STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145183	A. BUILDING _____ B. WING _____	03/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL MANOR	620 WARRINGTON AVENUE DANVILLE, IL 61832

(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 Complaint #1661194/IL83816- F225, F226 and F314 cited Federal Oversight and Support Survey (FOSS)	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		

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

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F 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to protect R16's privacy by failing to close a door during care, failing to ensure bathroom privacy, and failing to maintain window blinds to prevent visibility from the building exterior. These failures have the potential to affect three residents (R10, R11, R16) of six reviewed for privacy and dignity in the sample of thirteen, and one resident (R20) on the supplemental sample. Findings include: The facility's Resident Dignity policy dated 9/2011 documents, "Staff will respect this right in the following ways:.... Screen all care provided at bedside.... Expose body surfaces only to the extent necessary to provide care.... Close drapes, privacy curtains, and room doors as necessary to maintain privacy.... During transfers, including the use of mechanical lifts, the resident's body shall be covered to preserve dignity...." 1. On 3/9/16 at 7:15 am, E8, Certified Nursing Assistant, transferred R16 from the bed to a wheelchair. The door to R16's room was open and R16's gown was open in the back. The curtain in R16's room was not in position to protect R16's privacy, allowing R16's bare back and buttocks to be viewed from the hallway. On 3/9/16 at 7:15 am, E8 stated, "To protect a resident's privacy, I should have closed the door, pulled the curtains and covered (R16's) backside."	F 164		

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F 164	Continued From page 2	F 164		

2. On 3/9/16 at 3:50 pm, the windows in R10, R11, and R20's bathrooms had clear glass and were unscreened, without blinds or curtains. These windows were 5 feet 6 inches vertically up from the ground surface of the building exterior and were 16 inch hexagonal shape. There is an open gazebo and courtyard with unrestricted access directly outside these windows, allowing the potential for residents to be seen in their bathrooms by anyone in the courtyard.

On 3/10/16 at 10:47 am, E6, Licensed Practical Nurse, stated, "All three residents in those rooms (R10, R11, and R20) do transfer to the toilet in their bathrooms using the sit-to-stand mechanical lift."

The facility's Resident Roster dated 3/8/16 documents R10, R11, and R20 reside in these rooms.

3. On 3/9/16 at 1:45 pm, the window blinds in R10's room were bent, twisted, in poor repair and unable to be closed completely to protect R10's privacy from the building exterior. The blinds allowed an unscreened window area 10 inches high across the entire six feet width of the window. This window was 27 inches vertically up from the exterior ground surface. This window has a viewing pane which is 6 feet wide by 4 feet high. There is an open gazebo and courtyard with unrestricted access directly outside of R10's window, allowing the potential for R10 to be seen by anyone outside the building in the courtyard.

On 3/10/16 at 9:24 am, E9, Maintenance Assistant, stated, "I'll be having one of my guys down there replacing the blinds in (R10's) room."

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F 225 F 225 SS=E	Continued From page 3 483.13(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 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.	F 225 F 225		

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F 225	Continued From page 4	F 225		

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to immediately notify the Administrator of alleged abuse and failed to remove the alleged perpetrator from resident contact after an alleged observation of verbal abuse for one of four residents reviewed for abuse (R12) in a sample of 13. This also potentially affects ten residents (R22 to R31) in the supplemental sample.

Findings include:

The facility Final Report dated 2/5/16 documents an alleged incident of verbal abuse occurred on 1/31/16 at approximately 5pm when E22 (Nursing Assistant) spoke to R12 in a loud voice. This report documents the allegation was reported by E21(Dietary Aide) on 2/1/16 at 8:45am.

On 3/10/16 at 11:50am E1 (Administrator) stated E21 (Dietary Aide) reported an alleged incident of verbal abuse to E1 on 2/1/16 at 8:45am which reportedly occurred at approximately 5pm on 1/31/16. E1 stated E21 failed to report this incident immediately and if the incident was reported per facility policy E22 would have been removed immediately from further resident contact pending the outcome of the investigation at the time the alleged allegation was observed. E1 stated E22 worked with residents in the east wing until approximately 11pm the evening of 1/31/16.

