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FONDULAC REHABILITATION & HCC	901 ILLINI DRIVE EAST PEORIA, IL 61611

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F 000	INITIAL COMMENTS Annual Certification survey.	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, interview, and record review, the facility failed to obtain physician orders for restraints for two of three residents (R16, R19) reviewed for restraints in the sample of fifteen and also failed to obtain consents for the use of restraints, failed to complete a restraint assessment prior to applying a physical restraint, and failed to initiate a restraint reduction plan for one of three residents (R19) reviewed for restraints in the sample of fifteen. Findings Include: Facility Policy titled, "Physical Restraint " dated 10/07 documents: Definition of Physical Restraints: Physical restraint is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body, which the individual cannot remove easily and which restricts freedom of movement or normal access to one's body. They include, but not limited to: bed rails, self-release waist restraints,... under Procedure: 1. Complete Physical Restraint Assessment. 2. Obtain verbal and/or written consent from resident/legally	F 221		7/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/28/2015

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responsible party...4. Obtain M.D. order for restraint or adaptive device/enabler...19. After initial documentation, all physical restraints require quarterly documentation regarding the type of physical restraint used, resident's response to the physical restraint, and if any reduction plan has been attempted. 20. All physical restraint assessments must be completed and updated every 90 days thereafter.

1. On 7/6/2015 at 9:20 A .M., R16 is sitting in hallway in wheelchair with a self-release seat belt around waist. R16 was asked to release seatbelt from around waist, and R16 was unable to release seatbelt from waist.

R16's Physician's Order Sheet dated 3/1/2015 thru 3/31/2015, 4/1/2015 thru 4/30/2015, 5/1/2015 thru 5/31/2015, and 6/1/2015 thru 6/30/2015 documents no order for self-release belt.

R16's Physician's Order Sheet dated 7/1/2015 thru 7/31/2015 documents under Diagnosis: Dementia, Muscle Weakness, Diabetes.

R16's Care Plan dated, 2/14 documents, "Self-release belt, in chair, 3/29 continue with self-release seatbelt, 4/14, care plan reviewed, continue with use of self-release seatbelt through next review."

On 7/6/2015 at 9:20 A.M., E10 RN (Registered Nurse) states, "R16 cannot release self-release belt upon request."

On 7/7/2015 at 8:42 A.M., E3 RN CPC (Registered Nurse Careplan Coordinator) states, "I don't know the exact date that R 16 stopped

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being able to release the seatbelt but R 16 is not able to release it."

On 7/6/2015 at 1:30 P.M.,, E11 RN (Registered Nurse) states, "There is no current physician's order to use the self-release seatbelt in the wheelchair."

2. On 7/6/15 at 11:09 a.m., R19 was lying in bed with bilateral full side rails and a fall mattress on the floor on the side closest to the door. The bed was elevated to approximately 45 degrees and a large gap (approximately 6-9 inches) was noted between the middle of the bed and the side rail.

On 7/6/15 at 12:55 p.m., E15 (Certified Nurse Aide) stated R19 could not use the side rails for mobility and the side rails were put on to keep R19 from falling out of bed. E15 stated R19 fell out of bed "numerous" times before the full side rails were put on the bed.

R19's Physician Order Sheet dated 7/2015, document bilateral half side rails. R19's Hospice Plan of Care dated 6/15/15, documents "full side rails as ordered."

On 7/7/15 at 11:50 a.m., E3 (Care Plan Coordinator) stated R19 can move very little in bed and "to my knowledge (R19) has had half siderails since I started working here a year and a half ago. I have no idea when R19 had full side rails added to his bed." E3 stated E2 (Director of Nursing) would be responsible for getting consents from the responsible party." E3 verified R19 did not have a restraint reduction plan in place for the use of bilateral full side rails.

