|                          | -   |   |                     |   |           | M APPROVED                 |
|--------------------------|---|---|---------------------|---|-----------|----------------------------|
|                          |   | & MEDICAID SERVICES   |                     |   |           | O. 0938-0391               |
|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                     | E CONSTRUCTION  |           | ATE SURVEY<br>OMPLETED     |
|                          |   | 145489  | B. WING             |   |           | 9/18/2015                  |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                     | TREET ADDRESS, CITY, STATE, ZIP CO  | DE        |                            |
| PIPER C                  | ITY REHAB & LIVING  | CENTER  |                     | 00 MAPLE STREET<br>PIPER CITY, IL 60959   |           |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF COR<br>(EACH CORRECTIVE ACTION :<br>CROSS-REFERENCED TO THE A<br>DEFICIENCY) | SHOULD BE | (X5)<br>COMPLETION<br>DATE |
| F 000                    | INITIAL COMMENT   | ſS  | F 000               |   |           |                            |
| F 323<br>SS=D            | Annual Licensure a<br>483.25(h) FREE OF<br>HAZARDS/SUPER  |   | F 323               |   |           |                            |
|                          | environment remain as is possible; and  | isure that the resident<br>ns as free of accident hazards<br>each resident receives<br>on and assistance devices to   |                     |   |           |                            |
|                          | by:<br>Based on observat<br>review the facility fa<br>fall interventions an<br>interventions to pre   | NT is not met as evidenced<br>tion, interview, and record<br>ailed to implement preventative<br>of failed to implement post fall<br>vent fall reoccurrence for two<br>1, R15) reviewed for falls in a   |                     |   |           |                            |
|                          | Findings include:   |   |                     |   |           |                            |
|                          | wheelchair with an<br>lower foot. On 9/15<br>the boot was applie<br>injury incurred after<br>the bathroom when<br>from the toilet back<br>wheelchair wasn't c | 0:20am, R15 sat in a<br>orthopedic boot to the left<br>5/15, at 10:20am, R15 stated<br>ed on 9/14/15 because of an<br>a fall. R15 stated he fell in<br>transferring independently<br>to the wheelchair because the<br>close enough. R15 stated he<br>assistance to transfer until the |                     |   |           |                            |
|                          |   | Set dated 8/10/15 documents intact and requiring extensive  |                     | ттт   |           |                            |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

DEDADTMENT OF LIEALTH AND LIUMAN CEDVICES

TITLE

(X6) DATE

PRINTED: 09/23/2015

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.

|                          |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |                     |   | FORM     | 09/23/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|---------------------|---|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   | . ,                 | LE CONSTRUCTION   | (X3) DAT | E SURVEY<br>IPLETED                 |
|                          |   | 145489  | B. WING             |   | 09/      | 18/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| PIPER C                  | ITY REHAB & LIVING  | CENTER  |                     | 600 MAPLE STREET<br>PIPER CITY, IL 60959  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROV<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| TAG<br>F 323             | Continued From para<br>assistance of one s<br>The Fall Analysis Loc<br>R1 with an incident<br>Analysis Log June 2<br>incident on 6/8/15.<br>(Director of Nursing<br>found on the floor of<br>E2 stated the root of<br>10/29/14 was weak<br>assistance; R15 was<br>therapy evaluation of<br>6/8/15 R15 was four<br>floor after transferri<br>missed the wheelch<br>of the fall was R15<br>was re-educated or<br>The SBAR (Situation<br>Request) form, date<br>documents R15 fell<br>floor in front of the to<br>documents R15 fell<br>floor in front of the to<br>documents R15 slip<br>The SBAR form, date<br>documents R15 was<br>decreased strength<br>blood pressure. | ge 1<br>taff person for transfers.<br>og October 2014 documents<br>on 10/29/14. The Fall<br>2015 documents R15 with an<br>On 9/16/15 at 10:10am, E2<br>0) stated on 10/29/14 R15 was<br>f the bathroom by the toilet.<br>cause of R15's fall on<br>ness and not asking for staff<br>is re-educated and a physical<br>was completed. E2 stated on<br>nd sitting on the bathroom<br>ng without assistance and<br>hair. E2 stated the root cause<br>refusing to ask for help; R15<br>n safety.<br>on, Assessment, Background,<br>ed 9/2/15 at 7:55pm,<br>and was found sitting on the<br>toilet; the assessment<br>oped while transferring.<br>Atted 9/5/15 at 3pm, documents<br>from the toilet to the<br>essment documents R15 with<br>to get up from toilet and low<br>atted 9/6/15 at 6:30pm,<br>s found yelling for help and<br>the floor in the bathroom and<br>thead on the floor. The SBAR<br>gs that make the condition<br>esn't ask for assistance". The | F 323               | DEFICIENCY)   | PRIATE   |                                     |
|                          | SBAR documents a  | a physician order to send R15 valuation and treatment of  |                     |   |          |                                     |

