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F 000	INITIAL COMMENTS Annual Licensure and Certification survey. Complaint Investigation 1521672/IL76069- No deficiencies Validation Survey for Subpart U: Alzheimer Unit.	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.	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 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide privacy while providing wound care for one of 13 residents (R8) reviewed for privacy in the sample of 15. Findings include: The facility's Aseptic Wound and Skin Treatment Procedure dated 01/2002, documents staff should pull privacy curtains and close the door to the resident's room while providing wound care. On 4-7-15 at 10:10 a.m., E8 (Registered Nurse) provided wound care to R8's right lower leg in R8's room. During the cares, E8 did not pull a privacy curtain or shut R8's door, leaving R8 exposed to view from the hallway. On 4-7-15 at 11:10 a.m., R8 stated, "I only want people to see my wounds if they ask me." R8 verified R8 would want the door closed while nurses give R8 wound care. On 4-8-15 at 9:50 a.m., E2 (Director of Nursing) stated, "(R8's) curtain or door should be closed when providing wound care to give (R8) privacy."	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.	F 221		

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F 221	Continued From page 2 This REQUIREMENT is not met as evidenced by: Facility non-compliance resulted in two deficient practices. A. Based on observation, interview, and record review, the facility failed to identify, obtain an order, obtain a consent, and have a plan of reduction for restraints for two of three residents (R13, R16) reviewed for restraints in the total sample of 15. B. Based on observation, interview, and record review, the facility failed to have a medical justification or a plan of reduction in place for a restraint for one of three residents (R12) reviewed for restraints in a sample of 15. Findings include: A. 1. The Facility's Physical Restraint/Enabler Policy, dated 8/18/11, states, "To allow residents to be free of physical restraints which are not required to treat the resident's medical symptoms or as a therapeutic intervention...Physical restraints is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body, which the individual cannot remove easily and which restricts freedom of movement or normal access to one's body. They include, but are not limited to: bed rails, self-release waist restraints, soft waist restraints, lap top cushions, vest restraints, high back reclining chair with tray table, arm restraints, leg restraints, personal alarms and hand mitts...Procedure: Obtain verbal and/or written consent from resident/legally responsible	F 221		

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party...Obtain physician order for restraint or adaptive device/enabler. The order must include: specific medical/physical reason, type of restraint/enabler, "release and reposition at least every two hours" and when to be used...Initiate Restraint Elimination/Reductions Program ninety days from application."

On 4/6/15 at 10:00 a.m., R13 was asleep in R13's bed that was against the wall with bilateral full side rails up. E17 (Licensed Practical Nurse) confirmed that R13 uses the bilateral full side rails to keep R13 from crawling out of bed and falling.

R13's Physician's Orders, dated 4/2015, documents no order for side rails.

R13's Physical restraint assessment, dated 1/29/15, states, "(R13) uses side rails for the diagnosis of seizures. (R13) has not had any active seizure activity therefore padded side rails are not needed...Side rails do not restrict movement."

R13's current physical restraint care plan, dated 1/31/15, documents no plan of reduction for the use of the bilateral side rails.

R13's Minimum Data Set, dated 1/29/15, documents that R13 requires extensive assistance for bed mobility requiring the assistance of two staff members.

On 4/7/15 at 10:20 a.m., E2 (Director of Nursing) stated, "(R13) uses side rails to aid in bed mobility, so (R13) can grab the side rails to pull over. (R13) is affected on one side, so (R13) is not able to grab the side rail on that side. (R13) also has seizures. It's been over a year since

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(R13) had a seizure. (R13) needs assistance for bed mobility and transfers. There has been padding for the side rails, but (R13) doesn't like to use it. The side rails restrict (R13) from getting out of bed."

On 4/7/15 at 1:20 p.m., E2 (Director of Nursing) stated, "Side rails require a Physician's order." According to (R13's) current Physician's orders there is no order for (R13's) side rails.

2. On 4/7/15 at 9:55 a.m., R16 had bilateral full side rails up. R16's bed was against the wall, and the outer full side rail was padded. R16 was lying sideways in R16's bed with R16's head against the wall side rail and R16's bilateral legs over the padded side rail. R16 was yelling excessively and thrashing around in bed.

On 4/7/15 at 10:10 a.m., E12 (Certified Nursing Assistant) stated, "(R16) has side rails because (R16) tries to climb out of the bed...(R16) tries to climb over the side rails."

R16's Physician's Orders, dated 4/2015, documents no order for bilateral full side rails.

R16's current medical record contains no consent for the use of bilateral full side rails.

R16's Side rail Assessment, dated 3/14/15, documents that R16 uses a right sided half side rail.

R16's Nurses' Notes, dated 12/20/14 at 8:45 p.m., documents that R16 was trying to climb out of bed. R16's Nurses Notes, dated 3/30/15 at 6:00 a.m., documents that R16 was turning R16's body around in R16's bed. R16's Nurses Notes,

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dated 4/7/15 at 5:00 a.m., documents that R16 was repositioned frequently because R16 had R16's legs over the side rails and was turning side ways in the bed.

R16's Minimum Data Set, dated 3/14/15, documents that R16 is totally dependent for bed mobility requiring the assistance of two staff members.

R16's Current physical restraint care plan, dated 12/24/14, documents no plan for reducing R16's bilateral full side rails.

On 4/8/15 at 11:10 a.m., E2 stated, "(R16's) side rails aid in bed mobility, and (R16) has seizures. If the side rails are used for seizures they should both be padded. There is no consent for (R16's) side rails...There is no order for bilateral full side rails...(R16) turns (R16) completely around in the bed. Even if (R16) puts (R16's) legs over the side rails, we have to have them for seizure precautions. These rails do not restrict (R16) from getting out of bed. If (R16) wanted to (R16) would climb out of bed."

