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	146077	A. BUILDING _____ B. WING _____	09/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARK POINTE HEALTHCARE & REHAB	**1223 EDGEWATER MORRIS, IL 60450**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 246 SS=E	Annual License and Certification Survey 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and record reviews the facility failed to meet resident's care needs in a timely manner for four residents (R7, R15, R21, R23) of the eight reviewed for Activities of Daily Living (ADL) inside the sample of 24 residents, and four residents (R30, R31, R32, R33) in the supplemental sample. Findings include: On 9/17/14 at 12:30 AM, R7's call light was on. R7 was in bed asleep with a bed pan under her buttocks. On 9/17/14 at 12:50 PM, the call light was still on for R7. R7 was in bed with the bed pan still underneath her. On 9/17/2014 at 1:40 PM(1 hour and 10 minutes later), E17 and E18 (both Certified Nursing Assistants/CNA) entered the room to respond to the call light. E18 removed the bed pan from R7. E17 changed R7's incontinence pad but did not render perineal care.	F 246		

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

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F 246	Continued From page 1 On 9/17/14 at 12:55 PM, E17, stated she placed the bed pan underneath R7 around 12:30 PM then she went on break. E17 added she's not sure if another staff came in to remove and/or place another bed pan on to R7. When E18 was asked she stated she hasn't come in to see R7 since 12:30 PM. On 9/18/14 at 10:35 AM, Z1 and Z2 (Visitors) stated, the waiting time for call light response is somewhat lengthy. They said one time R7 needed to go to the bathroom urgently and she (R7) had to wait 20 minutes for staff to come and assist her. On 9/16/2014 during the Group Task starting from 1:30 PM until 3:00 PM, all eight residents (R15, R21, R23, R29 and R30-R33) all said staff will respond to the call light without addressing concerns/care needs and will say they will be back in a minute, and return in an hour. They all had a problem with the wait time to have care needs addressed. On 9/18/14 at 2:14 PM, E1 (Administrator) stated a solid green call light that is not blinking is a reminder to staff a resident is on a bed pan and staff had to check residents in a timely manner. A resident left on a bedpan for 40 minutes is not acceptable. On 9/18/14 at 4:05 PM, E2 (Director of Nursing/DON) during interview stated, staff must respond to call lights in a timely manner. E2 added the facility did not indicate in the policy time frame for call light response, but staff should respond within 10 minutes. E2 continued to say	F 246		

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F 246	Continued From page 2 for residents who are on a bed pan, staff should at least check residents within 15 minutes or every 15 minutes if resident is not yet finished. Facility's Call light Policy dated 7/14/2011 indicates: It is the policy of this facility to provide a communication call-light system that allows the resident to communicate a need from their room, bathroom, and bathing areas. Staff responds to acknowledge and assist in a timely manner. Procedure: The facility maintains that call-lights are acknowledged and assistance provided in a timely manner.	F 246		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record reviewed facility failed to follow consultant physicians orders for additional testing as a means of determining the need for further care, treatment and possible surgical intervention. This applies to one of five residents (R1) reviewed for indwelling urinary catheters in the sample of 24. The findings include;	F 309		

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F 309	Continued From page 3 On 9/15/14 at 7:30 AM, R1 was observed in a wheelchair at his bedside with an indwelling urinary catheter. R1 stated "the catheter causes pain and a lot of burning, including last night, it really hurt." R1's medical records document diagnosis including recurrent urinary tract infections (UTI) and benign prostatic hypertrophy (BPH). R1's indwelling urinary catheter assessment form include presence of urinary retention. R1's 7/14/14 Urologist progress note include: Patient seen at request of Z4 (attending physician), for an evaluation. Last office visit was in March 2012. {indwelling urinary catheter} was ordered by Z4 over a year ago. R1 cannot recall when the indwelling urinary catheter was changed last. Urine culture and sensitivity (C/S), done on 6/23/14 and grew out E-Coli and Serratia Marcesans. Z4 put R1 on Macrobid 100 mg twice a day for 7 days. R1 said the urine sample was taken from the drainage bag. No follow-up urinalysis (UA), was checked. R1 has no complaint of abdominal / flank pain. New orders for indwelling urinary catheter change and to re-check UA and Urine C/S. If Serratia persists, Then R1 will need a Cystoscopy as out patient at the hospital and a possible Infectious Disease consult." On 9/15 and 9/16/14 facility asked to review R1's 7/2014 UA and urine C/S results. On 9/17/14 at 10:00 AM, E2 (Director of nurses), stated R1's 7/14/14 UA and urine C/S were never completed. E2 said the last Urine C/S was 6/23/14. E2 then said R1's UA and Urine C/S were obtained and sent out 9/16/14.	F 309		

