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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey.	F 000		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide hygiene and nutritional assistance to residents identified as needing extensive assistance. This applies to 1 of 4 resident (R19) reviewed for ADL (Activities of Daily living) in the sample of 23 and four residents (R27, R28, R29 and R31) in the supplemental sample. The findings include: 1. R19 has multiple diagnoses which included Dementia with behavioral disturbances and Anemia based on the POS (Physician order sheet). R19 is on hospice care since March 9, 2015. R19's quarterly MDS(Minimum Data Set) dated September 23, 2015 has a BIMS (Brief Interview for Mental Status) score of "6" which shows that the resident is severely impaired with cognition. The same MDS shows that the resident required extensive assist of one staff for eating. Dietary progress note Sept 9, 2015- Sept 10, 2015 documented "Diet order: General, Regular, enriched cereal daily, med pass supple (dietary supplement) 60cc three times daily. Current wt:	F 312		

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

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118 lbs. Wt one month ago was 128 lbs. Wt six months ago was 136 lbs. 10 lb wt loss in one month. Reason for wt loss: decreased intake, refusing to eat, hospice care, wt loss expected. Feeding ability: extensive. Offer food fluids that (R19) prefers and can tolerate." Based on care plan review, no current dietary care plans were documented. Facility's policy titled "Nutrition Policy Manual for Palliative Nutrition and Hydration Policy" stated "the Dietary Manager will meet with the resident and/or residents family members for a list of foods and fluids that are preferred and well tolerated by the resident."
During dining room observations on October 28, 2015 at 11:50 AM , R19 received a Regular diet of Polish Sausage, mixed vegetables, potatoes, chocolate brownie, lemonade and water.
Resident fed self and took less than 50% of the total meal. No assistance or cues by staff were noted during observations.
During interview October 28, 2015 at 11:55 AM with E 22 (certified nursing assistant/CNA) stated that R 19 usually eats only 10% of meal most of the time. E 22 stated, resident needs cues to increase intake and likes all foods especially soup and coffee. When asked if soup was provided, E22 stated that it is always available for those residents that want it. (No soup was available at service station). Request for the same was made to the kitchen and offered to R19 who consumed 100% of the soup.
At interview October 28, 2015 at 11:58 AM when asked of food preferences R19 stated, "I love ice cream."
R19's care plan showed no intervention with regards to the residents need for feeding assistance and cuing.
2. During lunch observations on October 28, 2015 at 11:50 AM, R27 was observed sitting at

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the table. R27 was struggling to have his meal. R27's Minimum data set (MDS) dated July 23, 2015 showed R27's needed extensive assistance with one person physical assist (functional status) in eating. R27's care plan dated July 23, 2015 showed R27-"Dietary -requires feeding assist, encouragement and cuing." There was no assistance or cuing from the staff to guide R27 through the meals. At the end of the dining period, R27 had more than half of the food on the table and floor. On October 28, 2015, at 11:55 AM, R27 was observed again struggling to eat his meal. R27 had food dropping on his lap while eating. At 12:05 PM, E10 (Activity aide) was informed of the observation. E10 got an extra protective cloth for R27, removed the food on his lap and applied the protective cloth on R27's lap. At 12:09 AM, E11 started to assist and cue R27 in feeding. E11 stated he sometimes needs help and sometimes does not.

3. During lunch observations on October 26, 2015 at 11:50 AM, and October 28, 2015 at 11:55 AM, R28 was observed sitting in his high back reclining chair far away from the table with his body stretched out and legs off the leg rest. It was observed that R28 was served lunch before 11:55 AM but did not touch his lunch on both days until around 12:05 PM. On October 28, 2015, at 12:00 PM, E13 and E14 Certified nurse assistants (CNA) were informed of the observation. Both E13 and E14 assisted R28 in repositioning in his high back reclining chair and moved him closer to the table. R27's Minimum data set (MDS) dated October 9, 2015 showed R28 needed limited assistance with one person physical assist (functional status) in eating. R28's care plan dated July 23, 2015 showed R28-"needs independent or extensive assistance with eating

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at times". R28 started eating his meal after the proper positioning.

