted any reference checks for E7, E21-E29, E31-E32, CNA's. On 10/7/15 at 9:40am, E1, Administrator, stated the facility does not have a designated Human Resources Director and that E38, Assistant Administrator, had been helping with the responsibilities of that role which includes conducting the background and reference checks. E1 stated E38 went on leave a couple of weeks ago. On 10/8/15 at 10:15am, E1, Administrator, stated she was unable to find documentation that the background and reference checks had been completed at the time of staff being hired. On 10/8/15 at 2:15pm, E1 stated there is a "possibility for all CNA's to work anywhere in the	F 226		

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F 226	Continued From page 7 building." The Residents Census and Conditions of Residents dated 10/5/15 documents 173 residents reside in the facility.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to keep a resident's body covered when lying in bed with the door open for one of 23 residents (R14) reviewed for dignity in the sample of 26 residents. Findings include: On 10/7/15 at 11:55 AM, R14 was in R14's bedroom lying on the bed, bed was in the high position, with her pants pulled down to her hips and the call light lying on the floor. R14's skin and depends were both visible from R14's doorway. R14's Minimum Data Set (MDS), dated 7/23/15, documents R14's cognitive skills for daily decision making as moderately impaired, decisions poor, and cues/supervision required. R14's MDS also documents R14's functional limitation in range of motion in the upper and lower extremities, as being impaired. R14's	F 241		

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F 241	Continued From page 8 functional status on the same MDS documents R14 as being totally dependent on staff for self performance of activities of daily living. R14's Care Plan, dated 8/11/15, documents staff to provide all hygiene and dressing needs and all incontinent care needs for R14. On 10/7/15, at 12:00 PM, E34 and E35, Licensed Practical Nurses (LPN's), viewed R14's room and stated the call light should not be on the floor, the bed should be in the lowest position, and R14's pants should be pulled up. On 10/7/15, at 3:00 PM, Z3, Certified Nursing Assistant (CNA), stated Z3 went to change R14 by herself but then realized she could not roll R14 by herself. Z3 stated she left R14 with her pants down and R14's bed in the high position, while Z3 went to find help. Z3 stated R14's call light must have fallen on the floor when Z3 was trying to roll R14.	F 241		
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 observation, interview and record review the facility failed to identify, assess and implement interventions to provide pain control	F 309		

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for one of five residents (R20) reviewed with pain and failed to follow swallow precautions for one of six residents (R13) reviewed for swallow precautions, in the sample of 26.

Findings include:

1. The Progress Note dated 8/20/15 documents that R20 has diagnoses of Dementia, Left Breast Mass, End of Life Care, and Clostridium Difficile (C diff) Diarrhea. The Minimum Data Set (MDS) dated 8/27/15 documents that R20 has moderate cognitive impairment and no behaviors. The Pain Assessment dated 8/30/15 documents R20 has "chronic generalized pain" and is on scheduled pain medication. R20's Wound Record dated 9/30/15 documents a "mixed vascular" ulcer measuring 4.0 by 3.5 by 0.5cm (centimeter), erythema, 70% slough and "continues to be painful..."

The Care Plan dated 9/2/15 documents R20 is on hospice related to "end stage disease process, breast mass.." with the following interventions: "Manage pain and other uncomfortable symptoms" ; "Assess for and document characteristics of pain:...severity, frequency...aggravating factors..." and "Observe for nonverbal signs of distress/pain: guarding, moaning,.. grimacing...crying....loss of appetite...."

R20's Physician's Order dated 9/24/15 documents Norco 5-325 mg (milligrams) one tablet qid (4 times a day). R20's Medication Record dated 9/16-10/15/15 documents the Norco is scheduled to be given at 8:00am, 12:00pm, 4:00pm and 8:00pm.

