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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey. Complaint #1444822/IL72856: No deficiency Complaint #1444348/IL72322: No deficiency	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to assess and document the risks versus benefits for the use of restraints for 1 of 2 residents (R6) reviewed for restraints in the sample of 25. Findings include: 1. On 10/26/14 at 1:40 PM, R6 was observed to have a seat belt like restraint across her lap on her wheelchair. E26, Licensed Practical Nurse (LPN) stated that R6 has that seat belt due to attempting to ambulate without assistance. E26 stated R6 was confused and not interviewable. On 10/27/14 at varying times throughout the day, R6 was observed propelling herself up and down the first floor hallway with the seat belt across her lap. On 10/27/14 at 12:50 PM, R6 was observed in the first floor east dining room at the lunch meal service with her seat belt on across her lap.	F 221		

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

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

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F 221	Continued From page 1 On 10/28/14 at 10:15 AM, R6 was asked what the seat belt was and responded with mumbling, garbled words. She was asked how do you take it off, and R6 responded by staring at the seat belt and covering it up with her sweatshirt. She was asked again, and did not response. On 10/28/14 at the lunch meal service, R6's was wearing her seat belt. R6's October 2014 Physician's Order Sheet (POS documented R6's diagnoses, in part, as Senile Dementia. R6's Minimum Data Set (MDS), dated 09/01/13, documented R6 was severely cognitively impaired and the MDS, dated 10/15/14, did not document a cognitive status. The MDS documented the use of physical restraints as trunk restraint used daily. The Care Plan, dated 07/14/14, documented R6 having a self release belt related to seizures and poor trunk control. There was no restraint assessment in R6's medical record regarding R6's seat belt, her inability to remove the seat belt, and the risks versus benefits of using the seat belt. On 10/30/14 at 10:15 AM, E1, Administrator stated that the self release belts are utilized for residents who can release them independently. E1 stated staff would not release the self release belt during meal times because the resident wearing the seat belt could do this independently.	F 221		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a	F 241		

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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 ensure residents' dignity by serving meals timely and ensuring staff knock on doors and announce themselves before entering a residents room for 6 of 25 residents (R1, R19, R7, R15, R14 and R6) reviewed for privacy and dignity, in the sample of 25 and 2 resident's, R28 and R31, in the supplemental sample.

Findings include:

1. On 10/26/14 at 1:55 PM, E31, Certified Nurse Aide (CNA) went into R1's room without knocking on the door.

2. On 10/28/14 at 1:20 PM, E15 and E13, CNA's, were observed to take R19 into her room. R31 was sitting in the room. E13 and E15 did not knock on the door before entering the room.

3. According to the Facility Meal Time List, residents on the 4th floor are to receive breakfast at 8:15 AM, Lunch at 12:15 PM and Dinner at 5:15 PM.

On 10/26/14, R1, R14, R19 and R28 were located in the assist dining room on the 4th floor. They did not receive their trays until 6:00 PM.

On 10/27/14, R15, who eats in the main 4th floor Dining Room, got his tray at 6:15 PM. R15

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F 241	Continued From page 3 stated, "It's about time." R7 received her tray at 6:02 PM. On 10/28/14 at noon meal, R14 was observed to get her tray at 1:06 PM. R1 was observed to get his tray at 1:07 PM. 4. On 10/28/14 from 10:20 AM to 1:20 PM, the first floor east dining room was observed during the lunch meal service. The posted meal time for lunch was 12:00 PM. At 10:20 AM, R6 was observed to be taken to the first floor dining room and left there alone. R6 was observed to be sleeping at her table and/or just sitting staring blankly. There was a television observed, but was not on during this time. There was no entertainment, music or stimulus to occupy the residents time while waiting for the meal. On 10/28/14 at 1:00 PM, E27 and E28, CNA's stated that the meal service was usually not this late, but it can be about 15-30 minutes or so late.	F 241		
F 253 SS=C	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to maintain the floors, walls, and baseboards in residents' Common Shower Rooms and Dining Room , in clean and good repair on 100, 200, 300 and 400 Halls. This has the potential to affect all of the 163 residents	F 253		

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living in the facility.

Findings include:

1. During the environmental tour, on 10-28-2014 at 9:55 a.m., with E10, Housekeeping/Laundry Supervisor, the First Floor East Hall Shower Room, Second Floor East and West Shower Room, the Third Floor West Shower and Fourth Floor West Shower had the following: The shower stalls were observed heavily coated with scattered areas of black mold on stall floors and walls, around toilet bases and baseboards outside of the shower stalls. In the First Floor East Shower Room, Second Floor Dining Room and Fourth Floor Dining/Family Room the following was observed: Scattered areas of built up wax and thick crusty dried materials were observed at baseboards. There was fecal matter observed on the shower room stall of Third Floor West Shower Room. All residents in the facility utilize these shower rooms and dining room.

On 10-28-2014 at 9:55a.m., E10 confirmed the above observations.

On 10-29-2014, at 2:00p.m., R33 stated the first floor shower rooms were dirty and asked when they would be cleaned.

2. During the environmental tour, on 10-28-2014 at 11:20a.m., with E11, Maintenance Supervisor, the following areas were observed:

The First Floor West Shower contained a rusted metal cover plate and rack on the stall wall. The air conditioner cover was dislodged exposing unprotected sharp metal edges.

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The First Floor East Shower was missing wall title exposing light bulb and loose wires. There was an uncovered wall outlet exposing wiring. There were four square tiles pushed into the wall and missing tiles outside the shower stall.

In the Second Floor Hallway there were scattered areas of broken tile exposing insulation, rusted metal and decomposed wood.

In the Second West Shower Room, there were missing tile exposing insulation, rusted metal and decomposed wood.

In the Second East Shower Room, there were scattered areas of missing tile.

In the Fourth Floor Hallway, there were scattered areas of missing and broken tile.

In the Fourth Floor West Shower, there were missing tiles and an uncovered three inch section of missing shower stall at the entrance of the stall.

On the Fourth Floor, at the Nursing Station the cabinet doors were falling off the cabinet.

On 10-28-2014, during the Environmental Tour, E11 stated that section of the Fourth Floor was under construction for remodeling. E11 stated the cabinet was loose.
E11 confirmed the above observations were correct and would be addressed.

3. The Resident Census and Conditions of Residents, CMS 672, dated 10-27-2014 documents that the facility has 163 residents living in the facility,

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F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS	F 311		

A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide eating restorative programs for 3 of 9 residents (R15, R19 and R17) reviewed for restorative eating programs in the sample of 25.

