STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145795	A. BUILDING _____ B. WING _____	12/11/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TOWER HILL HEALTHCARE CENTER	**759 KANE STREET SOUTH ELGIN, IL 60177**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Subpart U	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164		

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

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F 164	Continued From page 1 Based on observation, interview and record review, the facility failed to maintain the privacy to 1 of 28 sampled residents (R18) while providing incontinence care. The Findings include: On 12/8/14 at 8:45 a.m., the initial tour was conducted with E16 (MDS (minimum data set nurse). After knocking and entering R18's room with E16, R 18 was observed laying in the first bed and the privacy curtain was not pulled to provide privacy. R18 was in bed totally uncovered from the waist down. E18 CNA (certified nursing assistant) was removing stool from R18's buttocks and perineal area. R18 was left uncovered during the entire observation. R18 said to E18 , " please cover me up". Review of R18's MDS dated 9/19/14, show R18 has a Brief Interview of mental Status cognitive score of 13 (interviewable, usually understands and is understood), alert and oriented, always incontinent of bowel and bladder and requires extensive to total assistance of the staff in ADL's (Activity of Daily Living).	F 164		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 241		

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F 241	Continued From page 2 review the facility failed to maintain a respectful environment providing dignity to 1 of 28 residents during a verbal interchange involving the receiving of routine medications. The Findings include: On 12/8/14 at 9 a.m. in the presence of E16 (MDS nurse) R22 was observed seated on the bed in her room. During the conversational introductions R22 asked for her nurse. E16 left the room to honor R22's request. E 17 (nurse) returned with E16. R22 requested E17 to give the medicine now. E17 stated to R22, "I already gave you your medicine'. E17 commented R22 is forgetful and the medicine was given earlier. R22 became anxious and stood up from the bed and said, you did not give me my medicine and why would you say you did when you did not and if you gave it to me, I would not be asking you for it. R22 said you came to me when I was eating breakfast, and I said I am eating now and for you to come back. You never came back. R22 asked E17 to check her papers and she would see the medicine was not given. E17 (nurse) said it was documented the medication was given and again said I gave you your medicine. This interaction was reported to E1 (administrator and E 2 (director of nurses) on 12/8/14 during the daily status at 1:30 p.m. R22 continued to say, I need my medication and began to name certain medications she was aware of that were prescribed and used for Diabetes, constipation, heart and high blood pressure. R22's voice changed and appeared obviously disturbed at the nurse saying she gave the medication and she did not.	F 241		

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F 241	Continued From page 3 On 12/9/14 during the daily status meeting with the facility at 10 a.m., E1 (administrator) and E2 (director of nurses) stated the facility conducted an investigation, into R22's allegations of not receiving the ordered medications (9 a.m.) on the morning of 12/8/14 from E17 (nurse). E1 stated the facility reported the allegation to the Illinois Department of Public Health (IDPH) as an allegation of neglect. E1 and E2 stated E17 admitted to not administering R22's medication and was terminated from employment. Review of R22's physicians orders on 12/9/14 show the facility notified R22's physician on 12/8/14 at 4 p.m. for orders to change the timing of the missed medications. The facility was ordered to administer R22's 9 a.m., medication at 5 p.m.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure call lights were within reach for 2 (R16, R22) residents reviewed for call lights in a sample of 28, and for 2 (R25, R29) residents in the supplemental sample. Findings include: 1). On 12/8/14 at 8:05am during tour of the facility, Along with E5 (Restorative Nurse/Tour	F 246		

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F 246	Continued From page 4 Guide, R16 was awake in bed. R16 ' s call light could not be visualized. R16 stated she could not reach the call light. E5 located the call light and handed it to R16. R25 was awake in bed. Her call light was not in reach. R25 stated she could not reach the light. R29 was awake in bed. Her call light was hanging down alongside the bed rail and not in reach. 2). On 12/8/14, R22 was sitting at her bedside, and her call light was not in reach. R22 ' s medical record documents she is legally blind. When asked if she could reach her call light R22 got up and began fumbling for the call light.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to complete comprehensive skin assessments; identify and treat skin impairments; provide appropriate care and services to prevent further skin breakdown; and to appropriately assess and treat pain for three (R1,R8,R9) of five residents reviewed for pain management and ulcers other than pressure in a sample of 28. Findings include:	F 309		

