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	146158	A. BUILDING _____ B. WING _____	05/20/2016

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HARBOR CREST HOME	817 17TH STREET FULTON, IL 61252

(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 314 SS=D	Annual Licensure and Certification 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on Observation, Interview and Record Review the facility failed to identify a pressure ulcer before it became unstageable, failed to develop treatment interventions related to a newly identified pressure ulcer and failed to revise care interventions to prevent further skin breakdown. This applies to 1 of 3 residents (R10) reviewed for pressure ulcers in the sample of 12. The findings include: The P.O.S.(physicians order sheet) dated May 2016 shows R10 has diagnoses to include COPD (Chronic Obstructive Pulmonary Desease) and hyperglycemia. The Braden Scale (tool to determine pressure ulcer risk) dated February 19, 2016 shows R10 to be at low risk for pressure ulcers. The care plan for skin breakdown shows R10 had a pressure ulcer to his right buttock which healed on July 31, 2014. The MDS	F 314		

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

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(minimum data set) dated December 17, 2015 shows R10 to be cognitively intact and requires extensive assist with transfers and personal hygiene.

The nurses note dated March 16, 2016 shows R10 reported a sore left outer ankle. The note shows the ankle had a 1 by 1 cm (centimeter) red scab with surrounding pink skin. The wound management record dated March 22, 2016 completed by E10 (wound care nurse) shows an unstageable pressure ulcer to R10's left outer ankle. On April 6, 2016 the ulcer was labled as stage III after debridement.

The care plan for skin breakdown with the goal date of July 12, 2014 had no updated or revised interventions for the pressure ulcer to the left ankle. According to this care plan R10 had a stage II pressure ulcer to his right buttock. The August 2, 2012 care plan for skin integrity shows no new interventions since 2012.

The wound management record completed by E10 on March 22, 2016, shows recommendations for air mattress to bed, extra padding to dressing on R10's left ankle and keeping feet up on pillows while in bed.

The wound management record dated March 29,2016 shows the pressure ulcer of unknown origin but E10 suspects it to be from pressure in the bed.

On May 19, 2016 at 10:30 AM, R10 was sitting in a recliner with his feet elevated and his shoes on. R10's left outer ankle wound had pink skin surrounding the wound.
The base had yellow granulation tissue and

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yellow drainage. The wound measurements from May 10, 2016 were 0.4 by 0.3 cm.

On May 19, 2016 E8 LPN (Licensed Practical Nurse) stated that he encourages the CNA's to put information about new open areas or redness on a shower skin assessment sheet.

On May 19, 2016 at 11:30AM, E9 CNA (Certified Nursing Assistant) stated she let's the nurse know if she see's redness or open areas.

On May 19, 2016 at 11:40AM, E4 (Care plan nurse) stated she is very behind in care plans. She also stated the care plans need to be updated as new issues arise. She stated she gets her interventions from the skin condition record the wound care nurse completes and she did not see one for him.

On May 19, 2016 at 11:15 AM, E2 DON (Director of Nurses) stated the care plan has to be up to date and skin assessments must be done weekly with the residents shower.

The facility's policy for Wound Care dated April 2015 shows that wound assessment is the foundation for the plan of care and assists in determining the cause of the wound. The assessment is essential for tracking progress or deterioration of the wound. The Skin Risk and Pressure Ulcer Treatment Protocol revised on July 17, 2014 shows for licensed nurse to inspect skin weekly and CNA to inspect skin daily with cares.

The Medication Administration Records and Treatment Administration Records for February and March 2016 do not show plan for skin

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F 314	Continued From page 3 assessments.	F 314		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to maintain a safe environment by not ensuring alarm devices were in place, not securing hair care chemicals and not storing a folding privacy partition in a safe manner. This applies to 3 of 12 residents (R2, R5 and R8) in the sample of 12 reviewed for safety and supervision and 8 (R16, R17,R21, R23,R25, and R27-29) in the supplemental sample. The findings include: On May 17, 2016 at 9:55 A.M., R16 was sitting in a recliner in his room. The call light was on the floor and the tab alarm was clipped to his shirt. The receiver box was laying in the chair next to him (not secured to anything). E1 (Administrator) and E12 LPN (Licensed Practical Nurse) assisted R16 to a standing position. R16 used his walker to take a step forward. The tab alarm box followed the resident and did not alarm. E1 said R16 must have dropped the call light. E12 said the tab alarm box will not work without being secured to a static	F 323		

