STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	14E200		05/14/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELIZABETH NURSING HOME	540 PLEASANT STREET ELIZABETH, IL 61028

(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	F 000		
F 312 SS=D	Annual Licensure and Certification Survey. 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 care with activities of daily living to ensure a resident ' s fingernails were trimmed and clean. This applies to 1 of 9 residents (R1) reviewed for grooming in the sample of 10. The findings include: The Minimum Data Set (MDS) of April 9, 2015 shows R1 requires extensive assistance from two staff with transfers, dressing, hygiene, bathing and toileting. The 4/9/15 MDS shows R1 has behaviors of physical symptoms (scratching self) that occurred daily. R1 ' s Risk for pressure ulcer care plan dated January15, 2015 shows, " [R1] has a tendency to scratch at skin/perineum areas, thighs, back, areas she can reach " and " with scratching tendencies, staff assist to keep [R1] fingernails cleaned, trimmed, and filed ... " On May 12, 2015 at 1:20 PM, R1 was in a reclining wheelchair in her room. R1 ' s fingernails extended beyond the tips of her fingers. E4 and E5 (Certified Nurse Aides -CNA) transferred R1 to the bed with a mechanical stand	F 312		

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

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F 312	Continued From page 1 lift. E4 and E5 removed R1 ' s pants and soiled incontinence brief. E4 and E5 held R1 's hands while E3 (Registered Nurse - RN) started to clean stool from R1 ' s vaginal area . E4 let go of R1 ' s hand to assist with washing, and R1 started scratching her vagina, getting stool on her hands. E5 washed R1 ' s vaginal area and the wash cloth had blood -tinged streaks. E4 told E5 that R1 scratched herself and it was bleeding. After cleaning R1 ' s hand, R1 starting scratching her vaginal area again, and her hands had stool on them. R1 had a brown black substance underneath the fingernails on her right hand. E4 and E5 turned R1 onto her side and R1 had a large open area to her left buttock and a smaller open area to her right buttock. R1 had multiple red/purple discolored areas to her buttocks, and E3 said all the marks are from R1 scratching herself. E3 said the physician has seen R1 several times and has changed her wound care treatment multiple times but R1 continues to scratch and injure herself. After completing care, E4 and E5 placed R1 on her back. E3 looked at R1 ' s nails and said they were long enough to be trimmed. E4 and E5 both said R1 ' s fingernails were long enough to be trimmed and were extending beyond her finger tips. E4 said R1 ' s nails are trimmed once a week on her shower days " if we can " because R1 scratches when she is in the shower and it ' s hard to hold her hands still. On May 13, 2015 at 1:50 PM, R1 was in bed resting. R1 ' s fingernails on both hands extended beyond the tips of her fingers. R1 had a brown/black substance underneath the nails on her right hand. On May 14, 2015 at 10:30 AM, E2 (Director of Nursing- DON) said R1 has a history of scratching herself and causing injury. E2 said R1	F 312		

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F 312	Continued From page 2 is seen by the wound care consultant for the wound to her bottom that was caused by her [R1] scratching herself and causing a sore. E2 said R1 should have her nails kept as short as possible so she cannot harm herself. E2 said R1 ' s fingernails do not need to be trimmed during the shower if the CNAs are unable to do it. E2 said the nails could be trimmed at a time that is more comfortable for R1 and they definitely should be trimmed if there is something underneath them. E2 said keeping R1 ' s fingernails trimmed and short is important because of her scratching her perineal area and buttocks. On 5/14/15 at 11:45 AM, E6 (RN) said R1 has a history of scratching her perineal area and buttocks, causing open scratches and sores. E6 said R1 ' s fingernails should not extend beyond the tips of her fingers, and it is important her fingernails are kept short so she cannot dig into her skin or injure herself. E6 said R1 ' s fingernails are long enough to have material under them then they need to be trimmed and kept clean. E6 said if it is difficult to trim R1's fingernails during her shower the CNAs should do it in her room while she is calm and resting. The facility did not provide a policy on nail care.	F 312		
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	F 315		

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F 315	Continued From page 3 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident had a medical diagnosis for the use of an indwelling urinary catheter. This applies to 1 of 1 residents (R3) reviewed for urinary catheters in the sample of 10.. The findings include: R3's face sheet shows she was admitted to the facility on June 21, 2010 with multiple diagnoses including overactive bladder and urinary frequency. The July 2, 2014 and March 11, 2015 MDS ' s (Minimum Data Set) each show R3 has no genitourinary diagnoses and list a diagnosis of urinary frequency. On May 12, 2015, R3 was observed in the lobby recliner with a urinary catheter drainage bag on the floor next to the chair. The November 15, 2011 physician order sheet shows an indwelling urinary catheter. No diagnosis for the use of the catheter was listed. The July 9, 2014 care plan documents R3 has a past history of urinary retention but no current diagnosis for urinary retention. On May 13, 2015, E2 DON (Director of Nursing), presented R3 ' s nursing notes from November 11, 2011. The nursing notes document a post void residual of 0 ml (milliliters) returned from the straight catheterization procedure. The November 14, 2011 nursing note documents R3 had a distended bladder, and a post void residual of 300 ml was obtained by straight catheterization. The nurse documented she requested a physician ' s order to leave the	F 315		