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F 309	Continued From page 5	F 309		

1). R8 is an 84 year old female whose medical record documents the following diagnoses: Renal failure, Chronic Obstructive Pulmonary Disease, right tibia and fibula fracture, arthritis, dementia, congestive heart failure, atrial fibrillation, and clostridium difficile (C Diff). R8 ' s medical record documents she was originally admitted on 9/24/14, hospitalized on 11/28/14, and readmitted to the facility on 12/5/14.
R8 ' s Minimum Data Set (MDS) dated 11/19/14 documents: Moisture associated skin damage.
On 12/8/14 at 11:50am, E6 (Restorative Nurse/Nurse on Duty)) stated R8 has no skin impairments. R8 was awake in her bed and agreed to visualization of her skin. R8 ' s buttocks were excoriated with red and purple discoloration. Her right buttock contained an open area with a pink wound bed, and the peri wound was purplish red. R8 ' s readmission nursing assessment dated 12/5/14 documented that her buttocks contained redness/ulcer.
At 12:05pm, E11 (Wound Care Nurse) checked R8 ' s skin. R8 ' s feet were both edematous (swollen) and her right heel contained an elastic bandage. E11 Stated R8 was admitted with a pressure ulcer on her right heel. Upon removal of the dressing there was also a reddened area in the fold of R8 ' s foot on the dorsal aspect where she bends and the dressing was tied. The plantar aspect of her foot also contained a reddened area that was hard to touch and not covered with any dressings. There were no current treatment orders for these impairments. E11 stated he was not aware of the skin impairments on R8 ' s buttocks and dorsal aspect of her foot. E11 stated he has not seen or assessed R8 since she had been readmitted to the facility. There was also no comprehensive body/skin assessment located in R8 ' s medical

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F 309	Continued From page 6 record. Her Physicians Order Sheet (POS) and treatment Order Sheet (TAR) contained no orders for the skin impairments. Her Nursing notes contained no documentation related to the excoriation. There was also no documented notification of physician. On 12/10/14 at 11:35am, E11 stated he does not complete comprehensive assessments of wounds. E 11 stated he only documents on the back of the TAR. The facility ' s policy for skin breakdown documents: -The attending physician will be notified of any change in condition. Policy--Monitor skin integrity of each resident. -Institute preventative and curative skin therapies as appropriate. -Implement preventative measures to minimize the risks of skin breakdown occurring in the facility. -If it is observed upon admission that skin integrity is compromised or pressure sores are present, the physician must be notified. Procedure--Assess each resident upon admission for risk factors for skin integrity. -Notify attending physician for treatment order. Physician Order Sheet dated 12/1/2014 through 12/31/2014 documents that R1 was admitted on 4/26/2013 with the following pertinent diagnosis: stroke, weakness, high blood pressure, dyspnea, gout. On 12/10/2014 at 9:34 AM, R1 was sitting in the room with a left hand splinting device on. R1 said staff will put the device on but she takes it off frequently because " it hurts." On 12/10/2014 at	F 309		