If continuation sheet Page 2 of 13

|                          |   | AND HUMAN SERVICES   |                    |     |   | FORM                     | 09/23/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|--------------------|-----|---|--------------------------|-------------------------------------|
| STATEMENT                | T OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | LE CONSTRUCTION   | (X3) DATE                | E SURVEY<br>PLETED                  |
|                          |   | 145489   | B. WING            |     |   | <b>09</b> / <sup>.</sup> | 18/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |                          |                                     |
| PIPER C                  | ITY REHAB & LIVING  | CENTER   |                    |     | 00 MAPLE STREET<br>PIPER CITY, IL 60959   |                          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTIO<br>(EACH CORRECTIVE ACTION SHOULD<br>CROSS-REFERENCED TO THE APPROP<br>DEFICIENCY) | ) BE                     | (X5)<br>COMPLETION<br>DATE          |
| F 323                    | three recent falls ar<br>Nurse's Notes docu<br>facility on 9/9/15. T<br>Summary, dated 9//<br>hospital diagnoses<br>Failure, Hypertensio<br>The SBAR form, da<br>documents R15 as<br>assistance from the<br>unable to support s<br>reinforced to ask fo<br>The Nurse's Notes<br>"(R15) states no pa<br>woke up with pain t<br>Hurts to put weight<br>self without pain an<br>discolorationMD<br>of LLE (left lower e)<br>The Left Tibia and F<br>9/13/15, documents<br>fracture of the proxi<br>The Nurse's Notes,<br>returning from phys<br>boot and to assist v<br>The Nurse's Notes,<br>E2 (DON), docume<br>of the 9/12/15 fall w<br>cause was determin<br>without assist; inter<br>lift to transfer and a<br>added to the wheele<br>On 9/16/15 at 10:10 | nd low blood pressure. The<br>ument R15 returned to the<br>The hospital Discharge<br>(9/15, documents R15's<br>to include Congestive Heart<br>on, and Urinary Tract Infection.<br>ated 9/12/15 at 12:45pm,<br>transferring without<br>to toilet and became weak and<br>self incurring a fall; R15 was<br>or assistance to bathroom.<br>9/13/15 at 8:30am document<br>ain from fall yesterdaythis am<br>to the left foot and ankle.<br>on it and not able to transfer<br>ad required more help. No<br>(physician) contactedX-Ray<br>xtremity)."<br>Fibula Radiology Report,<br>s R15 with a recent hairline<br>imal fibula.<br>, dated 9/14/15, document R15<br>sicians office with a orthopedic<br>with transfers.<br>, dated 9/14/15, completed by<br>ents the interdisciplinary review<br>vas completed and the root<br>ned to be R15 transferring<br>ventions to use a mechanical<br>a pressure pad alarm was | F                  | 323 |   |                          |                                     |

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| STATEMENT                | OF DEFICIENCIES<br>DF CORRECTION  | X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION   | (X3) DAT | . 0938-039<br>E SURVEY<br>IPLETED |
|--------------------------|---|---|---------------------|--|----------|-----------------------------------|
|                          |   | 145489  | B. WING             |  | 09/      | 18/2015                           |
| NAME OF                  | PROVIDER OR SUPPLIER  | ·   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  |          |                                   |
| PIPER C                  | ITY REHAB & LIVING  | CENTER  |                     | 600 MAPLE STREET<br>PIPER CITY, IL 60959   |          |                                   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETIC<br>DATE         |
| F 323                    | transferred self with<br>bathroom and when<br>wheelchair R15 mis<br>found sitting on the<br>refusing to ask for s<br>intervention to re-en-<br>that on 9/5/15 at 3p<br>toilet from the whee<br>was found sitting on<br>the fall was low blo<br>without assistance.<br>implemented after<br>notify the physician<br>the blood pressure<br>no interventions we<br>R15 transferring wi<br>stated that on 9/6/1<br>without assistance<br>wheelchair and was<br>floor. E2 stated the<br>low blood pressure<br>to the hospital for e<br>9/12/15 at 12:45pm<br>assistance from the<br>was found on the fl<br>stated that R15 did<br>9/13/15 in which a<br>fracture of the prox<br>stated the root case<br>transferring without<br>and refusing to ask<br>added to use a men<br>sensor pad was ad<br>stated R15 had a p<br>and an overall patter<br>assistance from the<br>stated R15 was re- | age 3<br>n 9/2/15 at 7:55pm R15<br>nout assistance to the<br>n transferring back to the<br>ssed the wheelchair and was<br>floor; the root cause was<br>staff assistance with an<br>ducate on safety. E2 stated<br>om, R15 transferred to the<br>elchair without assistance and<br>n the floor; the root cause of<br>od pressure and transferring<br>E2 stated the interventions<br>R15's fall on 9/5/15 were to<br>a medication was changed and<br>was monitored. E2 confirmed<br>ere implemented to address<br>thout staff assistance. E2<br>5 at 6:30pm, R15 transferred<br>from the toilet to the<br>s found sitting on the bathroom<br>e root case was weakness and<br>with interventions to send R15<br>evaluation. E2 stated that on<br>n, R15 transferred without staff<br>e toilet to the wheelchair and<br>oor in the bathroom. E2<br>n't complain of pain until<br>X-Ray was ordered and a<br>imal fibula was found. E2<br>e of R15's fall on 9/12/15 was<br>t assistance of staff, weakness<br>for help with interventions<br>chanical left for transfers and a<br>ded to R15's wheelchair. E2<br>educated multiple times to call<br>to transferring. E2 confirmed | F 3                 | 223  |          |                                   |