On 7/7/15 at 2:20 p.m., E2 (Director of Nursing)

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F 221	Continued From page 3 verified R19 did not have a physician order for full side rails, a restraint assessment was not completed, and a restraint consent was not obtained prior to placing the full side rails. When asked if E2 had assessed the gap between the mattress and the siderail on R19's beds, E2 stated Maintenance was responsible for entrapment assessments. E2 stated R19 had a history of sliding out of his bed prior to the full side rails. E2 stated "that is why the fall mattress is still next to (R19's) bed." On 7/7/15 at 1:55 p.m., E16 (Maintenance Director) stated no knowledge or experience in measuring the gap between siderails and mattresses on resident beds.	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have 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	F 225		7/25/15

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through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to report allegations of resident to resident verbal and physical abuse to the Administrator and the State Agency and failed to investigate these allegations for two of nine residents (R4 and R23) reviewed for abuse in a sample of 15.

Findings Include:

1) R4's Nurse's Notes dated, 6/4/2015 at 9:45 P.M., documents, "(R4) observed yelling profanities with name calling at (R26) and woman from therapy (unknown)."

R4's nurse's notes dated, 7/3/15 at 12:30 P.M., documents, "(R4) alert. Yelling and screaming all shift. Verbally abusive towards another resident at dinner (unknown)."

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On 7/7/2015 at 11:20 A.M., R26 (R4's roommate) stated, " My roommate cusses at me all the time, I am used to it, she yells all the time directly at me . I would be "ok" if they moved her, it would be much quieter."

On 7/7/2015 at 9:30 A.M. E2 DON (Director of Nurses) states, " I expect the staff to intervene immediately, and remove the resident. Staff need to report allegations immediately. I was not notified of any allegations of R4's verbal abuse on 6/4/2015 and 7/3/2015."

On 7/7/2015 at 10:15 A.M. E1(Administrator) states, "Staff did not notify me of R4's verbal abuse on 6/4/2015 or 7/3/2015. E1 stated, " No investigations were done."

2) R23's Physician Order Sheets dated 7/1/15 to 7/31/15 document R23 has a diagnosis of Dementia with Psychotic Features and Alzheimers with Dementia.

R23's Nurses Notes dated 4/3/15 document R23 grabbed R27's shirt collar and started shaking him.

On 7/9/15 at 11:10 AM, E1, Administrator, stated no information had been found related to the incident between R23 and R27 on 4/3/15. E1 was unable to provide any written evidence that R23's physical abuse was investigated or reported to the Administrator or the State Agency.

On 7/9/15 at 11:15 AM, E2, DON (Director of Nursing) stated the facility was not able to provide evidence the facility investigated or reported the allegation of abuse on 4/3/15.

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F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to follow the facility Abuse Policy for reporting and investigating allegations of resident to resident verbal and physical abuse for two of nine residents (R4 and R23) reviewed for abuse in a sample of 15. Findings Include: The Facility Policy titled," Abuse Prevention Program" dated 11/11/11 documents, the facility must ensure that all alleged violations involving mistreatment, neglect or abuse, including injuries of unknown source, misappropriation of resident property, and reasonable suspicion of a crime, are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures...Upon learning of the report, the administrator or designee shall initiate an investigation. 1. A nurse's notes dated 7/3/2015 at 8:00 P.M., documents, "R4 alert. yelling and screaming all shift. Verbally abusive towards another resident at dinner (unknown)."	F 226		7/25/15