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F 309	Continued From page 7 9:34 AM, E4(Certified Nursing Assistant, CNA) entered the room and said restorative will know why R1 did not have the hand splint on 12/9/2014. On 12/10/2014 at 9:41 AM, E5(Restorative Nurse) and E6(Restorative Nurse) both stated they were aware of R1's pain which caused R1 to refuse the splinting device. E5 and E6 said that R1's pain should have been assessed better and that the physician would be notified immediately. On 12/10/2014 at 10:25 AM, E5 and E6 said the physician ordered and x- ray of the hand. On 12/10/2014 at 12:25 PM, R1 was sitting in the room crying and holding her left hand. R1 said "my hand hurts and has been hurting for 3 weeks and no one has done anything. " The call light was pulled and E3(Nurse) entered the room. E3(Nurse) assessed R1 for pain. During the assessment. R1 said, " The whole God da-- place knew I have been having this pain." R1 continued to cry. On 12/10/2014 at 12:29 PM, E5(Restorative Nurse) said pain assessments should be done daily. The nurses have not been doing daily pain assessments. On 12/10/2014 at 12:29 PM, E3(Nurse) said that sometimes she assesses R1 for pain. R1 will not complain of pain, E3 also said she does not ask R1 if she is in pain, she waits for R1 to complain about pain. Care Plan for pain dated 10/29/2014 states, " administer pain medication as ordered, document frequency and intensity of pain symptoms using resident's verbal and non verbal indicators for pain, observe for causes of pain and try to eliminate it, document location and intensity of	F 309		

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F 309	Continued From page 8 pain if present, observe for signs and symptoms of pain and intervene as necessary." Physician Order Sheet dated 12/1/2014 through 12/31/2014 states, Pain Assessments every two hours. Medication Administration Records were reviewed from 9/1/2014 through 12/9/2014, there was no documentation of pain assessments, and no pain medications given. Pain Management Policy And Procedure undated states, "3. Residents will be monitored for breakthrough pain requiring PRN pain medication. 5. Pain Questionnaire will be reviewed and updated on a quarterly basis and as needed basis....8. Nursing documentation, pain flow sheet , MAR/PRN sheets will be utilized to review resident's pain and interventions. Specific or individualized interventions will be written on resident's care plan and reviewed on a quarterly basis and PRN for appropriateness." There was no Pain Questionnaire documentation for R1 from 9/1/2014 until 12/9/2014. X- Ray dated 12/10/2014 states, "Views of the left hand were obtained. No fracture or dislocation. Arthritis is noted to involve the base of the thumb and interphalangeal joints. Minimal diffuse soft tissue swelling is noted." On 12/11/2014 at 9:45 AM, E2(Director of Nursing) said that moving forward the nurses have been in-serviced on pain management. R9 is a 92 year old female who is alert and oriented to self and to place. E11 (wound care	F 309		

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nurse) stated on 12/10/14 at 10:20AM that R9 has diagnosis including including a stasis ulcer to left shin and paranoia. E11 also stated R9 is non-compliant with dressing changes because of her paranoia and crying.

On 12/8/14 at 1:20 PM during incontinence care, R9 was highly agitated and screaming repeatedly "I'm always in pain! I want Tylenol!" R9 was pointing in to her left leg. E8 and E9 (Both Certified Nursing Assistant/CNA) continued with incontinence care and stated that this behavior is R9's norm. She (R9) always screams in pain and when medication comes R9 refuses. At 1:35 PM E7 (Nurse)came and offered Tylenol, R9 refused.

On 12/8/14 at 2:00 PM, R9 was still screaming in pain and extremely agitated. E7 stated she paged the doctor.

Physician Order Sheet (POS) dated 12/8/14 indicates that physician ordered to increase Haloperidol 2 mg (topical) gel three times daily to 3 mg (topical/gel) three times daily.

Last Comprehensive Pain Assessment was completed 10/15/14 which was confirmed by E2 (don) on 12/10/14 at 11:50am. There was no indication a comprehensive pain assessment was conducted on 12/8/14 upon observation of R9 screaming in pain. There was no evidence R9 was monitored for daily pain assessments.

On 12/10/14 at 10:20 AM, E11 (Wound Care Nurse) rendered wound treatment to R9's stasis ulcer to left shin. E7 measured wound as Length (L) 12.5 cm x Width (W) 6.2 cm, with mild to moderate serous-sanguineous discharges. E7 stated that wound started in October as a small

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scratch but R9 kept scratching and it became bigger. E7 was unable to described wound size and appearance. E7 added he was not the staff who found it initially and that there was no comprehensive skin assessment made on 10/27/14. The first wound assessment was made on 11/3/14, measured as (L) 10 cm x (W) 6.0 cm. Treatment Record dated October 2014 indicates: 10/27/14- Cleanse left lower leg with normal saline, apply Bacitracin ointment and covered with dry dressing daily and as needed.