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F 309	Continued From page 4 R1's 9/16/14 Urine C/S report documented the presence of greater than 100,000 colony count of gram negative bacilli, resembling Proteus Mirabilis (UTI). On 7/18/14 at 4:10 PM, Z4 was notified of R1's 9/16/14 Urine C/S results and Z4 ordered Cipro 500 mg twice a day for 7 days, irrigate urinary catheter daily and to re-culture UA in 3 weeks.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility failed to implement approaches to manage indwelling urinary catheter's in attempt to prevent urinary catheter related complications and infections. This applies to one of five residents (R2), reviewed for indwelling urinary catheter care / maintenance in the sample of 24. The findings include;	F 315		

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F 315	Continued From page 5 On 9/15/14 at 8:30 AM, R2 was observed in bed with all four side rails padded and in an upright position. R2's indwelling urinary catheter tubing was observed draped over the side rails and preventing free flow of urine from bladder to drainage bag. On 9/15/14 at 3:00 PM, R2 was observed in a recliner chair at bedside with his indwelling urinary catheter drainage bag sitting directly on his lap, under a blanket. R2's family visitor was present and stated the staff placed the drainage bag on R2's lap approximately 10 minutes prior to this observation. R2's indwelling urinary catheter was not secured to the resident to prevent dislodgement of catheter. R2's current care plan includes 8/15/14 receiving treatment for urinary tract infection with antibiotics. R2's medical record includes: Totally dependent on staff for all areas of activities of daily living and cognitively impaired. 9/11/14 nursing progress note documents has a {indwelling urinary catheter}, with occasional leakage. Resident is unable to reposition himself in bed and chair and is willing to let staff reposition him frequently. The facilities indwelling urinary catheter policy and procedure failed to include: - to secure the catheter as a means of preventing dislodgement or urethral tears - to position the catheter and drainage bag to facilitate free flow of urine from the resident to the	F 315		

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F 315	Continued From page 6 drainage bag.	F 315		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview facility failed to provide care and services in a safe manner to prevent avoidable accidents. This applies to eight of eight sampled residents (R8, R14, R15, R16, R17, R18, R19 and R22) reviewed for incidents/ accidents involving staff in the sample of 24 and three residents (R25, R26 and R27) in the supplemental sample. The findings include; The facilities Incident / Accident reports 12/01/13 through 9/16/14 included 12 individual incidents of residents involved in avoidable accidents while being provided care by staff. - 12/10/13, R25 sustained a skin tear to the left leg while E3 (CNA), was applying leg rests on wheelchair. R25's 10/25/13 Minimum Data Set Assessment (MDS), Section G documents requires extensive to total assistance with bed mobility, transfers,	F 323		

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F 323	Continued From page 7 ambulation, dressing, hygiene and bathing. - 01/11/14, R8's sustained a left forearm skin tear during a staff assisted (E4 = CNA), shower. This incident report documents skin tear resulted from R8's forearm hitting E4's gait belt. R8's 11/25/13 and 7/18/14 MDS, Section G documents requires extensive to total assist with bed mobility, transfers, ambulation, dressing, hygiene, bathing and toileting. - 02/09/14, R26 sustained a skin tear to the left lower leg while being transferred from wheelchair to toilet by E5 (CNA). E5 documented after transfer, E5 started to pull the wheelchair back and the chair scratched R26's left leg. R26's 02/07/14 MDS, Section G documents requires extensive to total assist with bed mobility, transfers, ambulation, dressing, hygiene, bathing and toileting. - 04/25/14, R27 sustained a small laceration to his left thumb while E6 (CNA), was clipping the left thumb finger nail. R27's 3/14/14 MDS, Section G documents requires extensive to total assist with bed mobility, transfers, ambulation, dressing, hygiene, bathing and toileting. - 4/27/14, R19 sustained a "large" skin tear to the left forearm during a staff assisted transfer by E7 (CNA). R19's 4/25/14 MDS, Section G documents requires extensive to total assist with bed mobility, transfers, ambulation, dressing, hygiene, bathing and toileting. - 5/29/14, R18 sustained a skin tear to the left thigh, above the knee while being transferred in a mechanical lift by E8 (CNA). This incident report include the possible cause was the skin	F 323		

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being rubbed against by the lift sling and improperly placed under R18. R18's 05/27/14 MDS, Section G documents requires extensive to total assist with bed mobility, transfers, ambulation, dressing, hygiene, bathing and toileting.

