STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Certification Survey This was a FOSS survey.	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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 164	Continued From page 1	F 164		

Based on observation, interview and record review, the facility failed to ensure a resident ' s privacy was maintained during personal care by closing doors and window coverings, covering resident, and knocking before entering a bathroom.
This applies to 2 of 14 residents (R1, R11) reviewed for privacy in the sample of 17 and 1 (R18) in the supplemental sample.
The findings include:
1.On March 8, 2016 at 11:50 A.M., R11 was in her bed. The blinds on the window next to the bed were open. A male walked past the window outside the room. E4 CNA (Certified Nursing Assistant) and E5 CNA undressed R11 from the waist down and performed incontinence care. No attempt was made to close the blinds before, during or after the care.
On March 9, 2016 at 8:15 A.M., E2 DON (Director of Nursing) said she expects staff to provide privacy while providing personal care to a resident. If this is not done, a resident ' s dignity and privacy is compromised.
R11 ' s physician note from a University Hospital dated February 22, 2016, show she required assistance to transfer, dress, bathe and toilet.
R11 ' s nursing admission note dated March 3, 2016 shows R11 is incontinent and bedridden.
R11 ' s nurse ' s note dated March 3, 2016 at 2:00 A.M., shows R11 is unable to make her needs known. R11 ' s physician note dated March 4, 2015, shows R11 laying in a fetal position with random movements involving all extremities. It also shows R11 had no meaningful speech, no evidence of orientation and did not follow simple commands. The facility ' s Privacy Policy dated October 6, 2015 shows a resident ' s right to privacy will be upheld at all times to maintain a profound respect for human dignity. A closed door

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 164	Continued From page 2	F 164		

and/or drawn curtain shall shield residents from passers-by. Privacy will be afforded residents during toileting and other activities of personal hygiene. Drape resident for privacy during care.
2. R1's MDS (Minimum Data Set) of February 12, 2016 shows R1 requires extensive assistance from staff with transfers, bed mobility, eating, bathing, and toileting.

On March 8, 2016 at 1:35 PM, E5, E21, E4 (CNAs - Certified Nurse Assistants) transferred R1 from her wheelchair to her bed with a mechanical lift. R1 was placed on her bed, and her pants were removed, leaving R1 unclothed, and uncovered from the waist down. R1's bed was next to the window, and R1's blinds were open approximately 1 and 1/2 feet. After removing R1's clothes, E4 took the mechanical lift out of R1's room, and left her door open. R1 was exposed from the waist down and E21 yelled for E5 to shut the door. R1 remained exposed from the waist down without draping until her personal care was completed.

On March 11, 2016 at 8:50 AM, E32, and E33 (CNAs - Certified Nurse Assistants) said a resident should be draped during care.

3. On March 9, 2016 at 11:55 AM, E9 (LPN-Licensed Practical Nurse) was administering medications to R3. Without knocking on the shared bathroom door, E9 walked in on R18, who was sitting on the toilet.

On March 11, 2016 at 10:10AM, E3 (ADON - Assistant Director of Nursing) said staff should knock before entering a residents' bathroom.

The October 6, 2015 facility "Dignity Policy" states

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 164	Continued From page 3 Residents' private space and property will be respected by...knocking on door and requesting permission to enter their rooms...Privacy of the resident's body must be maintained while being cared for in their room, bathroom... The October 6, 2015 "Privacy Policy" states A closed door and/or drawn curtain shall shield the resident from passers-by...Privacy will be afforded to residents during toileting, bathing, and other activities of personal hygiene. Drape resident for privacy during care.	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 review, the facility failed to maintain a resident ' s dignity by ensuring a feeding tube was covered while seated in a common area. This applies to 1 of 14 residents (R11) reviewed for dignity in the sample of 17. The findings include: On March 10, 2016 R11 was in the dayroom with her feeding tube hanging outside of her clothing in full view to passers-by at 7:45 A.M., 8:00 A.M., 8:15 A.M., 9:00 A.M., 9:15 A.M. and 9:30 A.M. During this time period, R11 had a pastor visit, E14 (Activity Director) sat next to R11 and a man playing a guitar and singing sat next to her as well.	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 241	Continued From page 4 On March 10, 2016 at 9:20 A.M., E2 DON (Director of Nursing) said feeding tubes should be covered when a resident is in a common area to respect their dignity. The facility ' s undated Dignity Policy shows privacy of the resident ' s body must be maintained while in common areas of the facility and staff will ensure dignity is preserved.	F 241		
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, interview, and record review the facility failed to ensure a resident received pain medication prior to a wound treatment change. This applies to 1 of 10 residents (R1) reviewed for pain in the sample of 17. The findings include: R1's MDS (Minimum Data Set) of February 12, 2016 shows R1 requires extensive assistance from staff with transfers, bed mobility, eating, bathing, and toileting. The MDS shows R1 has one unstageable pressure ulcer with slough.	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 309	Continued From page 5	F 309		

R1's hospital records show R1 had a surgical debridement of a stage IV pressure ulcer on March 3, 2016.

R1's readmission orders dated March 7, 2016 shows an order for Tylenol 650 mg every 6 hours as needed, and Hydrocodone (narcotic pain med) every 6 hours as needed for pain.

R1's March 8, 2016 skin condition report shows R1 has a 7cm (length) x 5.5cm (width) x 6cm (depth) wound to her sacrum.

R1's March, 2016 Medication Administration Record shows R1 was medicated with Norco at 8:15AM on March 10, 2016 (over 5 hours before the dressing change).