On 12/10/14 at 2:00 PM, E2 (Director of Nursing) stated the facility does comprehensive pain and skin assessments quarterly and as needed upon discovery.

On 12/11/14 at 2:35 PM Z3 (Nurse Practitioner) stated he's (Z3) aware about R9's behavior, stasis wound and non-compliance with oral medications but Z3 added he's not aware of R9's constant pain related to her wound. Z3 also stated E2 (DON) talked to him this morning of 12/11/14, since R9's been refusing all of her oral medications, Z3 ordered Duragesic patch and will assess R9 for efficacy of this medication.

Facility's Pain Management Policy and Procedure indicates:

Purpose:

The purpose of the Pain Management Program is to maintain an interdisciplinary team approach to pain management that provides the resident with optimal comfort, dignity and quality of life.

Objectives:

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F 309	Continued From page 11 - To improve and maintain a resident's optimal functional level and quality of life. - To optimally control pain for all residents. - To reduce incident of unmanaged pain. - To ensure best practice interventions for residents with pain. Procedure: - Complete Pain Questionnaire upon admissions, readmissions, quarterly and with any change in condition. Any score greater than 5 requires completion of the Comprehensive Pain Assessment Tool which indicates the location of pain, intensity of pain, physical examination, diagnosis/procedures, pain characteristics, and non verbal indicators of pain. - For any new onset of continuous, unrelieved pain, MD will be notified for medication orders and Pain Assessment will be updated. - Nursing documentation, Pain Flow Sheet, MAR/PRN Sheets will be utilized to review resident's pain and interventions. Specific and/or individualized interventions (Pharmacological and Non-pharmacological) will be written on resident's care plan and reviewed on quarterly basis and PRN for appropriateness. R9's Medication Administration Record (MAR) dated October 2014 thru December 2014 has no evidence that she's (R9) being assessed for pain daily despite E8's and E9's report that they (staff) are aware of her constant screaming and refusal of Tylenol when offered. Facility addressed R9's behavior by increasing Haloperidol medication, but did not address the	F 309		

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F 309	Continued From page 12 underlying cause of behavior which was the pain.	F 309		
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, record review and interview, the facility failed to provide incontinence care for one (R8) of five residents reviewed for incontinence in a sample of 28. Findings include: R8 is an 84 year old female whose medical record documents the following diagnoses: Renal failure, Chronic Obstructive Pulmonary disease, right tibia and fibula fracture, arthritis, dementia, congestive heart failure, atrial fibrillation, and clostridium difficile (C Diff). R8 ' s Minimum Data Set (MDS) documents that she is always incontinent of bowel and requires extensive assistance, with two person physical assistance for hygiene; and extensive assistance, with one person physical assistance for toileting. On 12/8/14 at 11:50am, R8 was lying in bed on her back. R8 agreed to allow skin check with E6 (Restorative Nurse/Nurse on Duty) and E12 (Certified Nursing Assistant). Visualization would reveal that R8 had a bowel movement. Her buttocks were excoriated with a purplish red color, contained an open area and brown soft feces. After visualization, E6 and E12 fastened R8 ' s adult briefs and pulled her pants back into	F 312		

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F 312	Continued From page 13 place as the feces remained. E6 ad E12 exited the room without performing incontinence care for R8. At 12:05, E11 checked R8 ' s buttocks. R8 asked if she was going to have her briefs changed. The stool was still in R8 ' s brief. After visualization, E11 closed R8 ' s adult brief, and pulled her pants back into place without performing incontinence care. E11 exited R8 ' s room as R8 remained in bed without receiving incontinence care. The facility ' s policy for Skin Breakdown documents: Residents will be given peri care after each incontinence.	F 312		
F 318 SS=E	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 monitor and track the use and effectiveness of splints/orthotics/braces. This deficient practice has affected three (R1, R17, R18) out of six reviewed for range of motion in the sample of 28 and 23 residents (R29, R31-R51) in the supplemental sample. Findings Include:	F 318		