On 4/8/15 at 11:25 a.m., E5 (Minimum Data Set/Care plan Coordinator) stated, "(R16) is not restricted from (R16's) side rails. If (R16) wanted to get out of bed (R16) would climb over the side rails."

On 4/8/15 at 11:10 a.m., E2 stated, "(R13) and (R16) do not have a plan for reducing their side rails."

B. R12's POS (Physician Order Sheet) dated 3-1-15 indicates R12 has diagnoses of Dementia and Mental Retardation. There are no

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documented medical or clinical diagnoses in R12's medical record to describe R12's use of an enclosed wheeled walker, other than those noted below.

R12's MDS (Minimum Data Set) dated 1-13-15 documents, "(R12) is cognitively moderately impaired... requires assist of one for transfers and assist of two for ambulation." R12 is also coded on the MDS as "(Other) restraint used daily."

A Physician's Order for R12 dated 6-20-12, documents, "Discontinue lap cushion...use enclosed wheeled walker when up for safe mobility due to unsteady gait."

A Physical Restraint/Enabler Assessment dated 1-13-15 documents, "(R12) is unsteady on feet and has a loss of balance."

A Fall Risk Assessment for R12 dated 1-13-15 documents, "(R12) uses a restraint (enclosed wheeled walker) and has loss of balance, standing and walking."

R12's Enabler/Restraint care plan dated 5-8-14 documents, "device in place (enclosed wheeled walker)...used because gives resident free movement and safe from falls."

On 4-6-15 through 4-9-15, R12 was walking around the halls in R12's enclosed wheeled walker or sitting in R12's enclosed walker while R12 was up.

On 4-6-15 at 10:10 a.m., E9 [LPN (Licensed Practical Nurse)] stated, "(R12) uses an enclosed wheeled walker so R12 can keep R12's independence...(R12) walks with assist but the

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enclosed wheeled walker keeps (R12) mobile...R12 can get up on own but is wobbly."

On 4-6-15 at 12:09 p.m., E9 stated, "(R12) can not open (R12's) enclosed wheeled walker per self but has undone the strap and then crawled under the bar of the enclosed wheeled walker and got out."

On 4-7-15 at 9:15 a.m. E19 [CNA (Certified Nursing Assistant)] stated, (R12) uses an enclosed wheeled walker to ambulate...(R12) can not comprehend to use a regular wheeled walker...(R12) can ambulate with one to two assist depending on the day...(R12) can not undo the enclosed wheeled walker by (R12's) self."

On 4-7-15 at 9:25 a.m. E18 (CNA) stated, "(R12) is very active...can ambulate with assist...but can be independent with the enclosed wheeled walker." At 9:26 a.m. on 4-7-15, E18 asked R12 to release the bar across the enclosed wheeled walker...R12 was unable to release the latch on R12's own.

On 4-8-15 at 11:45 a.m., E17 (LPN) stated, "the enclosed wheeled walker keeps (R12) mobile otherwise (R12) is a fall risk...(R12) can ambulate with assist but is too unsteady to be up by herself...if (R12) was not in the enclosed wheeled walker (R12) would go face plant to the floor."

On 4-8-15 at 10:15 a.m., E2 [DON (Director of Nursing)] stated, "No attempts have been made to reduce the restraint (enclosed wheeled walker) we have no reductions in place at this time...R12 is one who wants to get up and go...(R12) can not walk independently...the enclosed wheeled walker keeps (R12) able to do so...(R12) will fall if

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F 221	Continued From page 8 not in the enclosed wheeled walker...(R12) can ambulate with one or two assist."	F 221		
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 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	F 225		

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appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to provide documentation that complete and thorough abuse allegation investigations had been done for two residents of 15 residents (R8 and R9) reviewed for abuse/neglect, in a sample of 15 residents and three residents (R22, R23 and R24) from the supplemental sample.

Findings include:

The "Investigation of Possible Neglect/Abuse" form dated 12/14/14 indicates that R8 was "Lowered onto CNA's (Certified Nursing Assistant's) lap" and was investigated as a possible fall due to possible staff to resident physical abuse. This form did not contain documentation as to the time of this occurrence nor the time E1, Administrator and Abuse Prevention Coordinator, had been notified of R8's incident to determine immediacy. There was no documentation of any review of the facility's policies and procedures to prevent further occurrences.

The "Investigation of Possible Neglect/Abuse" form dated 01/20/15 indicates that R9 had wandered into another room and had a laceration above the right eye upon exiting. This was investigated as a possible resident to resident physical abuse. This form did not contain documentation as to the time of this occurrence nor the time E1, Administrator and Abuse Prevention Coordinator, had been notified of R9's

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incident to determine immediacy. There was no documentation of any review of the facility's policies and procedures to prevent further occurrences.

The "Investigation of Possible Neglect/Abuse" form dated 03/30/15 indicates that R22 had reported loss of personal property and this was investigated as a possible theft. This form did not contain documentation as to the time of this occurrence nor the time E1, Administrator and Abuse Prevention Coordinator, had been notified of R22's incident to determine immediacy. There was no documentation of any review of the facility's policies and procedures to prevent further occurrences.

The "Investigation of Possible Neglect/Abuse" form dated 02/15/15 indicates that R23 and R24 had been involved in a possible resident to resident physical abuse issue. This form did not contain documentation as to the time of this occurrence nor the time E1, Administrator and Abuse Prevention Coordinator, had been notified of R24's incident to determine immediacy. There was no documentation of any review of the facility's policies and procedures to prevent further occurrences.

There was no documentation of when E1, as Abuse Prevention Coordinator, was notified and what policies were reviewed in regard to the above incidents in the active medical records of R8, R9, R22, R24 and the closed record of R23.