The facility Daily Census Report dated 3/10/16 documents R22- R31 resided in the east wing on 1/31/16.

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F 225	Continued From page 5 The facility policy, Abuse, Neglect Involuntary Seclusion, Misappropriation of Resident Property and Injuries of Unknown Origin dated 4/23/14 documents, "A facility employee or agent who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility Administrator. Additionally, this policy documents, "When an allegation of suspected abuse is received that and employee of a long term care facility is the perpetrator of abuse, that employee shall immediately be barred from further contact with residents of the facility, pending the outcome of any further investigation..."	F 225		
F 226 SS=E	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 operationalize the abuse prevention policy by not immediately reporting an alleged incident of verbal abuse to the Administrator and failing to immediately remove the alleged perpetrator from resident contact for one of four residents (R12) reviewed for abuse in a sample of thirteen. This also potentially impacts ten residents (R22 to R31) in the supplemental sample.	F 226		

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F 226	Continued From page 6 Findings include: The facility policy, Abuse, Neglect Involuntary Seclusion, Misappropriation of Resident Property and Injuries of Unknown Origin dated 4/23/14 documents, "A facility employee or agent who becomes aware of alleged abuse or neglect of a resident shall immediately report the matter to the facility Administrator. Additionally, this policy documents, "When an allegation of suspected abuse is received that and employee of a long term care facility is the perpetrator of abuse, that employee shall immediately be barred from further contact with residents of the facility, pending the outcome of any further investigation..." The facility Final Report dated 2/5/16 documents an alleged incident of verbal abuse occurred on 1/31/16 at approximately 5pm when E22 (Nursing Assistant) spoke to R12 in a loud voice. This report documents the allegation was reported by E21(Dietary Aide) on 2/1/16 at 8:45am. On 3/10/16 at 11:50am E1 (Administrator) stated E21 (Dietary Aide) reported an alleged incident of verbal abuse to E1 on 2/1/16 at 8:45am which reportedly occurred at approximately 5pm on 1/31/16. E1 stated E21 failed to report this incident immediately and if it was reported per facility policy E22 would have been removed immediately from further resident contact on 1/31/16 pending the outcome of the investigation. E1 stated E22 worked with residents in the east wing until approximately 11pm the evening of 1/31/16. The facility Daily Census Report dated 3/10/16 documents R22- R31 resided in the east wing on	F 226		

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F 226	Continued From page 7 1/31/16.	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, record review, and interview the facility failed to protect residents' dignity by allowing a physician to examine R5 and R19 in a public dining room. These failures affected two residents (R5 and R19) on the supplemental sample. Findings include: The facility's Resident Dignity policy dated 9/2011 documents, "Staff will respect this right in the following ways:.... Screen all care provided.... Close drapes, privacy curtains, and room doors as necessary to maintain privacy...." On 3/10/16 at 10:47 am, Z1, Primary Care Physician, examined two residents (R5 and R19) in the main dining room, auscultating R5's and R19's chests and backs with a stethoscope, and using an otoscope to view inside R5's and R19's ears. R5 and R19 were in an activity with seven other residents and E7, Activity Assistant, at the time of Z1's examination. On 3/10/16 at 10:55 am, Z1 stated, "The residents had mass today and they usually don't	F 241		

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F 241	Continued From page 8 want to come back to their rooms because they will miss the next activity, but I will keep in mind their privacy and dignity for next visit." R5's Minimum Data Set dated 1/1/16 documents R5 has a Brief Interview for Mental Status score of 8 out of 15, placing R5 as moderately cognitively impaired. On 3/10/16 at 11:20 am, R5 stated, "The doctor did listen to my chest and looked into my ears. I would rather he didn't do it in the dining room. I would prefer he would do it in my room." R19's Minimum Data Set dated 1/8/16 documents R19 has a Brief Interview for Mental Status score of 3 out of 15, placing R19 as severely cognitively impaired and was assessed as not reliable for interview.	F 241		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. 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	F 278		