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F 226	Continued From page 7 A nurse's notes dated 6/4/15 at 9:45 A.M., documents, "R4 observed yelling profanities with name calling at roommate (R26) and woman from therapy (unknown)." On 7/7/2015 at 10:15 A.M. E1 (Administrator) states, "I was not notified of any allegations of abuse (by R4) for 6/4/2015 and 7/3/2015, so there are no investigations and (the State Agency) was not notified." 2) R23's Pharmacy Consultation Report dated 9/3/14, documents R23 has a diagnosis of Scizo-affective with delusional disorder and R23 has occasional aggressive tendencies. R23's Nurses Notes dated 4/3/15 document R23 grabbed R27's shirt collar and started shaking him. R23's Behavior Monitoring Record dated April, 2015 does not include documentation of the incident from 4/3/15 between R23 and R27. On 7/9/15 at 11:10 AM, E1, Administrator, stated no information had been found related to the incident between R23 and R27 on 4/3/15. E1 was unable to provide any written evidence that R23's physical abuse was investigated or reported to the Administrator or the State Agency. On 7/9/15 at 11:15 AM, E2, DON (Director of Nursing) stated the facility was not able to provide evidence the facility investigated or reported the allegation of abuse on 4/3/15.	F 226		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		7/25/15

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A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.

The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the comprehensive care plan included hospice services for one of three residents (R18) reviewed for hospice in the sample of 15.

Findings include:

R18's Physician Order Sheets dated 7/1/15 document R18 was admitted on 6/18/15 with hospice services.

R18's Care Plan dated 6/18/15 does not address hospice services.

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F 279	Continued From page 9 E3, Care Plan Coordinator stated on 7/6/15 at 11:42 AM, that R18 was admitted with hospice services. E3 stated R18's Interim Care Plan, does not include hospices services.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to review and revise fall care plans for three of three residents (R11, R19, R20) reviewed for falls in the sample of fifteen. Findings include:	F 280		7/25/15

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1.) R11's current Falls Care Plan dated 5/6/15 does not include interventions or revisions for a fall reported on 5/12/15.

R11's Minimum Data Set dated 5/6/15 states R11's Brief Interview for Mental Status (BIMS) score is 13, indicating R11 has a minimal cognitive deficit

R11's Nurse's Notes dated 5/12/15 at 1:25pm, by E13 Registered Nurse (RN), documents E13 noted R11's left hand to be "purple and edematous and fourth and fifth digits noted swollen" and "(R11) has minimal range of motion to left fourth and fifth fingers." On 5/12/15 at 1:45pm, E13, RN's Nurse's Notes stated R11 "fell two days ago in the hall."

The facility's "Incident Report Form - (State Agency) Notification" dated 5/12/15 by E2, Director of Nursing (DON), states the "Type of Incident" on 5/12/15 at 1:30pm was a "Fall" and the "Type of Injury" was a "Hematoma".

A radiology report dated 5/12/15 by a local radiology company states R11's left fourth digit is dislocated without fracture.

A Nurse's Note dated 5/13/15 at 11:30am by E8, Licensed Practical Nurse (LPN), states E17, Medical Director's Physician's Assistant (PA) "reduced dislocated finger using ten milliliters lidocaine local block."

On 7/9/15 at 10:35am, E2, Director of Nursing (DON) verified there is no Fall Care Plan addressing R11's fall, reported on 5/12/15.

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2.) R20's current Falls Care Plan dated 5/6/15 does not include interventions or revisions for a fall reported on 5/12/15.

R20's score for the Brief Interview for Mental Status,dated 5/28/15, is 11, indicating that R11 has minimal cognitive impairment.

R11's Nurse's Note by E8, LPN, dated 6/26/15 at 12:50 pms states R20 was sitting on the toilet in R20's room and stated "My ribs hurt" and "I hit my side on the foot of the bed when getting up, Miss." The Nurse's Note by E8, LPN also stated: "Upon assessment 6 centimeter by 3 centimeter discoloratiom noted to right side."and that (R20) complained of pain on R20's right side throughout E8's assessment.

R20's radiology report from a local radiology company dated 6/26/15 states: "There are acute nondisplaced fractures of the ninth and tenth right ribs."

On 7/8/15 at 10:35 am, E2, DON verified that R20's current Falls Care Plan has an intervention dated 6/2/15 and no intervention revision for R20's fall with rib fractures on 6/26/15.

On 7/9/15 at 10:10am, E3, Minimum Data Set Coordinator and Care Plan Coordinator (MDS/CPC) verified there was no Fall Care Plan interventions addressing R11's fall on 6/26/15.