On 04/09/15 at 9:30 A.M. E1 stated that the times of R8, R9, R22, R23 and R24's alleged abuse incidents and the time E1, as Abuse Prevention Coordinator, was notified of these incidents were

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F 225	Continued From page 11 part of the facility's Quality Assurance (QA) Abuse/Neglect investigations' data forms. Likewise, the policy review and as needed policies changes were also part of the QA Abuse/Neglect investigation forms. E1 stated that it was the facility's "Corporate owners' policy" to not have to provide privileged QA data to the Illinois Department of Public Health's Long Term Care Division surveyors.	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 provide documentation of compliance with the facility's Abuse Prevention policy in regards to immediate notification of alleged abuse to the administrator and policy/procedure review related to alleged abuse investigations for two residents of 15 residents (R8 and R9) reviewed for abuse/neglect, in a sample of 15 residents and three residents (R22, R23 and R24) from the supplemental sample. Findings include: The facility's Abuse Prevention Program policy, dated 11/11/11, indicates under "Internal Reporting Requirements and Identification of Allegations: Employees are required to	F 226		

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immediately report any occurrences of potential/alleged mistreatment, neglect and abuse of residents and misappropriation of resident property they observe, hear about, or suspect to a supervisor and the administrator...Supervisors shall immediately inform the administrator or his/her designated representative." In this same policy, under "Internal Investigation of Allegations and Response:...Quality Assurance Review. Any investigation that concludes that abuse occurred shall be reviewed by the facility Quality Assurance committee for possible changes in facility practices to ensure that similar events do not occur again." Also, under the section titled "Step 7. Final Investigation Report," it documents, "After a conclusion based on the investigation is determined, internal reports, interviews, witness statements, and identities of individuals involved shall be released only with the permission of the administrator or the facility attorney. Even if the facility investigation is not complete, the administrator will cooperate with any Department of Public Health investigation in the matter."

The "Investigation of Possible Neglect/Abuse" form dated 12/14/14 indicates that R8 was "Lowered onto CNA's (Certified Nursing Assistant's) lap" and was investigated as a possible fall due to possible staff to resident physical abuse. This form did not contain documentation as to the time of this occurrence nor the time E1, Administrator and Abuse Prevention Coordinator, had been notified of R8's incident to determine immediacy. There was no documentation of any review of the facility's policies and procedures to prevent further occurrences.

The "Investigation of Possible Neglect/Abuse"

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	145886	A. BUILDING _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

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form dated 01/20/15 indicates that R9 had wandered into another room and had a laceration above the right eye upon exiting. This was investigated as a possible resident to resident physical abuse. This form did not contain documentation as to the time of this occurrence nor the time E1, Administrator and Abuse Prevention Coordinator, had been notified of R9's incident to determine immediacy. There was no documentation of any review of the facility's policies and procedures to prevent further occurrences.

The "Investigation of Possible Neglect/Abuse" form dated 03/30/15 indicates that R22 had reported loss of personal property and this was investigated as a possible theft. This form did not contain documentation as to the time of this occurrence nor the time E1, Administrator and Abuse Prevention Coordinator, had been notified of R22's incident to determine immediacy. There was no documentation of any review of the facility's policies and procedures to prevent further occurrences.

The "Investigation of Possible Neglect/Abuse" form dated 02/15/15 indicates that R23 and R24 had been involved in a possible resident to resident physical abuse issue. This form did not contain documentation as to the time of this occurrence nor the time E1, Administrator and Abuse Prevention Coordinator, had been notified of R24's incident to determine immediacy. There was no documentation of any review of the facility's policies and procedures to prevent further occurrences.

There was no documentation of when E1, as Abuse Prevention Coordinator, was notified and

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F 226	Continued From page 14 what policies were reviewed in regard to the above incidents in the active medical records of R8, R9, R22, R24 and the closed record of R23. On 04/09/15 at 9:30 A.M., E1 stated that the times of R8, R9, R22, R23 and R24's alleged abuse incidents and the time E1, as Abuse Prevention Coordinator, was notified of these incidents were part of the facility's Quality Assurance (QA) Abuse/Neglect investigations' data forms. Likewise, the policy review and as needed policies changes were also part of the QA Abuse/Neglect investigation forms. E1 stated that it was the facility's "Corporate owners' policy" to not have to provide privileged QA data to the State Agency surveyors.	F 226		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide therapeutic based activities for the Alzheimer's Unit. This has the potential to affect four residents of 13 residents (R4, R9, R12, R15) reviewed for activities on the sample and twenty four residents (R25, R26, and R36 - R57) on the supplemental sample that reside on the Alzheimer's Unit. Findings include:	F 248		

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A facility's undated Special Care Unit Therapeutic Programming policy, provided as current on 04/08/15, documents, "First, a Special Care Unit is "special" because it provides daily therapeutic programming."

The facility's undated Special Care Unit Mission Statement, provided as current on 04/08/15, documents, "We believe that the development of a safe, home-like environment, coupled with individually designed therapeutic programming, are the cornerstones to the achievement of our goal...It is our policy to maintain a comfortable and harmonious living environment with Alzheimer type residents who participate in, and benefit from, the therapeutic activity program and ADL (Activities of Daily Living) programs. Admission Criteria: Residents should be able to benefit from the "Resident Activity Program" designed to maximize resident's individual strengths and abilities in a success-oriented environment...residents should be able to participate in at least three activities per day on a consistent basis...Activities: The activity calendar for the current month is representative of activities held every month...each day lists the special activities; activities that occur each and every day."