Findings include:

1. R19's MDS (Minimum Data Set) of 10/12/14 documents R19 requires set up and supervision with eating.

R19's Physician Order Sheet (POS) of October 2014 documents an order for a regular pureed diet with pudding thick liquids. Fortified Pudding with meals and between meals 6 times daily.

R19 was observed at Dinner meal on 10/26/14 at 5:55 PM to 6:32PM to be eating thickened water, milk, and pureed diet with her fingers. E34, Certified Nurse Aide (CNA), cued R19 only one time to use her spoon. R19 was observed to eat with her spoon and pick up her glass of thicken milk and drink from it and then proceeded to finish the meal eating with her fingers. Staff provided R19 with no further cueing to assist her with eating.

On 10/27/14 at 8:55 AM, R19 ate her breakfast

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with her fingers and then would alternate eating with her fingers and spoon. E13 and E15, CNA's, E35, Central Supply/CNA and E29, Licensed Practical Nurse (LPN) were in the Dining Room assisting other residents. They did not cue R19 to eat with her spoon or assist R19. R19 would pick up her glass and drink her milk and then would proceed to drink her fluids with her fingers.

There is nothing in R19's Care Plan of 7/17/14 that documents R19 eats her food with her fingers and no restorative plan for eating.

2. R15's MDS dated 9/19/14, documents R15 requires no set up assistance and supervision for eating. R15's Care Plan dated 10/13/14 identifies R15 at risk for weight loss and includes interventions toward restorative dining as appropriate.

On 10/28/14 at 8:45 am, R15 was laying in bed. R15 did not come to breakfast nor was any tray taken to his room.

On 10/28/14 at 12:18 PM, R15 was in the dining room. He was served his meal at 12:50 PM which consisted of ground meat, dressing, a bowl of zucchini and cake with frosting on it. He was also given thickened fortified milk and water. R15 ate without any assistance using his fingers and fork often dropping food off the fork. He ate 50% of his cake, meat and dressing and ate none of his zucchinis. No staff cued/encouraged him to slow down and use a spoon for the meat and no one offered any alternate foods for foods uneaten. His butter was not used nor did staff

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cue/encourage its use. R15 sat at the table for a short while then left without any staff intervention to continue to eat or substitutes offered. He was in bed at 1:25 PM.

According to E33 Licensed Practical Nurse (LPN) at PM on 10/29/14, R15 often will refuse breakfast then eats a big lunch.

3. R17's MDS dated 9/3/14 identifies R17 as having cognitive impairment and requiring set up assist only for mealtimes.

R17's 10/2014 Physician's Order Sheet documents R17's diet as mechanical soft regular. R17's Care Plan identifies R17 as being at risk for weight loss related to a failure to thrive diagnosis. Interventions include monitoring and reporting any chewing/swallowing problems, provide diet as ordered, restorative dining as appropriate, provide supplements as ordered, provide/monitor intake of diet and fluids, provide dining room/meal accommodations; allow adequate time to eat, provide quiet and calm setting," in part.

On 10/28/14 at 8:41am, E14, LPN gave R17 her breakfast tray. She was served scrambled eggs, biscuits/gravy, oatmeal and orange juice. Staff did not remove the lid off her oatmeal. R17 did not eat but sat with her food on a plate in front of her. No staff provided intervention to encouraged R17 to eat. At 8:56 am, she was still not eating and no staff approached and/or provided any cueing to eat. She left the table at 9:45 am without any staff intervention.

On 10/28/14 at the noon meal, R17 received pork roast, dressing, zucchini, and cake at 12:43pm. As of 12:58pm, she was not eating. R17's meat

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F 311	Continued From page 9 was not cut up at tray delivery. R17 ate only bites of dressing and zucchini, 25% of meat, and 100% of her cake. No staff approached R17 during the mealtime to cue/encourage her to eat more or offer alternate food items. R17 sat for long periods of time unengaged in eating without staff interventions.	F 311		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide nail care and complete incontinent care for 2 of 9 residents (R7 and R4) reviewed for Activities of Daily Living, in the sample of 25 and 1 resident (R30) in the supplemental sample. Findings include: 1. R7's Minimum Data Set (MDS) of 8/11/14 documents R7 requires extensive assistance of staff for hygiene. R7's Care Plan of 10/13/14 documents R7 constantly scratches and picks skin. Intervention are, "Inform R7 of the infection related to fingernails & picking at skin. Encourage R7 to notify nursing every time itching increases."	F 312		

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R7 was observed on 10/28/14 at 1:52PM to have gauze bandage wraps on both hands and forearms. R7 stated she scratches and that's why she has the bandages. R7 pulled back a small section of the left forearm bandage and had an open wound the size of a dime. R7's fingernails were long and dirty.

2. On 10/27/14 at 9:25 AM, E27 and E28, Certified Nurse's Aides (CNA's) were provided R30 incontinent care. R30 was saturated with urine. There were rings of dried and wet urine observed on the bed sheet under R30. R30's hospital gown was saturated with urine. E27 used soapy water to wash R30's front perineal area and inner thighs and then rinse with water and dry. E27 rolled R30 to her left side and and used soapy water to wash her right buttock and right thigh, rinse and dry. She then rolled R30 to her right side and washed the thigh and hip area, rinsed and dried. E27 did not wash the left buttock or the abdomen area. E27 then removed the soiled bed sheet and applied a clean one without cleansing the mattress. E28 assisted in removing the soiled sheet and applying the clean one. E28 then assisted E27 in removing R30's gown and applying clean clothes.

The current care plan documented R30 was incontinent of bowel and bladder.

On 10/26/14 at 1:50 PM, R25, Licensed Practical Nurse (LPN) stated that R30 was incontinent of both bowel and bladder and required assistance with all cares.

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F 312	Continued From page 11 3. On 10/26/14 at 1:55 PM, R4 was wearing an incontinent brief and was incontinent of urine. R4's pants were wet with urine. E37, CNA performed incontinent care on R4. E37 did not cleanse R4's inner thighs during care. E37 used the same wash cloth when cleansing rectal area up buttocks over open areas. R4's Care Plan dated 10/13/14 documents that R4 is to be provided incontinent care after incontinence episode.	F 312		
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 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, record review and interview, the facility failed to timely identify/monitor and treat pressure ulcers and failed to follow preventative measures 4 of 9 residents (R1, R4, R11, R14) reviewed for pressure ulcer prevention in a sample of 25. This failure resulted in R11's developing multiple facility acquired pressure ulcers including two unstageable pressure ulcers to his ankle and toe. Findings include:	F 314		

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1. R11's Admission Sheet documents was admitted on 9/19/14. R11's Minimum Data Set (MDS) dated 9/29/14 documents that R11 is an extensive assistance with one person for bed mobility, transfers, toileting, personal hygiene and bathing.

