STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(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 Certification Survey Federal Oversight and Support Survey (FOSS)	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in	F 225		

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 225	Continued From page 1 accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review facility staff failed to immediately notify the Abuse Prohibition Coordinator of an allegation of abuse for one of two allegations of abuse reviewed. As a result the staff member was not immediately suspended and this allowed her to have potential access to 25 residents in Title 18 certified beds out of a licensed capacity of 102 residents. Findings include: An abuse allegation investigation dated August 11, 2010 reads as follows: "...On August 11, 2010 at 5:10 PM, (E16 Social Services) was notified by (E18 Registered Nurse) Clinical Coordinator of an allegation of abuse." E19, Activities Assistant, stated on 2/10/2011 at 1:30 PM that a resident (undesignated) stated to her (the activities assistant) on 8/11/2010 between 3:00 PM and 4:00 PM that (E15) Certified Nursing Assistant (CNA), "made her (the resident) feel like an imbecile." She stated that she (E19) considered the statement to be an allegation of abuse. (E19) stated she immediately reported this to (E18) Registered Nurse and Clinical Coordinator. (E19) stated she was not sure of the exact time but that it could not have been any later than a few minutes after 4:00 PM.	F 225		

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F 225	Continued From page 2 E18, RN (Registered Nurse), Clinical Coordinator stated on 2/10/2011 at 2:00 PM that she remembers the incident but does not remember what time she reported the incident to (E16), Social Services and Abuse Prohibition Coordinator. E18 stated that it could have been after 5:00 PM. E16, Social Service Coordinator and Abuse Prohibition Coordinator confirmed on 2/10/11 at 2:15 PM she was notified of the allegation at 5:10 PM on 8/11/10. E16 also confirmed E15 would have had access to all residents in the facility between the time the allegation was reported to E18 and when E15 was sent home. A facility timekeeping document titled "Audit Punch Report" shows the latest time E15 clocked out is at 6:00 PM on 8/11/2010. A facility document titled "Abuse Prevention and Prohibition" states, "...Any employee who has knowledge or reason to believe that a resident has been a victim of abuse is under duty to immediately (immediately is underlined) report such incident or suspicion to his /her immediate supervisor. Please note: The Resident must be protected from harm during the investigation..." A current review of the residents in Title 18 Certified beds show that five out of sixteen are cognitively impaired and have a potential for abuse.	F 225		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status.	F 278		

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F 278	Continued From page 3 A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to accurately assess and identify a significant weight loss (13%) in one week for R2, one of three residents sampled with weight loss and nutritional needs in a total sample of 7. The facility also failed to follow their policy for weighing residents and reporting weight loss to the Registered Dietician . Findings included:	F 278		

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F 278	Continued From page 4 The Physician's Order Sheet (POS) dated February 2011 lists the following diagnoses for R2: Cerebral Vascular Accident , Diabetes and Parkinson's. The Minimum Data Set (MDS) dated 2/8/11 states that R2 requires extensive assistance for all activities of daily living to include bed mobility, transfers and toileting. The MDS continues to identify that R2 has impairment of both upper and lower extremities on one side of her body and is unable to move that part of the body. The MDS dated for 1/20/11 documents R2's weight at 122 pounds and the MDS dated 2/8/11 documents R2's weight at 110 pounds. R2's nutritional assessment dated 1/23/11 states "... Assessment: (R2) admitted with reasonably good nutritional status, although BMI (Body Mass Index) of 22.3 slightly below goal for age. At this time, current eating pattern as reported by spouse puts (R2) at high risk for malnutrition, hypoglycemia. .....Current Accuchecks are running slightly high, even in evening/HS (hour of sleep). Plan: .....Spouse (as available) and unit staff to provide cueing/encouragement for (R2) to eat and take fluids. Weigh weekly and monitor for changes. Will recommend add an HS snack of chocolate ice cream to help prevent nocturnal/early AM hypoglycemia. Continue to weigh weekly and monitor for changes. RD (Registered Dietician) will follow up quarterly or PRN (when ever necessary)." The facility policy titled "Weighing Residents/Weight Loss" dated 1/21/10 states under the section "Scope" states "To ensure that residents are weighed regularly and that residents with significant weight loss are addressed. The section titled "Procedure" states " Nursing will weigh each resident upon	F 278		