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F 315	Continued From page 4 catheter in place, and the physician ordered the indwelling catheter. On May 13, 2015 at 9:30 AM, E2 stated it appeared the nurse had requested for the catheter to be placed and the physician had not provided a diagnosis. E2 stated no other post void residuals were performed. On May 13, 2015, E2 stated R3 was not seen by the urologist until last year for bladder stones. E2 stated R3 had not been to the urologist when the urinary catheter was placed in 2011. E2 stated the only diagnosis R3 had was overactive bladder. E2 stated R3 has no current diagnosis for the urinary catheter. The undated facility policy for catheters documents a resident who enters the facility without an indwelling catheter is not catheterized unless the resident ' s clinical condition demonstrates catheterization was necessary.	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical	F 329		

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F 329	Continued From page 5 record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the gradual dose reduction for seroquel (psychotropic medication) was attempted annually. This applies to 1 of 6 residents (R3) reviewed for gradual dose reduction of psychotropic medication in the sample of 10. The findings include: R3's care plan documents she was admitted to the facility on June 21, 2010 with multiple diagnoses to include anxiety. On December 16, 2010, R3 was diagnosed with dementia with behavior disturbances. The May 2015 MAR (Medication Administration Record) shows on October 26, 2011, R3 was prescribed Seroquel 50 mg twice a day. The MDS (Minimum Data Set) for July, 2 2014 and March 11, 2015 show R3 had no delirium or behaviors documented. The April 2015 monthly summary describes R3 as friendly, quiet, anxious and cooperative. The mood and behavior assessments documents R3 does not have physical or verbal behaviors, resist cares or displays any withdrawn behavior. On May 12, 2015 at 12:00 PM R3 was sitting in a recliner located in the lobby area. R3 was resting with her eyes closed. At 1:30 PM, R3 was resting	F 329		

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F 329	Continued From page 6 in bed with her eyes closed. On May 12, 2015 at 12:30 PM, E4 CNA (Certified Nursing Assistant) stated R3 has had no behaviors or rejection of care issues. E4 stated each resident has a behavior sheet in the tracking book, but she has not documented behaviors for R3 at any time. E4 stated R3 will sometimes make repetitive statements if she needs help getting up or if she is cold. E4 said once her issue is addressed she is quiet again. E4 stated (R3) makes no attempt on her own to get out of her wheelchair or the recliner. On May 12, 2015 at 1:15 PM, E8 (Activity Aide) stated R3 will make repetitive statements if she needs help with something, otherwise she is very quiet and sleeps most of the time. On May 13, 2015 at 8:50 AM, R3 was at the dining room table and staff was assisting her to eat her breakfast. R3 appeared tired. E6 RN (Registered Nurse) stated R3 is pretty cooperative when she is awake. R3 has a hard time staying awake throughout the day. E6 stated R3 tries to feed herself, but it depends how alert she is. She is pretty lethargic and not real active so staff has to feed her at mealtime. E6 said she had not noticed R3 to have any behavior issues. R3 ' s care plan meeting minutes for March 18, 2015 document the nursing notes and behavior tracking did not show any moods or behaviors. The minutes state (R3) sleeps a lot; late afternoon is her most alert time of the day, following many naps. The psychiatric progress notes for February 2014 to February 2015 show the psychiatrist documented R3 to have no behavior problems or care refusals. On May 13, 2015 at 9:00 AM, E2 (Director of Nursing) stated R3 had not had any physical or	F 329		

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F 329	Continued From page 7 verbal behaviors. E2 stated (R3) will repeat herself if she wants something. E2 stated R3 is tired most of the day and will lie down after meals. E2 stated R3 had been on Seroquel since 2011 and had not had a reduction in the dose or frequency. E2 stated the psychiatrist was afraid her behaviors would return, but could not define what behaviors R3 had. E2 stated R3 should have had an attempt to reduce the Seroquel twice in the first year it was ordered and then, a once a year a reduction should have been done to see if she would exhibit any behaviors. The facility policy for chemical restraints (psychoactive drugs) states the drugs will only be used as a last resort to protect a resident from injury to himself or others. Residents on chemical restraints who appear drowsy and unresponsive throughout the day should be immediately re-evaluated for appropriate use of medication.	F 329		