The Weekly Pressure Ulcer Record dated 9/19/14 documents that R11 had a Stage 2 pressure ulcer measuring 2.0 centimeters (cm) by 2.0 cm to his right buttock.

R11's Braden Scale for Predicting Pressure Sore Risk documents that on 9/19/14 R11 had a score of 16 with mild risk being score of 15-18 even though R11 had a pressure ulcer on admission.

R11's Weekly Pressure Ulcer Record dated 9/25/14 written by E18, Wound Nurse, documents R11's pressure ulcer as healing scar tissue, resolved.

R11's weekly Pressure Ulcer Record dated 10/10/14 documents R11 had a newly in- house developed Stage 2 pressure ulcer, measuring 6. cm x 5.4 cm to Right trochanter. There is no explanation as to why the facility did not identify this area sooner since he was dependent on staff for all activities of daily living according to the care plan.

R11's Braden Scale, dated 10/10/14, documents R11 has a score of 11 (high risk 10-12). R11 was at high risk for skin breakdown.

R11's Care Plan dated 10/13/14 documents that R11 is at risk for impaired skin integrity related to fragile skin. R11's care plan documents that staff are to float R11's heels, report changes in skin

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status to physician and complete the Braden Scale. The Care plan documents that staff are to notify the nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration noted during bathing and daily skin care.

R11's Care Plan dated 10/13/14 documents that R11 has a stage 2 facility acquired pressure ulcer to Right and Left trochanter and R ishium. The Care Plan documents that R11 is to use wheelchair cushion to reduce pressure. Reposition/redistribute weight every 2 hours while awake in bed and hourly while in wheelchair.

The Facility's Weekly Pressure Ulcer Record, dated 10/17/14, documented R11 developed a new, unstageable pressure ulcer on his left toe measuring 1.0 cm by 1.0 cm with 100% brown eshcar, and an unstageable pressure ulcer to his Left dorsal foot measuring 0.5 cm x 0.5 cm with 100% brown eschar. Again, the facility had no explanation as to why these areas were not identified more timely given his dependency on staff for all cares.

On 10/27/14 at 11:00 AM, R11 was lying on his back in low bed with mat beside bed. E40, Licensed Practical Nurse (LPN) was doing skin check and R11 did become combative so E40 did not proceed. Dressing to L greater trochanter was in place during skin check. E40 did undo dressing and L greater trochanter had area that was unstageable due to dark eschar covering area.

On 10/27/14 at 11:00 AM , E40 LPN stated that R11 can be combative and does pick at his dressings so they keep pants on him while in bed. R11's Care Plan fails to document these

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behaviors. The facility failed to develop interventions for R11's behaviors.

On 10/31/14 at 9:55 AM, E18 stated that stage 2 pressure ulcer to the left trochanter was found during a random whole house skin check on 10/10/14. E18 stated that she would have expected staff to have found this during care prior to this time. E18 stated that E18 was incontinent of urine during the random whole house skin check on 10/10/14.

The facility's Policy Pressure Ulcers/Skin Breakdown- Clinical Protocol documents under Interventions and Preventative Measures to immediately report any signs of a developing pressure ulcer to the supervisor. The Policy documents that if chair fast to change position at least every hour.

2. R4's MDS dated 9/16/14, documents that R4 requires an extensive assist with two plus persons physical assist for bed mobility. R4's MDS documents that R4 requires total dependence with two persons physical assist and is frequently incontinent.

R4's Physician Order Sheet (POS) dated 9/11/14 documents that R4 is to have duoderm to left ischeal tuberosity , change every three days and prn (as needed).

On 10/26/14 at 1:55 PM, R4 was observed to have opened areas on L (Left) buttocks. No dressing was in place when incontinent brief was removed. R4 was incontinent of urine.

0n 10/29/14 at 2:00PM, E39, Treatment Nurse stated that R4's open areas on L buttocks was

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from moisture associated skin dermatitis. E39 stated that R4 is to have a duoderm to left buttocks and changed every three days.

3. R1's Braden Scale Risk for Pressure Ulcer Assessment of 10/10/14 documents R1 is at high risk for developing pressures.

R1's MDS of 9/8/14 documents R1 is totally dependent on 1 or more staff for transfer and bed mobility.

R1's Care Plan of 9/18/14 does not address R1's high risk for development of pressure sores.

R1 was observed on 10/27/14 from 8:50 AM to 10:33 AM to be up in his wheel chair without being repositioned. At 10:33 AM, E15, Certified Nurse's Assistant (CNA) was in R1's room and stated she and E31, CNA, had just transferred R1 to bed. R1's incontinent brief was saturated with feces and urine and the back of his thighs were deep creased and red. E15 stated R1 had been up in his wheel chair since 7:45 AM.

4. R14's MDS of 8/14/14 documents R14 is totally dependent on 2 or more staff for transfer and bed mobility.

R14's Care Plan of 8/19/14 documents R14 is at risk for impaired skin integrity related to incontinence of bowel and bladder. Care Plan approach, in part; reposition resident as per facility protocol, provide incontinence care after incontinence episodes and apply barrier cream PRN (as needed).

R14 was observed on 10/27/14 every 5 to 10

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F 314	Continued From page 16 minutes, to be up in a geriatric reclining chair from 8:50 AM to 11:40 AM with no positioning or checking for incontinence. At 2:55 PM, R14 was observed in bed and E15 was in the room and stated she had just put R14 to bed. R14 had a large bowel movement and she had an opaque hydrocholloid dressing on her coccyx that was soiled with feces. E39 stated the dressing was for a preventative and R14 did not have a pressure sore at this time.	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 interview, observations and record review, the facility failed to provide thorough incontinent care and failed to assess/monitor/treat a urinary tract infection (UTI)according to their policy for 3 of 6 residents (R3, R7, R20) reviewed for incontinent/catheter care in a sample of 25. Findings include: 1. According to the Minimum Data Set (MDS)	F 315		

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dated 9/7/14, R3 has short/long term memory deficits and is moderately impaired. The MDS indicates she has a urinary catheter and is always incontinent of bowel.

R3's October 2014 Physician's Order Sheet (POS) documents an order dated 10/23/14 for a U/A (urinalysis) + C/S (culture and sensitivity.)