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F 278	Continued From page 5 admission and then at least three out of four weeks each month. If there is more than a 4 pound difference from the previous weight, the resident will be re-weighed. The Registered Dietician will review the weights on a weekly basis and will then re-assess the resident and identify if "significant" weight loss has occurred. Significant weight loss is identified as losing 5% body weight in the past 30 days and/or losing 7.5% body weight in the past 90 days and/or losing 10% body weight in the past 180 days. If the resident has indeed shown a significant weight loss, then an appropriate Plan of Care will be developed to address the weight loss. The Plan of Care will be developed with collaboration of the Registered Dietician, the Primary Physician and the staff as appropriate." R2's Weight Trend Graph dated 2/10/11 shows that R2 was weighed upon admission to the facility on 1/13/11 at 122 pounds. The second admission to the facility on 1/27/11 records the weight to be 126.50 pounds. The weight of R2 which was done on 2/1/11 records 110 pounds and weight on 2/8/11 is recorded to be 110 pounds. This Weight Trend Graphs records that R2 lost 16.5 pounds in 10 days and 13.04% in 12 days. R2's Nurses Notes dated 2/9/11 at 6:02 PM from E17, RD (Registered Dietician) states ".....Noted weight at 110 pounds, questionable how to reconcile this with previous weight of 122 pounds and 126 pounds, referred questions to clinical coordinator on weigh assessment..." On 2/9/11 at 10:20 AM E17, RD stated in interview that she was not aware of the decrease in R2's weight loss and that R2 should of been	F 278		

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F 278	Continued From page 6 re-weighed to determine if there was a mechanical error with the weight loss. E3, Clinical Coordinator stated on 2/9/11 at 2:55 PM that R2's care plan had not been updated to address weight loss and the policy for weighing residents was not followed for R2.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to review and revise care plan interventions for R2 one of two residents sampled for pressure ulcers in a total sample of 7. R2 has a facility acquired pressure	F 280		

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F 280	Continued From page 7 ulcer assessed as an unstageable suspected deep tissue injury that had not been addressed in the care plan for the necessary care and services to help promote healing. Findings include: The Physician's Order Sheet (POS) dated February 2011 lists the following diagnoses for R2: Cerebral Vascular Accident , Diabetes and Parkinson's. The Minimum Data Set (MDS) dated 2/8/11 states that R2 requires extensive assistance for all activities of daily living to include bed mobility, transfers and toileting. The MDS continues to identify that R2 has impairment of both upper and lower extremities on one side of her body and is unable to move that part of the body. The same MDS identifies that R2 has an unstageable pressure ulcer with suspected deep tissue injury. The facility's skin assessment titled "Braden Skin Assessment" dated 1/13/11 identifies R2 as high risk for pressure ulcers. The facility's documentation titled "Skin Assessment Form" documented on 1/29/11 states that R2 acquired a skin condition on 1/29/11 and is receiving a treatment to this area twice a day till healed. The skin assessment describes the area to be 3 cm (centimeter) by 0.5 cm red area on left outer heel. The skin assessment form states the cause of the area is "Pressure". R2's nurses note dated 1/29/11 states "(R2) has a 3 cm by 0.5 cm red area on left outer heel; treatment of 3M (skin prep) started bid (twice daily), pillow placed under legs to float heels."Nurses Notes dated 2/2/11 states "Area is a suspect deep tissue injury. Persistent dark red and boggy feel to area."	F 280		

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F 280	Continued From page 8 At 10:50 AM on 2/9/11 E20, RN (Registered Nurse) performed the treatment for R2's left outer heel and described the pressure area to be red in color and the center area feels mushy/boggy. Upon completion of the treatment E20, RN replaced the non-skid socks over the heels and placed the heels back onto the mattress of the bed. The facility's policy titled "Skin Impairment Prevention and Wound Management" dated 8/1/08 under the area "#4 Managing Tissue Load" states " It is the policy of this facility to manage tissue load and improve tissue tolerance to pressure, friction and shearing forces. This will be accomplished through the use of appropriate positioning practices, postioning devices, and support surfaces." Care Plan dated 1/27/11 for R2 does not address the pressure ulcer or the use of preventive devices to float (off loading) the heels to prevent further pressure on the heels. The Care Plan dated 2/8/11 states that R2 has an area that is a suspected deep tissue wound to the left outer heel but does not discuss the interventions to float or off load the heels to help prevent further pressure on the heels. E3, RN Clinical Coordinator confirmed on 2/9/11 at 2:55 PM the care plan for R2 does not address the issues of the pressure ulcer on the left outer heel or preventative measures to float or off load the heels .	F 280		
F 314 SS=G	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	F 314		