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F 318	Continued From page 14 On 12/8/2014 during initial tour at 8:15 AM, R1 was sitting in the room watching television, there was no hand splint on R1's left hand. On 12/9/2014 at 10:57 AM, R1 was sitting in the dining room watching a movie. R1's left hand was bent downward, there was no hand splint on the the left hand. On 12/9/2014 at 11:57 AM, R1 was sitting in the dining room again with no left hand splint device on. On 12/9/2014 at 3:00 PM, R1 was in bed, there was no left hand splint device observed. On 12/10/2014 at 9:34 AM, R1 was sitting in the room with a left hand splinting device on. R1 said staff will put the device on but she takes it off frequently because " it hurts." Physician Order Sheet dated 12/1/2014 through 12/31/2014 documents that R1 was admitted on 4/26/2013 with the following pertinent diagnosis: stroke, weakness, high blood pressure, dyspnea, gout. The Physician Order Sheet dated 12/1/2014- 12/31/2014 also states R1 had an order originated on 8/28/2013 that states, "Left resting hand splint for splinting and positioning and contracture prevention- on every morning and remove at bedtime- release at meals and as needed." The Care Plan for left hand resting hand splint dated 10/29/2014 states, apply left hand resting splint as ordered, every morning and remove at bedtime, release at meals and as needed. Observe for signs and symptoms of pain or discomfort and inform nurse if noted, check daily that the splint is clean and in good working condition.	F 318		

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Contracture Assessments dated 2/3/2014, 5/4/2014, 7/27/2014, 10/19/2014 all state R1 is noted with left hand contracture due to left sided weakness and stroke and requires the use of a hand splint.

Contracture Prevention and Management Policy undated states, " if resident refuses to wear orthotic, notify nurse immediately. The policy does not include procedures for ill fitting devices, there is no inclusion of monitoring the use or effectiveness of devices.

There is no documentation in the clinical record on refusals of hand splinting device for R1.

On 12/10/2014 at 9:41 AM, E5 (Restorative Nurse) and E6(Restorative Nurse) said they were aware R1 has pain in the hand and will refuse to wear the splint. E5 continued and said that we have not referred R1 to a therapist for evaluation of the splint, we have not assessed R1 for the effectiveness of the splint and we are not aware R1 takes the splint off. E5 concluded by stating we will refer R1 immediately to therapy to evaluate the hand splint.

On 12/10/2014 at 10:25 AM, E5(Restorative Nurse) and E6(Restorative Nurse) said we do not monitor or track R1 or any of the residents for usage or effectiveness of splints or devices. R1 has been assessed and now has a an order for a different kind of hand splint.

On 12/11/2014 at 10:34 AM, E 5(Restorative Nurse) and E6(Restorative Nurse) said, " We failed, we are short on monitoring residents everyday. We do not do any daily monitoring for feedback on refusals or effectiveness for usage.

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F 318	Continued From page 16 We will change our policy to incorporate daily monitoring and tracking for device usage." R1, R16, R17, R18, R29 and R31- R51 have all been identified as residents who utilize splints and/or braces.	F 318		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain a medication error rate of less than 5%. There were a total of 26 opportunities with three errors, resulting in an 11.5% error rate. The errors involved one (R19) of four residents reviewed for medication administration in a sample of 28, and for two (R30, R54) residents in the supplemental sample. Findings include: 1). On 12/9/14, at 7:00am, E7 (Licensed Practical Nurse/LPN) began morning medication pass. R19 ' s Physician ' s Order Sheet (POS) and Medication Administration Record Sheet (MAR) documented the following medication: Megace 40mg/ml, take 10ml by mouth once daily, 8:00am. This medication was omitted by E7. R19 ' s dietary assessment documents she was started on Megace related to weight loss and consuming less than 50% of her meals. There was no Megace for R19 on the medication cart, and E7 did not offer R19 Megace. When informed about	F 332		