On 4-6-15 at 9:16 a.m., the facility's Special Unit's activity calendar was posted in the hall close to the dining room. The calendar documented, 4-6-15, 9:00 a.m., Daily News/Religion...10:00 a.m., Sound of Music...1:30 p.m., Movie; On 4-7-17, 10:00 a.m., Daily News/Religion...11:00 a.m., Look in Good...1:30 p.m., Craft time...3:30 p.m. Stretches; On 4-8-14, 9:30 a.m., Devotions...10:00 a.m., Movies...10:30 a.m.,

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poems...1:00 p.m. Short Stories.

On 4-7-15 the newspaper was read at 10:15 a.m. and was finished at 10:25 a.m. On 4-7-15 from 1:00 p.m. to 3:00 p.m., based on intermittent, 15 minutes or less observation intervals, no activities were observed. On 4-8-15, a movie was playing for eight residents at 10:00 a.m., and the newspaper was read at 11:00 a.m. to five residents. On 4-8-15 from 1:00 p.m. to 3:00 p.m., based on intermittent, 15 minutes or less observation intervals, no activities were observed. R4, R9, and R12 were not observed attending or receiving any activities on 4-6-15 through 4-8-15.

On 4-8-15 E16 Activity Aide stated, "I work as an activity aide from 9:00:a.m. to 2 p.m...There is no activity aide after 2 p.m. on the days I work...We do what we can when we can...I try to leave books and magazines out for residents after I leave...I wanted to get someone to sing this afternoon but had paperwork to do instead...I can't go by the activity calendar because I don't have enough time with paper work to do...I can't do activities at 1:30 p.m. because I take my lunch then and I am off work at 2 p.m."

On 4-8-15 at 11:59 a.m. E6 Activity Director stated, "We have one activity aide a day...(E16) works from 9 a.m. to 2 p.m. with a half hour lunch (four and one half hours a day)...The other activity aide (E23) works from 8 a.m. to 4:30 p.m. with an hour lunch...The activity aides do all the work on the unit since I do the activities for the rest of the building...On the first Wednesday of every month a church band comes out and that Unit participates in the evening...Otherwise we don't have activities in the evening except maybe on holidays." E6 stated that activities were chosen

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F 248	Continued From page 17 from a list provided by the company organization and a web site of activities. E6 was not able to verbalize what made the Alzheimer's Unit's current activities therapeutic.	F 248		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to develop specific comprehensive care plans for four residents (R7, R8, R12 and R14) of 15 residents reviewed for care plans in a sample of 15. FINDINGS INCLUDE:	F 279		

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The undated facility policy (provided as current on 04/09/15) titled "Comprehensive Assessment/ Care Planning" directs staff, "Care plan- plan of care describing a need/problem, and indicating approaches/interventions to be instituted to assist the resident in maintaining/receiving proper care in relation to the problem. Care plans may be developed for problems that can be managed through simple/standard modifications."

1. R7's Physician Order Sheet dated April 2015 include the following diagnosis: Coronary Artery Disease. And the following physician's orders: Warfarin Sodium 6 MG (milligrams) one tablet by mouth daily.

R7's current care plan dated 2/10/15 does not include a care plan for R7's blood thinning medication, laboratory tests to monitor R7's blood levels nor side effects for staff to monitor for.

On 4/7/15 at 8:35 A.M., E5 (Care Plan Coordinator) stated, "This is (R7)'s current care plan. (R7) is on a blood thinner because of heart disease. This should be addressed on (R7)'s care plan. It got missed somehow."

2. R8's current Physician Order Sheet (POS) states, "O 2 (Oxygen) at two liters. Titrate to keep above 90%. Call MD (Medical Doctor) if below 90%."

On 4-7-15 at 9:40 a.m., Z2 (Hospice Certified Nursing Assistant/CNA) wheeled R8 into the shower room. R8 had oxygen being administered at two liters via nasal cannula. Z2 removed R8's

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nasal cannula. Z2 and E12 (CNA) then transferred R8 from the wheelchair to the shower chair. Z2 then took R8's wheelchair, oxygen cylinder, and nasal cannula, and placed it outside of the shower room. Z2 proceeded to shower R8, without having oxygen on, for approximately 20 minutes. At 10:05 a.m., Z2 and E22 (CNA) transferred R8 from the shower chair to the wheelchair. Z2 then re- applied R8's oxygen at two liters per nasal cannula and wheeled R8 back down to R8's room. While in R8's room, Z2 disconnected the oxygen hose from R8's oxygen cylinder, and re-attached the oxygen hose to R8's oxygen concentrator. Z2 then turned the oxygen concentrator on at three liter of oxygen via nasal cannula.

R8's current care plan does not include an oxygen usage care plan.

On 4-7-15 at 12:45 p.m., E5 (Care Plan Coordinator) stated, "We (the staff) should do oxygen usage care plans. (R8's) current care plan does not include an oxygen usage care plan and should have."

3. R12's POS (Physician Order Sheet) dated 3-1-15 to 3-31-15, R12 has a diagnosis of Dementia and Mental Retardation.

R12's MDS (Minimum Data Set) dated 1-13-15 documents, R12 requires assist with all ADL's (Activities of Daily Living).

R12's Nursing Note dated 11-24-14 documents, "(R12) will digitally remove feces and try to eat it." Another nursing note dated 12-7-14 for R12 documents, "(R12) digitally removes stool and

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attempts to eat it."

On 9-7-17 at 9:10 a.m., R12 was sitting in R12's enclosed wheeled walker, in the middle of the hall, rolling feces into balls with R12's hands.

R12's current care plan does not include a plan of care or interventions for staff to implement when R12 is playing or attempting to eat R12's own feces.

On 4-8-15 at 10:15 a.m., E5 MDS (Minimum Data Set) Care Plan Coordinator stated, "(R12) occasionally grabs (R12's) feces and tries to eat it."