On 10/6/15 at 9:10am R20 was lying quietly in

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bed. At 9:15am E8, CNA (Certified Nurse Aide) and E9, LPN (Licensed Practical Nurse) transferred R20 using the mechanical lift to the wheelchair. R20 was crying and stating "My feet are hurting" during the transfer. E9 gave R20 her medication once she was in the chair. E9 indicated the medication given included pain medication. At 9:30am R20 was crying and when asked stated, "I hurt everywhere." When asked to rate her pain on a scale of 1 to 10 with 10 being the worst pain imaginable, R20 stated her pain was a "10". When asked if her pain was the worst pain imaginable R20 stated, "Yes." When Z1, Sitter lightly touched R20's feet, R20 cried "Be careful, my toes!" When asked if R20 usually acts like this, Z1 stated when R20 is "moved or gotten up she does."

On 10/7/15 at 9:00am R20 was in the wheelchair in her room crying. When asked if she was having pain R20 stated, "Yes." R20 was unable to to rate her pain at the time. On 10/7/15 at 9:00am Z1, Sitter stated R20 started having pain when she got up. Z1 stated that R20 complained of her foot hurting and was crying "Help me, Help me."

On 10/7/15 at 9:30am E7, CNA stated she got R20 up today (10/7). E7 stated when getting R20 up she "cried- [R20] wants her momma, doctor and her dad...never said she was in pain." E7 stated in the past R20 will sometimes say "ouch my leg, sometimes does a lot of crying as touching her legs."

On 10/7/15 at 9:20am R20 was leaving the dining room in the wheelchair with assist from Z1. R20 was holding her right thigh and saying "help me." When asked what was wrong, R20 stated she was having pain. When asked where the pain

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was located, R20 stated, "My eyes" pointing to her eyes.

On 10/7/15 at 9:10am E9, LPN was asked if R20 had her Norco yet this morning (scheduled for 8:00am), E9 stated she's giving it right now and held up a medicine cup with medications for R20.

On 10/7/15 at 9:20am when asked if R20 has pain E9, LPN stated, "She's uncomfortable with the treatment (to heel), nothing else." When asked if she thought R20 was in pain yesterday (10/6) during the transfer from bed to wheelchair, E9 stated "well yes, some pain, some behavior." E9 stated they were giving R20 Morphine for a day or two, but her family thought R20 was too "sedated", so it was discontinued. When asked why pain medication was not given to R20 before moving her, E9 stated early in September they were giving the Norco to R20 before she got up, but sometimes R20 wouldn't take it until she was up, so the time was changed on 9/24/15 to qid.

On 9/7/15 at 9:55am E2, Director of Nursing stated staff need to recognize and assess for pain. E2 stated that behaviors and anxiety are many times because of pain. E2 stated she would expect staff to follow up with hospice and the Physician on the need for pain medications.

The facility policy on Pain Assessment and Management dated 3/2015 documents the following: "Pain management is a multidisciplinary care process that includes...Assessing the potential for pain...Effectively recognizing the presence of pain...the underlying causes of pain....developing and implementing approaches to pain management....monitoring effectiveness of interventions..and modifying approaches as

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F 309	Continued From page 12 necessary....Recognizing pain...Possible behavioral signs of pain...verbal expressions such as groaning, crying, screaming...facial expressions such as grimacing, frowning..." 2. On 10/5/15 at 4:45 PM, E37 CNA had just transferred R13 to his wheelchair, and E37 offered R13 a drink of regular water from a regular cup. R13 took a drink of water. E37 stated she thought R13 could have regular liquids because she has seen R13's family give R13 thin liquids. R13's Physician Orders (POS) dated 5/19/15 document a mechanical soft diet with nectar thick liquids. R13's Medical Nutritional Therapy Assessments dated 5/28/15 and 8/20/15 document R13's diet order as mechanical soft with nectar thick liquids. The Request for Diet Change form, dated 7/22/15 recommends mechanical soft and nectar thick liquids for R13's diet order. R13's Care Plan dated 8/12/15, under nutritional status, documents R13's diet as regular. R13's Care Plan, dated 8/12/15, under Individualized feeding plan, documents R13's diet as regular with thin liquids and for R13 to use nosey cups (cut out cup) with liquids. On 10/6/15 at 10:15 AM, E39, RN, shift supervisor, stated it would be incorrect if regular water was given to a resident with a nectar thick liquid diet order. On 10/7/15 at 4:20 PM, E40 Speech Therapy, stated R13's current diet order is mechanical soft with nectar thick liquids, regular soy milk, and a nosey cup. E40 stated R13 aspirates on thin liquids. E40 stated the nectar thick liquid order is posted on walls, in the intake book, in the hard chart, and every department head gets a copy of diet precautions. On 10/7/15, at 8:30 AM, E48, RN, stated she does not have a reason why R13's Care Plan is	F 309		