On March 10, 2016 at 1:30 PM, E19 (CNA-Certified Nurse Assistant) and E26 (Wound Care Nurse) positioned R1 on her left side in bed. E26 removed the dressing to R1's sacrum, and R1 had a large, grapefruit sized , deep open pressure ulcer to her sacrum. R1's humming became louder during repositioning, and while the old dressing was removed. E26 cleaned the wound with saline, and bone was present to the center of the wound. E26 pointed to open areas around the outside of the wound on the left side and said R1 had new breakdown, and said she knows the wound is "deep". E26 pointed to a dark circular spot inside the wound and said it was R1's exposed bone. E26 placed a 4x4 gauge pad, covered with Santyl inside the wound, and then placed 4 (4x4) Dakin's soaked gauze pads, over the gauze with Santyl, inside R1's wound, and taped a gauze pad over the top of the wound. R1 was then rolled onto her back, and R1's humming became louder with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 309	Continued From page 6 repositioning. E26 said R1 "normally definitely would have had pain medicine a half hour before the treatment change" and "I'm sure it's painful". E26 said R1 did not get pre-medicated for pain before the treatment. On March 9, 2016 at 1:30 PM, Z3 (R1's family) said R1 is usually unable to communicate, but she can tell when [R1] is in pain because her "humming becomes louder". On March 11, 2016 at 10:10AM, E3 (ADON - Assistant Director of Nursing) said a stage 4 pressure ulcer would be painful, and R1 should be pre-medicated for pain prior to her treatment change. E3 said the Norco given at 8:15 am, would not be enough, and another pain med should have been given prior to R1's treatment.	F 309		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to identify pressure ulcers before deep tissue injury and stage II wounds developed and failed to ensure pressure reduction interventions	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 7	F 314		

to the heels and coccyx were in place to prevent R15 from developing 3 pressure ulcers. The facility failed to ensure a resident was identified as high risk for pressure ulcers, failed to perform a wound care treatment as ordered and failed to notifiy a physician of a wound decline. The facility failed to perform complete wound assessments, failed to monitor an area of skin concern identified on admission, and failed to ensure reddend skin areas were reported to the nurse. These failures resulted in R15 (not at high risk to develop pressure) developing deep tissue injury to the left heel, and 2 Stage II pressure ulcers on the coccyx.
This applies to 3 of 8 residents (R15, R1, R6) reviewed for pressure in the sample of 17.
The findings include:
1. The medical record shows R15 was admitted to the facility on August 12, 2015. On August 27, 2015, experienced a fall and required surgical repair of the left hip. R15 returned to the facility on September 1, 2015 and the admission skin assessment showed no skin breakdown or impairment on the heels or coccyx. R15 ' s assessment for risk of skin breakdown score on September 1, 2015 was 14 (less than 12 indicates resident is at high risk). The MDS (Minimum Data Set) of September 5, 2015 shows R15 required assistance for ambulation, and toileting; R15 was incontinent of urine. R15 ' s care plan for pressure updated on September 1, 2015, states to assist the resident to reposition and toilet every 2 hours, and monitor skin for redness/open areas/excoriation and report to nurse. Specific interventions for pressure reduction to the heels were not identified.
The skin condition report dated October 15, 2015 shows R15 ' s left heel initially was measured as 2.0 cm x 2.0 cm area. The area was described

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 8	F 314		

as deep tissue injury. The wound description on the report shows the wound was purple/white calloused looking area with cracked edge. Maroon color noted below the callous. The physician order sheet dated October 15, 2015 shows R15 was referred to podiatry. On October 16, 2015, the podiatrist prescribed R15 to wear a multi-podius to bilateral heels while in bed. The skin report shows the deep tissue injury required treatment for 2 months until healed on December 11, 2015.

On March 11, 2016 at 9:30 AM, E26 (Wound Nurse) stated CNA (Certified Nursing Assistants) do skin checks daily when providing care and report any problems to the nurse. E26 stated residents with a hip fracture repair are at high risk postoperatively to develop heel pressure. E26 stated if the heels are not off loaded and not monitored, heel problems can go unnoticed.

Another skin condition report dated September 29, 2015 shows R15 developed a stage II pressure ulcer on the coccyx. Initial measurements of the open coccyx wound were 1.0 cm x 0.8 cm x 0.1 cm.

A third skin condition on R15 ' s upper buttock area was reported on October 20, 2015. This area measured 0.3 cm x 0.2 cm x 0.1 cm; the wound bed was open with epithelial tissue.

The facility skin condition policy dated June 2014 states all direct care staff will be trained to observe for and report skin conditions including redness, bruising and skin tears. This observation will be completed twice daily during routine care and weekly on shower days. Repositioning of the resident will be done according to their individual plan of care. If the resident is continent during repositioning the direct care staff only needs to observe the skin for redness. During respoitioning, linens will be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 9	F 314		

straightedned and reddened areas may be gently stimulated providing they are not over bony prominences.

2. R1's MDS of February 12, 2016 shows R1 requires extensive assistance from staff with transfers, bed mobility, eating, bathing, and toileting. The MDS shows R1 has 1 unstageable pressure ulcer with slough.

R1's admission assessment for predicting pressure sore risk dated January 25, 2016 shows R1 was at a mild risk for pressure ulcers, and showed that R1 had no sensory impairment, was able to respond to verbal commands, and had no sensory deficit which would limit her ability to feel or voice pain or discomfort.

R1's admission assessment dated January 25, 2016, shows she was chair ridden, required help with feeding, and was forgetful and confused. This assessment showed R1 was admitted with a "1 cm reddened area" to her right buttock. The next wound assessment completed on R1 was February 5, 2016 and showed a "4cm x 3 cm stage 2" pressure ulcer to R1's coccyx. There was no description of R1's wound bed, surrounding tissue, drainage, or odor.

R1's Emergency Department visit records dated February 2, 2016 shows R1 had a stage II pressure ulcer to the sacrum present during the visit, and R1 would require a wound care nurse consult, and frequent adjustments of position to help with her history of a pressure ulcer while she was at the hospital.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 10	F 314		

R1's February 8, 2016 assessment shows the wound increased to 6.8cm x 4.9cm x Unable to Determine the Depth, the wound bed declined, and was 100% covered with yellow/white slough and the wound was unstageable.

R1's wound care clinic assessment dated February 23, 2016 shows the original cause of R1's wound to her coccyx was from a pressure injury. This assessment shows R1 had a deep pressure ulcer wound that measured 4.5cm length x 2 cm width x 0.5 cm depth with exposed muscle, a medium amount of necrotic tissue within the wound including slough, and a large amount of necrotic foul smelling material in the wound (dead tissue).