3. Facility Incident Reports dated 7/18/14 at 4:00 a.m., 7/18/14 at 10:50 a.m., and 7/27/14 at 11:30 p.m., document R19 fell/slid out of his bed.

R19's plan of care dated 3/30/15, does not

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F 280	Continued From page 12 document R19's three fall in July of 2014. On 7/8/15 at 10:05 a.m., E3 (Care Plan Coordinator) verified that R19's three falls in July of 2014 were not addressed on the Care Plan.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to obtain a physician's order for an indwelling urinary catheter for one of two residents (R18) reviewed for urinary catheters in the sample of fifteen. Findings include: On 7/6/15 at 9:46 AM, R18 was in bed with a urinary catheter collection bag hanging from his bed. The Catheterizations (Indwelling) Catheter Insertion Policy dated 01/02 documents, "A Foley catheter is to be inserted only by order of the physician."	F 315		7/25/15

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F 315	Continued From page 13 R18's Physician Order Sheets dated 6/18/15 do not include an order for an indwelling urinary catheter. On 7/6/15 at 11:42 AM, E3, Care Plan Coordinator stated R18 did not have an order for the indwelling urinary catheter.	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 observation , interview, and record review, the facility failed to provide comfort and preventative interventions for a hand contracture for one of nine residents (R19) reviewed for range of motion/contractures in the sample of 15. Findings include: A Contracture Prevention Policy dated 9/2008, documents all residents will be encouraged to maintain the highest level of physical functioning...care plans for the resident shall include a goal for improvement or maintenance and the approaches that will be used to achieve the goal. On 7/6/15 at 11:09 a.m., R19 was laying in bed	F 318		7/25/15

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with the left arm bent at the elbow and drawn in towards his body. R19's hand was bent at the wrist and drawn in towards his body. R19's fingers were clinched shut against the palm of his hand. R19 did not have any type of splint or device to provide comfort and prevent the contractures from worsening.

R19's Physician Order Sheet dated 7/2015, documents R19 has diagnoses which include, Dementia and Cerebral Vascular Accident with left side paresis. R19's Minimum Data Set dated 6/23/15, document R19 has limited range of motion in upper and lower extremities. R19's Hospice Plan of Care dated 6/15/15, documents R19 has a left hand contracture. R19's Facility Plan of Care does not address R19's range of motion exercises or contractures.

R19's Range of Motion (ROM) Assessment dated 3/27/15, documents R19 is at high risk for contractures and has less than 25 percent functional range of motion in his left upper and lower extremities. The ROM Assessment also documents to continue active and passive range of motion and "recommended by (physical and occupational therapists) with doctor approval may include splinting."

R19's Restorative Nursing Program Documentation dated 5/2015 and 7/2015, documents staff are to provide active and passive range of motion when interacting with R19 with no frequency specified. R19's Restorative Nursing Documentation dated 5/2015 has 56 shifts with no documentation of ROM exercises being provided. R19's Restorative Nursing Documentation dated 7/1/15 through 7/9/15, has 24 shifts with no documentation of ROM

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F 318	Continued From page 15 exercises being provided. On 7/8/15 at 11:50 a.m., E14 (Certified Nurse Aide) stated R19 does not have a splint or device for the contracted left hand. E14 was unable to state how often R19 was supposed to be receiving ROM exercises. E14 stated R19 does not follow directions and hits and spits at staff when providing cares. On 7/8/15 at 10:07 a.m., E3 (Care Plan Coordinator) verified that R19's limited range of motion, left hand contracture, and range of motion exercises are not addressed on R19's care plan. E3 stated R19 does not have any type of splint or device for the left hand contracture. E3 also stated that E3 is responsible for restorative programs and was not aware that R19's range of motion exercises were not being performed on a regular basis.	F 318		
F 327 SS=D	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 observation, interview, and record review, the facility failed to provide fluids at residents' bedside for two of nine residents (R18, R19) reviewed for hydration in the sample of fifteen and failed to allocate the total amount of fluids provided and monitor the fluids for one of one resident (R1) reviewed for fluid restriction in	F 327		7/25/15

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the sample of fifteen.