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F 309	Continued From page 13 not updated. E48 stated therapy and the nurses are supposed to write new orders on Care Plans then give a copy of the order to the MDS staff. E48 stated this is the only way MDS staff know about a new order.	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide dining assistance for four of 18 residents (R16, R21, R26, R27) reviewed for dining services in the sample of 26. Findings include: 1. R21's Minimum Data Set (MDS) dated 9/22/15 documents R21 requires extensive assistance with one person physical assist for eating. On 10/5/15 at 12:40pm, R21, R27, R110 and R123 were positioned at a table in the dining room. R27, R110 and R123 each had their food in front of them. R21's plate of food was sitting on the tray at the table behind him. E45, Certified Nursing Assistant (CNA) was assisting R110 and R123 with eating their meals. E45 was the only staff member assisting the table of the four residents. At 12:55pm R21 was muttering and	F 312		

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reaching toward the table. At 1:05pm, R21 was muttering and yelled, "Hey!" and was reaching toward the drinks on the table.

On 10/5/15 at 1:15pm, E45, Certified Nursing Assistant (CNA) began assisting R21 and R27 with feeding.

On 10/5/15 at 2:05pm, E45, CNA stated there are "not usually one CNA for four residents; usually there are two CNA's."

On 10/6/15 at 12:20pm, R21, R27, R110 and R123 were seated at the dining room table. At 12:40pm, R21's food was sitting far back on the table in front of him with a cover on it. R21 was reaching toward his plate. At 12:55pm, E44 CNA removed the cover to R21's plate and was getting ready to assist R21 with feeding. R21 was grabbing the food with his fingers and placing the food in his mouth. R21 tried grabbing food quickly multiple times until E44 was able to begin feeding.

2. R27's MDS dated 7/27/15 documents R27 requires extensive assistance with one person physical assist for eating.

On 10/5/15 at 12:40pm, R21, R27, R110 and R123 were positioned at a table in the dining room. R27, R110 and R123 each had their food in front of them. E45, Certified Nursing Assistant (CNA) was assisting R110 and R123 with eating their meals. E45 was the only staff member assisting the table of the four residents.

On 10/5/15 at 1:07pm, R27 was tapping on top of her cover to the plate of her food and was muttering. At 1:15pm, E45, Certified Nursing

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Assistant (CNA) began assisting R21 and R27 with feeding.

On 10/5/15 at 2:05pm, E45, CNA stated there are "not usually one CNA for four residents; usually there are two CNA's."

3. The Physician Order Sheet (POS) dated September 2015 documents R16 has a diagnosis of Dementia. The Minimum Data Set dated 9/16/15 documents that R1 has severe cognitive impairment and requires limited assist of one for eating. The Care Plan dated 9/2/15 documents R16 has a potential for weight loss with interventions as follows: "Encourage oral intake of food and fluids with meals..."

The Nutritional Therapy Assessment dated 9/16/15 documents a 6.9% weight loss in the last 30 days for R16.

The Laboratory Report dated 10/2/15 documents R16's Albumin level is 2.9 with normal being 3.4-5.0.

