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F 000	INITIAL COMMENTS Annual Certification Survey Complaint #1363310 / IL 64868-No Deficiencies	F 000		
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 the facility failed to prevent cross contamination during urinary catheter care and treat a Urinary Tract Infection with the appropriate medication for one of one resident (R1) reviewed with urinary catheters, on the sample of ten. Findings include: The Physician's Order Sheet dated August 2013 listed the following diagnoses for R1 including Prostate Cancer, Benign Prostate Hypertrophy and Urinary Tract Infection. The Minimum Data Set dated 6/4/13 documented R1 as cognitively impaired, requires extensive assistance for activities of daily living, incontinent of bowel and has a urinary catheter.	F 315		

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

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A urine culture and sensitivity report of 8/12/13 shows growth of Morganella Morganii and Methicillin Resistant Staphlococcus Aureus (MRSA) both greater than 100,000 colony count. The report documents the Morganella Morganii was resistant to Tetracycline.

On 8/13/13 at 11:15 am E10 (Certified Nurse Aide, CNA) provided urinary catheter care for R1 who was incontinent of stool. E10 did not remove contaminated gloves after cleaning stool from R1. E10, with contaminated gloves, touched R1's urinary catheter tubing two to three inches from insertion site at the tip of the penis.

On 8/13/13 at 11:46 am E10 stated that she did not remove gloves after cleaning resident (R1) and wiping stool prior to putting on his clean brief.

The Physician's Order dated 8/13/13 states Minocycline 100mg(milligrams twice daily for 14 days.

On 8/14/14 at 10:20 am E2 (Director of Nursing) referenced R1's urinary culture and sensitivity report of 8/12/13 which showed the bacteria organisms Morganella Morganii and Methicillin Resistant Staphlococcus Aureus. E2 stated she just learned (8/14) that the Morganella was resistant to Minocycline(Tetracycline derivative). E2 stated that on 8/13/13 R1 was started on Minocycline 100 milligrams twice a day for fourteen days. E2 indicated that E4 (Licensed Practical Nurse,LPN) received the final urine culture and sensitivity report and faxed it to the doctor and did not pay attention to the sensitivity report. E2 stated, "If we have any questions

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F 315	Continued From page 2 about the sensitivity reports it our practice to inform the doctor. This practice is not in writing and should be."	F 315		
F 323 SS=D	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, record review and interview the facility failed to secure cylinders of compressed oxygen to prevent accidental upset and rupture, and failed to report and repair a loose toilet seat in the common men's restroom to prevent accidents for three residents (R3, R8, R12) reviewed for falls in the sample of ten. The findings include: 1. On 8/12/13 at 2:15 pm the oxygen supply storage room was toured with Maintenance Supervisor E7. There was a small tank of compressed oxygen on the counter by the sink, a medium sized "E" cylinder of compressed oxygen standing unrestrained just inside the oxygen room door and a unrestrained large "K"cylinder of oxygen stored in the corner of the room. There were metal racks designed for oxygen storage in the room and there was a chain on the wall for securing the large oxygen tanks but they were not	F 323		

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used. E7 confirmed at the time that the oxygen should be restrained to prevent the tanks from being knocked over.

The facility "Oxygen Storage and Assembly" policy dated 1/02 states, the purpose of the policy is "To properly store and assemble oxygen tanks and accessories in a safe and correct manner." The policy directs staff to store oxygen tanks in stands or carts. The policy states, " A chain, on a cart or on a stand must secure tanks."

2. The facility has a Central Men's and a Group Women's toilet room on the back hall. E7 stated on 8/12/13 at 12:20 pm that only four resident rooms are equipped with their own bathrooms. The other residents use the central toilet rooms.

On 8/12/13 at 12:20 pm R12 wheeled himself into the Men's toilet room. R12 had a personal alarm on his wheelchair. A few minutes later the personal alarm sounded. A Certified Nurse Aide E9 went into the bathroom and found R12 already seated on the toilet.

