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FREEPORT REHAB & HEALTH CARE CENTER	**900 SOUTH KIWANIS DRIVE FREEPORT, IL 61032**

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F 000	INITIAL COMMENTS Annual Certification 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: Based on observation, interview, and record review the facility failed to maintain privacy for a	F 164		

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

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

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F 164	Continued From page 1 resident while staff were providing peri-care. This applies to 1 of 13 residents (R7) reviewed for privacy in the sample of 14. The findings include: The Minimum Data Set (MDS) dated 9/11/2014 shows R7 needs extensive assist of two or more people for toilet use. On 11/17/2014 at 1:50 PM, E7 (Certified Nursing Assistant- CNA) and E5 (Licensed Practical Nurse-LPN) provided peri-care to R7. E5 (LPN) left the room to get more supplies. E7 (CNA) did not cover R7 up while waiting for E5 (LPN) to come back with supplies to continue peri-care. On 11/17/2014 at 2:10 PM, R7 stated he would have liked to be covered up while waiting for E9 to get more supplies. On 11/19/2014 at 10:46 AM, E7 (CNA) stated you cover the resident up when you are providing peri-care or personal care. The facility's policy on bed bath (cleansing) dated 01/2004 shows, "(to) be careful not to expose resident unnecessarily."	F 164		
F 166 SS=E	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to resolve concerns identified at the resident council meetings related to staff response to call lights and dirty laundry not being taken for washing timely.	F 166		

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This applies to 1 of 13 residents (R6) reviewed for quality of life in the sample of 14 and 5 residents (R16,17,18,24 and 25) in the supplemental sample.

The findings include:

The resident council minutes from January 7, 2014 show that call lights are not being answered in a timely manner and the Activity Director (AD) said it would be addressed with the appropriate department. The February 4th resident council minutes show that residents call lights are not being answered in a timely manner. The August 6, 2014 Minutes show call lights are not being answered in a timely manner. The AD took concerns to the proper department and have assured the council members that it is important and we will do what can be done to improve the call light answering. The October 2014 minutes show that laundry issues were resolved.
On none of the minutes for 2014 does it explain what actions the facility took to resolve resident concerns.

Resident interviews conducted on 11/17/14 with R6, R 16,17,18 found call lights were not being answered timely and dirty laundry is not being washed timely for some residents yet other resident's laundry is being picked up daily.

The resident council minutes show in June one resident requested that laundry be picked up more often, in July two residents were concerned about not getting their laundry picked up, in August one resident had concerns about laundry, in September one resident was concerned that it is taking a longer time for dirty laundry to be

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F 166	Continued From page 3 picked up. On 11/17/14 at 1:28 PM E1(Administrator) was asked whose responsibility it is to pick up residents dirty laundry. E1 stated it is the Certified Nursing Assistant's responsibility. On 11/19/2014 at 12:51PM, E1 was asked about the response to call lights. E1 stated there were a couple of times when residents complained about not answering call lights. It was addressed. Everyone is responsible for answering call lights. The facility has no specific time but it should be done as quickly as possible. The facility has no tracking system to monitor how quickly call lights are answered.	F 166		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225		

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F 225	Continued From page 4 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to thoroughly investigate allegations of abuse and failed to report allegations of abuse immediately to the Administrator. This applies to 2 of 14 residents (R4, R10) reviewed for abuse in the sample of 14 and 3 residents (R16, R21, R22) in the supplemental sample. The findings include: 1. The facility's abuse investigation dated 2/27/2014 showed an allegation of abuse was made regarding E15 (Certified Nursing Assistant-CNA) flicking water in R10's face. E22 (CNA) was given a written warning that showed, "You are receiving a written warning for failure to immediately report suspicion of abuse". 2. The facility's abuse investigation showed on 10/9/2014 R21 was seen rubbing R22 inappropriately by a Certified Nursing Assistant (CNA). The investigation showed only R21 and	F 225		