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F 278	Continued From page 9 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 interview and record review the facility failed to accurately code the MDS (Minimum Data Set) in the area of falls for one of three residents (R12) reviewed for MDS coding in the sample of thirteen. Findings include: The MDS Section J1800 dated 3/4/16 documents R12 as having one fall with no injury. The facility Occurrence Report dated 2/21/16 documents R12 incurring an abrasion to the right elbow during a fall. On 3/10/16 at 9:15am, E5 (MDS Nurse) confirmed R12's MDS dated 3/4/16 should reflect one fall with injury in section J1800.	F 278		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in	F 282		

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F 282	Continued From page 10 accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to follow care plan interventions related to prescribed visual appliances for one resident (R6) of eight residents reviewed for assistive devices in a sample of thirteen. Findings include: The Electronic Medical Record documents the following diagnoses for R6: Cerebral Infarction, Osteoarthritis, Difficulty in Walking, Hypertension, Osteoporosis, Restless Leg Syndrome and Insomnia. The Care Plan dated 2/2/16 documents to "Ensure that eyeglasses are worn appropriately, and that they are clean, free from scratches and in good repair." On 3/9/16 at 12:35pm R6 sat in a wheelchair in the main dining room at a table. R6 was not wearing glasses at this time. On 3/9/16 at 1:20pm R6 sat in a wheelchair in the hallway. R6 was not wearing glasses at this time. On 3/11/16 at 10:00am R6 stated that (R6) "wears glasses unless they forget to put them on me."	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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F 314	Continued From page 11	F 314		

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 decontaminate scissors and failed to cleanse their hands between glove changes when performing a pressure ulcer dressing change for one of three residents (R10) reviewed for pressure ulcers in a sample of 13.

Findings include:

The Physician Order Sheet dated 03/2016 documents a dressing change order for the pressure ulcer (dressing) on R10's sacrum to be changed daily and as needed.

1. On 3/9/16 at 2:25 PM E10 Registered Nurse (RN) performed a pressure ulcer dressing change for R10's sacral pressure ulcer. E10 took a pair of scissors out of her uniform pocket and placed them on R10's bedside table. E10 used the same contaminated scissors to cut the Calcium Alginate that was applied directly to the wound bed and peri-wound.

On 3/9/16 at 3:50 PM E10 confirmed that she used the scissors from her pocket to cut the

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F 314	Continued From page 12 Calcium Alginate without decontaminating them first. On 3/11/16 at 10:00 AM E1 Administrator stated that E10 should have sanitized the scissors prior to using them to cut R10's dressing. 2. On 3/9/16 at 2:25 PM E10 RN performed a pressure ulcer dressing change for R10's sacral pressure ulcer. During the procedure E10 cleansed the wound and then changed her gloves prior to measuring the wound and applying skin prep solution. E10 then changed her gloves again and applied the new dressing. E10 did not cleanse her hands in any way between glove changes. On 3/9/16 at 3:50 PM E10 confirmed that she did not wash or sanitize her hands between glove changes. On 3/11/16 at 10:00 AM E1 stated the R10 should have cleansed her hands between glove changes during the pressure ulcer dressing change. The facility's Hand Hygiene Policy dated 3/1/10 documents after removal of gloves use alcohol based rub.	F 314		
F 323 SS=E	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.	F 323		

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F 323	Continued From page 13	F 323		

This REQUIREMENT is not met as evidenced by:
Failures at this level required more than one deficient practice statement.
A. Based on observation, interview and record review the facility failed to implement preventative fall measures on five occasions for two of five residents (R6, R12) reviewed for falls in a sample of thirteen.

B. Based on observation, interview and record review the facility failed to supervise one of five (R15) residents reviewed for behavior symptoms in a sample of 13.

Findings include:

A.1. The Face Sheet dated 3/10/16 documents R12 with diagnoses to include History of Falling and Dementia.

R12's Care Plan dated 4/29/13 documents R12 at risk for falls with interventions to include a personal chair alarm (7/25/13), ensure the personal chair alarm activated with each resident interaction (8/27/15), wear hipsters (2/6/15), and toilet and ambulate before and after meals (5/21/15).

On 3/9/16 at 1:50pm, E19 (Nursing Assistant) removed R12's pants to provide incontinence care. R12 did not have hipsters on when E19 removed R12's pants. E19 stated, "I forgot to put them on this morning."