R1's skin condition report dated March 8, 2016 (return to facility from surgical debridement) shows R1's wound measured 7cm x 5.5cm x 6cm (length, width, depth), with 30% slough.

R1's wound care clinic documentation dated March 2, 2016 shows R1's wound was malodorous with dark necrotic tissue visible around the entire region ,with purulent drainage. This assessment shows R1 was admitted to the hospital (from wound clinic) for a bacterial infection, and stage 4 pressure ulcer of the sacral region.

R1's wound care clinic orders dated February 23, 2016 shows an order to clean the wound twice daily (and more if needed) with Dakin's (bleach based wound cleanser) or soap and water, then rinse with Dakin's, and cover with dry gauze, and moisten gauze with Dakin's sol then apply to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 11	F 314		

open area and cover with gauze.

R1's Pressure Ulcer care plan dated February 23, 2016 shows an intervention for "treatments as ordered."

R1's Treatment Administration Record (TAR) shows R1 did not receive any dressing changes with Dakin's on February 23, February 24, and the first treatment was not completed until the evening of February 25.

R1's wound culture dated February 25, 2016 shows the wound had gram negative rods, E. Coli, and Extended spectrum Beta Lactamase (ESBL - bacteria) present in the wound.

On March 10, 2016 at 1:30 PM, E19 (CNA-Certified Nurse Assistant) and E26 (Wound Care Nurse) positioned R1 on her left side in bed. E26 removed the dressing to R1's sacrum, and R1 had a large, grapefruit sized , deep open pressure ulcer to her sacrum. E26 cleaned the wound with saline, and a strong foul odor was present. R1's wound bed had gray, tan strands of slough present throughout, and bone was present to the center of the wound. E26 pointed to open areas around the outside of the wound on the left side and said R1 had new breakdown that wasn't there when she returned from surgery. E26 said she knows the wound is "deep" and described the wound odor as "rotting", and said there was an increase in slough to the wound bed compared to when R1 returned from the hospital after the surgical debridement. E26 pointed to a dark circular spot inside the wound and said it was R1's exposed bone. E26 placed a 4x4 gauge pad, covered with Santyl inside the wound, and then placed 4 (4x4) Dakin's soaked gauze pads,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 12	F 314		

over the gauze with Santyl, inside R1's wound, and taped a gauze pad over the top of the wound.

On March 9, 2016 at 1:30 PM, Z1 (Family Member) said R1's pressure ulcer was found when she was in the ER (emergency room) at the hospital. Z1 said when R1 got to the ER, and they rolled her over, the staff found the pressure ulcer. Z1 said R1 had it prior to going to the ER but the facility did not know it.

On March 10, 2016 at 4:40 PM, E27 (LPN - Licensed Practical Nurse) said the nurses do not conduct skin assessments on residents unless an area of concern is identified by a CNA, or on admission. E27 said R1 was high risk for skin breakdown on admission to the facility.

On March 11, 2016 at 8:30 AM, E23 (LPN) said the nurses rely on the CNAs to report any reddened areas they see during care to the nurses, and all reddened areas or areas of concern should be reported to the nurse by the CNAs .

On March 11 at 9:00 AM, E26 (Wound Care Nurse) said if a resident has an identified area of concern like R1 did with the reddened area on admission, the site should be assessed by both nursing or the Wound Care Nurse at least twice a week until the area resolves. E26 said a complete assessment should be documented on the treatment assessment sheet. E26 said preventative measures should be put in place, including a soft foam dressing to prevent the area from breaking down. E26 said she determined how to apply R1's treatments, and did not check with the wound care clinic on how they wanted the Dakin's and Sanytl applied. E26 said she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 13	F 314		

should have notified the wound care doctor on 3/10/16 after she noticed the decline in R1's wound with additional slough and breakdown present outside the wound, plus a stronger smelling foul odor. E26 said she did not notify the wound doctor of the decline. E26 said a complete assessment should be done on wounds to include size, depth, wound bed, drainage, color odor, and stage. E26 said the CNAs do skin assessments with cares and should report any areas of concern to the nurse. The nurse would then perform and document a complete assessment of that area.

At 9:40 AM, E30 (LPN) said she became aware of R1's pressure ulcer when R1 returned from the hospital on February 5, 2016. E28 said the hospital said R1 arrived to the emergency room with the pressure ulcer, but she (E28) did not know R1 had one.

At 10:10AM, E3 (ADON-Assistant Director of Nursing) said she felt R1 was high risk for skin breakdown on admission to the facility and R1's assessment for predicting pressure sore risk dated January 25, 2016, shows did not accurately assess R1's sensory impairment.

At 10:20 AM, Z2 (Primary Care Physician) said R 1 was at a high risk for skin breakdown on admission to the facility, and the wound to her sacrum was from pressure.

At 10:30 AM, E1 (Administrator) said wound care treatments should be completed as ordered. E1 and E2 said a physician should be notified immediately with a decline in a wound, and all reddened areas observed by a CNA should be reported to the nurse and an assessment

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 14	F 314		

completed if the area is pressure related. At 10:40 AM, E2 (DON-Director of Nursing) said R1 did not get a wound treatment with Dakin's solution on 2/23/16, 2/24/16, or in the morning on 2/26/16. E2 said the solution was not available because it was not delivered until later in the day on February 26, 2016. E2 said if a treatment square is blank, or initialed and circled, the treatment was not done.

3. R6's MDS of January 2, 2016 shows R6 requires extensive staff assistance with transfers, dressing, hygiene, bathing, and toileting.

On March 8, 2016 at 11:05 AM, E9 (LPN) said R6 had an event this morning in which she had a possible seizure or stroke, and would not be getting out of bed, until she was more alert.

On March 9, 2016 at 1:00 PM, E21 and E24 (CNAs) provided care to R6 while she was in bed. E24 said R6 had not been out of bed that day. E21 and E24 had R1 on her left side. R1 had dark red circular area to her right buttock. E24 said the area "wasn't so red" this morning.