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the omission, E7 stated R19 has been refusing to take the Megace every morning. R19 ' s MAR for Dec/2012 showed the medication signed out every morning as being given. There were no documented refusals for the Megace. E7 was asked to present R19 ' s bottle of Megace. E7 searched the medication cart and the medication room, and then stated she had actually given R19 the last dose on the previous morning at 8:00am. E7 stated she reordered the medication on 12/8/14, but the pharmacy failed to deliver it. When asked to present the order sheet, E7 stated " we don ' t keep them. " The pharmacy was phoned. Z2 (Pharmacy Technician) stated that the pharmacy has not received an order sheet from the facility. R19 was unable to be interviewed related to cognitive impairment. R19 ' s Minimum Data Sheet (MDS) documents a score of 7/15 indicating cognitive impairment. R19 was not able to state her medications, times of administration or to identify Megace when interviewed.

2). 12/9/14 at 11:17am, E7 began her noon medication pass. E7 administered noon medications for R54. R54 ' s MAR and POS documented the following medications: Bethanechol 25mg tablet, take one tablet by mouth three times daily. The Bethanechol was omitted by E7.

3). On 12/9/14 at 10:05am, E13 (LPN) administered medications to R30. R30 ' s MAR and POS documented the following medication: Carafate 1gm/10ml suspension, take 10ml (1gm) by mouth three times daily before meal. The instructions on the bottle of Carafate read: Shake well before use. E13 poured the medication into the medication cup and administered it to R30 without shaking the bottle.

The facility ' s policy for medication pass

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F 332	Continued From page 18 documents: -Reference MAR during entire prep & administration. This prevents errors. -Suspensions shaken per manufacturer ' s recommendation. If not shaken properly, the strength of the medication may be jeopardized. -Medications administered in allotted time. Allotted time is one hour before and one hour after scheduled time. The facility ' s Refill Management Program agreement with the pharmacy documents: The program will save you time by helping to identify orders before a resident ' s medication is exhausted. On a bi-weekly basis, the pharmacy will analyze its Refill Forecasting Report to identify medications that are eligible to be refilled based on the " Last Date Filled " and the " Day ' s Supply " . The pharmacy will then send the Refill Forecasting Report to your facility and identify which orders may need to be refilled. On 12/11/14, E2 (Director of Nursing) stated that the medications can be filled through computerized system that she has access to. When asked how the facility ensures the list is reviewed and medications are filled on time, E2 only stated the nurses refill the medications when they run out. Review of the facility ' s medication cart along with E2 showed that each medication had an attached label that could be pulled and faxed for refill prior to depletion of the medication.	F 332		
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.	F 441		

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F 441	Continued From page 19 (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 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to: follow professional standards of care and ensure appropriate handwashing/hand hygiene; failed to dispose of medication that fell on the floor; failed to ensure	F 441		

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urinary drainage bag was off the floor; and failed to ensure staff personal duffle bags were not stored on the resident isolation cart for three (R9, R22, R25) of six residents reviewed for infection control in a sample of 28 and for three (R31, R52, R53) residents in the supplemental sample.
Findings include:
On 12/9/14 at 6:50am, E13 was administering morning medications. Located on top of E13 ' s medication cart was a pill inside a medicine cup. When asked who the pill belonged to, E13 stated that it didn ' t belong to anyone. E13 stated she picked the pill up off the floor, placed it into a medicine cup and then placed it on top of her medication cart. E13 then continued passing medications.
R8 is on contact isolation for c difficile. On 12/8/14 at 8:15am, R8 was lying in bed. Her medical record documents that she is on contact isolation for clostridium difficile (C Diff). R8 had an indwelling urinary catheter. Located on the railing of the bed was a storage bag for the catheters urine collection/drainage bag. The drainage bag however, was on the floor next to the storage bag.
On 12/9/14, the isolation cart outside of R8 ' s room contained personal protective equipment to be donned by staff prior to entering the room. Located in the bottom drawer, along with personal protective gowns and masks was a back pack with a bottle of perfume visible. E15 (Certified Nursing Assistant/CNA) was inside the room providing care for R8. E15 stated that the bag belonged to her and she placed it on the cart.
On 12/10/14 at 10:14am, Z1 (Hospice CNA) provided personal care for R53. Z1 exited the room with a glove on her left hand. She was carrying soiled linen that was not bagged. Z1 stated that the policy is to carry the linen down the