R3's Nurse's Notes dated 10/23/14 at 3:10 am document "Pt had blood in urine in catheter, new order for UA C&S was ordered." The Nurse's Note dated 10/23/14 at 2245 (10:45pm) documents that the specimen had been collected.

R3's Physician's Progress Note dated 10/24/14 at 4:00 PM documents "Pt (patient) had blood in her indwelling foley yesterday." The note documented a UA was pending.

A Physician's Telephone Order dated 10/24/14 at 3:50pm documents "Please call my oncall" when UA results return.

R3's preliminary urinalysis result was returned on 10/27/14 which identified that a culture was done and results identify R3's urine to have clumps of white cells and mucus. Culture was pending.

On 10/28/14 at 9:45 am, E18 Licensed Practical Nurse (LPN) and E15 Certified Nurses Aide (CNA) entered R3's room to transfer her to bed. E18 unhooked R3's urinary bag from under the wheelchair and dropped it on the floor along with the tubing. E18 then repositioned the wheelchair and picked the bag up off the floor placing it on top of R3's bed. R3's catheter tubing had thick mustard colored urine in it that had large clumps of mucus present that rolled back toward her

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bladder. R3 did not respond to staff as they provided care, did a dressing change for a stage IV pressure ulcer on her sacrum.

At noon on 10/28/14, R3 sat in her wheelchair with her eyes shut during mealtime and did not respond. R3 was put back to bed and slept the afternoon. On 10/29/14, R3 was observed to sleep throughout the day and stayed in for breakfast.

The first entry into the nurses notes regarding R3's urine was on 10/23/14 when the blood in the urine was identified. Between 10/23/14 and 10/27/14, there is no documentation in R3's medical record regarding how the facility monitored R3 for a UTI. There is one entry on 10/27/14 after the second specimen was collected that documents the catheter is patent but fails to describe the characteristics of the urine. There was no documentation R3's vitals were taken during this time.

R3's UA Laboratory (LAB) results, dated 10/27/14, documented the specimen was not collected until 10/27/2014. This was four days after the physician ordered the UA. The results dated 10/29/14 identify a UTI with the culture results being >100,000 CFU (Colony Forming Unit)/ml (milliliter) of Escherichia Coli and VRE (Vancomycin Resistant Enterococcus). R3's Physician's Orders, dated 10/29/2014, documents, Macrobid (an antibiotic) 100 (milligrams)mg twice daily.

On 10/29/14 at 10:30 am, the facility offered no explanation or refutation as to why the UA ordered on 10/23/14 wasn't collected until 10/27/14 given that she has a catheter and no

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refutation in regards to the nurses lack of assessment/monitoring in light of a UTI.

On 10/31/14 at 8:35 am, E2, Director of Nursing (DON) stated she talked to the lab who confirmed that the specimen wasn't received until 10/27/14. E2 stated she confirmed with the nurse that the first specimen was collected on 10/23/14 but that the specimen wasn't taken to the lab. E2 stated the nurses didn't realize the lab results didn't come back until 10/27/14 then recollected the specimen. E2 also was unable to provide evidence that the facility monitored R3 for a UTI from 10/23/14 until 10/27/14 when the second specimen was collected and the only vitals she could find was one time on 10/24/14 7-3 shift -120/54, temperature 97.6 degrees, pulse 70, respirations 18, once on 10/27/14 7-3 shift - 124/86, 97.8, 80 pulse, 20 respirations, and twice on 10/29/14 7-3 shift, temp 98/1 and 3-11 shift 97.4 degrees. At 12:45pm, E2 stated no outputs are recorded on catheters unless the amount is less than 250cc per protocol. E2 acknowledged that standard practice is to usually record output for residents with catheters.

On 10/30/14 at 2:05pm, E30 Restorative Nurse stated R3 often sits with her eyes shut but does respond and can feed herself if she chooses to. When asked about R3 being quiet and seemingly unresponsive during care stated that is not normal for her.

The facility policy entitled "Catheter Care, Urinary" revised 10/2010 identifies it's purpose is to prevent catheter associated UTI's and documents under general guidelines that residents should be observed for complications associated with catheters with staff checking the urine for unusual

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appearance, (i.e. color, blood, etc.), and observe for other signs and symptoms of urinary tract infection or urinary retention, report to physician or supervisor immediately. The facility failed to follow their policy.

2. The MDS dated 7/22/14 identifies R20 as having cognitive impairment and requiring extensive assist of one staff for transfers. The MDS also documents that R20 is frequently incontinent of urine and occasionally incontinent of bowel. R20's Urinalysis Results dated 1/25/14 and 8/20/14 document an UTI with the causative bacteria of E. Coli . The care plan dated 8/13/14 identifies R20 as frequently incontinent with interventions for staff for clean skin with soap and water, apply moisture barrier.

On 10/28/14 at 1:30pm, R20 was transferred to the toilet by E19, Licensed Physical Therapy Assistant (LPTA.) R20 had a wet incontinent brief on which E19 removed. R20 sat on the toilet for a while and then assisted R20 to stand, wiped her with a piece of toilet paper and applied a new paper brief. No cleansing was done. E19 then pulled up R20's pants and transferred her to the toilet.

The facility policy entitled "Perineal Care" dated 10/2010, the purpose is to provide cleanliness and comfort to the resident, to prevent infections and skin irritation, and to observe the resident's skin condition.

3. R7's MDS of 8/11/14 documents R7 is always incontinent of bowel and bladder and requires extensive assistance with of one for toileting.

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F 315	Continued From page 21 R7's Care Plan of 10/13/14 documents R7 is incontinent of bowel and bladder. R7 was observed on 10/27/14 at 9:40 AM to be on the toilet. R7's incontinent brief was saturated with urine and had feces smears. R7 was transferred back to bed and E15, CNA, was observed to do incontinent care. E15 was observed to wash between R7's legs and pubis and then wash the labia with the same wash cloth. E15 then proceeded to rinse R7 between the legs and then rinse labia with the same wash cloth. When cleaning R7's buttocks, E15 wiped back and forth along perineal area.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on interview, observations and record review, the facility failed to provide adequate services and appropriate positioning/adaptive devices for the prevention of contractures for 2 of 10 residents (R3 and R18) reviewed with limited range of motion (ROM) in a sample of 25 and one resident (R28) in the supplemental sample. Findings include:	F 318		

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1. According to the Minimum Data Set (MDS) dated 9/7/14, R3 has short/long term memory deficits and is moderately impaired. The MDS indicates she requires extensive assist for mobility. The MDS also identifies that R3 has ROM limitations bilaterally upper and lower extremities but is not currently receiving ROM services.

