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	145437	A. BUILDING _____ B. WING _____	03/20/2014

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COLONIAL HLTHCARE & REHAB CTR	515 BUREAU VALLEY PARKWAY PRINCETON, IL 61356

(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.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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 157	Continued From page 1 by: Based on observation, record review, and interview the facility failed to notify the physician of a change in condition of a pressure ulcer for one of one resident (R18) reviewed for condition changes in the sample of 15. FINDINGS INCLUDE: Facility form titled Wound Assessment Details Report dated 3/10/2014 documents R18's left heel wound at 3.5 CM X 3.5 CM. On 3-17-2014 at 12:05pm E9 (Registered Nurse) measured the pressure ulcer on R18's left heel ulcer at a dimension of 6 CM(centimeters) X 4 CM. The facility Change in a Resident's Condition or Status policy states the Nurse Supervisor/Charge Nurse will notify the resident's Attending Physician or On-Call Physician when there has been a significant change in the resident's physical/emotional/mental condition. R18's "Wound Assessment Details Report" dated 03/06/14, 03/10/14 and 03/17/14 presents no evidence that R18'sphysician was notified of any of R18's wound assessment details. On 3/18/2014 at PM Z1(Physician)stated, "The facility has not made me aware of any change in (R18)wound on Left heel."	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have	F 225		

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F 225	Continued From page 2	F 225		

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 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, the facility failed to report an Identified Offender to the State

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Agency for one of ten residents (R30) reviewed for Resident Criminal Background checks.

Findings Include:

Facility Admission and Discharge logs dated 12/01/2013 through 3/18/2014 documents R30 was admitted to the facility on 1/30/2014 and was discharged on 3/17/2014.

R30's criminal background check conducted by the facility on 1/31/2014 reports R30 has a criminal history of one charge of domestic battery identified with Statue Citation 720 ILCS 5.0/12-3.2-A-2.

The facility policy 'Abuse Prevention Program Facility Procedures', undated, documents, "Pre-Admission Screening of Potential Residents: This facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. Prior to a new resident being admitted to the facility, this facility will: Conduct a Criminal History Background Check according to the Facility Identified Offender Policy and Procedure."

On 3/17/2014 at 11:00 a.m., E1 (Administrator) provided a document indicating there were currently no Identified Offenders residing at the facility and stated, "We currently do not have any Identified Offenders."

On 3/19/2014 at 10:50 a.m., E10 (Medical Records) verified that the required background check for R30 wasn't completed by the facility, and the facility did not notify the State Agency of R30's criminal history. E10 also stated at this

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F 225	Continued From page 4 time, "When a background check comes back with a hit, we send it to our Corporate Office for guidance. For (R30), the Corporate Office told me (R30) wasn't an Identified Offender."	F 225		
F 226 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to operationalized their Abuse Prevention Program Facility Procedures by not completing the required background checks prior to new residents residing at the facility for one out of ten residents (R30) reviewed for Resident Criminal Background Checks. Findings include: The facility policy 'Abuse Prevention Program Facility Procedures', undated, documents, "Pre-Admission Screening of Potential Residents: This facility shall check the criminal history background on any resident seeking admission to the facility in order to identify previous criminal convictions. Prior to a new resident being admitted to the facility, this facility will: Conduct a Criminal History Background Check according to the Facility Identified Offender Policy and Procedure."	F 226		

