STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145466	A. BUILDING _____ B. WING _____	09/06/2012

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
F 000	INITIAL COMMENTS	F 000		
F 309 SS=D	Licensure and Certification Survey 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, record review and interview, the facility failed to provide treatment and services to address new onset of diarrhea for R6. This resulted in R6 experiencing ongoing episodic diarrhea over the course of 15 days. This ongoing diarrhea resulted in avoidable discomfort and pain. R6 is one of one resident reviewed for incontinence in the sample of 10. Findings include: The Physician Order Sheet (POS) dated 9/12 documents the following diagnoses for R6: Generalized Weakness, Anxiety, Depression, Dementia, and Neurogenic Bladder with indwelling urinary catheter. On 9/4/12 at 10:30 a.m. R6 cried out that she had diarrhea and sobbed "they won't do anything about it." The facility's record titled "Activities of Daily	F 309		

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

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F 309	Continued From page 1	F 309		

Living" dated 8/12 and 9/12 for R6 reflects documentation (under the bowel movement section) of loose stools on multiple shifts from 8/21/12 through 9/4/12 (15 days). There is no documentation of loose stools prior to 8/21/12.

A facility faxed transmittal to R6's Physician, Z1 dated 8/31/12 documents a request by E8 (Registered Nurse) for "something to give resident (R6) some relief for loose watery stools." The same document reflects an order for Lomotil 2.5 milligrams, two tablets four times a day as needed (controlled substance schedule IV anti-diarrheal) by Z1 and noted by E9 (Licensed Practical Nurse).

The Medication Administration Record for R6 dated 8/12 and 9/12 shows no documentation of Lomotil being given.

The POS for R6 dated 8/12 documents an order for Immodium "one time dose now" on 8/24/12. The nursing notes for R6 dated 8/24/12 reflect that an Immodium order was received and given at 8:00 p.m. due to Certified Nursing Assistant reporting that R6 had diarrhea and loose stools times two in the past three hours.

On 9/4/12 at 2:10 p.m. E8 (Registered Nurse) acknowledged that on 8/31/12 an order from Z1 for Lomotil (controlled substance schedule IV antidiarrheal medication) was received but had not came in from the pharmacy yet because the pharmacy needed a paper prescription faxed to them. E8 acknowledged that R6 had not received the medication as of this time. E8 stated she did not work the weekend and did not know why the prescription was not followed up on over the

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F 309	Continued From page 2 weekend. Nursing notes for R6 dated 9/4/12 at 12:35 p.m. documents R6 continuing to have loose stools, awaiting prescription for Lomotil. On 9/4/12 at 2:20 p.m. E2 (Director of Nursing) stated she had not been notified over the weekend about the medication order for R6 and the facility's nurses were aware that a paper prescription was needed from Z1 in order to receive the medication from the pharmacy....."I will get the prescription today." At 4:10 p.m. on 9/4/12 E1 (Administrator) acknowledged that she too was not notified over the weekend of the need for R6's medication and stated "If they couldn't get the medication for her (R6), they should have sent her to the emergency room." On 9/4/12 at 3:40 p.m. E5 and E7 (Certified Nursing Assistants) performed catheter and perineal cleansing on R6. R6 cried and yelled that it hurt when her rectal area was cleansed. R6's perineal area appeared red at this time. E7 stated that R6 has had diarrhea for two weeks. On 9/5/12 at 9:50 a.m. Z1 stated per phone interview that he was not made aware of the need for a paper prescription for Lomotil until 9/4/12, and did not recall being contacted by anyone for a paper prescription prior to 9/4/12.	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	F 315		

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F 315	Continued From page 3	F 315		

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, record review and interview staff failed to maintain R4's urinary drainage bag below the level of the bladder to prevent back flow of urine. R4 is one of three residents reviewed for urinary catheters in the sample of ten.

Findings include:

The Physician's Orders Sheet (POS) dated September 2012 lists the following diagnoses for R4: BPH (Benign Prostatic Hyperplasia) and Incomplete Bladder Emptying. The POS has an order for R4 to have Foley Catheter #16 FR(french) with 10cc (cubic centimeters) balloon and R4 to receive catheter care every shift.