The facility restorative list did not have R3 as receiving ROM services.

On 10/28/14 at 9:45 am, R3 was sheet lifted from her wheelchair to bed by E18 Licensed Practical Nurse (LPN) and E15, Certified Nurses Aide (CNA.) R3 was rolled about bed but did not participate in her mobility at all. R3's feet appeared to have some foot drop present.

On 10/30/14 at 2:00 pm, E30, LPN/Restorative Nurse, stated R3 is not receiving ROM services because she has no limitations. E30 was unaware that R3's MDS identified her to have limitations upper and lower extremities.

2. R28's MDS dated 10/1/14 identifies that R28 is dependent on staff for transfers and locomotion. The MDS indicates that R28 has limitations of one lower extremity.

On 10/28/14 at 10/28/14 at 8:45 am and 12:15 pm, R28 was up in her wheelchair. She is an amputee of the right leg. The left leg was hanging off the wheelchair seat and her foot was noted to be extremely swollen. The wheelchair did not have any wheelchair pedals. No staff made any attempt at supporting R28's left leg in

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an effort to decrease the swelling.

On 10/30/14, the facility was made aware of the concerns and on 10/31/14 at 12:10pm, E2 Director of Nursing (DON) stated that R28 had pedals in her room that did not fit her wheelchair. E2 stated that the pedals have been replaced. E2 also agreed that R28's foot dangling contributes to lower extremity swelling and increases falls risks.

3. R18's local hospital Discharge Instructions, dated 10-24-2014, documented, in part, "LLE (left lower extremity) limited per MD (physician) orders and to be in brace at all times. Bed Mobility: mod (modern) assist 1 to 2 for rolling and supine>sit; max (maximum)." R18's Physician's Admission Orders, dated 10-24-2014, documented "leg brace on at all times."

R18 observed, on 10-26-2014 from 1:35p.m. to 5:30p.m. at least than 10 minute intervals, lying in bed without a brace on her left leg. R18 observed, on 10-27-2014 from 7:35a.m. to 9:50a.m. at less than 10 minute intervals, lying in bed without a brace on her leg.

Interview of E12, Occupational Therapy Aide, on 10-27-2014 at 9:50a.m., E12 stated R18 was not wearing her leg brace and should be.

R18's Interim Care Plan, dated 10-24-2014, documented extensive assistant of one plus persons physical assistance with bed mobility. It was also noted R18's Interim Care Plan did not document her left leg brace to be on at all times to include interventions and/or approaches for the use of her left leg brace.

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F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on interview, observations and record review, the facility failed to provide adequate services for gastrostomy tube (g-tube) including services to restore normal eating skills for 1 of 2 residents (R3) reviewed for gastrostomy tube services in a sample of 25. Findings include: 1. According to the Minimum Data Set (MDS) dated 9/7/14, R3 has short/long term memory deficits and is moderately impaired. The MDS indicates she requires extensive assist of one	F 322		

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staff for eating.

The October 2014 Physician's Order Sheet (POS) documents R3 had a Percutaneous Endoscopic Gastrostomy (PEG) tube placed 8/6/14 due to malnutrition and returned with a regular diet of pureed foods, nectar thickened liquids. The Tube feeding order is for TwoCal HN 45 milliliters (ml) for 12 hours at night on at 6pm, off at 6am. R3 also has a 150cc water flush ordered every 4 hours. On 10/16/14, R3 had Prostat 60ml ordered three times daily.

R3's Laboratory Results, dated 10/27/2014, document her Total Protein and Albumin within normal limits, BUN is elevated at 41 (normal 7-25), BUN/Creatinine 103 (normal 6-34).

The Pressure Ulcer Log, documents R3 currently has a stage IV pressure ulcer.

On 10/26/14 at 5:35pm, R3 was in her wheelchair with her tube feeding infusing. She did not receive a supper tray.

On 10/27/14, R3 did not receive a breakfast tray in her room and was still in bed. At at 11:07 am, E29 Licensed Practical Nurse (LPN) was giving R2 a health shake. E29 was asked if R3 eats and stated "Yes, (R3) eats somewhat." E29 also had pudding at bedside to give R3.

On 10/28/14 at 8:30am, R3 was in the small dining room on 400 Hall. She did not get her breakfast tray until 9am and was fed by E15, Certified nurses Aide (CNA) who used adaptive equipment. She at very few bites as she sat with her eyes closed and was cued at 9:07am to wake up and eat. At 9:13am, E15 got up to assist

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another resident and at 9:20pm, she was asleep with her meal sitting in front of her. No opportunity was given to R3 to feed herself and no further cues/encouragement and/or assistance was provided. R3 was taken back to her room at 9:30am and at 9:45am was transferred to her bed.

On 10/29/14 at 8:50am, R3 was in bed and her breakfast tray was untouched sitting on the overbed table beside the bed. The tray sat there untouched until 9:35am when E33 LPN was told that R3 hadn't been fed yet by the surveyor. At 9:38am, E15 CNA went into the room and three minutes later, came out with the whole tray and placed it on the cart. R3's meal was not warmed up and/or replaced with warm food before being offered to her.

At 11:45am on 10/29/14, R3 was still in bed. She had an unopened chocolate pudding and Vanilla Health Shake sitting on her over bed table that was labeled 10am snack. At 12:35pm, R3 was sitting in her wheelchair at the dining room table with the 10am pudding and health shake sitting in front of her. At 1:10 pm, she received her tray and again, ate only a few bites. R3's eyes remained closed and did not respond when spoken to.

R3's Care Plan dated 9/11/14, documents R3 has a history of weight loss and is still at nutritional risk. The goal is for R3 to remain +/- 3 pounds with interventions including notifying the physician of all weight loss, monitoring any chewing/swallowing problems, provide diet as ordered, "restorative dining as appropriate", provide alternate food choices if resident refuses 50% of meal, provide adaptive equipment, but

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F 322	Continued From page 27 fails to include any directions in assisting R3 to use her own adaptive eating equipment in an attempt to restore eating. Although R3 has buildup forks and spoons and the MDS documents that she requires extensive assist to feed herself, she was neither offered nor encouraged to participate in her mealtime by staff. Review of the Restorative Programs provided by E30 fails to include R3 on the eating restorative list despite the fact that she has adaptive equipment on her meal tray and does not feed herself. Dietary notes and/or physician notes reviewed since August 2014 when the tube was placed document that the mealtime is for pleasure feedings only. On 10/30/14 at 2:05pm, E30 Restorative Nurse confirmed that R3 is not on an eating program and that her eating skills were poor before she got the g-tube. E30 stated R3 does have likes/dislikes and if she likes the food, she will take it in her hand and eat it right down (i.e. Milky Way and Three Muskateers candy bars).	F 322		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.	F 325		

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This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to provide resident's diets as ordered, offer substitutions and cueing during meals to maintain residents' nutritional status for 3 of 9 residents (R1, R6 and R20) reviewed for nutritional concerns in the sample of 25.