4. During lunch observations on October 26, 2015 at 11:50 AM, and October 28, 2015 at 11:55 AM, R29 was observed sitting in her wheelchair far away from the table and stretching to get her food from her plate to her mouth. R29 was observed on both days with some food spills on the table and her clothings. On October 28, 2015, at 12:00 PM, E13 and E14 were informed of the observation. E13 and E14 assisted R29 to upright position in her wheelchair and moved her closer to the table. R29 stated on October 26, 2015 after being repositioned, "that feels better". R29's care plan dated February 25, 2015 showed R29-"feeds self with set up supervision".

5. On October 28,2015, R27 was observed sitting in his high back reclining chair in the D wing hallway after the noon meal. The gray sweatpants pants R27 was wearing were saturated with urine. R31 was also sitting in a wheelchair in the D hallway. R31's blue sweats were also saturated with urine. While E10 (activity aide) was assisting other residents out of the dining room, E10 was informed of R27's wet pants. E10 stated "as soon as I get someone to help, we will take you to the bathroom." At 12:45 PM, ten minutes later, R27 was still sitting in the wheelchair with his wet sweatpants on. E10 informed E14(CNA) that R27 needed incontinence care, E14 stated "there are only two CNA's right now on the floor. The other CNA and RN are on lunch."

R27's diagnosis includes Alzheimer's and prostrate cancer and is on hospice. R27's

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F 312	Continued From page 4 incontinence assessment dated July 29, 2015 assessed R27 as incontinent of bowel and bladder. R27's MDS dated July 23, 2015 assessed R27 as requiring extensive assist with two people in toileting. R27's incontinence care plan goals include to check and change resident every 2 hours and prn(as necessary) and wear briefs. R31's diagnosis includes Dementia and Benign Prostatic Disease. R31's bladder assessment dated April 22, 2015 assessed R31 as frequently incontinent of urine, wears briefs, incontinence care provided by staff and will continue scheduled toileting. R31's MDS dated July 20, 2015 assessed R31 as extensive assistance with one person physical assist. R31's care plan interventions of April 22, 2015 includes toilet resident upon rising, after breakfast, before lunch, before dinner, after dinner at hour of sleep and prn (as necessary.)	F 312		
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:	F 315		

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Based on observation, interview and record review the facility failed to thoroughly clean the resident ' s genital area after an incontinence episode, in a manner that would prevent the potential development of infection and to maintain hygiene.
This applies to 1(R12) resident observed for incontinence care in the sample of 13.

The findings include:

R12's physician order sheet shows a diagnosis includes multiple sclerosis and is also on hospice. R12 has an indwelling catheter due to urinary retention and a stage 3 pressure ulcer to the coccyx.

R12's Minimum Data Set (MDS) dated May 20, 2015 assessed R12 as severely cognitively impaired is totally dependent on staff for personal hygiene and is always incontinent of bowel. E18 (MDS/care plan RN) stated 10/29/15 at 1:35 PM R12 does not have a incontinence care plan because R12 has an indwelling catheter.

On October 27, 2015 at 10:00AM, E6 (Wound care nurse) was about to perform wound care on R12 when she realized R12 had a large semi soft bowel movement. E7 Certified assistant nurse (CNA) was also at R12's bedside to assist with wound care. During the incontinence care, it was observed that both E6 and E7 cleaned the area of the bowel incontinence without opening R12's legs to clean the front area of the perineal area.