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|                          |   | AND HUMAN SERVICES   |                     |   |   | FORM  | APPROVED                   |
|--------------------------|---|--|---------------------|---|---|-------|----------------------------|
|                          |   | & MEDICAID SERVICES  | <u> </u>            |   |   |       | 0938-0391                  |
| -                        | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     |   | LE CONSTRUCTION   |       | E SURVEY<br>IPLETED        |
|                          |   | 145489   | B. WING             |   |   | 09/   | 18/2015                    |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                     | S | STREET ADDRESS, CITY, STATE, ZIP CODE   |       |                            |
| PIPER CI                 | ITY REHAB & LIVING  | CENTER   |                     |   | 600 MAPLE STREET  |       |                            |
|                          |   |  | <u> </u>            |   | PIPER CITY, IL 60959  |       |                            |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)  | ID<br>PREFI)<br>TAG |   | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE  | (X5)<br>COMPLETION<br>DATE |
| F 323                    | Continued From pa<br>R15 was a 2 persor<br>E2 stated R15's fall<br>and, "this shouldn't<br>was." E2 confirmed<br>in September prior<br>address R15's com<br>transfers related to<br>re-education after th<br>The Fall Risk Asses<br>9/2/15 and 9/9/15, a<br>falls.<br>The Care Plan date<br>with self care deficit<br>to senile dementia,<br>"frequently incontine<br>self to the toilet." R<br>interventions of an a<br>R15.<br>The Care Plan date<br>high risk for falls du<br>balance, frequently<br>bowel with intervent<br>resident to ask for a<br>as an intervention o<br>added to this fall ca<br>the sit to stand lift a<br>The facility policy Fa<br>documents the polic<br>safety and to minim<br>falls will be discusse<br>will be written on the | ge 4<br>n transfer per the care plan.<br>Is were a re-education issue<br>be a problem but obviously it<br>d no interventions were placed<br>to R15's fall on 9/12/15 to<br>pliance with safety and safe<br>weakness except<br>he 9/2/15 fall.<br>Issments, completed 6/8/15,<br>all document R15 at risk for<br>ed 8/19/15 documents R15<br>ts requiring assist of two due<br>impulse control disorder and<br>ent of urine and tries to take<br>15 is documented with<br>assist of two staff to transfer<br>ed 8/19/15 documents R15 at<br>the to a history of falls, poor<br>incontinent of bladder and<br>tions to include encourage<br>assistance which was added to<br>on 8/11/13; the last intervention<br>are plan is dated 5/18/15 to use<br>as needed.<br>all Prevention, undated,<br>cy is to provide for resident<br>hize injuries related to falls. All<br>ed and any new interventions<br>e care plan. | F 3                 |   | DEFICIENCY)   | THATE |                            |
|                          | 9-1-15 to 9-30-15, c  | order Sheet (POS), dated<br>documents R1 with diagnoses<br>tion, and Alzheimer's with  |                     |   |   |       |                            |

If continuation sheet Page 5 of 13

PRINTED: 09/23/2015

| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING (X3) DATE SURVE<br>COMPLETED   NAME OF PROVIDER OR SUPPLIER 145489 B. WING 09/18/2019   NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE<br>600 MAPLE STREET<br>PIPER CITY REHAB & LIVING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE<br>600 MAPLE STREET<br>PIPER CITY, IL 60959 09/18/2019   (X4) ID<br>PREFIX<br>TAG SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) ID<br>PREFIX<br>TAG PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) (X5)<br>COMPLE<br>600 MAPLE STREET<br>PIPER CITY, IL 60959   (X4) ID<br>PREFIX<br>TAG SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH OFFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) ID<br>PREFIX<br>TAG PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) COMPLE<br>DEFICIENCY   F 323 Continued From page 5<br>Dementia. R1's same POS documents "Safety<br>Devices: tab alarm on bed/chair. Treatment<br>Orders: Pressure alarmed chair". F 323 F 323 ID   | /2015<br>DVED<br>0391 |
|---|-----------------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   PIPER CITY REHAB & LIVING CENTER 600 MAPLE STREET   PIPER CITY, IL 60959 PIPER CITY, IL 60959   (X4) ID<br>PREFIX<br>TAG SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) ID<br>PREFIX<br>TAG PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) (X5)<br>COMPLE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY)   F 323 Continued From page 5<br>Dementia. R1's same POS documents "Safety<br>Devices: tab alarm on bed/chair. Treatment<br>Orders: Pressure alarmed chair". F 323   | Y                     |
| 600 MAPLE STREET   PIPER CITY REHAB & LIVING CENTER 600 MAPLE STREET   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID   PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX PROVIDER'S PLAN OF CORRECTION SHOULD BE (X5)   F 323 Continued From page 5 Dementia. R1's same POS documents "Safety F 323 F 323 F 323   Orders: Pressure alarmed chair". Orders: Pressure alarmed chair". F 323 F 323   | 5                     |
| PIPER CITY REHAB & LIVING CENTER   PIPER CITY, IL 60959   (X4) ID<br>PREFIX<br>TAG SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) ID<br>PREFIX<br>TAG PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) (X5)<br>COMPLE<br>DATE<br>DEFICIENCY)   F 323 Continued From page 5<br>Dementia. R1's same POS documents "Safety<br>Devices: tab alarm on bed/chair. Treatment<br>Orders: Pressure alarmed chair". F 323   |                       |
| PREFIX<br>TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX<br>TAG (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIATE<br>DEFICIENCY) COMPLE<br>DATE   F 323 Continued From page 5<br>Dementia. R1's same POS documents "Safety<br>Devices: tab alarm on bed/chair. Treatment<br>Orders: Pressure alarmed chair". F 323 F 323   |                       |
| Dementia. R1's same POS documents "Safety<br>Devices: tab alarm on bed/chair. Treatment<br>Orders: Pressure alarmed chair".   | ETION                 |
| R1's Treatment Administration Record (TAR),<br>dated 9-1-15 to 9-30-15, documents "7-1-15, Tab<br>alarm to bed."   R1's Care Plan, dated 8-3-15, documents<br>"Resident has risk factors that require monitoring<br>and intervention to reduce potential for self<br>injuryA) pressure pad alarm to bed and chair."   On 9-16-15, periodically from 8:10 am to 1:25<br>pm, R1 was seated in a wheelchair in various<br>areas of the facility with no alarm device.   On 9-16-15, at 1:35 pm, R1 sat in a wheelchair;<br>an unattached sensor alarm cord was dangling<br>from R1's wheelchair seat. On 9-16-15, at 1:37<br>pm, E7, Registered Nurse (RN) removed R1's<br>alarm device from R1's bed and attached it to the<br>dangling sensor pad cord and stated "(E7) should<br>have a sensor pad cord and stated "(E7) should<br>have a sensor pad hocked up."   On 9-16-15, at 1:40 pm, E7 reviewed R1's<br>Treatment Administration Record (TAR) and<br>stated "(R1) only needs it while in bed" and<br>removed the alarm from his wheelchair.   On 9-16-15, at 3:55 pm, R1 received cares by E8<br>and E9, Certified Nursing Assistants (CNA) and<br>had been placed into a wheelchair. E8 attached<br>an alarm to the dangling sensor pad cord on R1's<br>wheelchair and stated "(R1) is supposed to have<br>the sensor pad on (R1's) wheelchair. I also like<br>to use the personal alarm", as E8 attached a<br>personal alarm device to the back of R1's shirt. |                       |