- 5/30/14, R15 sustained a left forearm skin tear during a staff (E9 = CNA), assisted transfer from wheelchair to the toilet. R15 stated her arm was bumped on wheelchair during transfer. R15's 6/11/14 MDS, Section G documents requires extensive to total assist with bed mobility, transfers, ambulation, dressing, hygiene, bathing and toileting.

- 6/19/14, R15 sustained a right hand / wrist bruise from the CNA (E10), holding onto her hand too tightly. R15 was standing in the shower and started to loose her balance, E10 grabbed her right hand tightly in an attempt to steady the resident.

- 8/06/14, R14 tripped over the CNA (E15), foot and fell during a transfer from recliner to wheelchair. R14's 7/25/14 MDS, Section G documents requires extensive to total assist with bed mobility, transfers, ambulation, dressing, hygiene, bathing and toileting.

- 8/10/14, R17 fell while ambulating with E11 (CNA). R17's 8/15/14 Minimum Data Set Assessment (MDS), Section G includes requires extensive assistance with ambulation by one staff and unsteady with walking without stabilization with a human assist.

- 9/04/14, R22 sustained a bruise to the forehead, as the result of being hit in the head by

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the mechanical lift during a staff (E20 = CNA), assisted transfer. E20 documented in incident investigation while removing the sling from the lift, the lift bumped R22 in the head. R22's 3/05 and 9/15/14 MDS, Section G documents requires extensive to total assist with bed mobility, transfers, ambulation, dressing, hygiene, bathing and toileting.

- 9/05/14, R16 sustained a right forearm skin tear while E12 (CNA), was turning the resident in bed. R16's 8/20/14 MDS Section G document requires extensive assistance with 2 staff for bed mobility and toileting and total assist with 2 staff for transfers.
-Review of R21's Face Sheet showed R21 is a 73 year old male with diagnosis of Tardive Dyskinesia and Parkinson.

-Review of the facility's Incident Reports showed R21 had the following fall occurrences: "5/18/2014 at 9:15 AM... R21 observed on the floor between the toilet and walls... 6/02/2014 at 6:10 PM... R21 observed on the floor in the bathroom... 6/08/2014 at 9 PM... R21 observed sitting on the bathroom floor... 6/09/2014 at 8 PM... R21 observed sitting on floor in front of sink... 6/19/2014 at 3:30 PM...R21 observed lying on the floor at the foot of his bed. R21 stated that he leaned forward and fell out of his wheel chair..."

Review of R21's plan of care, dated 6/11/2014, showed R21 had a potential for trauma-injury from falls. The interventions identified to prevent R21 from falling were not specific. R21's care plan showed none specific interventions such as: Anticipate fall times, anticipate toileting needs, and encourage R21 to ask for assistance.

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R21 was interviewed in his room on 9/18/14 at 3 PM and 9/17/2014 at 11:45 AM. R21 was alert and oriented. R21 was observed to have physical limitations. R21 said he could not walk and he had an incident of sliding from his wheel chair.

R21's nurse (E31) was interviewed on 9/18/2014 at 1:45 PM. E31 said, "R21 had a few falls trying to do things on his own. E31 said R21 told her (E31) he had several falls at home and his wife could no longer take care of him at home. E31 said, "He (R21) won't listen to instructions." E31 stated, staff try to be available to assist R21 as much as possible. E31 did not identify specific interventions implemented to keep R21 safe.

E13 was interviewed on 9/17/2014 at 2 PM. E13 said R21's Parkinson and his need to be independent put R21 at risk. E13 also said R21 had a few falls because he was unwilling to wait for staff to take him to the bathroom. E13 did not identified specific method implement to assist R21 to the bathroom and for staff to monitor R21.

II. Based on observations, interviews and record reviews, the facility failed to ensure three oxygen tanks were stored in a safe and secure manner.

This had the potential to effect all the residents living on the second floor.