Findings include:

1. R1's Minimum Data Set (MDS) of 9/8/14 documents R1 requires extensive assistance of 1 for eating. MDS documents R1 is 5'8" tall and weighs 115 lbs (pounds).

R1's Care Plan of 9/18/14 documents R1 is at risk for an alteration in nutrition related to therapeutic diet with honey thick liquids. Care Plan interventions, include in part; "Provide Alternative food choices if resident refuses meal if less than 50% of meal is consumed."

R1's Physician Order Sheet (POS) of October 2014 documents an order for a pureed diet with double portions at meals, Honey thickened liquids, Fortified Pudding daily, Fortified Potatoes daily, Fortified Cereal daily Snack three times a day, High Calorie Liquid supplement 240 ml (milliliters) TID (three times a day), Prostate 30 ml TID and no milk due to allergy.

R1 was observed at evening meal on 10/26/14. R1 did not get double portions. R1 got pudding thickened water and milk which he drank 50% of

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each. R1 ate less than 50% of his pureed green beans and pureed macaroni and cheese and was not offered substitution or cueing to eat during his meal. R1's butter was not opened and put on his food. R1 was observed to grab R28's thickened coffee and milk and proceed to drink. E24, CNA, took the coffee from R1 and took him out of the dining room.

R1 was observed on 10/27/14 at breakfast meal and did not get double portions. R1 ate less than 25% of his pureed toast, pureed egg and pureed oatmeal. R1's butter was not taken from the package and R1 was observed to pick up the butter and suck the butter out of the wrapper. When E35, Central Supply/Certified Nurse Aide (CNA) tried to feed R1 his toast and oatmeal he stated he did not like it. R1 was not offered any substitutions.

Facility weight records document R1 weighed 121 lbs in April 2014 and October 2014 weight was 114 lbs.

On 10/28/14 at 2:00 PM, E41, CNA and E42, Registered Nurse, stated they weighed R1 that morning and he weighed 112 lbs.

2. The MDS dated 7/22/14 identified R20 as having moderate cognitive impairment and requires only set up for meals. The monthly weight record documents R20 weighed 144 pounds in July, 131 pounds in August, 129.8 pounds in September and 132.4 pounds in October.

R20's Care Plan fails reflect R20's nutritional risk and failed to develop appropriate interventions toward weight loss prevention in light of her

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nutritional risks. The October 2014 Physician's Order sheet (POS) include a diet order for regular diet, fortified cereal, potatoes and pudding daily, no added salt, liberal renal diet, no bananas, oranges, orange juice, baked potatoes, no fresh tomatoes.

The Dietary Managers note dated 10/21/14 documents that R20's usual daily intake is 26-75%. A note dated 2/4/14 documents no changes to diet and "can feed self but requires cues and some assist.

On 10/28/14 at 8:40 am, R20 was at the table in the dining room. She was served scrambled eggs, biscuits/gravy, and oatmeal in a separate bowl. She used her fork with her right hand, and scooped food and ate with her fingers of her left. No staff intervention was provided. She ate only 50% of her eggs and bites of her biscuits/gravy with her cereal not uncovered during the meal time. No substitutes were offered and R20 ate less than 50% of her total meal.

On 10/28/14 at the noon meal at 12:45pm, R20 was served Pork roast, Fortified Potatoes, cake/frosting, and dressing. She received one glass of iced tea. Staff attempted to cut the meat up but it remained in long (3-4 inches) strings. The butter pad remained laying on the table unused. She had no assist at the table with her. R20 reached for her cake and with both hands, lifted the top off and attempted to eat it. Her hands were shaking badly and the cake was falling in pieces. No staff cueing/encouragement was provided. She made a couple attempts at loading her fork with meat but was unable to get it on the fork. R20 then sat not eating and watching residents sitting around her. At 1:07

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F 325	Continued From page 31 pm, she attempted to eat the rest of her cake which fell apart in pieces in the middle of her potatoes and meat/dressing. The cake remained in the middle of her plate. At 1:12 pm, E13 CNA offered to help and R20 declined. No substitues or alternate foods were offered at any time. 3. On 10/28/14 from 10:20 AM to 1:25 PM, R6 was observed sitting in her wheelchair in the first floor east dining room. There were no staff observed or any fluids offered. At 1:35 PM, R6 was observed exiting the dining room propelling herself down the hallway. No staff intervened. There was no food or fluids sitting at the table where R6 was to eat. R6 did not receive a lunch tray. The MDS, dated 10/15/14, documented R6 was severely cognitively impaired and required assistance with all cares, including meal set up and supervision during meals. R6 has had a documented weight loss of 10 lbs. from 100 lbs in January, 2014 to 90 lbs in October, 2014.	F 325		
F 327 SS=E	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to provide sufficient fluid intake to maintain proper hydration and health for 4 of 13 residents (R1, R3, R15 and R20)	F 327		

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reviewed for hydration in a sample of 25.

Findings include:

1. According to the Minimum Data Set (MDS) dated 9/7/14, R3 has short/long term memory deficits and is moderately impaired. The MDS indicates she requires extensive assist of one staff for eating/hydration.

The October 2014 Physician's Order Sheet (POS) documents R3 had a Percutaneous Endocopic Gastrostomy (PEG) tube placed 8/6/14 due to malnutrition and returned with a regular diet of pureed foods, nectar thickened liquids.

R3's Labs dated 10/27/14 documents BUN is elevated at 41 (normal 7-25), BUN/Creatinine 103 (normal 6-34). R3 currently has a stage IV pressure ulcer. R3's gastrostomy tube (Gtube) feeding is given between 6pm and 6am with water flushes of 150cc every 4 hours.

On 10/28/14 at breakfast meal, R3 was served thickened water only. No other fluids were provided with her meal. R3 was fed by E15, Certified Nurses Aide (CNA) and took only a few very small sips.