Facility ID: IL6003792

If continuation sheet Page 6 of 13

|                          | OF DEFICIENCIES   | & MEDICAID SERVICES<br>(X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | PLE CONSTRUCTION   | (X3) DAT | <u>. 0938-039</u><br>E SURVEY<br>IPLETED |
|--------------------------|---|---|---------------------|--|----------|--|
|                          |   | 145489  | B. WING             |  | 09/      | 18/2015                                  |
| NAME OF I                | PROVIDER OR SUPPLIER  |   |                     | STREET ADDRESS, CITY, STATE, ZIP CODE  | 1 00,    | 10/2010                                  |
| PIPER C                  | ITY REHAB & LIVING  | CENTER  |                     | 600 MAPLE STREET<br>PIPER CITY, IL 60959   |          |  |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | TEMENT OF DEFICIENCIES<br>/ MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECT<br>(EACH CORRECTIVE ACTION SHOL<br>CROSS-REFERENCED TO THE APPRO<br>DEFICIENCY) | LD BE    | (X5)<br>COMPLETIO<br>DATE                |
| F 323                    | Continued From pa<br>On 9-16-15, at 4:00<br>sensor pad alarm o<br>wheelchair."  | pm, E9 stated "(R1) has the   | F 323               | 3  |          |  |
| F 329<br>SS=D            | 483.25(I) DRUG RE<br>UNNECESSARY D  | EGIMEN IS FREE FROM<br>RUGS   | F 329               | 9  |          |  |
|                          | unnecessary drugs<br>drug when used in<br>duplicate therapy);<br>without adequate m<br>indications for its us<br>adverse consequer  | g regimen must be free from<br>An unnecessary drug is any<br>excessive dose (including<br>or for excessive duration; or<br>ionitoring; or without adequate<br>se; or in the presence of<br>aces which indicate the dose<br>or discontinued; or any<br>e reasons above.                                    |                     |  |          |  |
|                          | resident, the facility<br>who have not used<br>given these drugs u<br>therapy is necessar<br>as diagnosed and c<br>record; and residen<br>drugs receive gradu<br>behavioral intervent | thensive assessment of a<br>must ensure that residents<br>antipsychotic drugs are not<br>inless antipsychotic drug<br>y to treat a specific condition<br>locumented in the clinical<br>ts who use antipsychotic<br>ual dose reductions, and<br>tions, unless clinically<br>an effort to discontinue these |                     |  |          |  |
|                          | by:<br>Based on observat<br>review the facility fa<br>behaviors, to ensur   | NT is not met as evidenced<br>ion, interview, and record<br>iled to identify target<br>e implementation of gradual<br>to assess, monitor and  |                     |  |          |  |