On 4-9-15 at 9:15 a.m., E5 stated, "(E5) did not have a care plan with interventions in place addressing (R12) playing and/or eating (R12's) feces."

On 4-9-15 at 9:18 a.m., E2 (DON/Director of Nursing) stated, "(R12's) care plan should have addressed and had interventions in place regarding (R12) eating and/or playing with (R12's) own feces."

4. R14's Medication Administration Record (MAR) from 1-8-15 through 3-31-15, documents R14 has refused medications on 56 different occasions.

R14's current care plan does not include a medication refusal plan of care, or interventions for staff to implement when R14 refuses medications.

On 4-6-15 at 1:20 p.m., E2 (Director of Nursing)

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F 279	Continued From page 21 stated, "When a resident refuses a medication, the nurse circles the medication on the MAR. (R14's) refusal of medications should be care planned with interventions. I do not see (R14's) refusal of medications, with interventions, on (R14's) current care plan." On 4-7-15 at 9:30 a.m., E5 (Care Plan Coordinator) stated, "(R14's) refusing of medications and interventions has not been care planned for the staff to follow."	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280		

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Based on interview, observation and record review, the facility failed to revise care plans for two residents (R11 and R16) of 15 residents reviewed for care plans in a sample of 15 residents.

FINDINGS INCLUDE:

1. On 4/6/15 at 11:00 A.M., R11 was lying in bed sleeping. A top sheet and a bottom sheet were on R11's bed. The call light was looped around a half side rail, next to R11.

R11's current care plan, dated 7/14/14 includes the following problems: History of displaying suicidal ideations. History of attempting suicide. The following interventions were listed: "Resident will remain on 15 minute checks. Remove call light from resident's room and replace with courtesy bell. Remove sheets from bed and replace with heavy blanket. No silverware outside of dining room. Staff will ensure all silverware is left at table."

On 4/7/15 at 8:45 A.M., E10 stated, "I don't know if (R11) is on suicide precautions or not. No one ever told me to watch (R11) for that."

On 4/7/15 at 8:50 A.M., E8 (Registered Nurse) stated, "I don't know if (R11) is on suicide precautions or not."

On 4/7/15 at 10:00 A.M., E2 (Director of Nurses) stated, "(R11) is not currently on suicide precautions."

On 4/7/15 at 8:35 A.M., E5 (Care Plan Coordinator) stated, "This is (R11)'s current care plan. (R11) isn't supposed to be on suicide

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F 280	Continued From page 23 precautions. I didn't update (R11)'s care plan." The undated facility policy, provided as current on 04/08/15, titled "Comprehensive Assessment/Care Planning" directs staff: "The MDS (Minimum Data Set) and care plan shall be re-evaluated according to the following schedule: Within 14 days of determining that a significant change in a resident's status: Is not self limiting, Impacts more than one area of the resident's health status, Requires care plan revision." 2. On 4/7/15 at 9:55 a.m., R16 had bilateral full side rails up. R16's bed was against the wall, and the outer full side rail was padded. R16's current fall care plan, dated 12/24/14, states, "(R16) refuses to sleep on a bed. (R16) likes to sleep on the floor. (R16) will even roll off the bed side mat onto the floor. (R16's) bed has been removed from the room and mattress placed on the floor." R16's current physical restraint care plan, dated 3/19/15, documents that R16 has bilateral half rails in raised position while in bed. On 4/8/15 at 11:25 a.m., E5 (Minimum Data Set/Care plan Coordinator) stated, "When (R16) was admitted, (R16) was on a low bed with a floor mat next to it because (R16) would roll out of bed. Then later (R16) was put in a regular bed with side rails. (R16's) care plan should have been updated with R16's change."	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility	F 281		

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F 281	Continued From page 24 must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer oxygen by licensed personnel for one of one residents (R8) reviewed for oxygen use in the sample of 15. Findings include: R8's current Physician Order Sheet (POS), April 2015, states, "O 2 (Oxygen) at two liters. Titrate to keep above 90%. Call MD (Medical Doctor) if below 90%." On 4-7-15 at 9:40 a.m., Z2 (Hospice Certified Nursing Assistant/CNA) wheeled R8 into the shower room. R8 had oxygen being administered at two liters via nasal cannula. Z2 removed R8's nasal cannula. Z2 and E12 (CNA) then transferred R8 from the wheelchair to the shower chair. Z2 then took R8's wheelchair, oxygen cylinder, and nasal cannula, and placed it outside of the shower room. Z2 proceeded to shower R8, without having oxygen on, for approximately 20 minutes. At 10:05 a.m., Z2 and E22 (CNA) transferred R8 from the shower chair to the wheelchair. Z2 then re- applied R8's oxygen at two liters per nasal cannula and wheeled R8 back down to R8's room. While in R8's room, Z2 disconnected the oxygen hose from R8's oxygen cylinder, and re-attached the oxygen hose to R8's oxygen concentrator. Z2 then turned the oxygen concentrator on at three liter of oxygen via nasal cannula.	F 281		

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F 281	Continued From page 25 On 4-7-15 at 11:10 a.m., E12, CNA, removed R8's oxygen nasal cannula and assisted R8 with ambulation from the wheelchair to the restroom. E12 then assisted R8 with ambulation back to the wheelchair, and re-applied the oxygen nasal cannula. On 4-7-15 at 10:10 a.m., Z2 stated, "I detach and re-apply oxygen to (R8). I usually detach oxygen from (R8) during showers. The hospice nurse has tested (R8's) pulse oximetry without oxygen, and it usually drops." On 4-7-15 at 10:15 a.m., E8 (Registered Nurse) verified R8's oxygen concentrator was set on three liters of oxygen continuously, and should have been on two liters of oxygen continuously. On 4-7-15 at 11:10 a.m., E12 stated, "I took (R8's) oxygen off when I took (R8) to the restroom and then re-applied it. (R8) does get short of breath without it (oxygen)." On 4-8-15 at 1:00 p.m., E2 (Director of Nursing) stated, "The Certified Nursing Assistants cannot put the nasal cannula on or off of (R8), or turn the oxygen concentrator on or off." The facility's Oxygen Therapy Protocol dated 8/2003, documents "A Respiratory Care Practitioner or Licensed Nursing Personnel will titrate oxygen to maintain pulse oximetry above 90%."	F 281		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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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 interview, observation and record review, the facility failed to implement fall interventions for two residents of five residents (R8 and R11) reviewed for falls in a sample of 15.