On 8/12/13 at 1:30 pm the Men's central toilet room was toured with Maintenance Director E7 and Housekeeping Director E8. The toilet seat and lid were very loose on the toilet in the first stall. The bolt had broken on one corner and the toilet lid came off when lid was lifted. E7 and E8 stated at the time that no one had reported a problem with the toilet seat to them. E7 stated on 8/14/13 at 12:30 pm that he has a Maintanance Log at the Nurse's Station for staff to report items that need repair.

R3, R8, and R12, are at risk for falls per interview with Director of Nurses E2 at 10:30 am

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F 323	Continued From page 4 on 8/12/13 during the initial tour. The residents who do not have in room bathrooms utilize the common Men's restroom. R3 stated on 8/13/13 at 1:30 pm that he is at risk for falls and requires staff assistance to get off the toilet. R3 stated he is left alone for privacy in the Men's restroom. R12 is a fall risk and self transfers without staff assistance per observation on 8/12/13 at 12:20 pm. E2 stated on tour on at 10:40 am that R8 requires assistance of one staff with a walker but is non compliant. R8 is ambulatory and is a fall risk and independently uses the men's restroom. E7 and E8 stated on 8/13/13 at 12:20 pm that the staff should be reporting repair issues like loose toilet seats to E7.	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 give medications per manufacturer's specifications for three residents (R18, R4, R24) on the supplemental sample. The facility had 7 medication errors out of 29 opportunities for error, resulting in a 24.1% medication error rate.	F 332		

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Findings include:

1. On 8/12/13 at 4:30pm E3, LPN(Licensed Practical Nurse) administered Metoprolol 75mg(milligrams), Potassium Chloride 20 milliequivalents 2 tablets, Lovastatin 20mg and Tamsulosin HCL 0.4mg to R18. E3 gave the medications to R18 whole in 3 teaspoons of applesauce. R18 took a sip of water following the medication administration.

The label on the Metoprolol medication package states, "Take with or immediately after food/meal."
The 2007 8th Edition of Lexi-Comp's Drug Reference Handbook, page 813 states, "Food increases absorption. Metoprolol serum levels may be increased if taken with food."

The label on the Potassium Chloride medication package states, "Take with plenty of water. Take with a meal." The 2007 8th Edition of Lexi-Comp's Drug Reference Handbook, page 1010 states, "Administer with plenty of fluid and/or food because of stomach irritation and discomfort."

The Physician's Order dated 7/25/13 states to take the Lovastatin with a meal. The Lovastatin medication label states, "Take with a meal." The 2007 8th Edition of Lexi-Comp's Drug Reference Handbook, page 758 states, "Food...increases the bioavailability of lovastatin immediate release tablets."

The Physician's Order dated 7/25/13 states to take the Tamsulosin "30 min[minutes] after dinner." The Tamsulosin medication label states

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F 332	Continued From page 6 "Take 1/2 hour after same meal." The 2007 8th Edition of Lexi-Comp's Drug Reference Handbook, page 1171 states, "Take...30 minutes after the same meal each day." On 8/12/13 at 4:50pm E3 stated the dinner meal is usually served at 5:00pm. E3 stated she generally starts her medication pass with residents who are still in their rooms. E3 stated she usually gives R18 her medications between 4:00 and 4:30pm. 2. On 8/12/13 at 4:20pm E4, LPN(Licensed Practical Nurse) administered Atenolol 50 mg(milligrams) and Sodium Bicarb 650 mg with water to R4. The Physician's Order Sheet dated August 2013 indicates R4's Atenolol and Sodium Bicarb are to be taken with a meal. E4 stated "He (R4) had it before the meal. Guess I never realized it." 3. On 8/12/13 at 4:30 pm E4 administered Ferrous Sulfate 325 mg before the evening meal to R24. The Physician Order Sheet dated August 2013 indicates R24's Ferrous Sulfate 325 mg is to be given with meals.	F 332		
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 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 -	F 441		

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(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:
A. Based on record review and interview, the facility failed to have an Infection Control Program which analyzes resident infections to determine trends and patterns and to identify the need for corrective action, and which monitors the use of antibiotics. The facility failed to identify a trend of urinary tract infections involving R1, R2, R8, R9, R11, R14, R23, R24, R28, R31, R32, R33, R34, R35, R36, R37, R38 and R39 and implement

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corrective action. These failures have the potential to affect all 38 residents.