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F 225	Continued From page 5 four staff members were interviewed. There was no evidence that the allegation was investigated any further. 3. The facility's abuse investigation dated 4/16/2014 documented, R16 reported to E16 (Licensed Practical Nurse-LPN) that he overheard a staff member say they wanted to hit R4 with his cane while trying to get R4 up that morning. During the investigation, E3 (Registered Nurse- RN) stated she overheard E17 and E18 (Certified Nursing Assistants- CNA) talking about taking R16's cane and whacking R4 with it. E3 (RN) did not report this immediately to the Administrator. On 11/19/2014 at 2:15 PM E2 (Director of Nurses-D.O.N) stated staff should be reporting abuse immediately.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, and record review the facility failed to follow its policy for abuse by not reporting abuse to the Administrator immediately and failed to thoroughly investigate alleged abuse. This applies to 2 out of 14 residents (R4, R10) reviewed for abuse in the sample of 14 and 3 residents (R16, R21, R22) in the supplemental sample. The findings include:	F 226		

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F 226	Continued From page 6 The facility's abuse investigation dated 2/27/2014showed an allegation of abuse was made regarding E15 (Certified Nursing Assistant-CNA) flicking water in R10's face. The file only had an interview with E15 (CNA) and a written warning for E22 (CNA) for not reporting abuse. There was no evidence that any other staff or residents were interviewed. The facility's abuse investigation dated 10/9/2014 documented R21 was seen rubbing R22 inappropriately by a Certified Nursing Assistant (CNA). The only interviews done were with R21 and four staff members. There was no evidence that the allegation was investigated any further by interviewing other residents or staff. On 4/16/2014 R16 had stated that a CNA said they wanted to hit R4 with his cane during morning care. The investigation showed the allegation was overheard by E3. E3 (Registered Nurse) did not report immediately to the Administrator. The only interviews done were with R4, R16, E3 (Registered Nurse), E16 (Licensed Practical Nurse), E17 (Certified Nursing Assistant), and E18 (Certified Nursing Assistant). There was no evidence that the allegation was investigated any further by interviewing other residents or staff. On 11/19/2014 at 2:15 PM E2 (Director of Nurses-D.O.N) stated staff should be reporting abuse immediately. The facility's Abuse Prohibition protocol dated 12/2012 shows, "facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to the facility administrator". The facility's Abuse Prohibition protocol date 12/2012 shows, "Statements shall be taken from the suspect, the person making the accusations, the resident abused or neglected, other staff or	F 226		

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F 226	Continued From page 7 residents who may have witnessed the incident, and any other person who may have information related to the incident " .	F 226		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to have preventive measures in place prior to residents developing pressure ulcers on the heels, toes and buttocks. This applies to 2 of 6 residents (R7, R5) reviewed for pressure ulcers in the sample of 14. The findings include: 1. The care plan dated 9/4/2014 lists R7's diagnoses to include Enteritis, Clostridium Difficile, Urinary Tract Infection, Cachexia, and Dehydration. The Minimum Data Set (MDS) dated 9/11/2014 shows R7 needs extensive assist of two or more people for bed mobility. The Braden Scale for predicting pressure ulcers dated 10/22/2014 shows R7 is a high risk for development of pressure ulcers. The Progress Notes dated 10/7/2014 at 1:21 PM shows, "R7 was seen by foot doctor this morning	F 314		

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F 314	Continued From page 8 and it was found that R7 has 2 ST. (stage) II pressure ulcers noted to his left foot, 1 between his 3rd and 4th toes and the other between his 4th and 5th toes " . R7's Progress Notes dated 10/16/2014 at 1:45 PM show E5 (Licensed Practical Nurse-LPN) received report from nurse at hospital about R7 being readmitted back to the facility. The progress notes state, " ...areas to res (residents) left lateral heel, ventral side of right foot, left great toe ventral side and inner right side of right knee a scab ... " . The Admission Body Assessment dated 11/9/2014 shows R7 has " scabbed areas 2nd and 3rd toe and outer ankle right foot, left foot great toe scabbed area 1cm x 0.8cm left heel 2cm x 2cm black area " . Progress notes dated 11/17/2014 at 9:16 AM for R7 show, "Pressure ulcers measured this AM. Area under left great toe measures 1 cm x 1cm between 3rd and 4th toe measures 0.5cm x 0.5 cm, between 4th and 5th toe 0.5 cm x 0.5cm, area under 2nd toe left foot 0.4cm x 0.4cm, area under 3rd toe 0.4cm x 0.4cm and new area to left heel unstageable area to left heel 2cm x 2cm " . The facility provided a list of residents with pressure ulcers. R7 was listed as having "left great toe, 3 & 4 toe 4 & 5 toe left heel, facility acquired " . On 11/17/2014 at 1:50 PM, E5 (Licensed Practical Nurse- LPN) and E8 (Certified Nursing Assistant-CNA) provided peri-care to R7. A quarter size black, dry wound observed to left heel. Two pinpoint black circular wounds noted under the left 2nd and 3rd toes. Approximately a dime size black wound noted under the left great toe. Two black wounds the size of a pencil eraser observed between the left 2nd and 3rd and 4th and 5th toes. R7 was observed moving his legs	F 314		