FINDINGS INCLUDE:

1. On 4/7/15 at 9:30 A.M., R11 was in bed watching television. R11 stood up and transferred into a wheel chair located next to the bed. No pressure alarm sounded. A pressure alarm pad was noted on R11's bed. The cord to the alarm box was not connected.

R11's facility "Profile Face Sheet" includes the following diagnoses: Difficulty in Walking and Generalized Muscle Weakness.

R11's "Fall Risk Assessment" dated 3/21/15 documents R11's fall risk score as "High Risk."

R11's current Care Plan, dated 7/14/2014 includes the following problems: High risk for falls. History of falls. History of unsteady gait. And also includes the following interventions:" Pressure alarm when in bed."

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F 323	Continued From page 27 On 4/7/15 at 9:30 A.M., E10 (Certified Nursing Assistant) stated, "I don't know why (R11)'s alarm isn't working. (R11) has fallen many times." 2. On 4-6-15 at 11:00 a.m. and 12:10 p.m., 4-7-15 at 9:40 a.m. and 11:10 a.m., and 4-8-15 at 10:45 a.m., R8 was sitting up in a wheelchair without a personal alarm on. R8's Fall Care Plan dated 3-26-15, documents R8 is to have a personal alarm on while up in the chair. On 4-7-15 at 10:45 a.m., E2 (Director of Nursing) stated, "(R8) should have a personal alarm on at all times when up in the wheelchair." On 4-7-15 at 11:10 a.m., E12 (Certified Nursing Assistant) stated, "(R8) does not have a personal alarm on. I take care of (R8) approximately three times a week. (R8) has not had an alarm on for at least the past month." On 4-8-15 at 10:50 a.m., E8 (Registered Nurse) verified R8 did not have a personal alarm on.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		

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F 329	Continued From page 28 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide medical justification and documented psychotic behaviors for the use of an antipsychotic medication for one of six residents (R6) reviewed for antipsychotic medication in the total sample of 15. Findings include: The Facility's Psychotropic Medication Policy, dated 12/30/13, states, "Unnecessary drug is any drug used: without adequate monitoring; without adequate indications for its use...Any resident receiving such medications shall have a psychiatric diagnosis or documented evidence of maladaptive behavior, which can be considered harmful to themselves or others, destructive to property, or if emotional problems exist which cause the resident frightful distress...The behavioral tracking sheet of the facility will be	F 329		

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implemented to ensure behaviors are being monitored."

R6's Physician's Orders, dated 4/2015, documents that R6 has an order to receive Zyprexa (an antipsychotic) 2.5 mg (milligrams) by mouth at bedtime for the diagnosis of depression with psychotic features.

On 4/7/15 at 10:20 a.m., E2 (Director of Nursing) stated, "(R6) receives Zyprexa for depression with psychotic features."

R6's Psychotropic Medication Quarterly Evaluation, dated 3/23/15, documents no behaviors for the use of R6's antipsychotic.

R6's Psychotropic Medication Progress notes, dated 9/23/14, 12/26/14, and 3/23/15, document that R6 is pleasant and cooperative but can be rude at times. R6's Psychotropic Medication Progress notes document no psychotic behaviors.

R6's Minimum Data Set, dated 3/23/15, documents that R6 does not have any behaviors present, and is not putting R6 nor others at harm.

R6's current psychotropic drug use care plan, dated 10/8/14, states, "R6 requires use of psychotropic medication to manage mood and/or behavior issues."

R6's Behavior Monitoring Record, dated 10/2014, documents that R6 is being monitored for the behaviors of increased agitation and anger. Behavior monitoring record documents that R6 had one occurrence of agitation on 10/9/14. On 4/7/15 at 1:20 p.m., E15 (Social Services

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F 329	Continued From page 30 Director) confirmed that R6's behavior monitoring record, dated 10/2014, was the only one done for R6's use of Zyprexa in the last year. R6's Psychiatric Evaluation, dated 9/3/14, documents that R6 has been irritable and frustrated in the last two weeks, and no other behaviors were documented. R6's psychiatric evaluation also documents that R6 has a diagnosis of Major depression and Z3 (R6's Psychatrist) recommends Zyprexa 2.5 mg. At various times of the day on 4/6/15 and 4/8/15, R6 did not exhibit any behaviors. On 4/7/15 at 1:20 p.m., E2 (Director of Nursing) stated, "According to (R6's) behavior tracking forms, the increased agitation and anger are (R6's) psychotic behaviors." The American Psychiatric Association website entry dated 04/13/15, in regards to psychotic disorders indicates, "Mood disorders like major depressive disorder and bipolar disorder can become severe enough to result in psychotic symptoms like hallucinating or having delusions, also called psychotic features."	F 329		
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to serve a physician	F 367		

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prescribed diet for one resident of 15 residents (R15) reviewed for nutrition, in the sample of 15.