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F 226	Continued From page 5 On 3/19/2014 at 10:50 a.m., E10 (Medical Records) provided an undated and untitled document and stated, "This document is what the facility follows for the Identified Offenders protocol." This protocol begins by documenting, "The process for the Identified Offenders Program is as follows." This same protocol documents "If the Uniform Conviction Information Act (UCIA) response (commonly referred to as the background) contains criminal convictions, the facility must check the crimes listed on the criminal history response against the list of statute citation numbers from the Identified Offender Conviction List...If the UCIA response contains convictions that match the Identified Offender offenses, the resident is an Identified Offender and must be reported to the Identified Offender Program (IOP). Once the facility determins the resident is an Identified Offender, the facility must arrange for the resident to undergo a live scan State and Federal Bureau of Investigation (FBI) fingerprint-based Fee Applicant criminal history check within 72 hours...The facility must then immediately notify the IOP by submitting a completed Identified Offender Information Form, Nursing Home Resident Fingerprint Inquiry Consent Form, and a copy of the UCIA criminal history response." This document also adds "Additional Information: It does not matter if the crime is a felony or misdemeanor. If it is on the conviction list, it must be reported." Facility Admission and Discharge logs dated 12/01/2013 through 3/18/2014 documents R30 was admitted to the facility on 1/30/2014 and discharged on 3/17/2014. R30's Illinois State Police background check was completed by the facility on 1/31/2014. The Illinois State Police	F 226		

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F 226	Continued From page 6 background check documents a "hit" of criminal history indicating R30 had one misdemeanor charge of domestic battery. On 3/19/2014 at 10:50 a.m., E10 (Medical Records) verified that the required background check for R30 wasn't completed by the facility, and the facility did not notify the State Agency of R30's criminal history.	F 226		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and interview, the facility failed to provide pressure reducing equipment for R17. R17 is one of four residents reviewed for pressure ulcers in the sample of 15. FINDINGS INCLUDE: Facility policy titled Support Surfaces Guidelines dated Revised October 2010) instruct staff, "Any individual at risk for developing pressure ulcers should be placed on a pressure -reducing device."	F 314		

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F 314	Continued From page 7 On 3/17/14 at 10:40 A.M., R17 was transferred to a wheelchair by two CNAs (Certified Nursing Assistants) and taken to the facility dining room. No pressure reducing cushion was in R17's wheelchair. R17 was returned to bed at 12:50 P.M. R17's Admission Nursing Assessment dated 2/13/14 documents R17's coccyx as "reddened." R17's Patient Risk Profile dated 2/13/14 documents R17's Braden Score for the risk of developing pressure ulcers as 16 (At risk). The facility form Wound Assessment Details Report dated 3/15/14 documents R17's coccyx pressure ulcer as "Unstageable, 0.5 CM (Centimeters) X 0.5 CM, 100% Non-Granulating wound." On 3/18/14 E2 (Director of Nurses) stated,"If a resident is at risk for skin breakdown, it is our policy to provide a pressure reducing cushion for their wheelchair. I don't know why (R17) doesn't have a cushion in (R17)'s chair."	F 314		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on surveyor observation, record review and interview, the facility failed to administer medications as ordered by the physician. This	F 332		

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failure resulted in nine medication errors out of 27 opportunities for error, for a 33% medication error rate.

FINDINGS INCLUDE:

On 3/17/14 at 11:35 A.M., E8 (Registered Nurse) administered Calcium 600/Vitamin D 400 one tablet to R3.

R3's March 2014 Physician's Order Sheet (POS) includes the following medications: Calcium 600/Vitamin D 400 Units. Take two tablets by mouth once daily.

On 3/17/14 at 4:15 P.M., E6 (Licensed Practical Nurse) administered Carvedilol 6.25 MG (Milligrams)
one tablet to R26. R26's medicatio card instructs staff to "take this medication with a meal." R26 did not receive a meal until 5:10PM.

On 3/17/14 at 4:25 P.M., E6 (LPN) administered Metformin 500 MG one tablet to R25.
R25's current POS includes the following medications: Metformin HCL 500 MG by mouth every evening with dinner. R25 was not eating a meal at the time the medication was given and was not served the evening meal until 5:10PM.

On 3/17/14 at 4:38 P.M., E6 (LPN) administered Metoprolol Tartrate 25 MG (1/2 tablet) and QVar one puff to R27. E6 then returned the inhaler to the box and placed it in the medication cart.R27's medication card instructs staff to "take medication with a meal or immediately after a meal."R27 was not eating a meal at the time the medication was administered an was not

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observed eating dinner until 5:10PM.