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with his heels on the bed back and forth on the mattress while E5 (LPN) and E7 (CNA) provided peri-care. E7 and E8 (both CNA's) completed peri-care and did not put anything under R7's feet. R7's heels were resting on the mattress.
On 11/18/2014 at 8:35 AM, R7 was observed in bed. R7 did not have anything under his feet and his heels were resting on the bed.
On 11/17/2014 at 2:29 PM E5 (LPN) stated R7 had pressure sores before going to the hospital.
On 11/17/2014 at 2:29 PM E8 (CNA) stated R7 got his pressure sore on his heel from rubbing his feet on the bed. E8 (CNA) also stated she would have put a pillow under R7's heels to keep them from resting on the bed.
On 11/18/2014 at 10:49 AM, E6 (LPN) stated, "It is our (facility's) protocol to attempt to offload heels (keep residents heels from resting on the bed) " .
The facility's pressure ulcer prevention and treatment protocol dated 5/2007 shows, "All high and moderate risk residents may have the following, and if so, they will be addressed on the Care Plan: elbow/heel protectors " .
There was nothing on R7's care plan to address pressure ulcers on his left heel or toes.
2. On 11/18/14 at 10:00 AM, R5 was observed with 3 open areas to the buttocks. The right buttocks had 1 x 1 centimeters (cm) area, the left lower buttocks had a 2 x 1 cm area, and the left upper buttock had a 4 x 1.5 cm area. All sores were shallow with red wound beds.

On 11/17/14 and 11/18/14 at 10:00 AM, no cushion was seen on R5's wheelchair while she was in bed.

On 11/18/14 at 9:30 AM, E10 said she found the sores on R5 on 11/17/14. E10 said the wounds

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F 314	Continued From page 10 happened in the facility from shearing. R5 was admitted to the facility on 4/18/14. On 11/18/14 at 1:25 PM, E12 Certified Nurses Assistant (CNA) said R5 is transferred using mechanical lift with assist of 2 people. E12 said R5 is totally dependent on staff for transferring, rolling in bed, and toileting. R5's Progress Notes for 11/17/14 at 9:38 AM shows E10 (LPN), discovered 3 wounds on R5's buttocks The Skin Integrity Event Report dated 11/17/14 at 9:38 AM list the wounds as Stage 2 pressure sores. The Minimum Data Set (MDS) dated 10/14/14 list the Braden scale at 14, which is moderate risk for pressure ulcers. The MDS of the same date list transfer as total care with assist of 2 people, Range of Motion is impaired on both sides, and bed mobility help is extensive with assist of one person. R5's care plan did not address pressure ulcers as a risk factor until 11/18/14. The undated Pressure Ulcer Prevention and Treatment Protocol defines a pressure ulcer as a localized injury to the skin as a result of pressure, or pressure in combination with shear and/or friction. The protocol states when a resident develops a pressure ulcer, special devices will be used to relieve pressure.	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	F 315		

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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 facility failed to identify the need for continuing the use of an indwelling urinary catheter. The facility failed to clean the tubing of the urinary catheter to prevent bacterial contamination. The facility failed to clean the top of the urinary catheter tubing when changing from leg bag to a drainage bag on two residents. This applies to 2 out of 3 residents (R3 and R7) reviewed for urinary catheters in the sample of 14 residents.
The findings include:
1. The care plan dated 9/4/2014 lists R7's diagnoses to include Enteritis, Clostridium Difficile, Urinary Tract Infection, Cachexia, and Dehydration.
The Minimum Data Set (MDS) dated 9/11/2014 shows R7 requires extensive assist with two or more staff members for bed mobility and toilet use. The same assessment also shows R7 requires extensive assist with one staff member for personal hygiene.
The Progress Notes for R7 dated 10/16/2014 shows E5 (Licensed Practical Nurse-LPN) received report from the nurse at the hospital about R7 returning to facility. The progress note shows, " A 16 fr (French) foley catheter was