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place.
R16 's history and physical dated February 17, 2016 shows R16 has a history of hydrocephalus with a shunt placement and is a poor historian due to severe dementia.
R16 's Fall care plan reviewed on May 5, 2016 shows R16 is a high risk for falls. Interventions include: to be sure the resident 's call light is within reach and to use a chair alarm and to be sure the device is in place as needed. R16 's Elopement care plan initiated May 9, 2016 shows R16 has impaired safety awareness. R16 's impaired cognitive function care plan reviewed May 5, 2016 shows R16 has altered mental status, impaired decision making, short term memory loss and dementia.
On May 17, 2016 at 10:04 A.M., R17 was in her room in a recliner with her legs elevated. R17 had a cast from the left upper thigh to the foot. There were no alarms visible.
On May 17, 2016 at 10:04 A.M., E41 CNA (Certified Nursing Assistant) said she did not know if R17 was a fall risk or not and checked to see if there were any alarms under or attached to R17. E41 said R17 had no alarms. E41 then left R17 's room without returning with an alarm.
On May 17, 2016 at 10:10 A.M., R17 said she fell at home and broke her left leg and she is here for rehabilitation.
R17 's April 12, 2016 Transfer Assessment shows a total mechanical lift to be used for transfers, resident cannot bear weight, can not safely transfer with stand by assistance and verbal cues and cannot transfer herself. R17 's High Risk for Falls Care Plan initiated on April 15, 2016 shows confusion, gait/balance problems, vision/hearing problems and poor safety awareness as reason R17 is a high fall risk. This care plan shows as an intervention to use a

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chair/bed electronic alarm and ensure the device is in place as needed. R17 's MDS (Minimum Data Set) shows a history of a fall and fracture prior to admission to the facility.

On May 19, 2016 at 8:35 A.M., E2 DON (Director of Nursing) said if a resident is a high fall risk, extra precautions would be put into place. On May 19, 2016 at 11:30 A.M., E4 MDS/Care Plan Nurse said all residents have fall careplans. On May 19, 2016 at 12:00 P.M., E1 said all residents are a high risk for falls. The facility did not provide any fall prevention policy or procedure. The fall policy provided was for what to do after a fall occurred.

2. On May 17, 2016 at 10:00 AM, the door to the facility's beauty salon was open. No staff or salon personnel were in the beauty salon. A box containing a perm (hair care chemicals) was in an unlocked cabinet next to the sink. In a different unlocked cabinet there was a can of hairspray. Leaning against a door that lead from the beauty salon to a storage room was a large folded privacy partition. There was another door to the storage room that opened from the hallway. This door was also unlocked. This surveyor slowly started to open the door in the storage room and could feel the privacy partition starting to move. On May 18, 2016 at 11:00 AM, the salon door was open. The hair care chemicals and the privacy partition were in the same locations as observed the previous day. No staff or salon personnel were in the beauty salon on this day.

On May 18, 2016 at 11:30 AM, E11 (Environmental Services Manager) checked the door to the salon and the door from the salon to the storage room and said both doors do not lock. On May 19, 2016 at 10:45 AM, E11 said leaning the privacy curtain against the storage door was a

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safety hazard. E11 said the hair care chemicals should have been kept in a locked cabinet.

On May 19, 2016 at 8:35 AM, E1 (Administrator) said it was a safety hazard to have the privacy partition leaning against a door that does not lock. E1 said the perm should not have been left in the beauty salon.

The instructions on the perm show "Important: Always wear rubber gloves. Do not drip perm lotion on skin or scalp. Avoid contact with eyes." The instructions on the hair spray show "Avoid inhalation. Avoid spraying in eyes. Do not use on broken skin. Keep out of reach of children."

E1 and E2 identified R2, R5, R8, R16, R17, R21, R23, R25, and R27-R29 as having the diagnosis of dementia and either ambulate or self propel throughout the facility. The MDS (Minimum Data Set) for R2, R5, R8, R16, R17, R21, R23, R25, and R27-R29 showed all of these residents had dementia and moderate to severe cognitive impairment.

The facility's September 2014 Safety policy shows, "It is the policy of (the facility) to maintain a safe environment free of hazards for it's residents, families, and staff. The facility staff will work with due diligence to keep the facility free of hazardous materials, chemicals both inside and out of the facility."

The facility's undated Storing of Chemicals policy shows, "It is the policy of (the facility) to properly store all chemicals. All chemicals are to be secure under lock and key after use. No chemicals should be left out where a resident

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F 323	Continued From page 7 could access them."	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer medications as ordered. There were 28 opportunities with 6 errors resulting in a 21% error rate. This applies to 2 of 3 residents (R2 & R30) observed in the med pass. The findings include: On May 18, 2016 at 7:30 A.M., E14 LPN (Licensed Practical Nurse) crushed all of R30 's medications and opened all capsules. The medications were then mixed together with applesauce and administered to R30. The medications included two carbidopa-levodopa ER 25-100 tabs, a metoprolol succinate ER 25 mg (miiligram) tablet, a potassium chloride ER 20 meq (milliequivalent) tablet and a venlafaxine ER 150 mg capsule. On May 18, 2016 at 7:35 A.M., E14 crushed all of R2 's medications, mixed them with pudding and administered them to R2. The medications included an aspirin 81 mg EC tablet. On May 18, 2016 at 8:00 A.M., E14 said the facility has a standing order to crush everyone's medications and open everyone's capsules prior to administration if needed regardless of manufacturer's recommendations or individual resident conditions. E14 said she has always	F 332		