On 3/9/16 between 1:10pm-1:50pm R12 sat in a wheelchair; R12 was not ambulated after lunch.

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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 323	Continued From page 14 On 3/9/16 at 1:50pm, E19 transferred R12 into bed. E19 confirmed R12 was not ambulated after lunch, stating, "I didn't have time." An Occurrence Report dated 9/13/15 at 7pm documents R12 found on the floor without injuries. This same report documents the conclusion as "(R12) attempting to get up to get a pillow off of the bed for an unknown reason. Staff need to ensure they are toileting and ambulating (R12) according to toilet plan and care plan." On 3/10/16 at 9:30am, E3 (Assistant Director of Nursing) stated when R12's fall was investigated it was determined R12 was not ambulated and toileted after dinner per R12's plan of care. An Occurrence Report dated 2/21/16 documents R12 found on floor without injuries. This same report documents the conclusion as "...Root cause (R12) stood up because he thought someone was stealing food. (Personal chair) Alarm was not activated at time of the fall." On 3/10/16 at 9:30am, E3 (Assistant Director of Nursing) stated when R12's fall was investigated it was determined E23 (Former Nursing Assistant) de-activated R12's personal chair alarm to provide care to R12 and did not reactivate R12's personal chair alarm when R12 was transferred back into the wheelchair. A. 2. The Electronic Medical Record documents the following diagnoses for R6: Cerebral Infarction, Osteoarthritis, Difficulty in Walking, Hypertension, Osteoporosis, Restless Leg Syndrome and Insomnia. On 3/9/16 at 10:00am E18 (Certified Nursing Assistant) performed incontinence care for R6	F 323		

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	145183	A. BUILDING _____ B. WING _____	03/11/2016

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F 323	Continued From page 15	F 323		

raising R6's bed to E18's waist height. E18 then performed incontinence care and left the room at 10:12am. The bed was still in the raised position when E18 left R6's room. During continuous observation from 10:12am to 10:27am R6 lay in bed with the bed in an elevated position. At 10:27am, E18 returned to the room and lowered the bed.

On 3/9/16 at 10:27am, E18 (Certified Nursing Assistant) states "I left the bed up."

The Care Plan dated 2/2/16 documents R6 at risk for falls with the intervention of "keep bed height at appropriate level for resident with brakes locked."

The Facility's Quarterly Fall Risk Assessment dated 2/9/16 documents R6 at a high fall risk.

On 3/11/16 at 10:15am, E2 (Director of Nursing) states "I would expect the resident to be made comfortable and the bed to be returned to the lowest position."

The facility Fall Assessment, Risk Identification and Management Policy dated 3/20/12 documents the care plan for falls will be individualized to reflect the specific needs and risk factors of the resident.

B. 1. The Electronic Medical Record documents the following diagnoses for R15: Dementia, History of Falling, Difficulty in Walking, Muscle Wasting and Atrophy, Asthma, Major Depressive Disorder, and Urinary Tract Infection admitted to the facility on 2/29/16.

On 3/9/16 at 7:20am R15 entered R2's room

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F 323	Continued From page 16 without invitation. No staff intervened and R15 exited R2's room shortly after entering. On 3/11/16 at 10am, E1 (Administrator) stated R2 is on Contact Isolation for Extended Spectrum Beta-Lactamase (ESBL) in urine. E1 stated R2 is allowed to exit room and participate in facility activities because R2's infection is contained. On 3/9/16 at 7:25am, E3 (Assistant Director of Nursing) stated in regard to wandering into the isolation room "we talked about a guard, but (R15) might be too short and go under it, so we haven't put anything in place yet." E3 confirmed R15 should not be in R2's isolation room to prevent spread of infectious organisms. On 3/11/16 at 9:30am, E3 (Assistant Director of Nursing) stated "(R15) wandered prior to admission." On 3/9/16 at 10:45am during the resident Group Interview, a concern was voiced regarding R15 wandering into resident rooms. The Care Plan includes Focus area dated 3/9/16: "(R15) is an elopement risk/wanderer as evidenced by frequent wandering without purpose in facility". The intervention listed first for this focus area dated 3/9/16 is "Caution tape placed across doorway will deter (R15) from entering rooms at times."	F 323		
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.	F 332		

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F 332	Continued From page 17	F 332		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to administer six medications in their entirety for one resident (R21) on the supplemental sample. The facility had six medication errors out of 26 opportunities resulting in a 23.07% error rate.