On March 10, 2016 at 10:00 AM, E24 said R6 had the "same red areas yesterday" to her right buttock.

On March 11, 2016 at 8:00AM, R6 was assisted off the toilet by E8 (CNA), and R6 had a dark reddened area to her right buttock.

There was no assessment of R6's reddened buttock from March 9, 2016 until March 11, 2016 (3 days after the CNA was aware it was present).

The facility "Skin Conditions Policy" dated June,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 314	Continued From page 15 2014 shows: We strive to attain to maintain intact and healthy skin for our residents through a process of identification, monitoring, preventative and treatment protocols. All direct care staff...will be trained to observe for and report skin conditions including redness, bruising, and skin tears.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the failed to ensure a urinary drainage bag remained below the level of the bladder during care, failed to ensure catheter care was given in a manner to prevent cross-contamination, and failed to ensure a resident had a medical diagnosis for the use of a catheter. This applies 2 of 4 residents (R1, R4) reviewed for catheters in the sample of 17. The findings include:	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 315	Continued From page 16	F 315		

1. R1's MDS (Minimum Data Set) of February 12, 2016 shows R1 requires extensive assistance from staff with transfers, bed mobility, eating, bathing, and toileting.

R1's admitting POS (Physician Order Sheet) dated January 25, 2016 shows a diagnoses of Urinary Tract Infection.
R1's Emergency Department Record dated February 2, 2016 shows a diagnosis of Urinary Tract Infection.

On March 8, 2016 at 1:35 PM, E5, E21, E4 (CNAs - Certified Nurse Assistants) transferred R1 from her wheelchair to her bed with a mechanical lift. E21 unhooked R1's urinary catheter and held it above R1's bladder while R1 was attached to the mechanical lift. E21 then held the urinary drainage bag above R1's bladder and passed it to E5. E5 wiped R1's left groin area, and without folding the cloth, wiped up and down the catheter tubing. R1 was placed on her back, and E21 passed the catheter bag above R1's bladder to E5.

On March 11, 2016 at 8:50 AM E32, and E33 (CNAs) said the urinary drainage bag should remain below the level of the bladder at all times during care and transfers. E32 said a cloth should not be used to provide catheter care if it has already been used to clean an area, and a clean cloth should always be used. On 3/11/16 at 10:10 AM, E3 (Assistant Director of Nursing-ADON) said a urinary drainage bag should stay below the level of the bladder during care and transfers, and a soiled cloth should not be used to provide catheter care, without folding the cloth or getting a new cloth.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 315	Continued From page 17	F 315		

2. On March 8, 2016 at 2:55 PM, R4 was being turned side to side while perineal care was being provided. The urinary catheter was lifted up above the level of the bladder by E 4 and E 21 CNAs (Certified Nursing Assistants).
On March 9, 2016 at 12:20 PM E23 LPN (Licensed Practical Nurse) stated the urinary catheter should be kept below the bladder.
On March 9, 2016, at 1:30 PM E2 DON (Director of Nurses) stated she expects the staff to keep the urinary drainage bag below the bladder.
On March 10, 2016, at 11:48 AM, R19 CNA stated the urinary catheter should always be kept below the level of the bladder when providing care or transferring a resident.
On March 10, 2016, at 12:11 PM, E 25 CNA stated that the urinary catheter should always be kept below the waist.
R4 was admitted to the facility on February 6, 2015 according to the February 2016 POS, with multiple diagnoses including dementia and history of urinary tract infections. The February 20, 2016, quarterly MDS (Minimum Data Set) shows R4 to have moderate cognitive impairment and requires extensive assist with ADL's (Activities of Daily Living). The care plan dated November 17, 2015, shows R4 is an extensive assist for bed mobility, dressing and toilet use.
R 4's admission POS dated February 6, 2015, did not include a diagnosis showing the need for an indwelling urinary catheter. E24 (assistant administrator) stated on March 9, 2016 at 1:45 PM, it was an oversight that there is no formal diagnosis for the indwelling urinary catheter.
R4's care plan November 17, 2015 shows R4 is at risk for urinary tract infection due to an indwelling urinary catheter. One intervention shows to keep the drainage bag below the level of the bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 315	Continued From page 18 The facility policy titled Catheter Care Procedures, dated January 2016, shows the intervention Make sure that the urinary drainage bag and tubing remain below the level of the bladder.	F 315		
F 317 SS=D	483.25(e)(1) NO REDUCTION IN ROM UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a resident without limited range of motion on admission did not develop a contracture of the left hand. This applies to 1 of 8 residents (R3) reviewed for range of motion in the sample of 17. The findings include: The resident restorative admission assessment on June 1, 2015 states R3 was admitted related to dysphagia, and left side weakness. The assessment shows R3 ambulated with full weight bearing with good bilateral lower extremity strength. No limitation of R3's head, arms and legs were recorded. The range of motion of R3's hands was not recorded. The restorative program progress note on June 1, 2015 shows R3 has functional range of motion. R3 was ordered to receive physical and occupational therapy at the time of admission.	F 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 317	Continued From page 19	F 317		

The occupational therapy notes dated July 22, 2015 records R3 has bilateral upper extremity active range of motion without functional limits, bilateral grip strength is 4 of 5. On March 9, 2016 at 10:35 AM, Z1 (Physical Therapy Director) stated 5 means full (grip) strength, 4 is slightly less, but still relatively good based on R3's age.
The restorative note for R3 on September 23, 2015 states, "After assessment, the left hand is noted to have slight contracture. Small 'taco' hand splint put into place to prevent further decline". No additional assessment to describe the degree of contracture is recorded. R3's care plan was updated to include the use of the splint, but a passive or active range of motion restorative plan was not initiated. The quarterly restorative assessment dated December 3, 2015 does not address the contracture of R3's left hand. No further restorative assessments were found in the medical record for R3.
On March 8, 2016 at 1:50 PM, R3 was transferred from the reclining chair in the lounge to a wheelchair. R3 was able to come to a standing position with the staff holding her by the hands/wrists. R3 was stiff and took a few shuffled steps to the chair. R3 did not have a splint in the left hand.
On March 8, 2016 at 2:10 PM, E9 (LPN) soaked R3's left hand in a basin of warm water. After massage, E9 was able to slightly extend R3's fingers enough to observe the skin on the palm of her hand. E9 stated the warm water hand soak is not a scheduled treatment, but she does it for R3 because she thinks it feels good. With manipulation, E9 was able to position a clean hand splint in place. No range of motion exercises were completed prior to putting the splint in her hand.
On March 8, 2016 at 11:00 AM, E6 (RN) stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 317	Continued From page 20	F 317		