Facility ID: IL6003792

If continuation sheet Page 7 of 13

|                          |   | AND HUMAN SERVICES   |                     |   | FORM                     | 09/23/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|--|---------------------|---|--------------------------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  | . ,                 | TIPLE CONSTRUCTION  | (X3) DATE                | E SURVEY<br>IPLETED                 |
|                          |   | 145489   | B. WING _           |   | <b>09</b> / <sup>.</sup> | 18/2015                             |
| NAME OF F                | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP CODE   | <u> </u>                 |                                     |
| PIPER C                  | ITY REHAB & LIVING  | CENTER   |                     | 600 MAPLE STREET<br>PIPER CITY, IL 60959  |                          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION<br>( (EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPRON<br>DEFICIENCY) | D BE                     | (X5)<br>COMPLETION<br>DATE          |
| TAG<br>F 329             | Continued From pa<br>evaluate the continu-<br>medication usage for<br>reviewed for psycho-<br>sample of 11.<br>Findings include:<br>The facility Face Pr<br>was admitted to the<br>The Physicians Orc<br>September 2015, d<br>of Huntington's Disc<br>Depression, and Me<br>documents R21 rec<br>every evening for N<br>7/18/2013; and Ser<br>Schizophrenia, initia<br>The Psychotropic M<br>Evaluation, dated 8<br>is used for a target<br>refusal of assist, no<br>Depokote is used for<br>swings. Both medic<br>appears controlled.<br>The Behavioral Mon<br>2015 through Septe<br>Target Behavior mo<br>Suicidal Ideation ar<br>Huntington's Diseas<br>behaviors documer<br>/grabbed nurse, 9/1<br>in activities, and 9/1 | age 7<br>ued need for psychotropic<br>or one of three residents (R21)<br>otropic medication usage in a<br>rofile Sheet documents R21<br>e facility on 4/9/2012.<br>der Sheet (POS), dated<br>locuments R21 has diagnoses<br>ease, Schizophrenia, Anxiety,<br>ood Disorder. The POS<br>ceives Depakote ER 1000 mg<br>Mood Disorder, initiated<br>roquel 50 mg every evening for<br>ated 8/8/2013.<br>Medication Quarterly<br>3/3/2015, documents Seroquel<br>behavior of criminal history,<br>on compliance with safety;<br>or a target behavior of mood<br>cations document that R21 | F 32                | DEFICIENCY)   | PRIATE                   |                                     |
|                          | six month period.   | tes, dated 5/15/2015 through   |                     |   |                          |                                     |

If continuation sheet Page 8 of 13

|                          |  | I AND HUMAN SERVICES<br>E & MEDICAID SERVICES  |                    |     |  | FORM      | : 09/23/2015<br>APPROVED<br>: 0938-0391 |
|--------------------------|--|--|--------------------|-----|--|-----------|---|
| STATEMENT                | T OF DEFICIENCIES<br>OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                    |     | LE CONSTRUCTION  | (X3) DATI | E SURVEY<br>IPLETED                     |
|                          |  | 145489   | B. WING            | i   |  | 09/       | 18/2015                                 |
| NAME OF I                | PROVIDER OR SUPPLIER   |  |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE  | -         |   |
| PIPER C                  | CITY REHAB & LIVING  | CENTER   |                    | -   | 500 MAPLE STREET<br>PIPER CITY, IL 60959   |           |   |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENCY   | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL)<br>CROSS-REFERENCED TO THE APPROF<br>DEFICIENCY) | D BE      | (X5)<br>COMPLETION<br>DATE              |
| F 329                    | 9/7/2015, documen<br>6:00 AM, "(R21) cu<br>behaviors documer<br>On 9/17/2015 E2, E<br>stated " all behavior<br>Behavior Monitoring<br>notes. The staff sho<br>sadness for behavio<br>behaviors documer<br>Monitoring Record<br>I'm not sure staff kr<br>documented."<br>On 9/15/2015 at 10<br>at 10:30AM and 1:0<br>1:50PM, R21 was<br>12:00PM on 9/15/20<br>not display any beh<br>On 9/17/2015 at 9:4<br>stated "(R21) has n<br>aggressive that I kr<br>staff as much as po<br>(R21's) continued s<br>thing I have ever set<br>behind (R21's) whe<br>that (R21) can't do<br>On 9/17/2015 at 9:4<br>isolates (R21's) set<br>frustrated, and never<br>There are no docur<br>psychologist visits o<br>attempts in R21's c | At one behavior on 9/6/2015 at<br>arsing at staff", with no other<br>inted.<br>Director of Nursing (DON)<br>irs are documented on the<br>g Record or in the progress<br>ould be looking for crying and<br>iors. The current target<br>inted on the Behavior<br>are diagnoses not behaviors.<br>now what needs to be<br>D:00AM and 1:50PM, 9/16/2015<br>D0PM and 9/17/2015 at<br>ying on the bed watching<br>is in the dining room for lunch at<br>2015 and 9/16/2015. R21 did<br>haviors during the survey.<br>45AM, E6 (Registered Nurse)<br>never hit anyone nor is (R21)<br>now of. (R21) cooperates with<br>passible, but it is difficult due to<br>spastic movements. The only<br>een (R21) do is try to walk<br>belchair and become frustrated<br>it any more."<br>45AM, E2 (DON) stated "(R21)<br>If in the room, becomes<br>er becomes aggressive."<br>mented psychiatrist or<br>or gradual dose reduction | F 3                | 329 |  |           |   |