Findings include:

During the environmental tour with E 30 (director of maintenance) on 9/16/2014 at 1:30 PM, the following was observed:
In the second floor oxygen storage closet, two

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F 323	Continued From page 11 oxygen tanks were being stored standing free and unsecured. One tank was leaning partially out of the racking holding the oxygen tanks, and was at risk for falling. E30 said the oxygen tanks should be placed in the rack.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review facility failed to follow their "Central line and midline dressing change and peripheral line and assessment" policy and procedures for one of one sampled residents (R2), reviewed for central line management out of the sample of 24 and one resident (R28), in the supplemental sample. The facilities Central line policy and procedure does not document frequency of dressing changes to be completed if the insertion site is occluded with a gauze dressing. The findings include; On 9/15/14 at 12:00 PM, E2 (DON), stated facility	F 328		

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F 328	Continued From page 12 has two current residents with central lines (R28 and R2). 1) On 9/15/14 at 2:00PM, R28 was observed with a left antecubital double lumen central line. The central line dressing was dated 9/06/14. E23 (nurse), was observed to administer an antibiotic through this central line during this observation. E23 stated {R28} was admitted to facility 3 - 4 days ago. R28's face sheet and nursing admission assessment document 9/11/14 admission to facility. R28's 9/11/14 "initial care plan" documents the presence of a central line but no interventions for care, maintenance or assessment of site. R28's 9/11 - 9/15/14 physician order sheet (POS), does not include central line assessments or dressing change direction. R28's medical records failed to include central line catheter type, insertion date, catheter insertion site assessments, external catheter length or arm circumference measurements. 2) On 9/15/14 at 3:00PM, R2 observed with a triple lumen central line catheter in his right upper arm. R2's central line insertion site was occluded with a gauze pad and the dressing was undated. On 09/15/14 at 3:00PM, R2's treatment administration record and central line catheter record documented central line dressing changes were completed 9/01 and 9/08/14. No other documentation found in R2's medical records of central line dressing changes or site assessments, arm circumferences or external catheter length assessments after 9/08/14.	F 328		

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F 328	Continued From page 13 R2's September 2014 "central line catheter assessment record," treatment and medication administration records failed to document arm circumference measurements with each dressing change as per facilities central line policy and procedures. The only arm circumference documented in September 2014 was on 9/01/14. On 9/16/14, E2 (DON), stated R2's central line was discontinued 9/15/14. R2's 9/15/14 physician progress note documents central line discontinued 9/15/14 due to the the catheter came out over 7 cm. As of 9/16/14 at 8:45AM, R2's nursing progress notes and central line treatment record failed to include any documentation about the central line catheter migrating out of insertion site, physician notification and central line being discontinued. On 9/16/14 at 8:45AM, E13 (assistant director of nurses - ADON), during interview stated she was unable to find any nursing documentation in R2's medical record about the central line pulling out and being discontinued. E13 also stated this information should have been documented in the nursing progress notes. Facilities Central line dressing change and assessment policy and procedure documents dressing changes with site assessments, external catheter length and arm circumferences are to be completed weekly. The dressing is to be a transparent dressing. The policy does not address frequency of dressing changes if gauze is occluding the insertion site.	F 328		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS	F 329		

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F 329	Continued From page 14 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. 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 interview and record review the facility failed to track specific behaviors targeted for psychoactive drugs for three residents (R3, R12) in the sample of 24 and R34 in the supplemental sample. The facility also failed to gradually reduced psychoactive medications for two residents (R2, R11). Findings Include:	F 329		

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1. R2's Face Sheet documents R2 was re-admitted on 10/30/2013, 81 years old with the following diagnosis: seizures and paraplegia. Initial Psychiatric Evaluation dated 7/22/2014 states that R2 has a diagnosis of reactive psychosis. Behavior Interventions Monthly Flow Records were reviewed from December of 2013 thru August of 2014. The Flow Records document R2 was tracked for crying and had no episodes of crying. Psychotropic Use Care Plan dated 3/19/2013 states that R2 was admitted to the facility on the current regimen of Seroquel(psychoactive) and Zoloft(anti-depressant); the care plan does not address psychoactive drug reduction interventions.

Physician Order dated 8/25/2014 states R2 receives Seroquel 25 milligrams daily.

On 9/15/2014 at 12:15 PM, R2 was sitting in the dining room asleep in a chair with the television on.
On 9/16/2014 at 10:40 AM, R2 was laying in bed, alert and oriented to person, place and time.