On October 28, 2015 at 3:45PM, E2 Director of nursing (DON) stated, "I don't expect nursing to clean the frontal area if not soiled". When asked how nursing would know the front area was clean

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F 315	Continued From page 6 or dirty if nursing did not open R12's legs to check for cleanliness. E2 further stated, "She was not at the bedside, so she cannot say". Facility catheter care policy dated February 16, 2011 states, "all residents with Foley catheter receive ongoing care to prevent infection and maintain patency of a catheter." Catheter Procedure states: peri-care is provided (washing with soap and water around the urinary meatus) at least twice a day and or as needed.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to identify the significant weight loss, develop interventions to prevent further weight loss and failed to update & revise the care plan to address the resident's significant weight loss. This applies to 1 of 4 residents (R16) reviewed for weight changes in the sample of 23. The findings include:	F 325		

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R16 was admitted to the facility on September 1, 2015 with multiple diagnoses which included senile dementia, DM (diabetes mellitus) type II, dyslipidemia and hypothyroidism based on the POS (physician order sheet).
R16's initial MDS (minimum data set) dated September 11, 2015 showed a BIMS (Brief Interview of Mental Status) score of "7" indicating that the resident is severely impaired with cognition. The same MDS showed that R16 requires supervision with set up help only during eating.
R16's POS from October 1 through October 31, 2015 showed an order for general, regular consistency diet.
On October 28, 2015 at 11:45 AM, R16 was served lunch inside the first floor dining room. R16's meal tray consisted of blended vegetables, roasted potatoes, cut-up sausage and a brownie. R16 was also served a cup of coffee and a glass of juice. R16 left the dining table at 11:53 AM without touching the main entree. R16 only took a bite of the brownie. No facility staff redirected and/or cued the resident to eat. No facility staff offered any food substitute to R16. R16 was wheeling himself towards the door, to go out of the dining room when E21 (LPN/Licensed Practical Nurse) was informed of the observation. E21 stated that she is not the nurse in charge of R16, but wheeled the resident back to the dining room table. E21 stated that R16 did not eat the food and should be in the feeding table to be assisted and/or cued by the staff to ensure food intake.
R16's care plan with regards to decrease appetite and significant weight loss dated October 26, 2015 showed that nurse aide will offer replacement food and offer encouragement. This care plan did not show any intervention to prevent

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further weight loss.
R16's initial nutritional assessment dated September 9, 2015 showed height - 68 inches, weight- 144# (pounds), BMI (body mass index) - 21.9, age - 88 years old.
R16's weight records showed the following weights: September 8, 2015 - 144# (pounds) and October 5, 2015 - 134#. Based on the weight records, R16 had a 10# weight loss which is equivalent to 6.94% significant weight loss in one month.
Further review of the weight records showed that R16 weighed 134# on October 6, 2015, 135# on October 7, 2015, 133# on October 19, 2015 and 130# on October 26, 2015.
On October 28, 2015 at 1:15 PM, E23 and E24 (both CNA/certified nursing assistant) weighed R16 in the presence of E19 (LPN) and obtained 129#. Comparing the weight from October 5, 2015 and October 28, 2015, R16 had a 5# weight loss which is equivalent to 3.73% in 23 days.
In an interview held on October 28, 2015 at 2:40 PM, E20 (dietary manager) stated that residents in the facility are weight within the 5th day of the month and all re-weighs should be done by the 10th of the month. Per E20, within 7 days after the re-weigh, the dietitian is notified and an assessment in place for residents with the significant weight change.
The registered dietitian progress notes showed that R16 was assessed for the significant weight loss on October 27, 2015 with recommendation for a dietary supplement. The same dietitian progress notes showed that R16's BMI declined to 20.4. There was no other dietitian documentation prior to October 27 to address the significant weight loss obtained from October 5 through October 26, 2015.
R16's progress notes showed no documentation

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F 325	Continued From page 9 that the physician was notified of the significant weight loss when it was obtained between October 5 and October 26, 2015. R16's POS showed an order from the physician for the dietary supplement on October 28, 2015. On October 29, 2015 at 1:40 PM, E2 (Director of Nursing) stated that she had reviewed R16's records and did not find any documentation that the physician was notified of the resident's significant weight loss, until October 27, 2015 for the dietitian recommendation. The National Institute of Health states that in the elderly it is often better to have a BMI between 25 and 27, rather than under 25. If you are older than 65, for example a slightly higher BMI may help protect you from thinning bones. The facility's undated Nutrition policy manual and weight policy showed that a copy of accurate weights will be provided to dietary by the 10th of the month. Any resident with a significant, severe or insidious weight loss will be referred to the consultant dietitian for assessment of the resident's condition. The physician will be notified of any significant or severe weight changes.	F 325		
F 369 SS=D	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assess and provide appropriate assistive eating device to maintain ability to eat independently for a resident with involuntary movements of the upper extremities.	F 369		