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F 314	Continued From page 9 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 any pressure relieving devices to R2's pressure ulcer located on the left heel. The facility also failed to notify the Registered Dietician of this pressure ulcer and a 16.5 pound weight loss for R2. R2 acquired the deep tissue injury in the facility. R2 was one of two residents sampled (R2,R3) for pressure ulcers in a total sample of 7. Findings include: The Physician's Order Sheet (POS) dated February 2011 lists the following diagnoses for R2: Cerebral Vascular Accident , Diabetes and Parkinson's. The Minimum Data Set (MDS) dated 2/8/11 states that R2 requires extensive assistance for all activities of daily living to include bed mobility, transfers and toileting. The MDS continues to identify that R2 has impairment of both upper and lower extremities on one side of her body and is unable to move that part of the body. The same MDS identifies that R2 has an unstageable pressure ulcer with suspected deep tissue injury. The facility's skin assessment titled "Braden Skin Assessment" dated 1/13/11 identifies R2 as high risk for pressure ulcers. R2's nutritional assessment dated 1/23/11 states that	F 314		

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F 314	Continued From page 10 ".....(R2) current eating pattern .....puts (R2) at high risk for malnutrition and hypoglycemia.....Weigh weekly and monitor...". The facility's documentation titled "Skin Assessment Form" documented on 1/29/11 states that R2 acquired a skin condition on 1/29/11 and is receiving a treatment to this area twice a day till healed. The skin assessment gives the description of the area to be 3 cm (centimeter) by 0.5 cm red area on left outer heel. The skin assessment form states the cause of the area is "Pressure". R2's nurses note dated 1/29/11 states "(R2) has a 3cm by 0.5cm red area on left outer heel; treatment of 3M (skin prep) started bid (twice daily), pillow placed under legs to float heels."Nurses Notes dated 2/2/11 states "Area is a suspect [sic] deep tissue injury. Persistent dark red and boggy feel to area." The admission nursing notes of 1/26/2011 shows R2 did not have any skin issues upon admission. On 2/8/11 at 1:10 PM R2 was sitting in the wheelchair with no- skid booties on both feet and both feet were resting directly on the wheelchair pedals. R2 was transferred to her bed from the wheelchair by use of a mechanical lift at 2:10 PM by E9 and E14 CNA's (Certified Nurse Assistants), and was positioned on the left side with a pillow to the back area. R2's heels were sitting directly on the bed . On the same day at 4:30 PM R2 was lying in the bed directly on her back with her heels resting directly on the bed. R2 at 10:10 AM on 2/9/11 was sitting up in bed with her heels resting directly on the bed. R2 lifted her left heel up off the bed and a beefy reddened area with flaky skin and soft mushy center was present on the outer heel.	F 314		

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F 314	Continued From page 11 At 10:50AM on 2/9/11 E20, RN (Registered Nurse) performed the treatment for R2's left outer heel and described the pressure area to be red in color and the center area feels mushy/boggy. Upon completion of the treatment E20, RN replaced the non-skid socks over the heels and placed the heels back onto the mattress of the bed. R2's Weight Trend Graph dated 2/10/11 shows that R2 was weighed upon admission to the facility on 1/13/11 at 122 pounds. The second admission to the facility on 1/27/11 records the weight to be 126.50 pounds. The weight of R2 which was done on 2/1/11 records 110 pounds and weight on 2/8/11 shows to be 110 pounds. Total weight loss of 16.5 pounds was not reported to E17, Registered Dietician. On 2/9/11 at 10:20 AM E17, Registered Dietician stated that "No, I did not know about (R2)'s pressure ulcer . I found about it last night in our meeting with the Administrator.....No, I was also not told of the weight loss issue with (R2)....." Care Plan dated 1/27/11 for R2 does not address the pressure ulcer or the use of preventive devices to float (off loading) the heels to prevent further pressure on the heels, and the care plan does not address the issue of weight loss for R2. The facility's policy titled "Skin Impairment Prevention and Wound Management" dated 8/1/08 under the area "#4 Managing Tissue Load" states " It is the policy of this facility to manage tissue load and improve tissue tolerance to pressure, friction and shearing forces. This will be accomplished through the use of appropriate	F 314		