On 9/17/2014 at 1:28 PM, E28 (Minimum Data Set Coordinator) said she coordinates the psychotropic drug reduction program for residents. E28 said the facility attempts to reduce psychoactive drugs every three months. E28 continued to say the facility's psychiatrist retired in October of 2013 and was not replaced until recently. E28 continued to say R2 has had no behaviors and should have been reduced from the psychoactive drug. E28 concluded with saying" R2 will be placed on the list for psychotropic reduction the next available visit."

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Medications: Psychotropic Medications Policy updated 7/11/2011 states," 2. The facility will have a psychiatrist consult all residents receiving psychotropic medication annually and as needed to ensure quality of care, quality of life, behavior management and compliance with the regulatory guidelines."

2. R11's Face Sheet documents R11 was admitted on 11/20/2012 . The Initial Psychiatric Evaluation dated 6/10/2014 states R11 was on Risperdal for dementia and reactive psychosis. Behavior/ Intervention Monthly Flow Records were reviewed from March of 2014 until August of 2014, R11 was being tracked for delusions and had no episodes.

On 9/16/2014 at 11 AM, R11 was laying in bed asleep.
On 9/17/2014 at 11 AM, R11 was laying in bed, alert and oriented to person, place and thing.

On 9/17/2014 at 12:00 Noon, E28 (Minimum Data Set Coordinator) said R11 has been here a while on Risperdal(psychoactive drug) and because R11 has veterans benefits the Risperdal has not been adjusted/ reduced. E28 continued to say that R11 has had no delusions and could have been reduced but communicating with the veterans department is difficult. R28 also said R11 will be placed on list for the next reduction of Risperdal.

Physician Orders were reviewed from June of 2014 through current, September of 2014, R11 has an order for Risperdal .25 milligrams daily.

Medications: Psychotropic Medications Policy updated 7/11/2011 states," 2. The facility will have

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a psychiatrist consult all residents receiving psychotropic medication annually and as needed to ensure quality of care, quality of life, behavior management and compliance with the regulatory guidelines."

3. -Review of R12's Physician Order Sheet showed R12 is a 96 year old female with diagnosis including: Dementia. R12's physician ordered 0.125 mg of Risperdal daily.

Review of R12's August and September 2014 Behavior/Intervention Monthly Flow Record showed staff were tracking R12 for "Anxiety, "Yelling", and "Crying". R12's Behavior/Intervention Monthly Flow Record did not identified specific symptoms that R12 displayed when she was anxious.

Review of R12's care plan, original dated 8/29/2013, showed staff identified R12 at "risk for complications of psychotropic medication use." The goal was for R12 not to have complications from the use of psychotropic medications, and would be achieved by 11/15/14. R12's plan of care did not show the target behavior for the use of R12's antipsychotic medications. R12's plan of care showed staff made an attempted to reduce her Risperdal on 5/22/13, but no other reduction was documented as being done.

R12 was observed on 9/16/2014 at 11:15 AM. R12 was alert, but confused. R12 was calm and responded to questions.

4. Review of R34's Physician Order Sheet

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F 329	Continued From page 18 showed R34 is a 91 year old female with diagnosis including: Dementia. R34's primary physician had ordered Risperidone 0.5 mg one tablet twice a day. There was no assessment to show the target behaviors for the use of antipsychotic medications. Review of 34's August and September Behavior/Intervention Monthly Flow Record (for the tracking of R43's behavior) showed staff were tracking R34 for "Anxiety", "Insomnia" and "Agitation". This tracking sheet failed to identified the specific behaviors R34 displayed when she was anxious or agitated. R34 was observed during breakfast on 9/15/2014 and the noon meal on 9/16/2014. R34 was cooperative with staff and calm. On 9/17/2014 at 1:28 PM, E28 (Minimum Data Set Coordinator) said that the facility has been without a psychiatric doctor since October of 2013 and the facility will move forward in implementing the tracking of specific behaviors for residents to ensure that psychotropic drugs are reduced accordingly. Medications: Psychotropic Medications Policy updated 7/11/2011 states," 2. The facility will have a psychiatrist consult all residents receiving psychotropic medication annually and as needed to ensure quality of care, quality of life, behavior management and compliance with the regulatory guidelines."	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 19 The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the sanitary condition in the kitchen with food, equipment, and cleaning. This failure could potentially affect all of the 115 residents that are being served food in the facility. Findings include: On 9/15/14 kitchen observations was conducted with E21(Dietary Manager) started at 8:00 AM, and the following were noted: 1. There was a scoop inside the container of powdered sugar. E21 stated, the scoop is not supposed to be stored inside the container. 2. Inside the walk-in refrigerator there were two (5 pound) containers of cottage cheese that were opened and not dated. 3. The fruit juice dispenser had accumulations of sticky substances at the base of the dispenser.	F 371		