Findings include:

The Physician Order Sheet dated March 2016 documents R21 has a Gastrostomy Tube and is prescribed Carvedilol 25 milligrams (mg) two times a day, Cilostazol 50 mg two times a day, Lisinopril 20 mg once a day, Loratadine 10 mg once a day, Nuedexta 20-10 mg two times a day, and Pravastatin Sodium 40 mg once a day.

On 3/9/16 at 8:25 AM E6 Licensed Practical Nurse (LPN) crushed Carvedilol 25 mg, Cilostazol 50 mg, Lisinopril 20 mg, Loratadine 10 mg, Nuedexta 20-10 mg, and Pravastatin Sodium 40 mg and put them in a plastic cup to be administered into R21's gastrostomy tube. When administering these medications via gastrostomy tube, E6 left multiple particles of crushed medication in the bottom of plastic cup and disposed of the cup.

On 3/9/16 at 8:30 AM E6 stated she should have added more water to the cup in order to completely administer the remainder of the crushed medications.

On 3/9/16 at 11:00 AM E1 stated that E6 LPN should have made sure all of R21's crushed

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F 332	Continued From page 18 medications were dissolved and administered.	F 332		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to properly label and dispose of medications for one of eight residents (R14) reviewed for medications in the sample of thirteen and one resident (R21) in the supplemental sample. Additionally, the facility failed to store stock Intravenous medication supplies in a locked compartment permitting only authorized licensed nurse access. Findings include: 1. The Physician Order Sheet dated 2/26/16 for R14 documents a current medication order for R14 to receive Metoclopramide in a strength of 5 milligrams (mg) per (/) 5 milliliter (ml), and to receive a dose of 5 mg via gastrostomy tube every 6 hours. On 3/8/16 at 12:10 pm, the medication container for R14's Metoclopramide had a pharmacy label including instructions to administer a dose of 500 mg per gastrostomy tube every 6 hours. On 3/8/16 at 1:15 pm, E1, Administrator, stated, "The pharmacy is going to send us a new bottle with the corrected label." The facility's undated Drug Packaging and Labeling Specifications Policy documents ".... All medications for each specific resident shall be labeled with the following information.... Directions for giving medication...." 2. The Physician Order Sheet dated March 2016 documents R21 is prescribed Multivitamin Liquid 5 milliliters in the morning.	F 431		

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F 431	Continued From page 20 On 3/9/16 at 8:25 AM E6 Licensed Practical Nurse (LPN) poured the Multivitamin Liquid from the stock medication bottle into a medicine cup. After realizing there was too much Multivitamin Liquid in the medicine cup, E6 poured the excess medication back into the stock Multivitamin Liquid bottle. On 3/9/16 at 11:00 AM E1 (Administrator) stated that E6 LPN should not have poured the excess Multivitamin Liquid back into the stock bottle and instead should have disposed of it properly. The facility's Medication Disposal Policy dated 10/2009 documents oral liquids will be disposed by mixing with coffee grounds or kitty litter, or flushed. 3. On 3/10/16 at 9:24 am, the clean utility room next to the East Hall Nursing Station contained two plastic totes, 20 inches long by 16 inches wide by 12 inches tall, containing stock intravenous medicated solutions including two of each of the following types: 1,000 milliliter (ml) bags of 0.9 percent (%) sodium chloride , 250 ml bags of 0.9 % sodium chloride, 100 ml bags of 0.9 % sodium chloride, 1,000 ml bags of Dextrose 5 in Water (D5W), 1,000 ml bags of half strength D5W, 1,000 ml bags of Lactated Ringers, and 100 ml bags of D5W. The door to this clean utility room had a numerical keypad code entry lock. On 3/10/16 at 9:30 am, E9 (Maintenance Assistant) stated, "Our Certified Nursing Assistants, Housekeepers, and Maintenance Staff all know the codes to the utility rooms."	F 431		