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F 315	Continued From page 12 inserted d/t (due to) urinary retention ... " . The catheter was inserted while R7 was in the hospital. On 11/17/2014 at 10:00 AM R7 was observed lying in bed with urinary catheter collection bag laying on the floor. On 11/17/2014 at 1:45 PM E7 and E8 (both Certified Nursing Assistants- CNAs) provided peri-care to R7. R7 had a large bowel movement. E8 (CNA) cleaned R7's soiled catheter tubing with a wet wash cloth only. E8 (CNA) did not clean the tubing with an alcohol swab. E7 (CNA) then took apart the catheter connection to change from leg bag to a drainage collection bag. E7 did not clean the connection site of the collection bag with an alcohol swab. On 11/17/2014 at 2:15 PM E8 (CNA) stated the catheter end should have been cleaned before changing to a drainage collection bag. The tubing should have been cleaned with an alcohol swab after R7 soiled it with a bowel movement. On 11/18/2014 at 11:02 AM, E5 (LPN) stated that R7's indwelling urinary catheter was inserted in the hospital. They had kept the catheter in because the doctor ordered it even without a diagnosis for it. E5 also stated they have not tried any interventions to try and discontinure the catheter. No urinary catheter assessment was documented for R7. The urinary catheter is not listed on R7's care plan. 2. On 11/17/2014 at 1:16 PM, E7 and E9 (Certified Nursing Assistants- CNAs) put R4 into bed after lunch for nap. R4 had on a leg bag. E7 removed leg bag and attached urinary drainage bag to end of catheter. E7 did not cleanse the end of the catheter or the collection bag connection with alcohol. On 11/17/2014 at 2:15 PM stated the catheter	F 315		

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F 315	Continued From page 13 should be cleaned with alcohol when changing from leg bag to a drainage collection bag. The facility's catheter maintenance protocol dated 1/2004 shows, "Precede any entry into the drainage system by thorough cleansing with an alcohol sponge. To change from drainage bag to leg bag or leg bag to drainage bag, be sure to cleanse drainage tubing with alcohol and also end of catheter each time".	F 315		
F 323 SS=E	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: Based on observation, interview and record review the facility failed to have interventions to prevent a residents recurrent falls. The facility failed to ensure a resident had a functioning call light. The facility failed to ensure portable oxygen tanks were secured and medications and chemicals were in locked areas not accessible to residents. This applies to 2 of 12 residents (R3, R9) reviewed for safety and supervision in a sample of 14 and 3 residents (R17, R19, R26) in the supplemental sample. The findings include:	F 323		

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Continued From page 14

1. On 11/19/14 at 10:30am R9 said she had just arrived at the facility this morning.

On 11/19/14 at 10:45am E10 (Licensed Practical Nurse-LPN) said R9 used to transfer herself all the time when she lived on the 2nd floor. E10 said some days R9 is cognitively aware but it comes and goes.

On 11/19/14 at 10:45am E2 (RN-DON) said, "R9 has been reviewed in QA committee with the Medical Director but we have not noticed a pattern."

The Physican's Orders Sheet of November 2014 shows R9 was admitted to the facility March 2012 and has diagnoses to include: Dementia, Difficulty in Walking, Anxiety and Fractured Distal Radius (2012).

The nurse's notes document R9 had a total of 8 falls: 8/5, 9/5, 9/8, 9/18, 9/24, 10/23, 11/11, 11/13/14 that occurred between the hours of 2:30pm to 9pm. The care plan dated 10/16/14 shows the care plan was revised on 3/27/14, 9/18 and 11/14/14. R9 fell a total of 5 times between 9/18 and 11/13/14 before the care plan was revised on 9/18/14.

The care plan of 10/16/14 shows the problem: "R9 is at risk for falls due to history of falls prior to admission. R9 has been educated on the importance of waiting for staff before transferring but continues to self transfer." The 9/18/14 approach documents, "Educate R9 to wait for staff assistance with ambulating, transfer, toileting and when reaching for items."

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The fall risk assessment dated 10/7/14 shows R9 is high risk for falls. The MDS dated 10/7/14 shows R9 is occasionally incontinent of bowel and frequently incontinent of urine. R9 requires extensive assistance of 1 for transferring, ambulation, toilet-use, hygiene and bathing and has unsteady standing balance.