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F 371	Continued From page 20 4. During lunch time at 11:55 AM, there were flies hovering over the steam table where lunch meal was being served. There was a fly in the uncovered container of breadsticks. 5. The sanitizing red bucket had a cleaning cloth inside and no sanitizing agent upon chemical test method. 6. There were two tall garbage bins that were uncovered near the food serving area. One of the tall garbage bins was sitting beside the tea dispenser. 7. There was a stack of wet trays and baking pans stored in a shelf rack. There were three trays of burger buns and hot dog buns stored at the bottom shelf which was directly underneath the stack of wet baking pans. On 9/16/14 that started at 10:00 AM the following were observed: 8. During food temperature testing, E22 (Cook) did not clean the thermometer in between food temperature testing. E22 also used her gloved hand to wipe off string beans and mashed potatoes that was clinging into the thermometer. E22 then shook off the food substances from her gloved hands into an empty food container that was still sitting in the steam table. After food temperature testing, E22 proceeded to serve lunch while still wearing soiled gloves. On 9/16/14 at 12:37 PM, E21 (Dietary Manager) stated, staff must use sanitizer (quats) for the sanitizing bucket to clean in the kitchen, E21 did not know why staff did not use sanitizer in the bucket. The garbage bins are supposed to be	F 371		

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F 371	Continued From page 21 closed, but in this case the flap cover of the kitchen's garbage bins are not working. Pots, trays and pans are supposed to be stored dry in a clean area. The burger buns and hot dog buns are not supposed to be stored in the pots and pans storage. Staff should wipe/clean the thermometer in between food testing to prevent mixing of food particles to one another. E21 stated, cottage cheese should be labeled/dated upon opening its containers, it's only good for 7 days after it's opened because it's not pasteurized. Facility's Policy and Procedure of Storage of Dry Food and Supplies indicates: Policy: Food Service staff will follow safe methods of dry food storage. Purpose: To prevent foodborne illness. Procedure: Scoops will not be stored in dry food bins. Facility's Policy and Procedure for Sanitizing Solution indicates: Policy: Sanitizing solutions will be maintained and strategically located throughout the kitchen. Purpose: To prevent foodborne illness through cross contamination. Procedures: The sanitizing solution used for surface sanitizing will be twice the strength as solutions used to sanitize submerged utensils as in manual wash-rinse sanitize.	F 371		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 22 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 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 23 This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record review the facility failed to follow standard infection control practices during provisions of care for three (R2, R4, R7) of the eight reviewed for Activities of Daily Living (ADL) care in the sample of 24 and one resident (R35) in the supplemental sample. Findings include: 1) On 9/15/14 at 11:25 AM, E4 and E24 (both Certified Nursing Assistant/CNA) rendered incontinence care to R7. E4 and E24 cleaned R7's perineal area, wearing the same soiled gloves proceeded to dress and transfer R7 to her wheelchair for lunch. E4 and E24 used one set of gloves throughout care. 2) On 9/15/14 at 3:00 PM, E 10 and E 14 (both CNA's) rendered incontinence care to R2. Wearing the same soiled gloves E 14 applied barrier cream to R2's buttocks. E 10 and E 14 continued wearing the same soiled gloves and touched R2's indwelling catheter. R2 has a current Urinary Tract Infection (UTI). After the care, E 14 left the room with the soiled gloves on and went to soiled utility room, while E 10 removed the soiled gloves and left room without hand washing. 3) On 9/16/14 at 9:02 AM, R4 was sitting on the toilet, R4 had a bowel movement. E 25 (CNA) rendered perineal care with gloves and then assisted R4 to straighten out his clothes and transfer in the wheelchair, without changing the gloves or washing hands. After the care E 25	F 441		

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removed gloves did not wash hands and proceeded to open R4's closet to look for his belt, then placed belt on R4's his pants. E 25 did not change gloves during the entire toileting assistance and did not wash hands immediately after glove removal or care.