On 10/28/14 at 9:45am, R3 was transferred to bed by E18, Licensed Practical Nurse (LPN) and E15 CNA. No fluids were offered to R3 during the care provided. No fluids were available in her room. R3's room had no fluids available in the afternoon. R3 had thick mustard colored urine in her urinary catheter and her mouth appeared somewhat dry.

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On 10/29/14 at 8:50am, R3's breakfast tray was still sitting untouched on her overbed table. The liquids were covered. At 9:35am, E15 attempted to give her breakfast and then returned the tray to the cart within three minutes. Her fluids remained covered and untouched. R3 had no fluids in her room for staff to provide during care.

On 10/30/14 at 10:45 am, E1 Administrator, explained that residents with thickened liquids do not have water placed in their room and is it the responsibility of the staff to give the fluids sent out at snack time.

On 10/30/14 at 11:00 AM, a urine culture and sensitivity documented a urinary tract infection.

The care plan failed to include any intervention toward ensuring that R3 received oral fluids during the day with meals and care.

2. The MDS dated 9/19/14 identifies R15 as requiring only supervision to eat. The Registered Dietician (RD) Note dated 12/31/14 documents his minimal daily fluid requirements are 3045cc/day and he is assisted by staff. The October 2014 POS documents he is to receive honey thickened liquids. The care plan dated 10/13/14 fails to address his risk of dehydration due to the thickened liquids.

On 10/27/14 at 8:40 am, R15 had thickened water, orange juice, and milk. He independently drank only his orange juice, 25% of his milk and none of the water. Staff did not offer/cue and/or encourage him to drink more.

On 10/28/14 at 8:45 am, R15 was in bed asleep and did not get up for breakfast therefore had no

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fluids at that time. He had no fluids available in his room. Midmorning, he was given a glass of thickened orange juice which he drank on his way down to lunch. R15 was served water and fortified milk thickened. He did not drink either drink, had no assist with his meal and no staff intervention to cue/encouragement to drink more fluids.

3. The MDS dated 7/22/14 identifies R20 as having cognitive impairment and requires set up assist of one for eating. The RD assessment dated 5/28/14 identifies R20's minimum daily fluid requirements as 1843cc/day. The care plan dated 8/13/14 fails to include any interventions toward assuring R20's daily fluid requirements are met.

On 10/28/14 at 8:40am, R20 was at the table in the dining room. She was served only coffee with her meal. No cueing and/or encouragement was offered to drink her fluids and no other fluids were provided when she failed to drink the coffee. R20's room had no fluids at bedside to offer during care.

On 10/28/14 at the noon meal at 12:45pm, R20 was served only one glass of tea with her meal. R20's hands were shaking badly as she attempted to pick up the glass of tea and drink it. No other fluids were offered. R20 drank almost all her tea with no other fluids offered and/or encouraged.

4. R1's Physician Order Sheet (POS) of October 2014 documents an order for a pureed diet with double portions at meals, Honey thickened liquids, Fortified Pudding daily, Fortified Potatoes daily, Fortified Cereal daily Snack three times a

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F 327	Continued From page 35 day, High Calorie Liquid supplement 240 ml (milliliters) TID (three times a day), Prostate 30 ml TID and no milk due to allergy. R1 was observed at breakfast meal on 10/27/14 and received only a glass of thickened orange juice for liquids. R1 drank his orange juice and was not offered any other fluids. R1 was observed at dinner meal on 10/26/14 and noon meal on 10/27/14. On 10/26/14, R1 took R28's thickened milk and thickened coffee. On 10/27/14, R1 took R37's iced tea.	F 327		
F 366 SS=E	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to offer substitutions for food dislikes and/or foods uneaten for 4 of 22 residents, R1, R7, R14 and R15, observed at meals in the sample of 25 and 1 resident R29 in the supplemental sample. Findings include: 1. R1's Minimum Data Set (MDS) of 9/8/14 documents R1 requires extensive assistance of 1 for eating. R1's Care Plan of 9/18/14 documents R1 is at risk for an alteration in nutrition related to	F 366		

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therapeutic diet with honey thick liquids. Care Plan interventions, include in part; "Provide Alternative food choices if resident refuses meal if less than 50% of meal is consumed."

R1 was observed at evening meal on 10/26/14 to eat less than 50% of his pureed green beans and pureed macaroni and cheese and was not offered substitution.

R1 was observed to eat breakfast on 10/27/14 and ate less than 25% of his pureed toast, pureed egg and pureed oatmeal. When E35, Central Supply/Certified Nurse Aide (CNA) tried to feed R1 his toast and oatmeal he stated he did not like it. R1 was not offered any substitutions.

2. R14's Care Plan of 8/19/14 documents R14 is at risk for an alteration in nutrition related to decline in condition. Care Plan interventions include, in part; provide alternative food choices if resident refuses meal if less than 50% of meal is consumed.

R14 was observe at evening meal on 10/26/14 to eat only 25% of her pureed meat and was not offered a substitution.

3. R7 was observed on 10/27/14 at breakfast meal and ate 0% of her scrambled eggs and was not offered a substitution.

4. R15 was observed at evening meal on 10/6/14 to receive ground sausage, macaroni and cheese, green beans, 1/2 banana and a peanut butter and jelly sandwich. R15 stated he did not like what was served and was offered the peanut butter and jelly sandwich that was on his tray. R15 ate no food that meal and was not offered

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F 366	Continued From page 37 any substitutions. 5. R29 was observed at breakfast on 10/28/14 and did not eat anything. E36, Minimum Data Set (MDS) Nurse took the tray and stated R29 refused it. R29 was not offered any substations.	F 366		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure food is stored and prepared in a manner which prevents contamination; and failed to ensure dishes were sanitized properly. This has the potential to affect all 163 residents living in the facility. Findings include: 1. During initial tour of the kitchen on 10/26/14 at 1:00 PM, the following was observed: There was an open container of fresh tea brewing that was sitting on a cart that was 4 inches from the garbage.	F 371		

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There was a large tub of tuna salad with a date of 10/21/14 but no time the tuna was put into the refrigerator.

Along the seal of the ice machine there was rust and a black substance.

There was dried food debris on the can opener blade and on the base of the can opener.

There was a box on the floor by the food prepare area with garbage in the box.

The walk in freezer door would not open and there was ice accumulated outside the door. E23, Dietary Aide, stated there is a problem with the freezer door freezing shut and stated your have to pull real hard to get it open. E23 opened the door and there was frozen condensation on the roof of the freezer with zucchini, potatoes, strawberries and ham stored under the the frozen condensation and had condensation on the boxes and packages.