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| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING (X3) DATE SURVEY<br>COMPLETED   NAME OF PROVIDER OR SUPPLIER 145489 B. WING 09/18/2015   NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE<br>600 MAPLE STREET<br>PIPER CITY, IL 60959 600 MAPLE STREET<br>PIPER CITY, IL 60959 09/18/2015   |           |   | AND HUMAN SERVICES<br>& MEDICAID SERVICES   |           |   |  | FORM | 09/23/2015<br>APPROVED<br>0938-0391 |
|---|-----------|---|---|-----------|---|--|------|-------------------------------------|
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE   PPER CITY REHAB & LIVING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE   PHID SUMMARY STATEMENT OF DEFORMERS PREPRINT, L. 60959   PHETEX PREPRINT, L. 60959   PAGE FCAHO EPRICATORY ONLISE BE PRECEDED BY FULL<br>RECOLLATORY OR LSC DENTIFYING INFORMATION) PREPRINT<br>TAG PREPRINT<br>(CAHO EPRICATORY ONLISE BE PRECEDED BY FULL<br>RECOLLATORY OR LSC DENTIFYING INFORMATION) PREPRINT<br>TAG PREVIDENT OF ORDEROTIVE ACTORN HOLD BE<br>CROSS REFERENCED TO THE APPROPRIATE<br>DEFICIENCY   F 329 Continued From page 9<br>for the continued use of Depakote or Seroquel on<br>monthly visit progress notes from May 2015<br>through August 2015. F 329   On 8/17/2015 at 9-45AM, E2 (DON) confirmed<br>there were no psychiatrist or psychologist visits<br>and the medical doctor did not address the<br>continued use of psychotropic medications in<br>R21's clinical record. E2 also stated "1 don't know<br>when or if (R21) has ever seen a psychiatrist or<br>psychologist. I don't see any gradual dose<br>reduction attempts for Depokote or Seroquel in<br>the last year."   R21's clinical record does not provide evidence<br>the facility 's monitoring and tracking behavioral<br>episodes consistently, or evidence the facility has<br>adequate indications for R21.   The tacility "Psychotropic Medication Policy",<br>dated 530/2014, documents "47. Any resident<br>receiving such medications shall have a<br>psychiatric diagnosis or documented evidence of<br>maladaptive behavior, which can be considered<br>harmful to themselves or others, destructive of<br>property, or emotional problems exist which can<br>cause th   | STATEMENT | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA   |           |   |  |      |                                     |
| PPER CITY REHAB & LIVING CENTER   600 MAPLE STREET<br>PREFIX   000 MAPLE STREET<br>PREVIDENCE 101, 16, 00055     CMUID<br>PREFIX<br>TAG   SUMMARY STATEMENT OF DEFICIENCES<br>(EACH OFFICIENCY MUST BE PRECEEDED BY FULL<br>REGULTORY OR USCIDENTIFYING INFORMATION)   Dr.   PREFIX<br>CACH CORRECTIVE ACTIONS MOULD BE<br>(CACH CORRECTIVE ACTIONS MO |           |   | 145489  | B. WING _ |   |  | 09/  | 18/2015                             |
| PIPER CITY, REHAB & LIVING CENTER   PIPER CITY, IL. 60959     (M) ID<br>FREFIX<br>TAG   SUMMARY STATEMENT OF DEFICIENCIES<br>(EACH DEFICIENCY MUST BE PROCEEDED BY FULL<br>REGULATIONY OR LSC IDENTIFYING INFORMATION)   ID<br>FAG   PROVIDENS INAN OF CORRECTIVE, CONTROSHOULD BE<br>(CACH SERICENCY MUST BE PROCEEDED BY FULL<br>REGULATIONY OR LSC IDENTIFYING INFORMATION)   ID<br>FAG   ID<br>FORMERCITY, IL. 60959     F 329   Continued From page 9<br>for the continued use of Depakote or Seroquel on<br>monthy visit progress notes from May 2015<br>through August 2015.   F 329   F 329     On 8/17/2015 at 9:45AM, E2 (DON) confirmed<br>there were no psychiatrist or psychologist visits<br>and the medical doctor did not address the<br>continued use of psychotropic medications in<br>R21's clinical record. E2 also stated "I don't know<br>when or if (R21) has ever seen a psychiatrist or<br>psychologist. 1 don't see any paychiatrist or<br>psychologist. 1 don't see any provide evidence<br>the facility is monitoring and tracking behavioral<br>episodes consistently, or evidence the facility has<br>adequate indications for ontinued use of the<br>psychotropic medications for R21.   The facility "Psychotropic Medication Policy",<br>dated 5/30/2014, documents "#7. Any resident<br>receiving such medications sintal have a<br>psychiatric diagnosis or documented evidence of<br>property, or emdiciations set which can<br>cause the resident frightful distress. #0. The<br>behavioral tracking sheet of the facility will be<br>implemented to ensure behaviors and being<br>monitored. #9. Residents who use antipsychotic<br>drugs shall receive gradual dose reductions and<br>behavior interventions, unless clinically<br>contraindicated, in an effort to discontinue the<br>drugs.   ID<br>BOD STATERDED<br>BOD STATERDED<br>BOD STATERDED<br>BOD STATERDED<br>BOD STATERDED<br>BOD STATERDED<br>BOD STATERDED  | NAME OF F | PROVIDER OR SUPPLIER  |   |           |   |  |      |                                     |
| Prigry<br>TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX<br>TAG CEACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED To THE APPROPRIATE COMPLETIC<br>INFO<br>DEFICIENCY)   F 329 Continued From page 9<br>for the continued use of Depakote or Seroquel on<br>monthly visit progress notes from May 2015<br>through August 2015. F 329   On 8/17/2015 at 9:45AM, E2 (DON) confirmed<br>there were no psychiatrist or psychologist visits<br>and the medical doctor did not address the<br>continued use of psychotropic medications in<br>R21's clinical record. E2 also stated '1 don't know<br>when or if (R21) has ever seen a psychiatrist or<br>psychologist. I don't see any gradual dose<br>reduction attempts for Depokote or Seroquel in<br>the last year." R21's clinical record does not provide evidence<br>the facility is monitoring and tracking behavioral<br>episodes consistently, or evidence the facility has<br>adequate indications for CP1.   The facility "Psychotropic Medication Policy",<br>dated 5/30/2014, documents #7. Any resident<br>receiving such medications son documented evidence of<br>maladaptive behavior, which can be considered<br>harmful to themselves or others, destructive of<br>property, or envional problems exist which can<br>cause the resident frightful distress. #8. The<br>behavioral tracking sheet of the facility will be<br>implemented to ensure behaviors and<br>behavior interventions, unless clinically<br>contraindicated, in an effort to discontinue the<br>drugs."   | PIPER C   | ITY REHAB & LIVING  | CENTER  |           |   |  |      |                                     |
| for the continued use of Depakote or Seroquel on<br>monthly visit progress notes from May 2015<br>through August 2015.<br>On 8/17/2015 at 9:45AM, E2 (DON) confirmed<br>there were no psychiatrist or psychologist visits<br>and the medical doctor did not address the<br>continued use of psychotropic medications in<br>R21's clinical record. E2 also stated "I don't know<br>when or if (R21) has ever seen a psychiatrist or<br>psychologist. I don't see any gradual dose<br>reduction attempts for Depokote or Seroquel in<br>the last year."<br>R21's clinical record does not provide evidence<br>the facility is monitoring and tracking behavioral<br>episodes consistently, or evidence the facility has<br>adequate indications for continued use of the<br>psychotropic medication Policy",<br>dated 5/30/2014, documents "#7. Any resident<br>receiving such medications shall have a<br>psychiatric diagnosis or documented evidence of<br>maladaptive behavior, which can be considered<br>harmful to themselves or others, destructive of<br>property, or emotional problems exist which can<br>cause the resident frightful distress. #8. The<br>behavioral tracking sheel of the facility will be<br>implemented to ensure behaviors are being<br>monitored. #9. Residents who use antipsychotic<br>drugs shall receive gradual dose reductions and<br>behavior interventions, unless clinically<br>contraindicated, in an effort to discontinue the<br>drugs."  | PRÉFIX    | (EACH DEFICIENCY  | MUST BE PRECEDED BY FULL  | PREFIX    | x | (EACH CORRECTIVE ACTION SHOULI<br>CROSS-REFERENCED TO THE APPROF | ) BE | COMPLETION                          |
| SS=D SPREAD, LINENS   | F 441     | for the continued us<br>monthly visit progret<br>through August 201<br>On 8/17/2015 at 9:4<br>there were no psych<br>and the medical do<br>continued use of ps<br>R21's clinical record<br>when or if (R21) ha<br>psychologist. I don't<br>reduction attempts<br>the last year."<br>R21's clinical record<br>the facility is monito<br>episodes consisten<br>adequate indication<br>psychotropic medic<br>The facility "Psycho<br>dated 5/30/2014, do<br>receiving such med<br>psychiatric diagnos<br>maladaptive behavi<br>harmful to themsely<br>property, or emotion<br>cause the resident<br>behavioral tracking<br>implemented to ens<br>monitored. #9. Residrugs shall receive<br>behavior intervention<br>contraindicated, in a<br>drugs."<br>483.65 INFECTION | as of Depakote or Seroquel on<br>less notes from May 2015<br>5.<br>45AM, E2 (DON) confirmed<br>hiatrist or psychologist visits<br>ctor did not address the<br>sychotropic medications in<br>d. E2 also stated "I don't know<br>s ever seen a psychiatrist or<br>t see any gradual dose<br>for Depokote or Seroquel in<br>d does not provide evidence<br>oring and tracking behavioral<br>tly, or evidence the facility has<br>is for continued use of the<br>ations for R21.<br>tropic Medication Policy",<br>ocuments "#7. Any resident<br>lications shall have a<br>is or documented evidence of<br>or, which can be considered<br>ves or others, destructive of<br>nal problems exist which can<br>frightful distress. #8. The<br>sheet of the facility will be<br>sure behaviors are being<br>idents who use antipsychotic<br>gradual dose reductions and<br>ons, unless clinically<br>an effort to discontinue the |           |   |  |      |                                     |