Findings include:

A Hydration Program dated 2/2008, documents to provide adequate fluids to all residents to maintain proper fluid balance...establish individual interventions to prevent dehydration, record the amount of fluids the resident consumes at meals and any other specific times on the meal/fluid intake log.
The facility Fluid Restriction Policy dated 3/2013, documents to allocate the total cubic centimeters (cc) of fluid allowed between the daily meals, snacks, and medication administration on the "Fluid Restriction Plan"...Fluids allotted to nursing for medication administration should also be clearly documented on the form...

1. On 7/6/15 at 9:46 AM, 11:16 AM, 12:12 PM and 1:45 PM and on 7/7/15 at 9:22 AM, 11:15 AM and 1:45 PM, R18 did not have any fresh water in his room or at bedside.
R18's Care Plan, dated 7/6/15, documents R18 has a Fluid Volume Deficit concern. R18's Care Plan documents to keep fluid within resident reach.
On 7/7/15 at 1:35 PM, E19, NA (Nursing Assistant) stated R18 was not provided fluids in his room.
On 7/7/15 at 2:05 PM, E18, LPN (Licensed Practical Nurse) stated R18 could have water at his bed side. E18 stated when R18 was admitted there was confusion over his fluid consistency but R18 was thin liquids.

2. On 7/6/15 at 11:09 a.m., 12:03 p.m., 12:55 p.m. and 7/7/15 at 9:20 a.m., and 2:10 p.m., R19 did not have any fresh water in his room or at

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bedside.
R19's Physician Order Sheet dated 7/2015, documents R19 has a diagnosis of Dementia.
R19's Plan of Care dated 3/30/15, documents "keep fluids at bedside and offer during cares."
R19's Hydration Assessment dated 3/27/15, documents R19 is unable to obtain fluids independently and has confusion.
R19's Physician Order Sheet dated 7/2015, does not document that R19 is on thickened liquids.
On 7/6/15 at 11:29 a.m., E15 (Certified Nurse Aide) stated R19 is not allowed to have fluids in his room because he receives thickened liquids.
On 7/6/15 at 11:50 a.m., E13 (Registered Nurse) stated R19 is not on thickened liquids. E13 also stated that R19 should have fresh water available in his room and staff should encourage R19 to drink water when providing cares.

3. R1's Physician Order Sheet dated 7/2015, documents R1 is on a 2000 cc fluid restriction in a 24 hour period related to a diagnosis of Polydipsea.
R1's Plan of Care dated 5/11/15, documents to record fluid intake on daily logs. R1's Intake and Output Record dated 6/28/15 through 7/6/15, has not been completed since 6/29/15.
On 7/6/15 at 11:50 a.m., E13 (Registered Nurse) verified that R1 is on a 2000 cc fluid restriction per 24 hour period. E13 stated she was unable to find the "Fluid Restriction Plan" for R19. E13 stated the plan is usually kept in front of R19's Medication Administration Record. E13 was unable to provide any documentation to show the allotted amount of fluid that the Nursing department was able to give R1 each day. E13 stated she gave R1 "one glass" of water with each medication pass. E13 stated R1's fluid intake is monitored on the 24 hour intake and

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F 327	Continued From page 18 output record. E13 verified that R1's Intake and Output Record has not been completed since 6/29/15. On 7/8/15 at 11:25 a.m., E4 (Dietary Manager) verified R1's fluid restriction. E4 stated the Nursing department should have a "Fluid Restriction Plan" to show much fluids R1 is allowed during each shift from Nursing.	F 327		
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 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	F 329		7/25/15

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by:
Based on observation, record review and interview, the facility failed to ensure behaviors warranted the use of antipsychotic medications in one of three residents (R23) reviewed for behaviors in the sample of 15.