FINDINGS INCLUDE:

On 4/8/15 at 10:00 A.M., R15 was seated at a table at the nurse's station. E18 (Certified Nursing Assistant) placed a tray of food in front of R15 and stated," Here's your lunch." Included on the tray was a salami sandwich made with one slice of salami and two slices of brown bread, 20-25 cheese puffs, a bowl of fruited gelatin and a glass of water. E18 filled an empty glass with 240 ML (milliliters) of yellow liquid. The yellow liquid was poured from a pitcher labeled, "Lemonade." E18 proceeded to feed (R15).

On 4/8/15 at 10:05 A.M., E18 stated, "(R15) has a salami sandwich, cheese puffs, jello with fruit and regular (not sugar-free) lemonade. That's (R15)'s lunch. (R15) is getting ready to go to dialysis."

R15's Physician Order Sheet (POS), dated April 2015 includes the following diagnoses: Renal Failure, Vascular Dementia, Gastric Esophageal Disease, Anemia and End Stage Renal Disease. The POS contains the following physician's orders: Labs (laboratory tests) monthly at dialysis and Diet; Renal, LCS (Low Concentrated Sweets), NAS (No Added Salt), Double Meat Entree, No Real Potatoes, four oz (ounces) Milk, No Orange Juice, Oranges, Prune Juice, Tomatoes or Bananas.

R15's "Dialysis Facility/ Nursing Facility Communication" form dated 3/30/15 includes the following comments, "Please have patient watch fluid and salt intake. (R15) needed 6.1 KG (kilograms) = 13.42 LBS (pounds) removed

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(during dialysis today)."

R15's monthly lab test, dated March 2015 includes the following result:" Albumin 3.4 (goal: 3.6-5.5). Your albumin is low. This important protein test measures your infection-fighting protein as well as your tissue and muscle protein stores. It's important to increase protein by eating more eggs, meat, chicken, fish or cottage cheese."

The facility menu for the week of 4/5/15 lists the following to be served at the noon meal on 4/8/15: "Southern Catfish Fillets, Macaroni & Cheese, Coleslaw, Bread/Margarine, Mandarin Oranges."

On 4/8/15 at 11:10 A.M., E20 (Certified Nursing Assistant) stated, " I have worked here for three years. (R15) has dialysis on Mondays, Wednesdays and Fridays. (R15) usually goes (to dialysis) at 11:00 A.M. (R15) always has meat sandwiches and potato chips for lunch. (R15) usually gets a can of regular soda for lunch."

On 4/8/15 at 11:25 A.M., E3 (Food Services Supervisor) stated, "(R15) gets a lunch meat sandwich and potato chips (on dialysis days). The regular noon meal isn't finished cooking until 10:45 A.M. (R15) is on a special renal diet. (R15) is supposed to get a double meat portion."

On 4/8/15 at 12:35 P.M., Z1 (Registered Dietician) stated, "A salami sandwich, cheese puffs, jello and lemonade is not an adequate diet for (R15). (R15) is on a special diet because of (R15)'s renal failure. The facility should have a plan to ensure (R15) receives (R15)'s prescribed diet, even on dialysis days."

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F 431 SS=E	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. 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: Facility noncompliance resulted in two deficient	F 431		

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practices.

A. Based on observation, record review, and interview, the facility failed to reconcile controlled substance medications for one of 15 residents (R16) reviewed for medication storage in the sample of 15, and four residents (R26, R27, R28, R30) in the supplemental sample.

B. Based on observation, interview, and record review the facility failed to dispose of an expired insulin for one resident (R25) reviewed for medication storage in the supplemental sample.

Findings include:

A. On 4-7-15 at 2:00 p.m., E21 (Licensed Practical Nurse) verified the North medication room contained a locked container of R16, R26, R27, R28, and R30's discontinued controlled medications including the following: 1. R16's Lorazepam 0.5mg (milligram) 18 tablets. 2. R26's Morphine 20 mg/ml (milliliter) with 30 ml's left in the bottle, and Lorazepam 0.5mg 119 tablets. 3. R27's Suboxone Film 2mg-0.5mg one patch, and Carisoprodol 350 mg five tablets. 4. R28's Lorazepam 2mg/ml with 25 ml left in the bottle. 5. R30's Tramadol 50 mg 16 tablets.

On 4-7-15 at 2:05 p.m., E8 (Registered Nurse) and E21 (Licensed Practical Nurse) verified that discontinued controlled substance medications are placed in a locked box in the medication room until E2 (Director of Nursing) destroys them, and those discontinued controlled substance

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medications are no longer counted or reconciled by the nurses.

On 4-8-15 at 9:50 a.m., E2 stated, "The discontinued controlled substance medications are put in a separate box for destruction. If the staff are not reconciling the controlled substance medications in that box until destruction, we (the staff) would not know if those medications were missing."

On 4-8-15 at 9:25 a.m., E2 stated, "All controlled substance medications should be reconciled every shift by two nurses, including the controlled substance medications that have been discontinued."

The facility's Controlled Substances policy dated 10/06, documents the drugs in schedule II (and those in other schedules which have been restricted and stored in the controlled substance cabinet) will be counted and reconciled by the nurse coming on duty with the nurse that is going off duty.

B. On 4-7-15 at 1:40 p.m., R25's Lantus 100 u (units)/ml (milliliter) insulin was dated as opened on 2-23-15. E9 (Licensed Practical Nurse) verified R25's Lantus was opened on 2-23-15 , is still being used, and should have been discarded after 28 days of being opened.

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F 431	Continued From page 36 On 4-8-15 at 9:50 a.m., E2 (Director of Nursing) stated, "Insulin is only good for 28 days after being opened." The facility's undated Insulin Storage Recommendations policy, documents Lantus insulin is good for 28 days after being opened.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441		

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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:
Facility non-compliance resulted in two deficient practices.