Facility ID: IL6003792

If continuation sheet Page 10 of 13

|                          | OF DEFICIENCIES   | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:  |                     | TIPLE CONSTRUCTION                       | ( )      | TE SURVEY<br>MPLETED      |
|--------------------------|---|--|---------------------|--|----------|---------------------------|
|                          |   | 145489   | B. WING             |  | 09       | /18/2015                  |
| NAME OF                  | PROVIDER OR SUPPLIER  |  |                     | STREET ADDRESS, CITY, STATE, ZIP COD     | E        |                           |
| PIPER C                  | ITY REHAB & LIVING  | CENTER   |                     | 600 MAPLE STREET<br>PIPER CITY, IL 60959 |          |                           |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | ATEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFIX<br>TAG |  | IOULD BE | (X5)<br>COMPLETIC<br>DATE |
| F 441                    | Infection Control Pl<br>safe, sanitary and o<br>to help prevent the<br>of disease and infe<br>(a) Infection Contro<br>The facility must es<br>Program under whi<br>(1) Investigates, co<br>in the facility;<br>(2) Decides what p<br>should be applied t<br>(3) Maintains a rec<br>actions related to in<br>(b) Preventing Spre<br>(1) When the Infect<br>determines that a r<br>prevent the spread<br>isolate the resident<br>(2) The facility must<br>communicable dise<br>from direct contact<br>direct contact will the<br>(3) The facility must<br>hands after each d<br>hand washing is ind<br>professional practice<br>(c) Linens<br>Personnel must ha | stablish and maintain an<br>rogram designed to provide a<br>comfortable environment and<br>development and transmission<br>action.<br>of Program<br>stablish an Infection Control<br>ich it -<br>ontrols, and prevents infections<br>rocedures, such as isolation,<br>to an individual resident; and<br>ord of incidents and corrective<br>infections.<br>ead of Infection<br>tion Control Program<br>resident needs isolation to<br>of infection, the facility must<br>to<br>st prohibit employees with a<br>ease or infected skin lesions<br>with residents or their food, if<br>ransmit the disease.<br>st require staff to wash their<br>irect resident contact for which<br>dicated by accepted | F 4                 |  |          |                           |
|                          | This REQUIREME  | NT is not met as evidenced   |                     |  |          |                           |