Findings include:

Psychotropic Medication Policy dated 5/30/14 documents, "Any resident receiving such medications shall have a psychiatric diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others."

R23's Consultation Report for the use of Antipsychotic Medications, dated 9/3/14 documents, "Symptoms or behaviors must present a danger to the resident or others."

R23's Physician Order Sheets dated 7/1/15 to 7/31/15 document Seroquel XR 100 mg (milligram) by mouth at bedtime.

R23's Behavior Monitoring Records dated July 2014 to July 2015 document one incident of aggressive behavior on 5/3/15.

R23's Psychotropic Medication Quarterly Evaluation documents target behaviors for the use of Seroquel XR as "Combative with Cares, " with number of episodes per month for quarters one and two of 2015 incomplete (blank).

R23 was observed on 7/8/15 at 10:30 AM, 7/9/15 at 10:50 AM and 11:55 AM with no maladaptive behaviors noted.

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F 329	Continued From page 20 On 7/8/15 at 1:40 PM, E2, DON (Director of Nursing) stated R23 has hallucinations and screams at other residents. E2 stated R23 has never harmed another resident or herself."	F 329		
F 386 SS=D	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit; and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the resident's physician signed and dated all physician orders for two of 15 residents (R5 and R23) reviewed for medical record accuracy in the sample of 15. Findings include: R5's Physician Order Sheets dated 5/1/15 to 5/31/15, 6/1/15 to 6/30/15 and 7/1/15 to 7/31/15 do not have the signature of R5's Physician. R23's Physician Order Sheets dated 5/1/15 to 5/31/15, 6/1/16 to 6/30/15 and 7/1/15 to 7/31/15 do not have the signature of R23's Physician. E2, DON (Director of Nursing) verified on 7/9/15 at 11:15 AM, that R5 and R23's Physician Order	F 386		7/25/15

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F 386	Continued From page 21 Sheets for May 2015, June 2015, and July 2015 were not signed by the Physician.	F 386		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441		7/25/15

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infection.

This REQUIREMENT is not met as evidenced by:
Facility noncompliance resulted in two deficient practice statements.

A. Based on record review, interview and observation, the facility failed to post signage identifying the need for additional precautions for an isolation room and failed to provide personal protective equipment for individuals upon entering an isolation room for two of two residents (R17 and R18) reviewed for isolation precautions in a sample of 15.

B. Based on observation , interview, and record review, the facility failed to perform hand hygiene with incontinence care and failed to use soap or cleansing agent with incontinence care for one of five residents (R19) observed for incontinence care in the sample of 15.

Findings include:

The facility's "Transmission Based Precautions" policy, dated 12/2009, states: "Contact Precautions: are designed to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Contact Precautions apply to specified residents known or suspected to be infected with epidemiologically important microorganisms that can be transmitted by direct or indirect contact."

On 7/8/15 at 10:35 a.m. E2, Director of Nursing

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(DON), stated that when Contact Isolation is in place, Isolation barrels for soiled linen and trash are placed in rooms and a personal protective equipment (PPE) container with gloves, gowns and masks is set up outside or inside the door of the resident's room. E2, DON also stated that there is supposed to be a sign on the resident's door stating visitor's are to check with the nurse before entering the resident's room.

A.1) R17's clinical record includes a urine culture result from a local laboratory, dated 6/28/15, documenting that R17's urine was positive for Extended Spectrum Beta Lactamase, (ESBL), indicating the presence of antibiotic-resistant bacteria in R17's urine.

R17's Physician's Order Sheet also includes an order for Cipro, (an antibiotic), one 500 mg tablet twice daily for urinary tract infection.

R17's Quarterly Minimum Data Set dated 5/18/15 documents that R17 is "frequently incontinent".