R3 was in a restorative ambulation plan and does well with walking. R3 is able to walk 300 feet in the hall, but E6 was not sure how often she walks. E6 stated the left hand splint is removed by the resident and she does not have a major contracture of the hand; the splint is used as a preventative measure. E6 stated the restorative nurse does the resident assessments of contracture quarterly.

On March 8, 2016 at 11:10 AM, E8 (Restorative CNA) stated she had no idea why R3 had a splint in her left hand, and the floor CNA puts it in when they get her up and dressed in the morning. E8 stated R3 does not have scheduled range of motion exercise; she only works with her ambulation plan. E8 stated R3 walks 300 feet in the hall on a good day. E8 was uncertain how to measure 300 feet in the facility. The daily restorative daily progress record for March 2016 showed R3 walked between 150 - 300 feet on 6 out of 9 days by E8.

On March 9, 2016 at 8:45 AM, R3 was dressed and seated in a high back wheelchair in her room. The left hand was in a clenched position, no hand splint was in place.

On March 9, 2016 at 11:50 AM, E6 (Registered Nurse - RN) and E7 (Licensed Practical Nurse - LPN) observed the contracture of R3's left hand. The second and third fingers were bent at a 90 degree angle and the fingertips were pressed against the palm of her hand. The first finger and thumb were in a tight clinched together position. E6 was able to slightly move R3's fingers after massage to gain enough movement to insert and remove the hand splint. E6 stated there currently was not a restorative plan for range of motion of the left hand. E6 described the contracture of R3's left hand as "severe" .

The minimum data set (MDS) of September 5,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 317	Continued From page 21 2015 and most current MDS of November 28, 2015 shows R3 does not have any range of motion limitations. There was no contracture assessment recorded for R3's left hand after September 23, 2015. A restorative active or passive range of motion plan for the left hand was not in place for R3. The undated facility policy and procedure for the restorative program states program plays an essential role in both attaining and maintaining the resident's level of function. The procedure states residents will be assessed by the restorative nurse on admission, as part of their MDS, and with significant changes. Residents will also be assessed when there is a change in their level of ADL ability such as transfers and ambulation. Restorative CNA will be trained with approaches and carried out according to the resident's individual needs. Charting on the restorative program will be completed on a quarterly basis by the restorative nurse. Charting will address physical function, tolerance of programs and/or explore the need for additional programs.	F 317		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by:	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 22	F 323		

Based on observation, interview and record review, the facility failed to ensure resident safety during a transfer by not using a gait belt, failed to keep water temperatures less than 112 degrees Fahrenheit and failed to secure stored oxygen tanks to prevent tipping.
This applies to 1 of 14 residents (R11) reviewed for safety in the sample of 17 and 2 residents (R27, R28) in the supplemental sample.
The findings include:
1.On March 8, 2016 at 11:50 A.M., E4 CNA (Certified Nursing Assistant) and E5 CNA transferred R11 from the wheelchair to the bed without using a gait belt. E4 lifted R11 by grabbing the back of her pants and pulling them up and turning R11 to a standing position. E5 was holding R11 under her right armpit during the transfer.
On March 10, 2016 at 9:20 A.M., E2 DON (Director of Nursing) said the delegate sheet on a resident ' s bathroom door tells direct care staff what type assistance each resident needs to safely transfer. All CNA ' s are to have gait belts. All residents are to be transferred with a gait belt unless they are able to self transfer. Gait belts are used for resident safety. It is not acceptable to use resident ' s clothing to hold during a transfer instead of a gait belt.
R11 ' s Restorative Progress Note dated March 3, 2016 shows R11 has impaired balance and needs two people to assist with transferring and a gait belt requires total care by staff and is a fall risk. The facility undated Transferring Policy\Procedure shows to place a gait belt around the resident ' s waist and grasp the resident by the gait belt to assist to a standing position.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 23	F 323		

2. On March 9, 2016 at 10:30 AM, during the environmental tour, room 311, and room 312 had water temperatures of 134° (degrees) F (Fahrenheit) and 138° F respectively.

On March 9, 2016 at 10:40 AM, E 20 maintenance supervisor for safety, water temperatures should be between 100-110° F, and resident could be injured by water temperatures higher than the safe range.
On March 11, 2016 at 9:30 AM, E3 ADON (Assistant Director of Nursing) said, water temperatures in the 130's°F could cause a burn/scald to the resident.

The August, 2014 water temperature policy shows, "Tap water in the facility shall be kept within a temperature range to prevent scalding of residents."
PROCEDURE:
(1). Water heaters that service resident rooms, bathrooms, common areas, and tub/shower areas shall be set to temperatures of no more than the maximum allowable temperature per state regulation.
(2). Maintenance staff is responsible for checking thermostats and temperature controls in the facility and recording these checks in a maintenance log.
(3). Maintenance staff shall conduct periodic tap water temperature checks and record the water temperatures in a safety log.
(4). If at any time water temperatures feel excessive to the touch (i.e., hot enough to be painful or cause reddening of the skin after removal of the hand from the water), staff will report this finding to the immediate supervisor.