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crushed resident medications and opened capsules if she thinks she needs to. On May 18, 2016 at 8:30 A.M., E2 DON (Director of Nursing) said the facility standing orders apply to all residents in the facility. E2 said if enteric coated, delayed release or extended release medication tablets and capsules are opened and or crushed before administration the residents may not get the desired dose, a drug interaction may occur and the intended benefit of the drug may be lost.
On May 19, 2016 at 8:15 A.M., E8 LPN (Licensed Practical Nurse) said extended release and enteric coated medications should not be crushed. If these medications were crushed, the therapeutic intent is compromised and the resident does not receive the intended benefits.
On May 18, 2016 at 12:05 P.M., Z2 ANP (Advanced Nurse Practitioner) said she was not aware there is a facility policy being applied to her residents which allow all tablets to be crushed and all capsules to be opened. Z2 said the intention of her orders to crush medications only applies to those medications which the manufacturer recommends may be crushed. Z2 said she would expect to be notified if a resident requires an enteric coated, extended release or delayed release medication ordered in a different form for administration so she could review and/or revise the orders if needed.
On May 19, 2016 at 12:50 P.M., Z1 (Physician) said it is right to question the practice of crushing all medications and opening all capsules for medications the manufacturer does not recommend this be done to. Medications of this type must be approved to be administered in this way. Z1 said the intention of his orders to crush medications applies only to those medications that are approved by the manufacture to be crushed or removed from their capsule. Z1 said

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F 332	Continued From page 9 he was not aware the facility had a standing order that applied to all of his residents to crush all medications and open capsules at the nurse's discretion and without checking with him or the pharmacy first. The facility Resident Census list dated May 12, 2016 show 37 of the 47 residents present are Z1 and Z2 ' s patients. The NIH (National Institutes of Health) recommends Levodopa and Carbidopa ER tablets should be swallowed whole and not crushed. The NIH also recommends venlafaxine ER capsules should be swallowed whole. The ISMP (Institute for Safe Medication Practices) recommend enteric coated aspirin should not be crushed. The undated facility policy for Administration of Medication shows to safely administer physician ordered medication staff shall check the PDR (Physician Desk Reference), pharmacy or drug book to make sure crushing is appropriate.	F 332		
F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of	F 425		

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F 425	Continued From page 10 a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure medications were available and not in stock past their expiration date. This applies to all 47 residents of the facility. The findings include: The facility's resident census report (CMS 671) dated May 17, 2016 shows 47 residents are currently in the facility. On May 18, 2016 at 9:30 A.M., the West Nurses' Station medication cart had the following expired medications available for administration: - a stock bottle of ferrous sulfate 325 mg (milligram) tablets with a manufacturer's expiration date of April 2016. -a stock bottle of loperamide hcl 2 mg tablets with a manufacturer's expiration date of March 2016. -a stock bottle of docusate sodium 100 mg gel tablets with a manufacturer's expiration date of April 2016. The West Nurses' medication room had the following expired medications available for administration: -a stock bottle of ferrous sulfate 325 mg tablets with a manufacturer expiration date of April 2016. -a stock bottle of acetaminophen ER 650 mg caplets with a manufacturer expiration date of March 2016. -Eleven compro 25 mg rectal suppositories with R 31's name on the packaging and a manufacturer	F 425		

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F 425	Continued From page 11 expiration date of March 2016. On May 18, 2016 at 9:55 A.M., the North/South medication room had five- acetaminophen 650 mg rectal suppositories with R15's name on them in the refrigerator and an expiration date of January 2016. The south medication cart had the following expired medications available for administration: -a stock bottle of ferrous sulfate 325 mg tablets with a manufacturer expiration date of April 2016. -a stock bottle of senna plus tablets with a manufacturer expiration date of February 2016. -a stock bottle of Vitamin C 500 mg tablets with a manufacturer expiration date of March 2016. -a stock bottle of ferrous sulfate 325 mg tablets with a manufacturer expiration date of April 2016. The facility's undated Expired Medications policy shows expired medications are to be destroyed/returned to the pharmacy and must be removed from stock and stored away from general inventory. On May 18, 2016 at 9:30 A.M., E12 LPN (Licensed Practical Nurse) said she is working on the West side today and is not sure who goes through the medication cart to check for expired medications. On May 18, 2016 at 9:55 A.M., E14 LPN said she tries to go through the medications at least once a month to check for expired medications. On May 19, 2016 at 8:20 A.M., E8 LPN said if a stock medication is needed and not available on one nursing unit it can be obtained from the other nurse's station, med cart, or room.	F 425		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 12 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to have an infection	F 441		