R17's current Care Plan date 6/17/15 states R17 has "Alteration in Bladder Elimination related to incontinence". R17's current Care Plan also states R17 is "On Contact Precautions due to ESBL Proteus infection in the urine." and lists interventions, including, "Wear gloves and gowns when entering room, remove gloves and gowns before leaving room."

On 7/6/2015 at 9:45 a.m. E3, Minimum Data Set and Care Plan Coordinator (MDS/ CPC), stated that R17 is in Contact Isolation for ESBL in R17's

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F 441	Continued From page 24 urine. On 7/6/15 at 9:45 a.m., 12:05 p.m., 1:30 p.m. and 3:15 p.m. and on 7/7/15 at 8:00 a.m. and 9:35 a.m. R17's room did not have any sign on R17's door indicating that R17 requires Isolation Precautions nor a sign directing visitors to check with a Nurse prior to entering R17's room. There was no personal protective equipment (PPE), including gloves and gowns, present inside or outside R17's room to alert employees and visitor's of the potential for contact with a bacterial microorganism requiring Isolation Precautions. On 7/7/14 at 9:40 a.m. E8, Licensed Practical Nurse (LPN), verified that there was no Isolation sign on R17's room door and that R17 is currently on Contact Isolation for ESBL in R17's urine. E8, LPN also verified that personal protective equipment, including gowns and gloves, should be right inside R17's door or right outside the door. E8, LPN then entered R17's room, opened R17's dresser drawers and closet without wearing gloves and left R17's room without performing hand hygiene. E8, LPN then verified that there was no personal protective equipment (PPE) present inside or outside R17's room and that to enter a resident's room who is on Contact Precautions, employees should wear a protective gown and gloves. E8 walked down B Hall to get PPE for R17's room. 2) During the initial tour on 7/6/15 at 9:46 AM, R18 was in bed, door was open and red bags were visible in waste containers located in the	F 441		

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room. There was no isolation sign noted on the door to the room.
R18's Care Plan dated 7/6/15 documents R18 is in contact isolation due to MRSA (Methicllin-Resistant Staphylococcus Aureus) in a sacral wound with a start date of 6/18/15.
On 7/7/15 at 9:22 AM, R18 was in his room in bed. No isolation sign was noted on the door to the room.
On 7/6/15 at 10:15 AM, E1, Administrator, stated R18 was in isolation due to MRSA in a stage IV pressure ulcer located on R1s coccyx.

B. A Perineal Cleansing Policy dated 9/21/10, documents to use soap or other cleansing agent when providing perineal/incontinence care...wash pubic area with wet washcloth and cleansing agent chosen...wash perianal area thoroughly...remove gloves and wash hands, apply new incontinent product, clothes or reposition comfortably...remember to change or remove gloves and wash hands when going from working with contaminated items to clean items.

On 7/6/15 at 12:55 p.m., E15 provided incontinence care for R19. E15 put on gloves and washed R19's buttock/rectal area with a water moistened towel with no soap or cleansing product. Then without removing or changing E15's gloves, E15 placed a clean adult brief under R19 and rolled him on his back. E15 continued with the same soiled gloves and pulled a trash bag out her shirt pocket and then washed R19's pubic area with a clean water moistened towel with no soap or cleansing agent, finished applying the adult brief, pulled up R19's pants and covered him with a blanket. E15 then removed the soiled gloves and positioned R19. E15