3. On March 9, 2016 at 10:15 AM, in the oxygen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 24 (O2) supply closet, two O2 cannisters were sitting on the floor unsecured. On March 9, 2016 at 10:30 AM, E20 said, all O2 cannisters are to be secured to the wall or in a carrier. On March 11, 2016 at 9:30 AM E3 said, O2 cannisters should never be free standing, and should be secured to the wall. The April, 2015 Oxygen Storage Policy states " To provide for storage of an adequate oxygen supply in a safe, consistent manner per regulation." PROCEDURE: under number 4 says (4). E tank (small tank) shall be secured at all times.	F 323		
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 have a hydration plan in place to ensure a resident's daily fluid needs were met. This applies to 1 of 5 residents (R1) reviewed for hydration in the sample of 17. The findings include: R1's MDS (Minimum Data Set) of February 12, 2016 shows R1 requires extensive assistance from staff with transfers, bed mobility, eating,	F 327		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 327	Continued From page 25	F 327		

bathing, and toileting.

R1's admitting POS (Physician Order Sheet) dated January 25, 2016 shows a diagnoses of urinary tract infection, dehydration, esophagitis, and Lewy body dementia.

R1's Emergency Department Record dated February 2, 2016 shows a diagnosis of Urinary Tract Infection, and dehydration.

R1's nursing admission assessment dated January 25, 2016 shows R1 was admitted with a urinary catheter.

R1's hydration care plan dated February 18, 2016 shows, "water pitcher will be filled and kept within reach by resident." R1's MDS shows she is dependent on staff for activities of daily living and eating.

On March 8, 2016 at 1:35 PM, E5, E21, E4 (CNAs - Certified Nurse Assistants) transferred R1 from her wheelchair to her bed with a mechanical lift. R1 had a urinary catheter with dark yellow urine in the tubing and drainage bag.

On March 10, 2016 at 8:25AM, R1 was sitting at the dining room table, with her arms at her side. R1 was dependent on staff for assistance with eating, and drinking. R1 had a full, untouched glass of juice and milk.

R1's Nutritional Assessment dated March 8, 2016 identified R1's risk factors as dementia, and urinary tract infection. The Nutritional assessment does not identify R1's history of dehydration, and shows R1's fluid needs are 2,835cc per day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 327	Continued From page 26	F 327		

R1's oral liquid intake from January 27, 2016 to March 7, 2016 shows an average daily intake of approximately 1000cc per day. No new hydration interventions had been implemented as of March 9, 2016 for R1.

R1's hydration care plan was not initiated until February 18, 2016 (24 days after her first admission with UTI, and dehydration).

On March 10, 2016 at 10:35 AM, E21 CNA said she was not aware of a hydration plan, or interventions for R1 until a sign was placed on her door on March 9, 2016.

On March 11, 2016 at 8:35 AM, E27 (Licensed Practical Nurse) said she was not aware of a hydration plan for R1, and R1 does not accept fluids well. At 10:10 AM, E3 (ADON-Assistant Director of Nursing) said R1 should have a plan to ensure her hydration needs are met because of her history of having a catheter, dehydration, and stage 4 pressure ulcer. E3 said staff should encourage R1 to drink anytime they are in her room, and should also monitor her intakes. At 10:20 AM, Z2 (Primary Care Physician) said a hydration plan in general for elderly residents is important, and R1 should be monitored for proper fluid intake with her chronic conditions.

The June, 2013 facility "Hydration Policy" states Our facility recognizes the importance of the adequate hydration of its residents. This facility shall provide each resident with sufficient fluid intake to maintain proper hydration. An ongoing assessment in consultation with the R.D. (Registered Dietitian) and physician shall determine the individual plan of care regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 327	Continued From page 27 hydration and the monitoring of fluid intake.	F 327		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure residents on pureed diets received the planned protein, vegetable and starch servings. This applies to 3 of 14 residents (R2, R8, R12) reviewed for diets in the sample of 17 and 4 residents (R19, R20, R21, R22) in the supplemental sample. The findings include: On March 8, 2016 at 9:15 AM, E11 (cook) stated there are 6 residents requiring puree meals. On March 8, 2016 at 11:20 AM, E11 (cook) prepared the puree bread serving for the noon meal. E11 used six slices of bread in the commercial food processor and milk to blend. E11 added 1 cup initially and then added a second cup of milk during the processing. E11 stated the consistency should be pudding thick. When finished, the bread texture was thin and of a runny consistency. The mixture tasted like raw bread dough. On March 8, 2016 starting at 12:05 PM, seven residents were served a puree diet. At 12:35 PM, the tray line was completed. E11 measured out	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 363	Continued From page 28	F 363		

the remaining portions of puree food in the steam table. E11 stated she used 6 fillets of breaded fish and chicken broth to make the puree fish and there were 6 servings leftover after serving 7 meals. E11 stated she used 8 scoops of vegetables and used the vegetable liquid to blend, and 4 servings were leftover. E11 stated she used 6 scoops of scalloped potatoes and close to 2 cups of milk. There were six servings left over. E11 measured four bread servings leftover after using six slices of bread and serving seven residents. E11 used the correct serving size utensil when serving the meals and measuring the leftovers. E11 stated she had about six servings of the breakfast egg casserole leftover from breakfast that morning. E11 explained that it was not unusual to have " quite a bit " of leftover puree food even though the right number of servings were made. E11 could not explain why that happens.

The recipe for Pureed Fried Fish states one portion provides two ounces of protein. The directions state to make one serving: Use one fish fillet, 2 tablespoons chicken broth and serve with a #10 scoop (2/5 cup serving).

On March 8, 2016 at 12:20 PM, R2 consumed 100 % of the puree food served to him. R2 scraped the sides of the plate to get every bite of food. After the meal, R2 ' s daughter requested more and he ate 100% of the pudding served to him. R2 is provided an oral supplement after meals to ensure he consumes enough calories.

On March 8, 2016 at 1:15 PM, R22 ' s lunch tray showed she consumed a small cup of oral supplement and approximately ½ of the puree fish serving. No vegetable, potato or bread was consumed.