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control program in place that monitors resident and staff illnesses, ensures residents and staff are screened for Tuberculosis and offer/ administer employee influenza vaccines in season.
This applies to all 47 residents of the facility.
The findings include:
The facility ' s May 17, 2016 Resident Census and Conditions Report (CMS-672) shows 47 residents in the facility.
On May 18, 2016 at 11:45 A.M., E2 DON/Infection Control (Director of Nursing) said when an employee calls in sick an absence report form is filled out and it is placed in their personnel file. E2 said she is unable to locate a log that monitors employee illnesses. The last one I found was from 2011. On May 19, 2016 at 8:30 AM, E1 (Administrator) and E2 were in E2 ' s office looking through cardboard boxes for current employee illness logs. The facility was unable to provide a current log used to monitor employee illnesses when requested. The facility ' s undated Management and Reporting of Employee Infection Policy shows the purpose is to monitor the source of infection; protect residents, employees and visitors from infectious diseases and detect patterns of disease transmission within the facility. No evidence was provided showing implementation of this policy during this survey.
On May 18, 2016 at 11:45 A.M., E2 said nobody tells her if there is an infection or a new antibiotic order, E2 said she has to go look at the logs at the nurse ' s station. Resident antibiotic logs are kept at the nurse ' s station. If the nurse gets cultures back or receives orders for antibiotics the information is entered and I get the logs at the end of the month and put them in a binder. If we don ' t have a log it ' s probably not the end of the

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	146158	A. BUILDING _____ B. WING _____	05/20/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR CREST HOME	817 17TH STREET FULTON, IL 61252

(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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world. The doctor knows because he orders the antibiotics. The only resident illnesses that we monitor are those in which antibiotics were ordered. E2 said R17 is the only resident that has been on isolation in the past month and that was for shingles-not some infectious stuff. The facility ' s resident infection log does not have R17 listed. The facility does not have an infection control committee to my knowledge. E2 said she doesn ' t know if they have been monitoring trends here. The facility does not monitor residents with viral, parasitic or fungal infections, only those that would require an antibiotic to treat.
The facility's undated Infection Control Committee Policy shows the Director of Nursing (E2) is on the committee. This policy shows this committee shall be responsible for the investigation, reporting, control and prevention of infections, all occupational exposures to blood, body fluids or other potentially infectious materials, and for monitoring staff performance to ensure that infection control policies and procedures are properly implemented.
The undated facility's Infection Control Policy shows it is the responsibility of the QAA Committee to assure that infection control policies are implemented and followed. This policy shows its purpose is to establish guidelines to follow to prevent the transmission of infectious or communicable diseases and to control noscomial infections. The facility was unable to provide evidence this policy is being implemented.
The facility's May 1, 1998 Tuberculin Testing of Residents and Staff Procedure shows when hiring a new employee or admitting a new resident the employee, family and/or physician will be questioned regarding previous TB testing, exposure, history of positive TB testing and

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previous treatment for TB. This facility procedure shows this is done because MMWR (the Centers for Disease Control and Prevention ' s Morbidity and Mortality Weekly Report) states residents/employees must receive the Mantoux test within 72 hours after admission or employment. E1 provided a list of employees hired from April 17, 2015-May 19, 2016 and wrote on the list a "facility failure exists." The facility provided list of resident admissions from April 18, 2016-May 9, 2016 was incomplete with information requested regarding dates of TB screening. Of the 48 total hires, 31 were never screened for tuberculosis. On May 20, 2016 at 10:50 AM, E1 said the facility did not perform TB (tuberculosis) testing on all residents and employees as required.

The facility ' s undated Immunization of Employees Policy shows long-term care and skilled care residents are prone to developing serious complications when contracting the flu, all direct-care health care workers shall be required to receive the influenza vaccination, unless medically contraindicated. The facility provided list of employees hired from April 17, 2015-May19, 2016 shows the facility did not offer or require flu vaccination in the month of March 2016 i.e.; none of the seven employees hired in March of 2016 received an influenza vaccine. On May 20, 2016 at 10:50 AM, E1 said they stopped offering the flu vaccine in February 2016 because the flu season was over. The CDC (Centers for Disease Control and Prevention) recommends influenza vaccination from October 1- March 31st annually. On May 18, 2016 at 12:10 PM, E14 LPN (Licensed Practical Nurse) said if employees don ' t want a flu shot they sign a waiver. " I have been here about eight years and have only had two flu shots " .

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