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F 314	Continued From page 12 positioning practices, positioning devices, and support surfaces." E3, RN Clinical Coordinator confirmed on 2/9/11 at 2:55 PM the care plan for R2 does not address the issues of the pressure ulcer on the left outer heel, preventative measures to float or off load the heels or the decrease in weight that R2 has experienced.	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: Based on observation, record review and interview the facility failed to provide appropriate perineal care for one of one residents R2, sampled for incontinence care in a total sample of 7. Findings include: The Physician's Order Sheet (POS) dated February 2011 lists the following diagnoses for R2: Cerebral Vascular Accident , Diabetes and Parkinson's. The Minimum Data Set (MDS) dated 2/8/11 states that R2 requires extensive	F 315		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 13 assistance for all activities of daily living to include bed mobility, transfers and toileting. The MDS continues to identify that R2 has impairment of both upper and lower extremities on one side of her body and is unable to move that part of the body. R2's care plan dated 1/27/11 states that the use of a mechanical lift is utilized for all transfers and that R2 is incontinent of bowel and bladder. E13, CNA (Certified Nurses Assistant) on 2/8/11 at 2:10 PM performed incontinence care on R2. E13,CNA completed the procedure and then took another disposable no rinse cloth and went down the perineal area on the right side, left side and the middle of the perineum with the same cloth and same area of the cloth. Upon disposing of the cloth there was visible stool seen on the cloth. E13,CNA stated on 2/8/11 at 2:20 PM that she did not realize she did not change cloths when she did the care and confirmed there was stool on the cloth.	F 315		
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	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	02/10/2011

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F 323	Continued From page 14 review the facility failed to use interventions contained in R4's Care Plan to prevent falls/injuries. In addition facility staff failed to use gait belts on two occasions when transferring R4. Gait Belts are to be used for R4 per facility policy. R4 is one of three residents sampled for falls/injuries. Findings include: R4's first person care plan dated 2/8/11 states, "...I have been admitted to the (facility) from the hospital after having a fall at home, down my stairs, resulting in a (fracture) at (3rd Lumbar vertebrae). I have a history of atrial fibrillation, hypertension, anxiety, depression, chronic affective disorder, and osteoporosis...Mobility: Transfers: I need assist with my transfers. Ambulating: I need assist with my ambulation. Safety Notes/Falls: I am at risk for falls. I am in a hi lo bed with a mobility monitor...Keep my bed in the lowest position when I am in it...My goal is to have no falls or serious injury from falls..." On 2/8/2011 at 2:30 PM R4 was in her bed with her personal alarm not attached. At the same time R4 was in her bed with the bed in the highest position. When asked what she would do if she needed to go to the bathroom; would she activate her call light and get help from staff? R4 stated she would not want to bother the staff, she "would just get up and go..." On 2/10/11 at 11:00 AM E20, Registered Nurse, stood R4 up to check her buttocks for pressure sores. E20 stood R4 with the aid of R4's rolling walker. R4 was heard to make the comment when she first stood "...I feel unsteady..." E20 went ahead with the inspection and failed to get	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	02/10/2011

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F 323	Continued From page 15 assistance or to use a gait belt for safety. R4 stood with just her walker for at least 3-4 minutes. On 2/10/11 at 11:30 AM, E14 Certified Nursing Assistant, transferred R4 from her chair to her wheelchair and transferred her from her wheelchair to the toilet and back again without a gait belt. A facility policy titled "Safe Resident Handling Program" states, "...4. Gait Belt: Residents who require limited assistance (fully weight bearing) will be transferred with a gait belt. Gait belts are to be used on anyone that is not independent. If they are stand-by assist, they need to have a gait belt..."	F 323		
F 371 SS=E	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 protect resident food from potential contamination, by failing to cover food items on trays delivered to resident rooms for two of two meals observed (R1, R2, R3, R4,); staff failed to wear gloves, to avoid bare hand contact with ready to eat food in the kitchen;	F 371		