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This applies to 1 of 4 residents (R3) reviewed for ADL's (activities of daily living) in the sample of 23.
The findings include:
R3 has multiple diagnoses which included Dementia and RA (Rheumatoid Arthritis).
R3's annual MDS (Minimum Data Set) dated September 30, 2015 shows a BIMS (Brief Interview for Mental Status) score of "6" indicating that the resident is severely impaired with cognition and would require limited assistance for eating.
During lunch observation held on October 27 at 11:45 AM, inside the first floor dining room. R3 was leaning towards the right side and have uncontrolled involuntary movement of both hands. R3 was served salad in a regular bowl. R3 attempted to feed himself using an adaptive knife (with big handle, but light weight), no staff cued or redirected the resident until E15 (dietary aide) was informed of the observation. E15 told R3 to use the adaptive fork (big handle but light weight) to eat the salad and left R3's table. R3 attempted to eat the salad using the adaptive fork but due to the uncontrolled involuntary movement of both hands, most of the salad fell on the resident's lap and/or on the protective clothing. R3 then, used his fingers to eat the salad. During the same lunch observation at 12:00 noon, R3 was served beef cabbage casserole, peas & carrots and cheese cake. R3 ate the meal using the same adaptive fork but due to the uncontrolled involuntary movement of the resident's bilateral hands, most of the food fell on R3's lap, on the protective clothing and/or on the table (around the plate). R3 would alternately use the adaptive fork or fingers to eat the food from the plate and the food that fell on the table or on the lap. E16 (registered dietitian) was inside the

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F 369	Continued From page 11 first floor dining room during this lunch and was informed of the above observation. E16 stated that the uncontrolled hand movements of R3 are more pronounced. E16 stated that she will inform the therapy department about it. R3's care plan with regards to nutrition showed that the resident feeds self and would require set up as needed. There was no care plan in place to address the use of any adaptive utensils for meals related to R3's uncontrolled involuntary hand movements. R3 was assessed by the occupational therapist on October 28, 2015. The rehabilitation screening form dated October 28, 2015, "Per staff when pt. (patient) fatigued leans to right. Would recommend weighted built up utensils & scoop plate." On October 29, 2015 at 9:10 AM, E17 (Occupational Therapist/Therapy manager) stated that the occupational therapist first assessed R3 with regards to eating difficulty was on October 28, 2015. Per E17, R3 needs a built up spoon and a scoop plate, instead of the adaptive utensils (big handle but light weight) because of the resident's tremors. E17 stated that the built up spoon is more appropriate because it has a bigger handle with weight, to give pressure when gripping (stronger grip) and to engage the muscle to decrease tremors. On October 29, 2015 at 11:30 AM, E18 (MDS/care plan coordinator) stated that R3 has been using the adaptive utensils (big handle but light weight) for a while now per POA (Power of Attorney) request, but R3 was not assessed by the therapist for the appropriateness of the device until October 28, 2015.	F 369		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		

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F 441	Continued From page 12 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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	146077	A. BUILDING _____ B. WING _____	10/29/2015

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
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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure proper protective equipment (PPE) are worn when caring for residents on isolation; failed to perform hand hygiene between patient care; and failed to prevent contamination of residents items in isolation room.

This applies to one resident (R5) observed for infection control in the sample of 23 and 4 residents (R24, R26, R29, R30) n the supplemental sample.