On 10/5/15 at 12:40pm R16 was served milk, mashed potatoes with gray, Salisbury steak, peas/carrots and a roll. R16's Salisbury steak was not cut up and the roll was not buttered. At 1:10pm R16 tried to cut her Salisbury steak with her fork, but was unable to do it. At 1:15pm E6, CNA was walking around the dining room recording food intakes, but did not encourage R16 to eat or cut up her meat. At 1:20pm E3, CNA (Certified Nurse Aide) cued R16's tablemate (R26) but did not encourage R16 to eat or cut her meat up. At 1:25pm R16 pushed away from the table and was trying to leave the dining room. E4, CNA was present but did not encourage R16 to

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F 312	Continued From page 16 eat or offer to cut up her meat. Continuous observations were made of R16 from 12:40pm to 1:30pm. R16 ate her mashed potatoes and drank half of her milk, but ate nothing else. 4. The POS dated September 2015 documents R26 has a diagnosis of Alzheimer's disease. The MDS dated 9/7/15 documents R26 has severe cognitive impairment and requires extensive assist with hygiene/ dressing and is independent with eating. The Care Plan dated 9/9/15 documents R26 has a potential for weight loss with the following intervention: "Encourage oral intake of food and fluids with meals and between meals." On 10/5/15 at 12:40pm R26 was served potatoes with gravy, ground meat, peas/carrots, pears and a roll. There were no fluids served for R26. R26 was sleeping and not eating. At 1:15pm E6, CNA was walking around the dining room recording food intakes, but did not wake up or encourage R26 to eat. At 1:20pm E3, CNA came up to R26 and stated, "You're not eating." E3 unwrapped R26's silverware and got her a glass of ice tea. E3 told R26 to wake up, gave her a bite of food, then E3 left. At 1:25pm E4, CNA gave R26 a bite of pear and then left. At 1:30pm R4 came back and encouraged R26 to eat. At 1:30pm E5, Assistant Director of Nursing sat down and tried to feed R26. Neither E3, E4 or E5 heated up R26's food which had been sitting since 12:40pm. Continuous observations were made of R26 from 12:40pm to 1:33pm. R26 ate her 10% of mashed potatoes, one bite of meat and pear and drank half of her ice tea.	F 312		
F 314	483.25(c) TREATMENT/SVCS TO	F 314		

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F 314 SS=D	Continued From page 17 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 consistently and accurately assess and implement pressure relieving methods and provide increased protein as ordered to help heal and prevent development of new and recurring pressure ulcers for two of five residents (R8, R21) reviewed for pressure ulcers in the sample of 26. Findings include: 1. R21's Wound History report dated 9/30/15 documents one unstageable open pressure wound to the left heel, one Stage II open pressure wound to the right buttock and one open pressure wound to the left buttock. The treatments for each of those wounds listed in the report document interventions including "Pressure reducing device for chair..." R21's Physician Order dated 8/12/15 documents an order for, "Double protein at meals." R21's tray ticket documents R21 is to receive a double protein serving at meals.	F 314		

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R21's Physician Order Sheet dated 9/13/15 documents an order for, "... wheelchair with four inch cushion." R21's Care Plan dated 4/28/15 documents, "Use a 4 in (inch) cushion for pressure reduction when (R21) is in chair."

On 10/5/15 at 12:40pm, R21 was sitting in his wheelchair at the table in the dining room. There was no cushion on the seat of his chair.

On 10/6/15 at 10:55am, R21's door sign Care Plan documents 4 inch cushion on w/c seat. There was no cushion noted in R21's wheelchair.

On 10/5/15 at 1:15pm, E45 CNA stated R21 had been served one portion of pureed Swiss steak. R21 ate 100% of his Swiss steak. R21 was taken out of the dining room at 2:00pm without being offered a second portion of protein as ordered.

On 10/6/15 at 8:55am, E44 CNA stated R21 was given pureed eggs. E44 stated R21 had eaten 100% of the pureed eggs and that it was one portion. R21 was not offered extra protein and was taken back to his unit. R21 did not have a cushion in his wheelchair at this time.

On 10/6/15 at 10:50am, E41, Registered Nurse stated R21 had "everything (wounds) on (R21's) buttocks was healed. The pressure ulcer on the right buttock just re-opened last Thursday or Friday." E41 stated they are using several interventions to heal and prevent new pressure ulcers from forming, including double protein at meals.