E6, CNA (Certified Nursing Assistant) assisted E5,CNA with catheter care for R4 on 9/4/12 at 1:20 PM. E6 removed the urinary drainage bag from the side of the bed and raised the bag above R4's bladder while he was lying on his back in the bed. Urine was seen traveling down the catheter tubing toward the insertion site of the catheter. E6 then laid the urinary drainage bag onto the bed while E5 continued with catheter care.

E6 stated on 9/4/12 at 1:30 PM that she did raise

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F 315	Continued From page 4 the urinary drainage bag above R4's bladder while E5 was doing catheter care. A Urine Culture Microbiology report dated 7/11/12 shows the organism Escherichia Coli present in the urine sample. A telephone order from the Physician dated 7/11/12 reads for R4 to receive the antibiotic Macrobid 100 milligrams twice a day for seven days for Urinary Tract Infection.	F 315		
F 332 SS=E	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 ensure that medications were administered as ordered for five out of 46 opportunities of medication administration, resulting in a 10.8% medication error rate. This failure affected R2, R5, R11, R12, R13. Findings include: 1. On 09/04/12 at 11:30am, E4, Licensed Practical Nurse (LPN), administered one tablet of Tylenol 325 milligrams (mg) to R11. R11's Physician Order Sheet (POS) dated September 2012 orders that R11 is to receive two tablets of Tylenol 325mg during the 12:00pm medication pass.	F 332		

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F 332	Continued From page 5 On 09/04/12 at 1:30pm, E4 confirmed that she had only given one tablet of Tylenol 325mg to R11 on the noon medication pass, and that the order documents to administer two tablets. 2. On 09/04/12 at 11:40am, E4, LPN, administered insulin to R12 using a Novolog Flex Pen. During preparation of the Novolog Flex Pen for use, E4 attached the disposable safety needle to the Novolog Flex Pen, dialed the Pen to two units, and administered the insulin to R12. E4 did not flush the air out of the needle prior to injecting the two units of insulin into R12. On 09/04/12 at 11:40am, E4 stated that she did not inject two units of insulin through the needle prior to administering the insulin. Manufacturer's recommendations direct: "Perform a safety test. This removes air bubbles and ensures that the pen and needle are working properly. Select a dose of two units. Always perform the safety test before each injection." 3. On 09/04/12 at 11:55am, E4, LPN, administered one tablet of Tylenol 325 milligrams (mg) to R2. R2's POS dated September 2012 orders that R2 is to receive two tablets of Tylenol 325mg during the 12:00pm medication pass. On 09/04/12 at 1:30pm, E4 confirmed that she had only given R2 one tablet of Tylenol 325mg on the noon medication pass, and that the order documents to administer two tablets. 4. On 09/04/12 at 12:06pm, E4 prepared to	F 332		

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F 332	Continued From page 6	F 332		

administer 1mg of liquid Ativan to R13 by measuring 0.5 milliliters (ml) of liquid Ativan into a medication cup. The liquid Ativan was to be administered sublingually (under the tongue). E4 then began to add liquid supplement to the medication cup when the surveyor interrupted the medication preparation.

R13's POS dated September 2012 directs that R13 is to receive Ativan 1mg sublingually every four hours as necessary.

On 09/04/12 at 12:06pm, E4 stated that she was preparing the Ativan liquid to be swallowed.

5. On 09/04/12 at 12:10pm E4, LPN, administered insulin to R5 using a Humalog Flex Pen. During preparation of the Humalog Flex Pen for use, E4, LPN, attached the disposable safety needle to the Humalog Flex Pen, dialed the Pen to ten units, and administered the insulin to R5. E4 did not flush the air out of the needle prior to injecting the ten units into R5.

On 09/04/12 at 11:40am, E4 stated that she did not inject two units of insulin through the needle prior to administering the insulin. E4 stated that she was not aware that the needle needed to have the air flushed out of it.

R5's POS dated September 2012 directs that R5 receive 10 units of Humalog insulin with the 12:00pm meal daily.