Findings include:

The Infection Control Surveillance and Monitoring policy dated 5/07 states the Director of Nurses and/or Administrator will be responsible for maintaining records of surveillance and monitoring of infections. The policy does not address the monitoring of antibiotic use. Infection Control Logs dated October 2012 through August 2013 list resident infection data for each month, but do not provide an analysis of the data to identify trends, patterns or corrective action taken.

On 8/14/13 at 10:25 a.m. E1 Administrator stated she was previously the Director of Nurses and the Infection Control Preventionist. E1 stated there was no written analysis of the Infection Control Log data. E1 stated the facility did not have a formal process to monitor the use of antibiotics. E1 explained that each month the pharmacy provides a listing of antibiotics dispensed and from that list E2, current Director of Nurses, writes the antibiotic order on the Infection Control Log. E1 stated there is no documentation of a review of the antibiotics for sensitivity to the identified organism; rather it is the responsibility of the nurse who receives the lab report to check that the antibiotic is effective. When asked if the facility had identified any trends in infections in recent months, E1 stated they had identified a trend of urinary tract infections (UTI) at the end of July 2013. E1 was unable to demonstrate knowledge of any trend in the organism with the UTIs. E1 stated once the trend of UTIs was identified at the end of July, staff started to

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observe incontinence care provided by direct care staff and provide education. E1 stated at this time two Certified Nurse Assistants (CNA) had been observed for incontinence care and five CNAs had received education. E1 stated the concern with UTIs would be taken to the next Quality Assurance (QA) meeting. Quarterly QA Attendance records document the last quarterly meeting was held 7/18/13.

Infection Control Logs dated April through August 2013 document the following data regarding residents with UTIs:

April - R23 and R8 with UTIs - both identified the organism escherichia-coli (e-coli)

May - R2, R8 (two UTIs), R24, R34, R39 - three of these listed the organism as e-coli and one did not list the organism

June - R11, R24, R31, R36, R37, R38 - three of these listed the organism as e-coli; four did not list the organism

July - R1 (two UTIs), R2 (two UTIs), R8, R9, R14, R24, R28, R32 (two UTIs), R33, R34, R35 - seven of these listed the organism as e-coli; four did not list the organism

August - R24 and R32 - one with the organism listed as e-coli

The Resident Census and Condition of Residents form dated 8/12/13 lists a current census of 38 residents.

B. Based on interview, observation and record review the facility failed to disinfect multi use

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blood glucose meters to prevent potential cross contamination for 4 of 10 residents(R13,1,8,12) on the sample of 10 and 10 residents(R4,18-26) on the supplemental sample. The facility failed to use technique to prevent cross contamination during incontinence care for one of five residents(R1) with incontinence.

Findings include:

1. On 8/12/13 at 4:30pm E3, LPN(Licensed Practical Nurse) checked R18's blood glucose level. When finished, E3 wiped the blood glucose meter with a germicidal disposable wipe and laid it on a tissue on the medication cart. On 8/12/13 at 4:40pm E3 stated she wiped the blood glucose meter with the germicidal wipe for about 30 seconds, before laying it on the tissue to air dry.

The label of the Germicidal Disposable wipe states it contains a quaternary/alcohol based solution. The instructions on the label states, "Unfold a clean wipe and thoroughly wet the surface for a full 2 minutes.....Let air dry..."

The Cleaning and Disinfecting of Glucometer policy dated 6/9/10 states, "Cleaning and disinfecting with a Germicidal Disposable Wipe will be completed each time is blood glucose monitor is used....Wipe down area to be cleaned...Air dry..."

On 8/12/13 at 5:00pm E11, Corporate Nurse stated staff are expected to follow the instructions listed on the germicidal wipes used for disinfecting the blood glucose meters.