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 371	Continued From page 16 failed to manually wash, rinse and sanitize six of six coffee and hot water carafes to ensure cleanliness of equipment; and failed to label potentially hazardous food stored in the walk in cooler with the date and time of preparation to ensure residents receive a sound/wholesome product on two of two days observed. The findings include: 1. On 2/08/11 at 11:45 am Dietary staff, E10 was slicing fresh red peppers. E10 was not wearing gloves and was holding the red pepper with his bare hand as he was slicing them. E10 stated that the red peppers would be served as a garnish. E10 was still handling the red peppers with bare hands during a subsequent observation at 11:50 PM. E8 stated on 2/10/11 that E10 should have been wearing gloves to prepare and handle any ready to eat foods. 2. The noon meal service was observed in the Renewal Dining Room on 2/08/11 at 12 noon. Four of the residents were served room trays, R1, R2, R3, and R4. The hot food on the plate was covered with a plastic dome and the beverages had lids, but the cold items on the plates such as cottage cheese, pears, cookies, chips, and pickles were not covered. On 2/08/11 at 12:35pm Certified Nurse Aid (CNA) E13, took lunch trays for R1 and R2 from the dining room to their rooms on the 200 hallway, without covering the cold food items. CNA E14 took additional room trays down the 200 hall without covering the cold foods for R3 and R4 at 12:40 PM. On 2/09/11 at 12:30pm CNA E15 took a room tray down the hall to resident room 217 with an uncovered bowl of pudding. Dietary Manager E8 stated during interview on 2/10/11 at 8:50 am that	F 371		

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 371	Continued From page 17 all food taken out of the dining room for delivery to residents should be covered and that they have now started covering the entire tray with plastic wrap. 3. Hot coffee and hot water was held in stainless coffee carafes in the Renewal Dining room and Assisted Living Dining room on 2/8, 2/9 and 2/10/11. Each dining room had three carafes, one for regular coffee, decaffeinated coffee and hot water. The coffee and hot water was dispensed into cups for service to the residents during the meal. During interviews with residents on 2/9/11 residents mentioned that they thought beverages from the coffee cups had a funny taste. On 2/10/11 at 9:30 am the coffee and hot water was dispensed from the carafes into coffee cups to taste. The hot water had a coffee taste to it. On 2/10/11 at 9:10 am the carafes in the dining rooms were inspected with Dietary Manager E8. E8 stated the coffee and hot water is brewed in the dining rooms and is poured into the carafes. The carafes are refilled for each meal. The lids of the carafes were opened for inspection . There were coffee stains and white mineral deposits observed around the opening of the inside lids of the carafes. The brewing draw tube mechanism was removed from the carafe. The opening to the carafes was small approximately two inches in diameter the inside was metal lined. Some of the brew stems were clear plastic that was stained black and some were metal tubes. Each draw tube was approximately a 1/4 inch diameter. The draw stem in the hot water carafe was plastic and was stained a dark brown on the outside. A cloth was inserted into the draw stem and thick black matter came off on the cloth. E8 stated that it must have been used for coffee.	F 371		

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	145381	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 18 When asked how the carafes were washed, E8 stated that the carafes are run through the dishwashing machine on a daily basis. E8 stated that they do not delime the plastic inner lids of the carafes and they do not use a bottle brush to clean the inside of the draw tubes or the carafes. The design of the coffee carafes does not allow adequate cleaning and sanitizing of all internal food contact surfaces if only run through the dishwashing machine. The use of the draw stem tube in both coffee and water carafes allowed the flavor of coffee to be transferred to the hot water. 4. The initial tour of the kitchen was conducted on Tuesday, 2/08/11 at 9:25 am. The walk in cooler contained several pans of potentially hazardous food items that had no labeling to identify the type of product , the date it was opened, nor the time of preparation. Food items included opened, cooked turkey roast, ham, sausage links, corn beef, and roast beef. Cook E11 stated on 2/08/11 at 9:30 am that these items had been used on the previous Saturday and should be discarded today (2/08/11). There were other pans of left over foods such as roast beef, spaghetti sauce, barbecue beef , macaroni and cheese, and beef and noodles which E11 stated were left overs for employees, that were dated but did not have the time documented as required for cooling potentially hazardous foods. A bold sign was observed on the front of one of the refrigeration units that stated that all opened or left over food items must be labeled with the date of preparation. Dietary Manager E8 stated on 2/08/11 that they keep most prepared food items 3 days, with the exception of cheese which keeps longer. E8 stated on 2/10/11 at 8:50 am that all food items should covered and be labeled	F 371		

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	145381	A. BUILDING _____ B. WING _____	02/10/2011