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hall to the soiled utility room, then place it in a bag. E2 (Director of Nursing) stated that linen must be bagged prior to transport.
On 12/9/14 at 6:50am, E14 (Licensed Practical Nurse/LPN) performed blood glucose monitoring for R31. E14 used a disposable sanitizing wipe to cleanse the glucometer. E14 wiped the front surface of the machine for approximately 5 seconds, threw the wipe in the trash and proceeded to take R31 ' s blood monitoring reading. The instructions on the canister of disposable cloths documented to thoroughly wipe the entire surface of the glucometer when sanitizing.
The facility ' s policy for Blood Glucose Meter Cleaning/Disinfecting documents: It is the policy of the facility to clean/disinfect all blood glucose meters in between resident ' s use to assure the blood glucose meters are free of pathogenic microorganisms and are safe to handle and use. Follow product label instructions to disinfect the meter.
The facility ' s policy for infection control documents:
- Wash hands whenever they are soiled with body substances, before food preparation, before eating, after using the toilet, before performing invasive procedures and when each resident ' s care is completed.
-Gloves must be changed between residents and between contacts with different body sites of the same resident.
-Place all soiled linens in plastic bags before taking them to the soiled utility room.

On 12/8/14 at 1:20 PM, E8 and E9 (both Certified Nursing Assistants/CNA) rendered incontinence care to R9. R9 had a small bowel movement. E8 did perineal care, dressed R9 and straightened

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F 441	Continued From page 22 R9's clean linens without changing gloves and sanitizing hands in between task all throughout incontinence care. On 12/9/14 at 10:00 AM, E10 (CNA) rendered incontinence care to R52. E10 kept changing gloves during incontinence care but no hand washing/hygiene made prior to applying new set of gloves or prior to doing cleaner task. After completing care, E10 asked R52 if he wants another pillow. When R53 nodded, E10 then took the pillow from R52's room mate's bed and placed it under R52's head. E10 stated that the pillow was sanitized and pillow cases were changed that morning (12/9/14). On 12/10/14 at 1:25 PM, E8 and E9 rendered incontinence care to R25. E8 changed gloves and donned new set of gloves after each task but no hand washing/hygiene made in between glove changing. On 12/11/14 at 12:22 PM E2 (Director of Nursing/DON) stated, when doing peri-care staff should change gloves and do hand washing before proceeding to another task. E2 also stated, when a resident need another pillow staff should ask housekeeping to provide a new pillow. E2 added, residents are supposed to have their own dedicated pillow and cannot share it to one another. On 12/8/14 at 8:45 a.m. R22 was observed to be incontinent of stool in bed. E18 CNA (certified	F 441		

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F 441	Continued From page 23 nursing assistant) was observed wearing a pair of gloves to remove the stool. After cleaning the stool away from R22's buttocks, E18 proceeded to use wet wipes to remove the stool and clean the skin on the buttocks and perineal area, apply clean disposable diaper, pick the soiled cloth diaper containing stool off the floor and place in a clear plastic bag, open the room door wearing the soiled glove and proceed to the soiled utility room wearing the soiled right glove. The facility's Infection Control policy and procedure for preventing disease transmission indicate, for handwashing policy and glove use was reviewed with E1 (administrator) and E2 (director of nurses) on 12/11/14 at 10 a.m. during the daily status meeting . The facility directs their staff to change gloves between contacts with different body sites of the same resident, remove gloves before leaving the resident's room and not to walk in the hallways with gloves on.	F 441		