On 10/7/15 at 12:25pm, E43 Dietary Aide stated R21 had pureed pork loin with gravy. E43 stated

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R21 had been served a "single serving" of the protein. R21 ate 100% of the pork loin. R21 was not offered any additional protein and was taken back to his unit. R21's wheelchair did not have a cushion on the seat.

On 10/8/15 at 1:55pm, Z2, Nurse Practitioner stated, "... did (added) double protein... for wound healing..."

The facility policy for Prevention of Pressure Ulcers dated September 2013 documents, "General Guidelines... 6. The facility should have a system/procedure to assure... changes in condition are... addressed. Interventions and Preventive Measures:General... 3. For a person in a chair:.. b. Use... cushion as indicated to relieve pressure... Risk Factor- Poor Nutrition d. Encourage proper dietary... intake."

2. According to the current Physician's Order Sheet (POS) for 9/16/2015 - 10/15/15, R8 has multiple diagnoses including Anemia, Arthritis and Dementia. The hospital Discharge Summary dated 7/22/15 also lists diagnoses of Chronic Kidney Disease, Degenerative Joint Disease, and Diabetes. The Minimum Data Set 9/18/15 assesses R8 as requiring extensive assistance for bed mobility, non- ambulatory, and at risk for pressure sores.

R8's POS lists an order for Skin Check Weekly on Thursdays, 7 - 3 shift. The POS also includes an written order by Z2 (Nurse Practitioner) dated 9/24/15 for Calmaseptine to heels daily, and heel protectors bilaterally. Nurses Notes for 9/24/15 at 10:00pm documents those orders, but does not include assessment or description of the heels. Nurses Notes dated 9/25/15 states, "R' (right) heel dry skin (thick) {no} open areas L' (left) heel

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{no} opened areas. . . Heel protectors encouraged refuses {at times}. . . ." No other nurses notes for 9/25/15 to 10/6/14 addresses the condition of the heels.

On 10/5/15 at 11:00am, foam boots with R8's name on them were on top of R8's clothes closet. On 10/5/15 at 1:15pm, 1:30pm, 2:00pm, 2:20pm and 3:00pm, R8 was in bed with no heel boots and her heels resting on the bed. The foam boots were still on top of R8's clothes closet.

On 10/6/15 at 10:15am, Z3 and Z4 (Certified Nurse Aide/CNAs) transferred R8 to bed. Z3 removed R8's shoes and left her socks on. Upon request, Z3 removed R8's socks so as to visualize R8's heels. R8's right heel was red with peeling skin around the perimeter. Z3 replaced R8's socks and replaced the bed covers. No heel protectors were placed nor were R8's heels elevated off the mattress. The foam boots were on top of R8's clothes closet.

On 10/6/15 at 10:45am, E17 (Licensed Practical Nurse) confirmed with the Treatment Administration Record (TAR) for 9/16 - 10/15/15 that R8's Calmaseptine treatment was on the evening shift, and the heel protectors bilaterally. The TAR entry for heel protectors also said "CNAs to apply and sign off." The entry was designated "11 - 7" and E17 said maybe the heel protectors were just at night. E17 concurred that the order did not specify and that R8 spent much of her time in bed during the day. E17 also stated that the CNA documentation would be on the CNA ADL (Activities of Daily Living) tracking sheet. R8's ADL tracking sheet for 10/15 had no entry or documentation regarding the heel protectors. At 10:55am, E17 attempted to place

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F 314	Continued From page 21 the foam boots, and R8 stated, "those aren't mine, those don't go on my feet." On 10/6/15, R8 remained in bed with heels resting on the mattress at 12:00pm, 12:30pm and 2:00pm. On 10/7/15 at 9:30am, R8 was in bed with no heel protectors and heels resting on the mattress. At 11:00am, R8's heels were elevated on a pad off the mattress. R8's careplan for risk of skin breakdown last reviewed on 9/22/15 does not include or address the use of heel protectors. The careplan does state, "Conduct a systematic skin inspection WEEKLY and PRN (as needed). Pay particular attention to bony prominences." R8's TAR for 9/16 - 10/15/15 documents only one skin check dated 9/24/15. As per the Physician's Order for weekly skin checks on Thursdays, skin check should have been completed on 9/17/15 and 10/1/15. On 10/8/15 at 12:30pm, E2 (Director of Nursing) confirmed that skin checks should be done/documented once a week. The facility policy for Prevention of Pressure Ulcers dated September 2013 states, "When in bed, every attempt should be made to 'float heels' (keep heels off of the bed) by placing a pillow from knee to ankle or with other devices as recommended by clinical staff or by the physician." The facility policy for Pressure Ulcer Risk Assessment states, "Skin will be assessed for the presence of developing pressure ulcers on a weekly basis or more frequently if indicated. . . . Nurses will conduct skin assessments at least weekly to identity changes."	F 314		
F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN	F 363		