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F 431	Continued From page 21 The facility policy, Consultant Pharmacist's Responsibilities, undated, documents, "Check medication storage areas for appropriateness and compliance with all pertinent regulations."	F 431		
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 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	F 441		

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F 441	Continued From page 22 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Failures at this level required more than one deficient practice statement. A. Based on observation, interview and record review the facilty failed to decontaminate scissors during a dressing change and failed to cleanse hands between glove changes. This failure affected two of three residents (R10, R6) reviewed for infection control in a sample of 13. B. Based on observation, interview, and record review the facility failed to prevent the risk of infection between two of five residents (R2 and R15) reviewed for behaviors in a sample of 13. Findings include: A. 1. The Physician Order Sheet dated 03/2016 documents a dressing change order for the pressure ulcer (dressing) on R10's sacrum to be changed daily and as needed. On 3/9/16 at 2:25 PM E10 Registered Nurse (RN) performed a pressure ulcer dressing change for R10's sacral pressure ulcer. E10 took a pair of scissors out of her uniform pocket and placed them on R10's bedside table. E10 used the same contaminated scissors to cut the Calcium Alginate that was applied directly to the wound bed and peri-wound. On 3/9/16 at 3:50 PM E10 confirmed that she	F 441		

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F 441	Continued From page 23 used the scissors from her pocket to cut the Calcium Alginate without decontaminating them first. On 3/11/16 at 10:00 AM E1 Administrator stated that E10 should have sanitized the scissors prior to using them to cut R10's dressing. A. 2. On 3/9/16 at 2:25 PM E10 RN performed a pressure ulcer dressing change for R10's sacral pressure ulcer. During the procedure E10 cleansed the wound and then changed gloves prior to measuring the wound and applying skin prep solution. E10 then changed gloves again and applied the new dressing. E10 did not cleanse hands in any way between glove changes. On 3/9/16 at 3:50 PM E10 confirmed that she did not wash or sanitize her hands between glove changes. On 3/11/16 at 10:00 AM E1 stated the R10 should have sanitized hands between glove changes. The facility's Hand Hygiene Policy dated 3/1/10 documents to utilize alcohol based rub after removal of gloves. A. 3. The Electronic Medical Record documents the following diagnoses for R6: Cerebral Infarction, Osteoarthritis, Difficulty in Walking, Hypertension, Osteoporosis, Restless Leg Syndrome and Insomnia. On 3/9/16 at 10:00am E18 (Certified Nursing Assistant) performed incontinence care for R6. E18 failed to perform hand hygiene between	F 441		

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F 441	Continued From page 24 glove changes. The Facility's Incontinent Care -Male & Female policy dated 8/27/12 documents "5. Complete hand hygiene and apply gloves...10. Remove gloves and complete hand hygiene. 11. Repeat above procedure." On 3/11/16 at 10:15am, E2 (Director of Nursing) states "I would expect that staff to perform hand hygiene between glove changes." B. 1. The Electronic Medical Record documents the following diagnoses for R15: Dementia, History of Falling, Difficulty in Walking, Muscle Wasting and Atrophy, Asthma, Major Depressive Disorder, and Urinary Tract Infection. On 3/9/16 at 7:20am R15 entered R2's room. No staff intervened and R15 exited R2's bedroom shortly after entering the room. On 3/11/16 at 10am, E1 (Administrator) stated R2 is on Contact Isolation for Extended Spectrum Beta-Lactamase (ESBL) in urine. E1 stated R2 is allowed to exit room and participate in facility activities because R2's infection is contained. On 3/9/16 at 7:25am, E3 (Assistant Director of Nursing) stated in regard to wandering into the isolation room "we talked about a guard, but (R15) might be too short and go under it, so we haven't put anything in place yet." E3 confirmed R15 should not be in R2's isolation room to prevent spread of infectious organisms. The Care Plan includes Focus area dated 3/9/16: "(R6) is an elopement risk/wanderer as	F 441		

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F 441	Continued From page 25 evidenced by frequent wandering without purpose in facility." The intervention listed first for this focus area dated 3/9/16 is "Caution tape placed across doorway will deter (R15) from entering rooms at times." On 3/11/16 at 9:30am, E3 (Assistant Director of Nursing) states "(R15) has a history of wandering prior to admission."	F 441		