The resident diet list provided on March 11, 2016, showed seven residents (R2, R8, R12, R19,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 363	Continued From page 29 R20, R21, R22) have prescribed puree diets.	F 363		
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the pureed food was of a smooth consistency. This applies to 3 of 14 residents (R2, R8, R12) reviewed for diets in the sample of 17 and 4 residents (R19, R20, R21, R22) in the supplemental sample. The findings include: On March 8, 2016 at 11:20 AM, E11 (cook) prepared the puree bread serving for the noon meal. E11 stated the puree food should be pudding thick and a smooth consistency. E11 lifted a spoon of the bread mixture to test the consistency. The bread mixture was thin and ran readily off the spoon. E11 described the consistency as pudding thick. On March 8, 2016 at 12:40 PM, a sample tray of the pureed diet was observed and sampled. The scalloped potatoes mixture contained chunks of potatoes. The potato mixture was thin and runny, having a soup like consistency with notable pieces. The puree fish and mixed vegetable serving were of a thin, runny consistency. E11 stated she used seven ½ cup portions of scalloped potatoes and used close to 2 cups of milk to puree the potato serving. The recipe for Pureed Scalloped Potatoes states	F 365		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 365	Continued From page 30 to place ½ cup potatoes with 1 Tablespoon of hot milk (per serving) in a food processor and blend. Add liquid as needed to reach desired consistency.	F 365		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure soiled food preparation equipment was sanitized between uses, failed to ensure food service equipment was covered to prevent contamination during transport, and failed to prevent unauthorized staff from entering the kitchen during food service. This has the potential to affect all 82 residents in the facility. The findings include: The Resident Census and Conditions of Residents report dated March 8, 2016 shows 82 residents reside at the facility. 1. On March 8, 2016 at 11:20 AM, E11 (Cook) used the commerical food processor to prepare puree bread servings for the noon meal. E11 disassembled the equipment and took the mixing	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 371	Continued From page 31	F 371		

bowl, blade and cover to the 3 compartment sink. E11 washed and rinsed each item. Using a dip method, E11 put the pieces in the sanitizer solution and then immediately removed them. E11 shook the container to rid any remaining sanitizer solution from the pieces and proceeded to prepare the puree dessert serving. The dishes were not allowed to air dry.
The sign above the 3 compartment sink states proper dishwashing procedure includes to soak dishes for 45 seconds in the sanitizer solution and let air dry.
On March 8, 2016 at 11:35 AM, E11 (Cook) stated the correct dishwashing procedure includes to soak for 3-5 minutes in the sanitizer solution and not to put dishes away wet. E11 thought she left the dishes in the sanitizer solution for 45 seconds.
2. On March 8, 2016 at 11:17 AM, a male dietary staff member carried serving utensils down the hallway from the kitchen through the 100 and 500 wing halls uncovered. The serving utensils were used to serve the residents their noon meal.
On March 9, 2016 at 11:20 AM, E10 (Dietary Manager) stated all food and service items should be covered when transported out of the kitchen.
3. On March 8, 2016 at 12:10 PM, during the noon meal service, E13 (Certified Nursing Assistant - CNA) entered the kitchen and was looking for an extra empty glass. E13 was not part of the dietary staff. E13 did not wash his hands and he was not wearing hair covering.
On March 8, 2016 at 12:30 PM, E13 (CNA) stated he entered the kitchen because he needed another glass for a resident. E13 stated he was not aware he needed to wear hair cover when entering the kitchen.
A sign posted on the entrance door to the kitchen states, " No unauthorized staff in the kitchen " .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 371	Continued From page 32 On March 8, 2016 at 11:25 AM, E12 (Social Services) entered the kitchen to present list of residents wanting a sick tray served to their room. E12 did not wash her hands or have hair cover in place.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a residents' physician prescribed medication patch was available for 11 days. This applies to 1 of 14 residents (R1) reviewed for	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 425	Continued From page 33	F 425		

medications in the sample of 17.

The findings include:

R1's January Physician Order (POS) shows R1 was admitted with diagnoses to include generalized weakness, and Lewy body dementia with behavioral disturbances.

R1's Minimum Data Set of February 12, 2016 shows R1 is cognitively impaired and requires extensive assistance from staff with transfers, bed mobility, eating, bathing, and toileting.

R1's January POS shows an order for Exelon 4.6mg patch topical, daily.

R1's January and February MAR (Medication Administration Record) shows R1 did not receive the Exelon patch from January 26, 2016 through February 4, 2016 (a total of 11days).

On March 9, 2016 at 1:30 PM, Z3 (family member) said R1 did not get her Exelon patch for about a week after she came to the facility, and she was told the facility couldn't get it.

On March 11, 2016 at 10:20 AM, Z2 (Primary Care Physician) said the Exelon patch is used for people with Dementia to attempt to slow the progression of the disease, and decrease behaviors associated with dementia, and R1 was on it because of her Lewy body dementia.

On March 10, 2016 at 2:00 PM, E1 (Administrator) said a resident's ordered medication should be available at the facility by the next scheduled dose, and it should be available no later than the next day. E1 said the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 425	Continued From page 34 Director of Nursing should be notified if a medication is not covered, and then investigate if another med can be ordered, or if the facility needs to accept payment for the medication until authorization is given. E1 said the facility would pay for the medication until it is either changed by the physician, or until approval/authorization is given. E1 said a resident should not go days without getting their ordered medication. On March 10, 2016 at 4:40 PM, E27 (LPN-Licensed Practical Nurse) said if a medication is not available, the nurse should notify the physician, and the medication issue should be resolved that shift prior to the nurse leaving. E27 said the medication should be changed, discontinued, or the facility should accept payment for the medication so it can be delivered and available. The October 1, 2014 facility "Medication Administration/General Guidelines" states Medications are administered as prescribed, in accordance with good nursing principles and practices... Medications are administered in accordance with the written orders of the attending physician.	F 425		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 431	Continued From page 35 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure medications were clearly labeled with resident identification, and failed to ensure expired medications were removed from the medication cart. This applies to all 82 residents in the facility. The findings include: 1. The Facility's Resident Census and Conditions	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 431	Continued From page 36	F 431		

of Residents federal form dated March 8, 2016 shows there were 82 residents residing in the facility.