2. On 11/19/14 at 8:45am, R19's "soft touch" call light was tested and did not work. The call light failed to sound at the nurse's station or light outside of the R19's room.

The nurse's note dated 11/18 at 2:18pm documents, "R19 would yell numerous times for help but call light was within reach of resident. When staff would go in she forgot what she wanted."

The November 2014 Physician's Order Sheet shows R19 was admitted to the facility on 11/4/14.

3. On 11/17/14 at 10:15am, a portable liquid oxygen units was sitting on the floor next to the wall, in front of R9's bed. R26 has to maneuver around the oxygen to avoid knocking it over. There was a portable liquid oxygen unit sitting on the floor beside R3's bed. All oxygen units were not secured or stored in a manner to prevent them from falling or being knocked over.

The National Fire Protection Association Standard No. 99: Standard for Health Care Facilities documents in Chapter 5.3.3.3.2, "Cylinders in service and in storage shall be individually secured and located to prevent falling or being knocked over.
4. On 11/17/14 at 9:45 AM, an insulin medication

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F 323	Continued From page 16 pen was found on the bed of a resident. The insulin pen had a needle on the end and was ready to be injected. At 10:00 AM, E6 LPN (Licensed Practical Nurse), stated the insulin pen should not be on the bed, it should be locked in the medication cart. E6 stated the pen was labeled for R17 and he does not keep his own insulin or give his own injection. The facility's 12/1/07 policy for Storage of Medications, Biologicals, Syringes and Needles documents: 3.3 -Facility should ensure that all medications are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. 5. On 11/17/2014 at 11:26 PM, the second floor dialysis storage room had the key in the lock. At 12:30 PM, the key was still in the lock of the storage room. The storage room had bleach, dialysate, blood tubes, alcohol swabs, alcohol based hand rub, dialysis equipment, and a refrigerator for specimens. On 11/17/2014 at 12:50 PM, E3 stated, "No, the key should be hanging up on the wall (next to the door) and not in the lock." The facility's policy on housekeeping standards dated 01/2003 states, "Cleaning supplies should be kept in locked cupboards or rooms for the protection of the residents."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and	F 325		

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F 325	Continued From page 17 (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to identify and revise nutrition approaches for a resident who experienced unplanned weight loss in the past 11 months. This applies to 1 of 4 residents (R12) reviewed for specialty care in the sample of 14. The findings include: According to R12's electronic face sheet, R12 has diagnoses including Ileostomy, Chronic Kidney Disease, Hypertension, Atrial Fibrillation, Osteoarthritis, Depression and Thyroid disorder. R12's Minimum Data Set of 12/31/2013 shows R12 had a Brief Interview for Mental Status (BIMS) score of 15 (Independent) and R12's weight on this document was 191 pounds(#) . The MDS shows that R12 is not on a planned weight change program. The Care Area Assessment for Nutrition identified no problems. The MDS of 9/16/2014 shows a BIMS score of 14 and a weight of 181 pounds. The weight history for R12 shows a 5 pound loss between December 2013 to February 2014, March to June 2014 R12 lost 7 pounds, July to September 2014 R12 lost 3 pounds and from October to November 7th R12 lost 5 pounds (13 pounds in 11 months).	F 325		

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F 325	Continued From page 18 On 11/18/2014 at 3:30 PM R12 was seated in her wheel chair across from the first floor nurses station. R12 was asked if she was ready for the evening meal. R12 stated, "I'm hungry now". On 11/19/2014 between 7:30 - 8AM, R12 ate her breakfast. R12 needed no assistance to eat and ate and drank everything but 50% of her water. At 8:35AM R12 was asked if she enjoyed her breakfast. R12 replied she was still hungry. On 11/19/14 at 8:50AM, E19 (Certified Nursing Assistant) stated she was assigned to R12 today. E19 stated R12 falls asleep during meals and sometimes needs cues to wake up and finish eating. E19 said sometimes R12 forgets that she has eaten and asks for snacks. E19 explained that she will go to the kitchen for a snack for R12. At 8:55AM on 11/19/2014 E6 (Licensed Practical Nurse - LPN) said R12 is alert most days, hasn't noticed any weight loss with R12 and that R12 does a lot of snacking. Between 11:44AM and 12 Noon on 11/19/2014, Z1(consultant dietitian - RD) and E4 (Food Service Supervisor) were asked about the facility's system to monitor residents weight and what is done about those who lose weight. E4 stated he looks for weight loss trends for 3 months. Z1 said that she looks at residents with significant weight loss and others that are brought to her attention. The facility's Dietary weight monitoring committee policy adopted March 2011 describes (#2) -The dietitian should review the monitoring documents and the intake lists on each visit and make recommendations as needed. The RD may need to be called if the committee deems there is a need for interaction before the next visit. Under	F 325		