On 8/13/13 at 4:00pm E1, Administrator provided the following list of residents receiving blood

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F 441	Continued From page 11 glucose monitoring: R1,R8,R12,R13, R4 and R18-26. 2. On 8/12/13 E4, LPN(Licensed Practical Nurse) checked R4's blood glucose level at 4:20 pm and R24's blood glucose level at 4:30 pm. Each time E4 wiped the blood glucose meter with a germicidal disposable wipe for approximately 30 seconds after each use. The blood glucose meter was not allowed to be wet with the Germicidal Disposable wipe for the minimum of two minutes. 3. On 8/12/13 at 11:15 am E10 (Certified Nurse Aid, CNA) was providing incontinence care for R1 who was incontinent of stool. E10 did not remove contaminated gloves after wiping stool from R1's buttocks and proceeded to dress and transfer R1 from the bed to wheelchair. E10 touched clean items with contaminated gloves including the cleansing solution, R1's clean brief, clothing, bed linens, wheelchair and gait belt. At 11:46 am E10 stated that she did not remove contaminated gloves after cleaning (R1) and wiping stool.	F 441		
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation and record review, the facility failed to provide at least 80 square feet of space per resident bed in 30 of 30 multiple-bed resident bedrooms. The undersized bedrooms	F 458		

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F 458	Continued From page 12 provide only 77.3 square feet per resident bed. This has the potential to affect 38 of 38 residents. The findings include: Historical room size documentation and actual measurements demonstrate that the undersize dual occupancy bedrooms 2, 4, and 5-32 provide only 77.3 square feet per resident bed. The occupied resident bedrooms are equipped with the minimum required furnishings such as bed, bedside table comfortable chair and dressers. There were no infection control issues identified. There are 30 dual occupancy bedrooms in the facility. There are two private resident rooms. All of the bedrooms are Medicaid (Title 19) certified and rooms 2, and 4-11 are dually certified for Medicare (Title 18) and Medicaid according to the " Medicare/Medicaid Certification and Transmittal" form dated 10/25/12. The Centers for Medicare and Medicaid Service Form CMS-672 "Residents Census and Conditions of Residents" report dated 8/12/13 lists a resident census of 38 residents.	F 458		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 465		

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interview, the facility failed to ensure that appliances in wet areas were plugged directly into ground fault circuit interrupter (GFI) protected outlets in the laundry room. The facility failed to repair the roof in a timely manner to prevent ceiling and soffet water damage. The facility failed to repair a water damaged wall and prevent further water damage around the rim flush sink in the soiled utility room. The exhaust system of the soiled utility room was not maintained in a properly functioning condition. These failures have the potential to affect all 38 residents.

The findings include:

1. On 8/12/13 at 2:15 pm the laundry room was toured with Maintenance Director E7 and Housekeeping Supervisor E8. There were two chemical dispensing units with manual pumps mounted on the wall directly beside the washing machine. There were dried chemical streaks down the wall that extended down past the 110 volt electrical outlet beside the washing machine. The window air conditioner was plugged into this outlet and a power strip extension cord was also plugged into the outlet. There were two cords plugged into the power strip. E7 stated that these two power cord electrical plugs were for the washing machine and the electric chemical pump dispenser for the washing machine. When asked if the outlet was protected with a Ground Fault Circuit Interrupter (GFCI), E7 stated "It does not appear so."

Corporate Administrator E6 stated on 8/13/13 at 4:30 pm that they consulted with their corporate maintenance staff who confirmed that the outlet should be GFCI protected. E7 also stated that the washing machine and the chemical pump should

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	145466	A. BUILDING _____ B. WING _____	08/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN LAKES REHAB & HEALTH CARE	310 EADS AVENUE PARIS, IL 61944

(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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be plugged directly into the wall and not a power strip.

2. On 8/12/13 at 3:00 pm the outdoor courtyard was toured with Maintenance E7. There was a large hole rotted though the wooden soffet at the roof line corner where the valley of the roof comes together. The open cavity was approximately 18 inches in diameter. The roof shingles looked deteriorated and curled. E7 stated that they need a new roof. He stated the front of the building has a new roof on the front side but the back side does not. The roof has leaked and has caused damage inside the building.