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F 441	Continued From page 26 opened R19's door, walked out into the hall for approximately 15 seconds, then walked back into R19's room and washed her hands. On 7/6/15 at 1:15 p.m., E15 verified she did not wash her hands or remove gloves after providing incontinence care and before touching clean items. E15 stated "I would have changed my gloves if they were (visibly soiled)." On 7/6/15 at 2:45 p.m., E2 (Director of Nursing) stated gloves should be changed or removed when working from contaminated items to clean items. E2 also stated staff are to wash their hands after providing incontinence care and before leaving the room. E2 stated soap or a cleansing agent should be used when providing incontinence care.	F 441		
F 456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on interview and observation, the facility failed to replace or repair equipment to maintain proper working order/appearance for four residents (R19, R22, R23 and R25) of 13 residents reviewed with equipment in a sample of 15 residents. Findings include: 1. On 07/08/15 at 2 P.M., the cold water was running in a steady stream into the sink in R23 ' s room. The cold water faucet handle was	F 456		7/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145266	A. BUILDING _____ B. WING _____	07/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 456	Continued From page 27 manipulated several different ways, but could not be shut off. E12, Maintenance Director, stated the cold water faucet should not be in that condition and was only able to stop the cold water from running by shutting off the main control valve for the cold water under the sink. At this same date and time, the hot water faucet handle had a large amount of greenish-white, rock hard build-up all around its base. On 07/08/15 at 2 P.M., E12, Maintenance Director, stated that E12 had not been aware of the degree of corrosion around the hot water faucet. 2. On 07/08/15 at 1:15 P.M., R22 and R25 ' s the privacy curtain was torn along the top portion of an area where the curtain guides had come out of the sliding track for them. The privacy curtain could not be moved back or forth from that spot. E12, Maintenance Director, stated that the privacy curtain could not be used properly in that state of disrepair. 3. On 7/6/15 at 11:09 a.m. and 2:55 p.m., R19 had a fall mattress in place on the floor next to his bed on the door side. R19's fall mattress was noticed to be heavily soiled and had a large "U" shaped tear. On 7/6/15 at 11:35 a.m., E15 (Certified Nurse Aide) verified R19's fall mattress was soiled and torn. E15 stated she was not sure who was supposed to clean and maintain the fall mattresses.	F 456		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional	F 514		7/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 514	Continued From page 28	F 514		

standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to ensure the accuracy of medication orders and advanced directives for two of nine residents (R3, R5) reviewed for physician order accuracy in the sample of 15.

Findings include:

1. R5 was observed on 7/6/15 at 9:50 AM, 10:44 AM, 11:55 AM, 12:50 PM, 1:45 PM, on 7/7/15 at 9:20 AM and 11:23 AM with no G-tube (gastrotomy tube) in place.

R5's nurse's note dated 5/10/15 document that the resident pulled the gastrotomy tube out. R5's Physician was contacted and gave orders to leave the G-tube out.

R5's Physician Telephone Orders dated 5/10/15 document to discontinue G-tube.

R5's Physician Order Sheets dated 7/1/15 to 7/31/15 document Lasix 80 mg (milligrams), Synthroid 75 mcg(micrograms), Polyethylene Glycol 17 grams, Ranitidine 300 mg, Docusate

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F 514	Continued From page 29	F 514		

50mg/5milliliters, Ferrous Sulfate 325 mg and Cardizem 120 mg to be administered per G-tube.

E18, LPN (Licensed Practical Nurse) stated on 7/7/16 at 11:23 AM that R5 pulled her G-tube out about a month ago and Physician ordered the G-tube to be left out. E18 stated physician orders should have been changed to reflect by mouth instead of by G-tube.

2. R3's clinical record includes a witnessed "Uniform Do-Not-Resuscitate (DNR) Advance Directive", dated 8/24/2011 and signed by R3's Health Care Power of Attorney (HCPOA) and R3's Physician. Located just inside the cover of R3's clinical record there is a separate 8 inch by 11 inch red-colored paper with "DNR", (Do Not Resuscitate), printed in large letters in the center of the page.

R3's Physician's Order Sheets for June 2015 and July 2015 document R3's "Code Status" as "Full Code".

On 7/9/15 at 11:35a.m., E2, Director of Nursing (DON) verified that R3's clinical record includes a "Uniform Do-Not-Resuscitate (DNR) Advance Directive" and the physician's Order Sheets, dated June and July 2015, incorrectly identify R3's code status as Full Code.