2. On 10/27/14 at 3:40PM, in the kitchen the following was observed:

There were 2 whole turkey breasts in the reach in refrigerator. There was a date of 10/26/14 but no time written on the cover. When asked how the facility knows food is cooled down properly, E24, Dietary Manager, stated it is written on the cool down log. E24 provided The facility SAMPLE HACCP (Hazard Analysis and Critical Control Points) - 2 STEP COOL DOWN TEMPERATURE MONITORING SHEET FORM which showed no documentation on the form since 10/25/14. The directions on the form documents that staff are to write the date. Start timing cool down when food

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reaches 135 degrees Fahrenheit (F). Document temperature at 2 hours which should be 70 degrees F or less. Temperature at 6 hours of 41 degrees F or less. The form documents on 9/16/14, Roast Beef was 186 degrees at 1:30 PM, in 2 hours was 143 degrees and was down to 51 degrees at 7:10 PM. On 10/11/14 it is documented that Pork Roast was 192 degrees at 12:45PM temperature in 2 hours was documented as 174 F. and temperature was 137.5 F. degrees at 5:00 PM.

3. On 10/29/14 at 9:05AM, in the kitchen the following was observed:
The dumb waiter (food elevator) was heavily soiled with dried food debris and what appeared to be dirt in the corners.
There was dried powder drink mix, cake mix and other food items on the dumb waiter.

The containers of Iced Tea had blue lids that were blackened with dirt.

The dish machine was observed to be a low temperature dish machine with Ultra San sanitizer (Chlorine Sanitizer). E24 could not find test strips at the dish machine and stated she would have to go to storage to get test strips. E24 brought back test strips for Quaternary Ammonia and Chlorine. E24 tried both test strips and they did not change colors to show the dish machine was sanitizing correctly. At 9:30AM, E24 stated E25, Dietary Manager of a sister facility, had fixed the dish machine stating it was not sanitizing because there was an air bubble in the line. E25 confirmed there was air in the sanitizer line and stated he was working to get the air bubbles out and the machine was now sanitizing. E24 stated the facility did not have any documentation that

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	145160	A. BUILDING _____ B. WING _____	10/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CAPITOL HEALTHCARE AND REHAB CENTER	555 WEST CARPENTER SPRINGFIELD, IL 62702

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F 371	Continued From page 40 showed the dish machine was being tested for sanitation and stated she would implement a sheet to be kept on the dish machine. 4. The facility's Resident Census and Conditions of Residents form, dated 10/27/14, documented the facility had a census of 163 residents.	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 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	F 441		

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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 and record review, the facility failed to ensure staff change their gloves and wash their hands during incontinent care and failed to ensure equipment was cleansed after it was soiled to prevent the spread of infection for 3 of 8 resident (R7, R3, R20) in the sample of 25 and 1 resident (R30) in the supplemental sample.

1. R7's MDS of 8/11/14 documents R7 is always incontinent of bowel and bladder and requires extensive assistance with of one for hygiene.

R7's Care Plan of 10/13/14 documents R7 is incontinent of bowel and bladder.

R7 was observed on 10/27/14 at 9:50AM to be on the toilet. R7's incontinent brief was saturated with urine and had feces smears. R7's wheel chair cushion was viably soiled. There was a small amount of feces smeared on R7's toilet riser. E15, Certified Nurse's Aide (CNA), washed R7's buttocks and with same soiled gloves then used a gait belt to transfer R7 from the toilet to the wheel chair. R7 was placed onto the soiled wheel chair cushion by E15 and E31 CNA's. E15 and E31 then put R7 into bed. E15 was observed to do incontinent care and wore same soiled

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gloves to put barrier cream on R7's buttocks. On 10/28/14 at 1:30PM, the feces smear was still on the riser.

2. On 10/28/14 at 9:45am, E18, Licensed Practical Nurse (LPN) donned gloves to check whether R3's wound vacuum was intact. E18 touched R3's rectal area, rubbed the dressing of the sacral pressure ulcer and determined that the dressing needed to be changed. E18 then with the same gloves on, touched R3's bed linens and clothes before removing her gloves.

3. On 10/28/14 at 1:30 pm, R20 was transferred to the toilet by E19, Licensed Physical therapy assistant (LPTA) who had gloves on. R20 had a wet incontinent brief on which E19 removed and placed in the garbage can.. R20 sat on the toilet for a while and then assisted R20 to stand, wiped her with a piece of toilet paper and applied a new paper brief then pulled up her pants before removing the soiled gloves.

4. On 10/27/14 at 9:25 AM, E27 and E28, CNA's were observed during incontinent care for R30. R30 was saturated with urine. There were rings of dried and wet urine observed on the bed sheet under R30. R30's hospital gown was saturated with urine. E27 and E28 removed the soiled bed sheet and apply a clean one without cleansing the mattress. E28 then assisted E27 in removing R30's gown and applying clean clothes. E27 was observed to place the soiled linens and gown into a plastic bag and place it on the floor. E27 was then observed with the same soiled gloves on place a clean blanket on R30.

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F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON	F 465		

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure the facility's kitchen floor and residents' equipment are maintained in clean and good repair. This has the potential to affect all 163 residents living in the facility.

Findings include:

1. On 10/26/14 at 1PM, the kitchen floor was observed to have food debris and dirt build up under the equipment and along the walls. On 10/27/14 there was a large amount of food debris and empty disposable cups and straws under the dish machine and the kitchen floor and under equipment were soiled with dried food debris.

On 10/28/14, at 9:44AM, E1, Administrator, was informed of the above and stated it use to be worse, they hired professional cleaners a couple of weeks ago and they came in and did a thorough cleaning.

2. On 10/26/14 at 1:45PM, R1's incontinent brief was saturated with urine. E31, Certified Nurse's Aide, CNA, stated she needed to do incontinent care. E31 attempted to pull R1's bed curtain around the bed but was unable because the

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F 465	Continued From page 44 curtain was stuck and would only go so far. On 10/28/14 at 2PM, R1's wheel chair seat was torn. 3. On 10/27/14 at 9:55AM, R7's recliner in the room had the vinyl peeling off the seat of the recliner. 4. On 10/28/14 at 9:45am, R3's air mattress was soiled with spills of food and debris. R3's gastrostomy bag pole was also soiled with spilled formula. 5. The Facility's Resident Census and Conditions of Residents Form, dated 10/27/2014, documents the Facility has 163 residents living in the facility.	F 465		