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F 371	Continued From page 19 with the date. E8 was not aware that the time also needed to be documented. On 2/09/11 at 10:35 am food preparation and holding was observed. The walk in cooler was revisited and it was noted that there was a container of ground cooked bacon, and a loaf of ham that was not labeled and dated. A large clear plastic container of whole cooked ribs approximately 18 inches deep was stored in the walk in cooler. The ribs were not covered and there was no label to indicate when the ribs had been cooked and placed in the cooler. Dietary Manager E8 stated that these ribs had been batch cooked over the last couple of days, cooled ,then were transferred into the large container for holding. The ribs were on the menu on 2/09 for supper. E8 stated the chef should have labeled the ribs with the date of preparation and they should be covered. On 2/9/11 at 11:20 am, Chef E12 stated E10 had cooked the first batch on Sunday or Monday and E12 then had cooked the next two batches on Tuesday and put them in the big container on Wednesday. E8 stated that three cases of ribs, approximately 30 pounds per case were cooked. E10 stated on 2/09/11 at 11:30 am that he had not cooked any ribs on Sunday or Monday because he had forgotten. These conflicts during interviews with E8, Chef E12, and Cook E10 on the exact dates the ribs were cooked showed the importance of correct labeling.	F 371		
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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 20 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, record review and interview a facility staff member failed to wash her hands for the required time after direct patient contact. Also, the same staff member failed to	F 441		

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	145381	A. BUILDING _____ B. WING _____	02/10/2011

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F 441	Continued From page 21	F 441		

wash the hands of R1 after he used the bathroom but before he ate lunch. R1 is one of seven residents sampled. Also a facility staff member failed to remove her gloves after giving incontinence care to R2. In addition the facility failed to enure that hairbrushes and combs used in the beauty shop were kept free of hair and failed to disinfect the equipment between residents. The beauty shop is utilized by residents (R3) in three of three nursing units. The facility also failed to utilize a disinfectant for cleaning and disinfecting environmental surfaces that was effective for Clostridium Difficile (C. diff) for one of one residents, R10, who was treated for C. diff infection in the facility.

The findings include:

1. The February 2011 Physician's Orders documents R1 is a resident with diagnoses of Chronic Kidney Disease and Acute Kidney Failure. The Care Plan states R1 has a urinary catheter that needs care every shift. On 2/8/2011at 11:30 AM, E14, Certified Nursing Assistant was observed cleaning R1's urinary catheter. At the same time R1 had a bowel movement and E14 cleaned R1's anal area and buttocks. R1 was observed to touch his own body, the toilet, the grab bars, and the wall next to the toilet. After the procedure E14 washed her hands, but she washed for 5 seconds or less. In addition she failed to wash the hands of R1. The lunch meal was served directly after the procedure and R1 used his bare hands to help feed himself. He touched the meal tray and all utensils. He also touched some of his food.

2. E13, CNA (Certified Nurses Assistant) performed incontinence care for R2 on 2/8/11 at

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	145381	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 22 2:10 PM. R2 had a bowel movement and visible stool was seen on these gloves. E13, CNA failed to remove her gloves after the procedure. E13, upon completion of the incontinence care, with the gloves still on, touched R2's arm, clothing, covers, bed and side rails. 3. On 2/10/11 at 2:15 PM the beauty shop was toured. Environmental Services Director E5 stated that residents on all the nursing units utilize the services of this shop. Beautician Z2 stated that she provides hair care services for the facility residents two to three half days per week. There were two salon stations, each station had a towel laid out on the counter with over a dozen hairbrushes on each towel . Z2 stated that these were clean hairbrushes that were ready to use for residents. The brushes on the second counter were inspected and all 15 hair brushes had visible hair entwined in the bristles. Hair could be also seen in the bristles of the other hair brushes on the second counter. A half dozen extra hair brushes stored in a clean storage container in the beauty shop closet also had hair in the bristles. The rolling storage caddy that contained the permanent wave rods, rollers, clips and other hair supplies was dusty and had hair clipping and dust in the drawers. Two containers of brush style rollers, that Z2 identified as being clean, were soiled with hair that could be easily pulled from the bristles. Z2 stated that she uses a comb to remove the hair from the brushes and rollers and then soaks them in a brush cleaning product at the end of the day, then lets them air dry. Z2 stated she does not use the same disinfectant solution on the brushes and rollers that she uses on the combs. The product label stated it was for	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 23 brush cleaning and hair removal and makes no claim as a disinfectant. Z2 stated on 2/10/10 at 2:20 PM that she soaks the soiled combs in a disinfecting solution. A quart sized glass comb container was stored in the upper cabinet above the shampoo bowl. There were about eight combs soaking in a white, cloudy, liquid with floating debris that was only about three inches deep. The liquid was not deep enough to immerse the entire surface of the combs. The comb container was stuck to the shelf in the cabinet, it took effort to remove the container to inspect the combs. Z2 stated that she usually changes the solution twice a week and acknowledged that it needed to be changed. Z2 stated that she fills the container half full of disinfectant and half full of water to make the solution. The label on the gallon comb disinfectant stated that it was a ready to use product that required no dilution. Residents on the 25 bed Certified Renewal Unit utilize the services of the beauty shop, including R3, who stated on 2/09/11 at 8:45 AM that she just returned from the beauty shop. . 4. On 2/10/11 at 10:00 am the "Line Listing of Resident Infection" logs for the facility were reviewed with Infection Control Coordinator, E3. The November 2010 log documented that R10, was admitted to the Renewal Unit (Medicare Certified Unit) on 11/28/10 from the hospital with a Clostridium Difficile infection. Treatment was listed as oral Vancomycin. The facility Resident Discharge List documented that R10 expired on the Renewal unit on December 19, 2010. The Renewal Unit contains 25 certified resident beds. E3 stated that they have not had	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	02/10/2011