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F 363 SS=E	Continued From page 22 ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure that pureed diets were planned and served for three of three residents (R8, R13 and R21) reviewed for pureed diets on the sample of 26 and 25 residents on the supplemental sample (R4, R32, R42, R66, R72, R74, R83, R85, R95, and R107 through R122). The finding include: E12, Cook was preparing the pureed lasagna at 10:00 A.M. on 10-6-15. According to the recipe, a three inch by four inch piece was the planned serving size for a regular diet. E12 stated that he was going to puree one three inch by four inch piece for each resident receiving a puree diet. The recipe stated that the three inch by four inch piece would yield three ounces of protein per serving. The spreadsheet listed the pureed diet was to be served "1 Pc. (piece) Pureed Lasagna." The spreadsheet did not have measurements to be followed for pureed diet serving size. On 10-6-15 beginning at 11:35 A.M., the noon meal service was observed. E12, Cook and E13,	F 363		

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F 363	Continued From page 23 Cook were serving from steam tables. E13 served the first pureed diet and she used one four ounce (by volume) dipper. E12 and E13 stated that they would use one four ounce dipper to serve the pureed Lasagna. On 10-6-15 at 12:05 P.M., E16 Registered Dietitian was shown the spreadsheet and was asked what would be the serving size for the pureed Lasagna. E16 stated it should be at least six ounces (serving size volume). According the resident diet list dated 10-6-15, 28 residents (R4, R8, R13, R21, R32, R42, R66, R72, R74, R83, R85, R95, and R107 through R122) have puree diet orders.	F 363		
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, record review, and interview, the facility failed to ensure that potentially hazardous food requiring refrigeration was labeled with the date and time of preparation and rapidly cooled to an internal temperature of 41 degrees Fahrenheit (F.) or below, failed to	F 371		

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F 371	Continued From page 24 ensure that manual chemical sanitizing solution was used at the required concentration, failed to ensure that food contact surfaces were clean and free of residues, and failed to ensure that the walk in vegetable refrigerator ceiling and wall were free of black residue and condensation. These failures have the potential to affect all 173 residents. The findings include: 1. E12, Cook, stated on 10-5-15 at 8:30 A.M. that roast beef was the protein source for the 10-7-15 noon meal. E12 stated he sliced the beef and it was in the oven. E12 stated the beef was a 30 pound beef round that was cooked the previous day, 10-4-15 by E14, Cook. E12 stated the beef was in the pan it was cooked in and the juice. E12 stated the pan was covered with aluminum foil and labeled. E12 pulled the discarded foil out of the trash. The foil had the date and a time of 5:00 P.M. E15, Dietary Manager was shown the foil and he verified that the information on the foil did not include recorded times or temperatures to ensure that beef roast was cooled to 41 degrees F. or below. A cooling log or documentation was not provided to ensure that beef roast was cooled within the correct times and temperatures. E13 stated on 10-7-15 at 8:50 A.M. that the beef roast internal temperature was 203 degrees F. at 6:00 P.M. when it was pulled out of oven on 10-4-15. E13 stated that on 10-4-15 at 7:00 P.M. the internal temperature was 70 degrees F. E13 stated that she did not record the temperatures and times. The Dietary Department is managed by an outside contractor. The "food preparation" policy and procedure used in the Dietary Department	F 371		