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F 325	Continued From page 19 #4, the fourth bullet under regarding Residents to be reviewed in the weight committee should be anyone at or near the significant weight change guidelines for the MDS 3.0 and the sixth bullet shows others as deemed necessary and prudent by the committee. A policy on weights dated February 2011, under number 8 describes, " Must be aware of weight loss or gains that are on a trend, must (be) addressed as they occur ". No definition of how the facility defined a trend was included.	F 325		
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on observation, Interview and record review the facility failed to offer bedtime snacks to all residents.	F 368		

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This applies to all 59 residents in the facility.

The facility's Resident Census and Condition form (HCFA 672) dated 11/17/14 shows a census of 59.

The findings include:

During the group interview on 11/17/14 at 2PM, Five residents (R16, 17, 18 24 and 25) stated they were not offered bedtime snacks. Three residents reside on the second floor and two reside on the first floor.

On 11/18/14 at 3:35PM, the E20 (evening cook) stated that he is the one who prepares the evening snacks. E20 showed a tray of specific liquids for residents at bedtime. E20 said that he sends a container of cookies/bars to each floor (30 for first floor and 20 for second floor) with ½ gallon of flavored drink. E4 (Food Service director) stated it goes to each nurses station at 7PM.
E20 showed the containers that had been returned from the night before. E20 counted out the number of cookie/bars showing that 6 of 20 portions were returned from the second floor and 26 of 30 portions were returned from the first floor. There was no tracking of who accepted and who refused the HS snack.
E4 stated the facility has no policy on bedtime snacks but provided a list of specific residents who are to receive snacks nightly. The nurses are responsible for passing the snacks.

F 431 SS=E — 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS — F 431

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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.

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 label multiple dose vials of Influenza vaccine and Tuberculin Skin

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F 431	Continued From page 22 Test Antigen in the second floor medication room. This applies to 5 of 14 residents (R3, R4, R7, R8, R10) reviewed for medication in the sample of 14 and 14 residents (R16, R17, R27-38) in the supplemental sample. The findings include: On 11/19/14 at 9:30 AM, the second floor medication room had 2 open multi-dose vials without an open date, time, or initials of the nurse that opened them. The vials were an Influenza vaccine, and a Tuberculin Skin Test Antigen. On 11/19/14 at 9:30 AM, E5 Licensed Practical Nurse (LPN) said she did not know when the vials were opened, or why the vials were not label. E5 said Influenza vaccine and Tuberculin skin test Antigen multi-vials should have a label with an open date and time, and initials of who opened them. On 11/19/14 at 12:05 PM E2 Director of Nursing (DON) said all multiple dose vials of Influenza Vaccine and Tuberculin Skin test Antigen should be labeled when opening with the date, time and initials of the nurse that opened it. If that information is not on the vials, they are discarded. The facility's policy on Storage and Expiration of Medications, and Biologicals, dated 01/01/13 states, "Facility staff should record the date opened on the medication container" and "Facility should destroy and reorder medications and biological with soiled, illegible, worn, makeshift, incomplete, damaged or missing labels. "	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	F 441		

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F 441	Continued From page 23 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to post precautionary signs for residents in isolation.	F 441		

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This applies to 1 of 2 residents (R7) reviewed for isolation precations in a sample of 14 and 1 resident (R23) in the supplemental sample.

The findings include:

1. On 11/17/14 at 10:15am R7 was seen from the hallway laying sideways in his bed and yelling for help. R7 had isolation linen and waste containers in his room but there was no isolation sign on the door. E5 (LPN) said, "He (R7) has C-Diff (Clostridum Difficile) there should be a sign on the door that says see the nurse before entering."

The November 2014 Physician's Order Sheet shows R7 was re-admitted to the facility on 11/9/14. The care plan documents R7 was re-admitted to the facility with a diagnosis of C-Diff and is on isolation precautions.