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F 441	Continued From page 24 another C. diff infection and currently do not have any residents under isolation precautions. E3 explained routine contact isolation procedures used to control the spread of C. diff. E3 was not aware of any special disinfectants being used for cleaning environmental surfaces of R10's room. E3 stated that Housekeeping Supervisor E6 would have that information. E3 printed out the facility policy pertaining to Clostridium Difficile. On 2/10/011 at 2:20 PM E6 stated that housekeeping staff had utilized Contact Isolation for C. diff, for R10 which included wearing gowns, and gloves, and red bagging any cleaning rags or mop heads used for R10's room. E6 stated that they used the house disinfectant for surface cleaning of the bedroom and bathroom and floors. When asked if she knew if the disinfectant was effective against C. diff, E6 stated she remembers specifically asking the chemical vendor about using it for C. diff and thought she was told it was appropriate. E6 provided literature for the house disinfectant and stated she would look for the e-mail she had received from the vendor. The manufacturer's informational literature for the house disinfectant identified the product as a one step quaternary disinfectant cleaner effective against a broad spectrum of bacteria. It was virucidal, and fungicidal. It did not state that it was sporicidal. The literature listed the pathogenic bacteria, fungi and viruses it was effective against and this did not include spore forming, Clostridium difficile bacteria. On 2/10/11 at 3:00 PM E6 reported back that she could find no additional information for the product that indicated it was effective for C. diff.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(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 25 The facility policy entitled "Guidelines for Clostridium Difficile Associated Disease" (CDAD), dated April 2010 states, " The environment of a resident with CDAD should be cleaned thoroughly at least daily, with special attention to those items likely to be soiled with feces, i.e., bed rails, and bedside commodes. The residents's room should be cleaned last and the water and mop head changed prior to cleaning another room. An EPA approved disinfectant-detergent should be used for all environmental cleaning, preferably one that is hypochlorite-based (i.e., household chlorine bleach)."	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to provide emergency nurse call stations for the men's and women's public restroom located in the front lobby area of the facility. One of seven sampled residents (R5) was observed using the public restroom. The findings include: There were two public restrooms located in the lobby area of the facility. These restrooms are for the public and for the residents who live in the independent apartments. The residents on the	F 463		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145381	A. BUILDING _____ B. WING _____	02/10/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK-LINDSEY VILLAGE	101 WEST WINDSOR ROAD URBANA, IL 61801

(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 463	Continued From page 26 nursing unit have access to the front lobby through a common hallway. The men and women's public restrooms were not equipped with locks and they were not provided with emergency nurse call stations. On 2/09/11 at 4:50 pm Nurse E7 was observed walking beside R5 towards the public restroom in the front lobby area. E7 opened the door of the men's public restroom for R5. R5 walked into the bathroom with his rolling walker. E7 did not accompany R5 into the bathroom. E7 closed the bathroom door and waited outside for R5. E7 stated they let (R5) use the men's public restroom occasionally. E7 stated other residents from the nursing units also occasionally use the restroom when it is closer than their own bathrooms.	F 463		