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F 371	Continued From page 25 states to "place potentially hazardous food in a shallow pan or cut/slice to promote rapid cooling. Time/Temperature Control for Safety (TCS) foods will be cooled from 135 degrees F. to 70 degrees F. within 2 hours. TCS food will be cooled from 70 degrees F. to 41 degrees F. within 4 hours. Total cooling time cannot exceed 6 hours. TCS foods will be labeled and dated." Once the observation and concern was reviewed with E15 and total length of time could not be verified, he voluntarily discarded the beef roast intended for service to residents and made a substitution for the noon meal. 2. On 10-6-15 at 10:05 A.M., the hot water sanitizing dishmachine was not functioning. Therefore, all washing, rinsing and sanitizing was being manually done in the three compartment sink. The quaternary ammonium sanitizing solution was tested to provide 0 (zero) parts per million available sanitizer resulting in resident dishware not being sanitized. 3. The following food contact equipment and surfaces were observed between 8:30 A.M. and 9:30 A.M. on 10-6-15. E15, Dietary Manager witnessed and acknowledged the presence of the unclean equipment and surfaces: a). The meat slicer had meat and grease residue present on the back of the blade, on the back blade guard, on the motor housing, and on thickness blade adjustment controls. b). The large floor mounted mixer had dark brown and light colored food splatters present on the armature and food contact surface of the mixer above the mixing bowl.	F 371		

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F 371	Continued From page 26 c). The large table mounted mixer had white colored food splatters present on the sides, on the mixer armature and on the food contact surface of the mixer above the mixing bowl. d). A large yellow cutting board was stored under the preparation counter with dark brown residue present. e). The table mounted vegetable chopper had old food residue from previous operation present on it. f). Two large 12 inch frying pans on a hanging storage rack had a heavy accumulation of burnt on food and grease residue present on them. The pans' aluminum was pitted and the nonstick surface was worn off. g). The tilt skillet cooking surface had an accumulation of grayish brown residue on it that was easily removable with friction. 4. On 10-6-15 at 9:20 A.M., the walk in vegetable refrigeration unit had black residue present along the junction of the ceiling and the wall in the left corner. Boxes of lettuce were stored under the residue. Condensation was present along the junction of the back wall and the ceiling. According to the facility's "Resident Census and Conditions of Residents" dated 10-5-15 and signed by E1, the Administrator, 173 residents reside at the facility.	F 371		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 27 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. (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	F 441		

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review the facility failed to establish an infection control program to monitor and track symptoms of employee illness. This failure has the potential to affect all 173 residents residing in the facility. In addition the facility failed to prevent the potential spread of infection by failing to use good hand hygiene (R16), failing to provide education on the use of Personal Protective Equipment (PPE) to a private caregiver and failing to use a disinfectant on the floor of one resident (R20) reviewed with Clostridium difficile (C. difficile) infection.

Findings include:

1. The Employee Illness Spreadsheet dated 7/1/15-10/8/15 documents employee call in's, but doesn't document specific symptoms of illness (vomiting, cough, fever, diarrhea), which is needed to monitor and trend employee illness, in order to prevent the potential spread of infection to residents.

On 10/8/15 at 2:30pm E2, Director of Nursing (DON) stated employees call the "call in phone" and leave a message when ill. E2 stated the shift supervisor listens to the message and takes the staff off the schedule. E2 stated no one questions staff about their symptoms or monitors the employee's return to work after illness. E2 stated if an employee is ill for 3 days they must provide a Physician's excuse to return to work, but per the union contract they have seven days to provide the Physician's note.

On 10/8/15 at 3:00pm E1, Administrator stated the employee union contract states that staff "do not have to talk to a person when they call in, must have a call-in phone." E2 stated when they try to question employees about symptoms, the

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union says we are "interrogating staff."

The facility policy titled "Employee Health-Infection Control" dated 8/2008 documents the following: "..Identify and address health-related issues that affect staff, including those that can affect residents and those that may be affected by residents..Monitor and investigate exposure to, and presentation of, infections among employees..."

The Resident Census and Condition of Residents report dated 10-5-15 documents a facility census of 173 residents.