On 3/17/14 at 4:47 P.M., E6 (LPN) administered Bethanecol 25 MG one tablet and to R28. R28's medication card for Bethanechol instructs staff to "take on an empty stomach one hour prior to meals or two to three hours after a meal." R28 was served the evening meal at 5:14PM.

On 3/17/14 at 4:47PM E6 (LPN) administered Caredilol 25 MG one tablet
R28's medication card for Carvedilol instructs staff to "take with food or a meal." R28 was not eating at the time of the medication administration and was served the evening meal at 5:14PM.

Bethanechol 25 MG one tablet. R29's medication card for Bethanechol instructs staff to "take on an empty stomach one hour prior to meals or two to three hours after a meal." On 3/17/14 at 5:20 P.M., R29 was observed eating dinner.

On 3/17/14 at 5:00 P.M., E6 (LPN) administered Creon Dr 6,000 Units one tablet to R29. R29's medication card for Creon Dr instructs staff to "take with food."R29 was not eating at the time of the medication administration and was not served the evening meal until 5:20PM.

Facility policy titled Administering Medications dated (Revised April 2010) instructs staff "Medications must be administered in accordance with the orders, including any required time frame."

On 3/19/14 at 10:15 A.M., E2 (Director of Nurses)

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F 332	Continued From page 10 stated "Medications are to be administered following required time frames. If the instructions say before meals, they should be given before meals or if says after meals, they should be given after meals."	F 332		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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.	F 441		

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F 441	Continued From page 11 (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 surveyor observation, record review and interview, the facility failed to perform hand hygiene prior to wound care for one of five residents (R17) reviewed for infection control and failed to perform hand hygiene and wear gloves prior to performing blood glucose testing for one resident (R25) in the supplemental sample. FINDINGS INCLUDE: 1. Facility policy titled Dressings, Dry/Clean dated (Revised October 2010) instructs staff to "wash and dry your hands thoroughly...put on clean gloves...remove soiled dressing...and discard into plastic bag...wash and dry your hands thoroughly...put on clean gloves...cleanse the wound...apply the ordered dressing...remove disposable gloves and discard...wash and dry your hands thoroughly." On 3/18/14 at 8:45 A.M., E7 (Registered Nurse) performed wound care for R17. E7 began the treatment by applying gloves without first performing hand hygiene. E7 then squirted wound cleanser onto a gauze pad and began cleaning the wound. Without performing hand hygiene nor applying clean gloves, E7 then opened the dressing and applied it to R17's wound. E7 then assisted the CNA (Certified Nursing Assistant) in pulling up R17's pants and arranging the	F 441		

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bedcovers, after which E7 removed gloves and performed hand hygiene.

R17's Wound Assessment Details Report dated 3/15/14 documents R17's coccyx wound as 0.5 CM (Centimeters) X 0.5 CM X Unstageable depth.

On 3/19/14 at 10:15 A.M., E2 (Director of Nurses) stated it was her expectation and staff policy that staff perform hand hygiene before beginning a treatment and also after cleansing a wound, before the application of a new dressing.

2. Facility policy titled Blood Sampling-Capillary (Finger Sticks) dated (Revised April 2012) instructs staff to "Wash hands. Don gloves..."

On 3/17/14 at 4:25 P.M., E6 (Licensed Practical Nurse) prepared to perform a capillary blood glucose test on R25. E6 wiped the blood glucose machine with a disposable cleansing cloth, went into R25's room and lanced R25's finger and obtained a blood sample without performing hand hygiene nor applying gloves. E6 then stated,"I forgot to wear gloves."

On 3/19/14 at 10:45 A.M., E2 (Director of Nurses) stated it was facility policy for staff to perform hand hygiene and apply gloves before performing capillary blood glucose testing.