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|                          |   | AND HUMAN SERVICES  |                    |     |   | FORM     | 09/23/2015<br>APPROVED<br>0938-0391 |
|--------------------------|---|---|--------------------|-----|---|----------|-------------------------------------|
| STATEMENT                | OF DEFICIENCIES<br>OF CORRECTION  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:   |                    |     | LE CONSTRUCTION   | (X3) DAT | E SURVEY<br>PLETED                  |
|                          |   | 145489  | B. WING            |     |   | 09/      | 18/2015                             |
| NAME OF                  | PROVIDER OR SUPPLIER  |   |                    |     | STREET ADDRESS, CITY, STATE, ZIP CODE   |          |                                     |
| PIPER C                  | ITY REHAB & LIVING  | CENTER  |                    |     | 600 MAPLE STREET<br>PIPER CITY, IL 60959  |          |                                     |
| (X4) ID<br>PREFIX<br>TAG | (EACH DEFICIENC)  | TEMENT OF DEFICIENCIES<br>Y MUST BE PRECEDED BY FULL<br>SC IDENTIFYING INFORMATION)   | ID<br>PREFI<br>TAG |     | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOUL<br>CROSS-REFERENCED TO THE APPROI<br>DEFICIENCY) | D BE     | (X5)<br>COMPLETION<br>DATE          |
| F 441                    | review, the facility f<br>blood glucose meta<br>prevent cross conta<br>cross contaminatio<br>administration. Thi<br>residents (R20)revi<br>administration in a<br>residents (R9, R23)<br>Findings include:<br>1. The facility's pol<br>of Glucometer (data<br>blood glucose meta<br>each resident test t<br>issues. 1. Cleaning<br>Germicidal Disposa<br>each time the blood<br>pre-moistened towa<br>On 9-16-15, at 11:0<br>respectively, E7, Ra<br>performed blood gli<br>E7 did not sanitize<br>R9 and R23's testin<br>On 9-16-15, at 11:3<br>have wiped it betwa<br>alcohol swabs. Som<br>don't know what the<br>On 9-16-15, at 11:3<br>typically would wipe<br>post with sani-cloth<br>2. The facility's poli<br>(dated 10-27-10), d | tion, interview, and record<br>ailed to disinfect a multi-use<br>or between resident use to<br>amination and failed to prevent<br>in during medication<br>s failure applies to one of 10<br>ewed for medication<br>sample of 11 and two<br>) in the supplemental sample.<br>icy Cleaning and Disinfecting<br>ed 6-9-10), documents "The<br>ers will be cleaned between<br>o avoid cross-contamination<br>and disinfecting with a<br>able Wipe will be completed<br>d glucose meter is used with a<br>elette."<br>04 am and 11:08 am<br>egistered Nurse (RN)<br>ucose testing for R9 and R23.<br>the glucose meter in between<br>ng.<br>85 am, E7, RN, stated "I should<br>een residents. I usually use<br>netimes we have other wipes. I<br>ey are called." | F 4                | 141 |   |          |                                     |

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| DEPARTMENT OF HEALTH AND HUMAN SERVICES             |  |   |                   |  |   |        |                               | RINTED: 09/23/2015<br>FORM APPROVED<br>MB NO. 0938-0391 |  |  |
|---|--|---|-------------------|--|---|--------|-------------------------------|---|--|--|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION |  | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER: |                   |  | TIPLE CONSTRUCTION  |        | (X3) DATE SURVEY<br>COMPLETED |   |  |  |
|   |  | 145489  | B. WING           |  |   |        | 09/18/2015                    |   |  |  |
| NAME OF PROVIDER OR SUPPLIER                        |  |   |                   |  | STREET ADDRESS, CITY, STATE, ZIP CODE   |        |                               |   |  |  |
| PIPER CITY REHAB & LIVING CENTER                    |  |   |                   | 600 MAPLE STREET<br>PIPER CITY, IL 60959 |   |        |                               |   |  |  |
| (X4) ID<br>PREFIX<br>TAG                            | (EACH DEFICIENC)   |   | ID<br>PREF<br>TAG |  | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHO<br>CROSS-REFERENCED TO THE APPI<br>DEFICIENCY) | ould e | BE                            | (X5)<br>COMPLETION<br>DATE                              |  |  |
| F 441   | (EACH DEFICIENCY MUST BE PRECEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)<br>Continued From page 12<br>prepare medication using gloves."<br>On 9-16-15, at 7:58 am, E6, RN, dropped R20's<br>Torsemide 5mg tablet on the top of E6's<br>medication cart. E6 picked the pill up with E6's<br>bare hand, placed it in R20's medicine cup, and<br>administered it to R20.<br>On 9-17-15, at 1:37 pm, E2, Director of Nursing<br>(DON), stated "It is not acceptable for a nurse to<br>touch a pill with bare hands and give it to the<br>resident." |   | F                 | 441                                      |   |        |                               |   |  |  |

Facility ID: IL6003792

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