On March 10, 2016 at 12:00 PM, E27 (LPN -Licensed Practical Nurse) removed a bottle of Senna S (stool softener), Prosight (eye vitamins), and Vitamin-B6 from the 100 wing medication cart. E27 said the Senna S expired in February, 2016, and the Prosight and Vitamin B6 expired January, 2016. E27 said these medications were part of the floor stock and would be used for any resident who had that medication order.
E27 removed a Morphine 20 Mg/ML bottle that expired on January 16, 2016, and an Ativan 2mg/ml, 30ML bottle that expired January 15, 2016, and said both of the medications would have to be wasted.
E27 removed 4 bottles of artificial tears, 1 Alcon eye drop, 1 Visine Advanced Eye drop, and 1 Refresh Liquigel that did not have clear labels, or dates when they were opened. E27 said the bottles would need to be thrown away, are only good for 90 days after opening, should be dated when opened, and should have clear labels to identify which resident they belong too. E27 said the residents' names are written on the eye drop bottle with marker, but the marker comes off easily when they are used, and it is difficult to tell whose they are.

On March 11, 2016 at 10:10AM, E3 (ADON-Assistant Director of Nursing) said eye drop bottles should be dated when they are opened, and should be clearly labeled with a resident name. E3 said it is hard with eye drops because the name rubs off the bottle with handling, and all expired medications should be removed from the cart.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 431	Continued From page 37 The October 1, 2014 facility "Medication Administration/General Guidelines" policy states Eye drops need to be dated and initialed when first used. Follow manufacturer's guidelines for discarding. 2. On March 10, 2016 at 2:00 P.M., a bottle of Systane Balance eye drops with an expiration date of February 2016 and a stock bottle of Prosight vitamin and mineral tablets with an expiration date of January 2016 were on the medication cart that serves the 300 wing and 200 wing- even numbered rooms.	F 431		
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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 441	Continued From page 38	F 441		

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 prevent cross contamination while providing incontinence care to a resident and while handling soiled linens. This applies to 2 of 14 residents (R1, R11) reviewed for infection control in the sample of 17. The findings include:
1. On March 8, 2016 at 11:50 A.M., E4 CNA (Certified Nursing Assistant) and E5 CNA performed incontinence (urine and liquid stool) care on R11. E4 cleansed the perineal area and without changing gloves touched the resident's bare skin, clothing, chair and heel protectors.
On March 9, 2016 at 8:15AM, E2 DON (Director of Nursing) said she expects gloves to be changed in between procedures and when they become soiled.
The facility ' s Incontinence Care Policy dated January 20, 2016 shows to remove gloves promptly after use and before touching other items and environmental surfaces and to discard soiled linen properly. The facility ' s Standard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

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F 441	Continued From page 39	F 441		

Precaution Policy dated November 2, 2011 shows to use gloves when handling soiled clothing and to remove gloves and wash hands when moving from one task to another. The facility ' s policy for Hand washing and Glove Use dated November 1, 2011 shows hands should be washed after removing gloves. The purpose of the facility ' s Hand washing Policy dated November 11, 2015, is to prevent the transmission of microorganisms from patient to patient and from inanimate surfaces to patients by the hands of all healthcare providers. The facility ' s policy for Handling Soiled Linens dated September 2014 shows visibly soiled linens will be placed on top of a clean under pad with gloves on, then gloves are removed and hands washed. The clean pad will be wrapped around the soiled linens and transported to the soiled utility room for cleaning.

2. R1's Minimum Data Set of February 12, 2016 shows R1 requires extensive assistance from staff with transfers, bed mobility, eating, bathing, and toileting. The MDS shows R1 has 1 unstageable pressure ulcer with slough.

R1's wound culture dated February 25, 2016 shows the wound had gram negative rods, E. Coli, and Extended spectrum Beta Lactamase (ESBL - bacteria) present in the wound, and contact isolation recommended.

On March 8, 2016 at 1:35 PM, E5, E21, E4 (CNAs - Certified Nurse Assistants) transferred R1 from her wheelchair to her bed with a mechanical lift. R1 had a dressing intact to her sacral region, and had a urinary catheter in place. E5 and E21, rolled R1 onto her left side and E5 cleaned R1's bottom. After washing and drying R1's bottom, E5 placed the linen on the floor by

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145200	A. BUILDING _____ B. WING _____	03/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN GROVE LIVING AND REHAB	502 NORTH STATE STREET FRANKLIN GROVE, IL 61031

(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 441	Continued From page 40 R1's bed. After providing care, E5 removed her gloves, then picked up the dirty linens off the floor, and tucked the linens into her arm. E5 left, the room, went into the soiled utility room with the linens under her arm, grabbed the linens from under her arm, and placed them in a utility bin. E5 left the utility room without washing her hands. The September, 2014 facility "Handling Soiled Linens" policy states Gloves will be removed and hands washed following cleaning of linens.	F 441		
F 468 SS=F	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to firmly secure a hand rail to the wall. This has the potential to affect all 82 residents in the facility. The findings include: The Facility's Resident Census and Conditions of Residents federal form dated March 8, 2016 shows there were 82 residents residing in the facility. On March 9, 2016 at 10:40 AM, the hand rail between room 402 and 404 was not firmly attached to the wall. The hand rail has three support brackets that attach to the wall. The assembly that holds the hand rail to the support	F 468		

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F 468	Continued From page 41	F 468		

bracket allowed the rail to move freely three inches down the support bracket. All residents in the facility had access to this area.

On March 9, 2016 at 10:30 AM, E20 Maintenance Supervisor said, all hand rails should be firmly attached to the wall, and a loose hand rail could cause a fall to a resident.
On March 11, 2016 at 9:30 AM, E3 ADON (Assistant Director of Nursing) said, a loose hand rail is a huge safety hazard for the residents and their visitors. E3 said, all residents had access to that area.

The July, 2012 Maintenance Policy includes, "Provide a safe environment for residents, families, visitors, and staff", and " meet life safety code requirements."
PROCEDURES:
1. It is the job of all staff to identify areas of concern regarding the maintenance of the building.
2. Preventive maintenance will occur throughout the year...
A specific policy was requested for hand rails but not received.