4) On 9/16/14 at 10:00 AM, R35 was resting in bed. A pervasive urine odor was coming from R35. R35's bedding was wet with urine. E24(CNA) and E26(CNA) rendered incontinence care. E24 wiped R35's perineal area with a wet towel, E26 did the same thing when they repositioned R35. Both E24 and E26 proceeded to apply clean incontinence pad dressed R35, and straightened out R35's bedding while still wearing soiled gloves. Both staff removed gloves did not wash hands and proceeded to transfer R35 to wheelchair.

On 9/18/14 at 4:05 PM, E2 (Director of Nursing/DON) stated, staff must change gloves when doing care from dirty to clean task. Staff should not leave the room with their gloves on and without hand washing. Staff must wash hands before they start resident care, before and after use of gloves.

Facility's Policy and Procedure for Hand Washing/ Hand Hygiene Policy indicated:

Policy: To prevent the spread of infection through good hand washing hygiene.

Procedure:

Employees must wash hands under these conditions:

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F 441	Continued From page 25 a. Before and after direct contact with residents. b. After removing gloves. Hand hygiene is always the final step after removing and disposing of personal protective equipment.	F 441		
F 456 SS=B	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to maintain resident's wheel chairs in good repair and clean condition for residents; and operate refrigerators in resident's dining areas in a clean and safe manner. This applies to R40, R36, R39, R37 and R38 in the supplemental sample, who are wheel chair bound. This also has the potential to effect residents who receive snacks stored in the refrigerators located in the dinning areas on the first and second floors. The findings include: 1. During the environmental tour on 9/15/2014 at 7:45 AM, residents were observed in the dinning area on the second floor. R40, R39, R36, R37 and R38 were sitting in wheel chairs. The wheel chairs were observed to be dirty with dried liquid spills on the sides and/or food debris. Other	F 456		

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F 456	Continued From page 26 residents, R39's wheel chair had torn arm and foot rests. The nurse on duty, E29, was interviewed at 8 AM on 9/15/2014. E29 said resident's wheel chairs should be cleaned on the night shift, and she would have someone clean the resident's wheel chairs. 2. During the environmental tour of the facility on 9/16/2014 at 1:30 PM, with E30 (director of maintenance) the following was observed: -In the kitchen area near D Wing, the refrigerator was dirty with multiple dried liquid spills and food debris. Two small containers of a tomato like substance, one plate of white substance were being stored without a label, which would identify the food item or date of storage. This refrigerator also had three small containers of gelled deserts dated 9/09/2014. This gelled desert was being stored appropriately seven days after being served. A small container of veggie dip was labeled as opened on 7/20/2014. The freezer compartment was dirty with a build up of frost. -The kitchen area on the first floor had a refrigerator. This refrigerator was dirty with dried liquid spills and food debris. The freezer compartment had build up of frost. The refrigerator compartment had a boloney sandwich which was being stored with no label of the date this food item had been prepared. A pitcher of dark color juice was in the refrigerator that was not labeled. This unlabeled dark color juice could not be identified, nor the length of storage known. Also present in the refrigerator were 4 small container of vanilla pudding, dated 9/10/2014, and 5 containers of green jelled deserts, dated 9/09/2014. E30 said the refrigerator should had been cleaned, and food labeled.	F 456		

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F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations and interviews the facility failed to ensure it is pest free. This failure affected four residents (R13,R15, R21, R23) in the sample of 24 and 5 residents(R29- R33) in the supplemental sample reviewed for environment . Findings include: During environmental rounds, from 9/15/14 starting at 8:25AM through 9/16/14 starting at 9:30AM flies were noted in the first floor dining room, the kitchen, and hallway of the B wing/unit. On 9/16/14 at 12:12 PM, R13 was eating lunch in her bedroom. A fly was in her (R13's) bed. R13 stated, she wished the facility could do something about the flies. R13 said the flies hover over her food and it bothers her a lot. R13 also said sometimes the flies come from the bathroom and would fly to her food. On 9/16/2014 during the Group Task 8 of 8 residents(R15, R21, R23 and R30-R33) all said there are flies all over the building and it has increased and continues since December of 2013. All 8 residents said it was a problem for	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146077	A. BUILDING _____ B. WING _____	09/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 469	Continued From page 28 them and the flies are present during meals, and activity of daily living skills. On 9/17/2014 at 10:00AM, E1(Administrator) said they called the exterminator to come in today due to the complaint of flies. On 9/18/2014 at 3:00 PM, R21 was in the room with a variety of flies. R21 had a fly swatter on the bed. R21 said the flies are a problem.	F 469		