Manufacturer's recommendations direct: "Perform a safety test. This removes air bubbles and ensures that the pen and needle are working properly. Select a dose of two units. Always

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F 332	Continued From page 7 perform the safety test before each injection."	F 332		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to obtain and administer medication for diarrhea ordered by the physician for one of one resident (R6) reviewed for incontinence in a sample of 10. This resulted in R6 having repeated episodic diarrhea and discomfort without benefit of the ordered anti-diarrheal medication. Findings include: The Physician Order Sheet (POS) dated 9/12 documents the following diagnoses for R6: Generalized Weakness, Anxiety, Depression, Dementia, and Neurogenic Bladder with indwelling urinary catheter. A facility faxed transmittal to R6's Physician, Z1 dated 8/31/12 documents a request by E8 (Registered Nurse) for "something to give resident (R6) some relief for loose watery stools." The same document reflects an order for Lomotil 2.5 milligrams, two tablets four times a day as needed (controlled substance schedule IV anti-diarrheal) by Z1 and noted by E9 (Licensed Practical Nurse). The facility's record titled "Activities of Daily	F 333		

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F 333	Continued From page 8	F 333		

Living" dated 8/12 and 9/12 for R6 documents the following under the bowel movement section: 8/31/12 on first and second shifts, loose stools, 9/1/12 on third shift, three loose stools, 9/3/12 on second shift, two loose stools, 9/4 on first shift, four loose stools.

The Medication Administration Records dated 8/12 and 9/12 for R6 shows no documentation of Lomotil being given from the receipt of the order on 8/31/12 to 9/4/12 (5 days).

Nursing notes for R6 dated 9/4/12 at 12:35 p.m. documents R6 continuing to have loose stools, awaiting prescription for Lomotil.

On 9/4/12 at 10:30 a.m. R6 cried out that she had diarrhea and sobbed "they won't do anything about it."

On 9/4/12 at 2:10 p.m. E8 (Registered Nurse) acknowledged that on 8/31/12 an order from R6's physician, Z1 for Lomotil (controlled substance schedule IV anti-diarrheal medication) was received but had not came in from the pharmacy yet because the pharmacy needed a paper prescription faxed to them. E8 acknowledged that R6 had not received the medication as of this time. E8 stated she did not work the weekend and did not know why the prescription was not followed up on over the weekend.

On 9/4/12 at 2:20 p.m. E2 (Director of Nursing) stated she had not been notified over the weekend about the medication order for R6 and the facility's nurses were aware that a paper prescription was needed from Z1 in order to receive the medication from the pharmacy....."I

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F 333	Continued From page 9 will get the prescription today." At 4:10 p.m. on 9/4/12 E1 (Administrator) acknowledged that she too was not notified over the weekend of the need for R6's medication and stated "If they couldn't get the medication for her (R6), they should have sent her to the emergency room." On 9/4/12 at 3:40 p.m. E5 and E7 (Certified Nursing Assistants) performed catheter and perineal cleansing on R6. R6 cried and yelled that it hurt when her rectal area was cleansed. R6's perineal area appeared red at this time. E7 stated that R6 has had diarrhea for two weeks. On 9/5/12 at 9:50 a.m. Z1 stated per phone interview that he was not made aware of the need for a paper prescription for Lomotil until 9/4/12, and did not recall being contacted by anyone for a paper prescription prior to 9/4/12. An undated facility document titled "Inservice for all Nurses Regarding All Medications Not Sent Timely From Pharmacy!" states "If any nurse receives the tote at night and does the checkoff list she is to list any expected meds (medications) that did not come. If she receives any notice from the pharmacy that hard scripts (paper prescriptions) are needed and she is unable to obtain hard script the DON is to be immediately notified in each case!! No resident is to be without their scheduled meds at any time!!!! If scheduled meds do not come in they are to call pharmacy and request these meds from back up pharmacy to be sent!!!!"	F 333		
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	F 458		

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F 458	Continued From page 10 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 provide only 77.3 square feet per resident bed. This has the potential to effect 31 of 32 current residents. Findings include: Historical room size documentation and actual measurements demonstrate that the undersize dual occupancy bedrooms 2, 4, 5, 6, 7, 8, 9, 10, 11,12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, and 32 provide only 77.3 square feet of space per bed. The occupied resident bedrooms are equipped with the minimum required furnishings such as bedside table, comfortable chair, and dresser drawers. All the rooms are Medicaid (Title 19) certified and rooms 2, 4, 5, 6, 7, 8, 9, 10 and 11 are also Medicare (Title 18) certified for 2 beds in each room. According to Centers for Medicare and Medicaid Service Form CMS-672, "Residents Census and Conditions of Residents", the facility has 32 residents. One of the 32 residents resides in a private room.	F 458		