2. The Progress Note dated 8/20/15 documents that R20 has diagnoses of Dementia and Clostridium Difficile Diarrhea. The September 2015 Physician Order Sheet (POS) documents R20 is in Contact Isolation.

On 10/5/15 at 9:15am E46, LPN (Licensed Practical Nurse) stated that R20 was still symptomatic (loose stools) for C. difficile infection.

On 10/5/15 at 11:25am Z1, Private Caregiver was sitting in R20's room without any PPE, including gloves being used.

On 10/6/15 at 9:15am E8 and E7 CNAs (Certified Nurse Aide) and E9, LPN were in the room with Z1, who was not wearing any PPE. E8, E7 and E9 did not educate Z1 on the need for PPE. At 9:15 and 9:30am Z1 fed R20 breakfast and was sitting in R20's room without any PPE being used.

On 10/7/15 at 9:00am, Z1 emptied the bedside trash receptacle by removing the plastic bag, with

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her bare hands and no gown, placing the bag in the barrel in the room. A soiled disposable brief was in the trash receptacle. Z1 did not wash her hands. At 9:30am Z1 was sitting in R20's room without any PPE being used.

On 10/7/15 at 10:00am Z1 stated R20's son (Z5) told her that R20 had C. difficile. Z1 stated she asked Z5 if she needed to do anything and was told to just wash hands, that he doesn't wear gown or gloves. When asked if staff had provided any education to her on the need to wear gloves and gown when in the room with R20, Z1 stated "No, staff has never told me anything."

On 10/7/15 at 10:55am E11, RN (Registered Nurse) Unit Coordinator stated Z5 was educated by nursing to use PPE when in R20's room. E11 stated Z1 is a sitter to provide comfort for R20. E11 stated she did not educate Z1 about the need to wear PPE. E11 stated "when she (Z1) came in-education would be done." E11 then went and talked with Z1 and told her that "her agency or us should have educated her." E11 confirmed she shouldn't have "assumed" that education had been provided to Z1.

The facility policy titled, "Clostridium Difficle" dated 7/2014 documents the following, "Visitors will be encouraged to wear gowns and gloves, and instructed on proper hand hygiene...Healthcare workers will wear gloves and gowns upon entering the room of a resident with C. difficle (Clostridium difficile) infection..."

3. The Progress Note dated 8/20/15 documents that R20 has a diagnosis of Clostridium Difficile Diarrhea. The September 2015 Physician Order Sheet (POS) documents R20 is in Contact

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F 441	Continued From page 31 Isolation. On 10/5/15 at 9:15am E46, LPN (Licensed Practical Nurse) stated that R20 was still symptomatic (loose stools) for C. difficile infection. On 10/6/15 at 12:25pm E10, Housekeeper stated she uses a cleaning agent to clean the floor in R20's room. The Material Safety Data Sheet dated 12/15/14 states the product used by E10 is a "cleaning agent." The facility policy titled "Resident Room Cleaning" dated 7/2014 documents the following, Prepare disinfectant according to manufacturer's recommendations...Utilize disinfectant solution based on type of precaution..." The facility policy titled "Clostridium Difficle" dated 7/2014 documents "Disinfection of items with potential fecal soiling....using a disinfecting agent recommended for C. difficile..." On 10/7/15 at 10:30am E47, Environmental Director confirmed that facility staff are to use a disinfectant to clean the floors. E47 confirmed the current disinfectant in use is a quaternary ammonia product and is not effective against C. difficile. 4. On 10/5/15 at 1:35pm E7 and E6 (Certified Nurse Aides) provided perineal care to R16 following a urinary incontinence. After cleaning R16's perineal area, E7 did not remove the glove used during the perineal care. Still wearing the contaminated glove, E7 touched the tube of protective ointment, container of disposable	F 441		

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F 441	Continued From page 32 wipes, top sheet, bedspread, bolsters and R16's shirt before removing her gloves. On 10/5/15 at 1:40pm E7 stated she "forgot to change my gloves when finished with peri [perineal] care."	F 441		