A. Based on observation, interview and record review, staff failed to perform hand hygiene before, during and after administering medications for three residents (R8, R13 and R14) on the sample of 15 and four residents in the supplemental sample (R31, R32, R33 and R34) reviewed for medications.

B. Based on observation, interview, and record review, the facility failed to prevent cross contamination during wound care for one of two residents (R8) reviewed for pressure ulcers in the sample of 15.

FINDINGS INCLUDE:

A. On 4/6/15 at 12:00 P.M., E14 prepared to administer Phenytoin 100 MG (milligrams) and Gabapentin 400 MG to R13. Without performing hand hygiene, E14 punched both pills from the medication card directly into E14's hand. E14 then placed both pills in a medication cup. E14 administered the medication to R13 by scooping the pills onto a plastic spoon and placing the

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spoon into R13's mouth. E14 returned to the medication cart, threw the medication cup in the trash receptacle, touched (E14)'s hair, took the medication keys from (E14)'s pocket, opened the medication cart and then documented the medication administration in the Medication Administration Record. E14 did not perform hand hygiene after the medication administration.

On 4/6/15 at 12:05 P.M., E14 prepared to administer Metoclopramide to R31. Without performing hand hygiene, E14 punched the medication directly into E14's hand and then placed it into a medication cup. E14 administered the medication to R31 via a spoon. E14 touched (E14)'s hair, threw the medication cup away and documented the administration. E14 did not perform hand hygiene after the medication administration.

On 4/6/15 at 12:08 P.M., E14 prepared to administer Acetaminophen 325 MG, three tablets, to R14 by pouring the tablets directly into E14's hand. E14 administered the medication to R14 by placing the tablets in R14's mouth. E14 did not perform hand hygiene prior to administering the medication nor after administering the medication.

On 4/6/15 from 12:10 PM to 12:22 PM, E14 continued to administer medications to R32, R33, R34 and R8 without performing hand hygiene before or after administering medications. E14 continued to touch (E14)'s hair, wipe (E14)'s nose, adjust (E14)'s glasses and document the medications administered.

The facility policy titled, "Medication Administration" dated (revised 7/3/13) directs

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. BUILDING _____ B. WING _____	04/09/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALEDO REHAB & HEALTH CARE CENTER	304 S.W. 12TH STREET ALEDO, IL 61231

(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 39	F 441		

staff, "Avoid touching medication. If contact with the medication is likely, prepare medication using gloves. Appropriate hand washing or use of an alcohol based gel must be performed throughout the medication pass. This should occur: Before and after medication pass."

On 4/6/15 at 1:35 P.M., E14 stated, "I didn't wash my hands when I did meds (medication pass) for you."

B. R8's Nursing Wound/Ulcer Assessment dated 4-8-15, documents R8 has three wounds to the right lower extremity.

R8's Right Post Ankle Wound Culture and Gram Stain lab result dated 3-17-15, documents R8 has a moderate growth of Methicillin Resistant Staphylococcus Aureus (MRSA) in R8's right ankle wound.

On 4-7-15 at 10:10 a.m., E8 (Registered Nurse) cleansed R8's three right leg wounds, including the right ankle wound infected with MRSA, with the same gauze using an up and down scrubbing motion.

On 4-7-15 at 10:15 a.m., E8 verified E8 used the same gauze and normal saline to cleanse R8's three right leg wounds.

On 4-8-15 at 9:50 a.m., E2 (Director of Nursing) stated, "Separate wounds should be cleansed with different gauze. The wounds should be cleansed from the inner part of the wound, outward."

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F 441	Continued From page 40 The facility's Aseptic Wound and Skin Treatment Procedure dated 01/2002, documents wounds are to be cleansed from the center outward, never going back over the area which had been cleansed. If two wounds are present, treat each wound as separate wounds. The facility's undated Dressing Change policy provided as current on 04/07/15, documents that if there are multiple wounds, each dressing should be changed separately to avoid contamination form one site to the other.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON 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 interview, observation and record review, the facility failed to prevent a significant lint accumulation in the upper compartment of the dryer, prevent unpleasant odors throughout the facility and repair a broken section of a wall. These failures have the potential to affect all 58 residents. Findings include: 1. On 4/7/15 at 1:30 PM, approximately a quarter of an inch of lint covered the upper compartment of the facility's dryer.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145886	A. BUILDING _____ B. WING _____	04/09/2015

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F 465	Continued From page 41 On 4/7/15 at 1:35 PM, E7 (Maintenance Director) confirmed that the lint was present in the upper compartment of the dryer, and that the lint currently needed to be cleaned. E7 also stated that E7 cleans it when the laundry staff request E7 to clean the area. E7 could not provide any logs of cleaning the dryer cabinet to review. 2. From 4/6/15- 4/9/15, a strong odor of urine was pervasive throughout the facility and could be detected at varying degrees throughout the day. On 4/7/15 at 10:15 AM, R35 stated that R35 frequently detects a foul odor of urine on the North-South hall. On 4/9/15 at 10:00 AM, R13 stated that R13 frequently detects a foul odor of urine when moving throughout the facility. 3. On 4/7/15 at 1:15 PM, a rectangular hole measuring approximately 12 inches by six inches was observed in R13's bathroom wall. On 4/7/15 at 1:20 PM, E7 (Maintenance Director) confirmed that there was a hole present in R13's wall and stated that the hole in R13's wall should be repaired. E7 also stated that there was no work order for the hole in R13's wall to review. The Centers for Medicare and Medicaid Services-672 Resident Census and Conditions of Residents form completed on 4/6/15 by E2 (Director of Nursing) documents the facility's current census is 58.	F 465		