2. On 11/19/14 at 9:05am, R23's call light was being tested by surveyor. R23 said, "I got here (admitted) yesterday." E5 (LPN) said, "You need a mask and a gown if you are going to be in her room. She has neutropenic precautions so we are contagious to her [R23]. There was no precautionary sign on R23's door. The November 2014 POS shows R23 was admitted on 11/18/14 with diagnosis of Neurotropic Pneumonia.

The facility's Infection Control Policy and Procedure revised 8/2009 shows, "An individual with suspected or diagnosed as having a infectious disease or condition after admission shall be placed in isolation in accordance with the rules and regulations as definded by the Center

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F 441	Continued From page 25 for Disease Control." On 11/18/14 at 11:20 AM, E1(Administrator) stated it was the Director of Nurses (DON) responsibility to initiate and monitor residents on isolation precautions and terminate isolation when ordered by the physician.. This would include initiating isolation such as providing gowns and gloves and signage for the doors. E2 (RN-DON) stated she would initiate the isolation and report to the shift coordinator what the isolation was for and what type of isolation is required.	F 441		
F 456 SS=C	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain kitchen pipes, refrigerator gaskets, the 2nd floor hopper sink hose and shower hose in good working order. This applies to all 59 residents in the facility. The facility's Resident Census and Condition form (HCFA 672) dated 11/17/14 shows a census of 59. The findings include: 1. On 11/18/14 between 9:30 and 10:20AM the kitchen food service observation was made. Behind the coffee machine, on the table top,	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145234	A. BUILDING ______ B. WING ______	11/20/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FREEPORT REHAB & HEALTH CARE CENTER	**900 SOUTH KIWANIS DRIVE** **FREEPORT, IL 61032**

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F 456	Continued From page 26	F 456		

water was pooling. A thin copper pipe was visible that had water dripping off it. Water was pooled at the back of the table, a white rag was placed to hold the water back. The rag was saturated so water was moving past it and dripped down the side of the table the coffee machine sat on.

Under the stainless steel counter in the area between the 3 compartment sink and the dish machine, there was standing water where the floor and wall meet. There was a corroded copper pipe that had water slowly coming out. It glistened when the light was put on it.

On 11/19/14 at 9:10AM, E11 (maintenance) was asked about routine monitoring of physical items in the building. E11 stated that when it comes down to pipes that are not in the basement or not a mixing valve, he is dependent on staff to notify him when things are not working. E11 was asked if he knew about the leaking of the pipe to the coffee machine. E11 said he was not aware of where the coffee machine leak was. E11 said there is another company who is responsible for the coffee machine. E11 said accurate information was not communicated to him. E11 also said he was not informed of the pipe under the counter between the three compartment sink and the dish machine.

On 11/18/14 at 10:15AM the gasket on the walk in refrigerator door was not intact. A piece of the gasket that should be attached to the outer wall of the walk-in was attached to the door gasket when opened.
2. On 11/17 and 11/18/14, the shower hose in the 2nd floor shower room was leaking. The hopper sink hose in the 2nd floor soiled utility room was leaking into the basin. On 11/18/14 at 9am E11

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F 456 Continued From page 27 F 456

said, "[The facility] has a Corporate plumber now who can address plumbing issues.

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

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

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to have the meat slicer, can opener and stand mixer clean and sanitized when not in use and failed to clean light fixtures in resident common areas.

This applies to all 59 residents in the facility.

The Resident Census and Condition form (HCFA 672) dated 11/17/14 shows the facility has a census of 59.

The findings include:

1. On 11/18/14 between 9:30 and 10:20AM the facility meat slicer was checked. There was a film of debris around the edge of the back side of the blade. E4 (Food Service Director) checked the blade and confirmed that the blade needed to be cleaned. The nearby can opener had built up dark debris on the blade from contact with food. E4 said the opener had been used that day.
The large stand mixer had small spots of light debris under the top arm of the machine where utensils attach. When asked E4 said that he does

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F 465	Continued From page 28 checks of the kitchen daily. 2. There were numerous dead insects in 2 of 4 florescent light fixtures in the 2nd floor shower room. The facility's policy revised 1/2003 entitled, "Housekeeping Standards" documents, "Clean light fixtures on a scheduled program."	F 465		