On 8/12/13 at 3:15 pm water damage to the ceiling outside of the Dining room was identified. There was a 4 foot long crack in the ceiling plaster that extended from the ceiling light fixture to the outside wall in the corridor beside the dining room. The ceiling around the crack was bowed down and the underlying structure was exposed. There was brown staining along the crack from previous water damage. This damage was located directly over the large activity board that was mounted on the wall in the main corridor by the dining room. E7 stated this crack was caused by water damage from the roof leak. E7 stated he had tarred the valley of the roof in an attempt to repair the leak but the damage still needs to be repaired and the roof replaced. On 8/14/13 at 1:50 pm E7 stated that they had a hail storm on 4/10/13 that further damaged the old roof. E7 stated the hole in the soffet was present before the hail storm but it has gotten worse with the continued leaking. E7 stated a bid was received for repair to the roof on 7/13/13.

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F 465	Continued From page 15 3. On 8/12/13 at 1:45 pm the wall board was pulled away from the wall beside the rim flush sink in the soiled utility room. There was water damage behind the wall. The drain from a condensate line was laying across the back of the rim flush sink, the end of the drain tube was pointed toward the floor instead of into the rim flush sink. 4. The exhaust fan in the soiled utility room was functioning poorly in that it had a weak air draw when tested with a tissue. There was an odor of feces in the room from the soiled linen hampers and the biohazard container. The facility Resident Census and Condition of Residents report form dated 8/12/13 listed a census of 38 residents.	F 465		
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee	F 520		

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except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview the facility failed to ensure that a Physician was in attendance at each of the last four quarterly Quality Assurance and Assessment(QAA) Committee meetings. The facility failed to identify a trend of residents with urinary tract infections including R1, R2, R8, R9, R11, R14, R23, R24, R28, R31, R32, R33, R34, R35, R36, R37, R38, and R39, specifically those with Escherichia coli (E-coli) Urinary Tract Infections and develop an action plan. These failures have the potential to affect all 38 residents residing in the facility.

Findings include:

1. Quality Assurance Committee Physician, Z1's signature is not on the Quarterly QAA Attendance Meeting sign in sheet dated 10/18/12. On 8/14/13 at 10:26am the Administrator (E1) stated Z1 was the Physician member of the QAA Committee. E1 stated, "(Z1) does not always attend, he just reviews the minutes and signs off on them. He was not at the last two QAA meetings that I attended."

On 8/14/13 at 11:00am the Director of Nursing (E2) stated, "(Z1) has not come to the QAA meetings since December 2012, when I started

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going to them. He reviews the minutes and signs the sign in sheet."

On 8/14/13 at 11:48am the Social Services Director/Activity Director (E13) stated, "(Z1) has not been to any QAA meetings in the last 12 months. He does sign off on them though."

2. On 8/14/13 at 10:25 a.m. E1 Administrator stated she was previously the Director of Nurses and the Infection Control Preventionist. When asked if the facility had identified any trends in infections in recent months, E1 stated they had identified a trend of urinary tract infections (UTI) at the end of July 2013. E1 was unable to demonstrate knowledge of any trend in the organism with the UTIs. E1 stated once the trend of UTIs was identified at the end of July, staff started to observe incontinence care provided by direct care staff and provide education. E1 stated at this time two Certified Nurse Assistants (CNA) had been observed for incontinence care and five CNAs had received education. E1 stated the QAA Committee had not reviewed the urinary tract data for June, July or August 2013. E1 stated this concern with UTIs would be taken to the next QAA meeting. Quarterly QAA Attendance records document the last quarterly meeting was held 7/18/13.

Infection Control Logs dated April through August document the following data regarding residents with UTIs:

April - R23 and R8 with UTIs - both identified the organism Escherichia-coli (e-coli)

May - R2, R8 (two UTIs), R24, R34, R39 - three of these listed the organism as e-coli and one did

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F 520	Continued From page 18 not list the organism June - R11, R24, R31, R36, R37, R38 - three of these listed the organism as e-coli; four did not list the organism July - R1 (two UTIs), R2 (two UTIs), R8, R9, R14, R24, R28, R32 (two UTIs), R33, R34, R35 - seven of these listed the organism as e-coli; four did not list the organism August - R24 and R32 - one with the organism listed as e-coli On 8/14/13 at 10:26am E1 stated "the QAA committee has not looked at June, July or August yet." The Resident Census and Report of Condition dated 8/12/13 states that 38 residents currently reside in the facility.	F 520		