The findings include:

(1). On October 26, 2015 at 11:20 AM, E5 (Nurse) was observed in R24 washroom without wearing a PPE. According to R24's care plan with review date September 6, 2015, R24 requires contact isolation due to clostridium difficile (C.Diff). E5 was observed coming out of R24's room without performing hand washing. E5 then opened the medication cart, removed a blood glucose monitor and the disinfectant wipe container and brought the equipment into R24's room. On completing the blood glucose check, E5 wrapped the blood glucose monitor with some disinfectant wipes and laid the blood glucose monitor on top of R24's wash hand basin. E5 the laid the disinfectant wipe container on top of R24's toilet water tank E5 performed hand wash, came out of the room again to draw an insulin injection for R24. E5 administered the insulin injection to R24 and laid the insulin injection pen on R24's toilet water tank without any barrier. E5 then removed her gloves, washed her hands and collected the blood glucose monitor, the

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disinfectant wipe container and the insulin pen and placed all back in the medication cart. When informed of the observation, E5 stated, the medication cart on the D wing only has one disinfectant wipe container and that she should not have taken it inside R24's room. E5 further stated "I should have used a different one for him". When informed about not wearing PPE prior to entering the resident's room; E5 stated, "I don't have to put on PPE unless I am in close contact with resident or changing the resident during incontinence care". On October 28, 2015 at 10:30 AM, E2 Director of Nursing (DON) stated R24 was supposed to have a dedicated blood glucose monitor and other non critical use common use items in his room. Review of R24's care plan showed, "wear gloves when entering the room if you will have any contact with resident or residents infected area".

(2). On October 27, 2015 at 9:10 AM, Z1 hospice certified nurse assistant (CNA) was observed entering R26's room to answer the call light without wearing any PPE. R26's risk for infection care plan with goal date of December 14, 2015 showed R26 with extended spectrum beta lactamase (ESBL) of urine and requires contact isolation. Upon entering the room, Z1 was observed turning off R26"s call button and moved the call light closer to R26 on the bed sheet. While exiting the room, Z1 was informed of the observation of not wearing a PPE, Z1 stated "I was not performing any patient care to the resident".

(3). On October 27, 2015 at 9:45 A.M, E7 CNA was observed performing hand wash for less than five seconds after assisting with R5's dressing change. When prompted, E7 stated,

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"Yes I know I was supposed to sing 'happy birthday', but was just in a hurry".

(4). On October 28, 2015 at 12:00P.M, it was observed during lunch on the D wing dinning area that R28 and R29 needed to be properly repositioned for their meals. When informed of the observation, E13 CNA assisting with feeding R5 and R32; and E14 assisting with feeding R33 both left their residents and failed to perform any hand hygiene, assisted R29 with proper positioning. Still with no hand hygiene, E13 and E14 went ahead and repositioned R28 properly in his high back reclining chair. Both E13 and E14 was observed back to assist the previous residents without performing hand hygiene.

(5). On October 28, 2015, at 12:43 PM, Z2 (Hospice Nurse) was observed in R30's room without PPE and without performing hand hygiene after touching R30 with bare hands. The facility's infection control log titled D wing September 2015 identified R30 with ESBL of the urine. When informed of the observation, Z2 stated "I was about to go out of the room and noticed R30's leg out of the bed and went ahead to assist R30 back to bed. Z2 was observed holding R30's thigh areas with her bare hands and asked E14 to pass her some gloves. Upon receiving the gloves, Z2 put the gloves on to her hands without performing hand hygiene. When asked if Z2 realized R30 is on contact isolation, Z2 stated "I don't really work with the patient, it was my first time with her". Z2 further stated, "the resident's safety is more important than putting on gloves".

Review of facility's policy titled handwashing/cleansing with revised date 5/05,

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F 441	Continued From page 16 showed, "handwashing is done before and after resident contact..". The policy showed, "if using a system with soap and water..rub hands together for about 15 seconds, making sure to wash between finger". Review of facility's policy titled infection control-isolation categories of transmission based precautions policy updated 6/28/11 showed, "during contact precautions in addition to wearing gloves as outlined under standard precaution, wear gloves (clean, non-sterile) when having any contact with the environment or the patient in the room. The policy also showed, "In addition to wearing a gown as outlined under standard precautions, wear gloves (clean, non sterile) when having any contact with the environment or the patient in the room".	F 441		