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| F 000 | INITIAL COMMENTS<br><br>Annual Licensure and Certification Survey.<br><br>Investigation of Complaint 1575339/IL80449. F469 cited.<br><br>Investigation of Complaint 1575780/IL80975.<br><br>No Deficiencies cited. | F 000 | | |
| F 309 SS=G | 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation interview and record review, the facility failed to assess and monitor and provide treatment and services in a timely manner to a resident with an acute humeral fracture. This failure resulted in a worsening of the fracture and increased pain for the resident.<br><br>This applies to 1 of 2 (R1) residents reviewed for falls with injury in the sample of 28 residents.<br><br>The facility also failed to have an effective communication system with the dialysis center to coordinate care pre and post dialysis.<br><br>This applies to 2 of 2 (R10 and R24) residents | F 309 | | |

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

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reviewed for dialysis in a total sample of 28.

The findings include:

On 10/20/15 at 10:30 AM R1 was sitting in a wheel chair with his left arm on a pillow with visible swelling of the hand and wrist. R1 stated he was in a lot of pain. R1 stated he broke his arm and it throbs like a tooth ache. R1 also stated he was supposed to go to the orthopedic doctor for follow up but they keep canceling the appointments and has not seen an orthopedic doctor since he broke his arm.

R1 feels his pain is not managed at all. On 10/20/15 and 10/21/15 R1 did not have a sling on his arm. R1 said he had a sling after the initial fracture but when he went to the hospital (for a non-fracture related issue) he came back to the facility without the sling. R1's nursing notes indicate R1 was sent out on 10/14/15 and returned on 10/16/15. R1 stated the sling made it more comfortable for him and helped ease the pain.

R1's nursing notes were reviewed for September and October 2015 and there is no mention of R1 refusing to wear the sling. There are several nurses notes documenting R1's sling was on when he first returned from the hospital on 9/29/15.

R1's nursing incident note of note of 9/29/15 states R1 was observed lying on the floor on his left side with his left arm underneath. Assessment done, no visible injury noted. R1 complained of pain of 9 out of 10 when passive range of motion performed on his left arm. Physician ordered to send to ER for evaluation and treatment. R1

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returned from hospital the same day with a sling on his left arm. The X-ray results dated 9/29/15 show R1 had a nondisplaced fracture through the left humeral neck.

The emergency department report dated 9/29/15 states R1 should follow up with physician in seven to ten days. The nursing note of 10/6/15 (seven days post fall) documents the staff nurse reminded and informed R1's physician of the follow up with the Orthopedic doctor. The nurse documented the physician will talk with the scheduler.

The nursing notes dated 10/20/15 documents that the transport did not show up for R1's ortho appointment.

On 10/21/15 at 1:00 AM E6 (appointment scheduler) stated that a new appointment had been made for 10/27/15.

On 10/22/15 at 1:30 PM, R1 stated that his pain is at 8 out of 10 and his arm throbs like a tooth ache. R1 said he hasn't had his sling since he came back from the hospital on 10/16/15.

On 10/22/15 at 1:30 PM, E8 (staff nurse) caring for R1 said that R1 did not complain of pain, and there was no swelling of his arm. When E8 looked at his arm she did say it was swollen. E8 stated the assessment for R1's arm would be in the nursing notes. E8 stated she would call Z1 (Nurse Practitioner) to evaluate R1.

R1's nursing notes were reviewed for September and October 2015 and there was no assessment for R1's arm. There was no mention of circulation, motion or sensation of the affected

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arm. There is no documentation of any pain relieving measures such as applying ice or elevation of the arm. There is no documentation to show that R1's primary physician was notified of the delay in orthopedic treatment and if any treatments needed to be put in place until R1 could be seen by the orthopedic doctor.

On 10/22/15 at 2:15 PM Z1 stated that she was not aware that R1 had swelling to the affected arm/hand and increased pain. Z1 also stated she was not aware that R1 was without a sling for any period of time and she was also not aware that R1 had missed the orthopedic appointment. Z1 stated she will assess R1, order another X-ray and increase his pain medication.

The X-ray report dated 10/22/15 documents a change in R1's fracture from non displaced to displaced. The X-ray showed there is an acute or subacute minimally displaced fracture through the left humeral neck. The distal fragment is displaced laterally by 4-5 mm and is impacted onto the humeral head by approximately 13 mm. This was not evident on the initial X-ray done on 9/29/15.

On 10/23/15 at 10:44 AM, Z1 documented the X-ray results from 10/2215 were reviewed and R1 will be sent out to the emergency room stat for possible casting and the orthopedic consult is pending.

R1's care plan reviewed on 10/21/15 does not have any mention of his humeral fracture, what kind of care is needed, limitations R1 may have and ways to reduce pain. There is no mention of immobilizing the arm, what the arm should be mobilized with and for what period of time it

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| F 309 | Continued From page 4<br>needed to be mobilized.<br><br>1. R10 has a medical history of Renal failure on the October 2015 physician order sheet.<br><br>On 10/21/15 at 9:30 AM, E5 (LPN, Licensed Practical Nurse) stated R10 goes out to dialysis on Tuesdays, Thursdays and Saturdays. E5 stated a communication sheet is sent to dialysis and then it is returned with the resident and scanned into the computer. E5 was only able to locate one communication document from dialysis for February and one for March of 2015.<br><br>On 10/21/15 at 3:00 PM, E2 (DON) confirmed there were no other dialysis communication sheets.<br><br>The October 2015 nursing notes only document about R10's pain medication. There are no nursing notes concerning dialysis or any assessments pre or post dialysis. R10's documented weights under "weights" in the electronic medical record shows only one day documented as a dialysis weight (9/25/15) but it is unclear if it is a pre or post dialysis weight.<br><br>The undated facility policy titled, "Care of Dialysis Resident," documents, "Correlation of services will be established between the dialysis team and the facility staff."<br><br>R24 has a medical history of chronic kidney disease and dialysis as documented in the October 2015 physician order sheet.<br><br>There are sporadic dialysis communication | F 309 | | |

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| F 309 | Continued From page 5<br>sheets for R24. There is one in August 2015 and none for September 2015 and three for October 2015.<br><br>On 10/23/15 E2 stated there is a system to send a communication sheet with the resident to the facility, but residents not always bring the sheet with them to the facility. E2 said here after the nurse will follow up with the dialysis center if the resident did not bring the communication sheet. | F 309 | | |
| F 318 SS=D | 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to evaluate and provide positioning devices to promote comfort and positioning.<br>This applies to 2 of 3 residents (R11 and R8) in the sample of 28 residents reviewed for positioning and range of motion.<br>The findings include:<br>1. On October 20, 2015 at 11:05 AM, R 11 was observed on his wheelchair leaning on the left side. R 11's left hand was about six inches away from the floor. On October 21, 2015 at 1:45 PM, R11 was in his wheelchair in front of the first floor nursing station. R11 was leaning on the left side, | F 318 | | |

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| F 318 | Continued From page 6<br>there was no positioning device noted.<br>On October 22,2015 at 1:00 PM, E3 (Restorative Nurse) stated there was no positioning device for R11 at this time but there should be a pillow on the side to keep him more comfortable and to be able to sit properly.<br><br>2. On 10/20/15 at 10:45 R8 was in his wheelchair with both legs on the wheelchair seat and wheeling with his hands through out the facility. R8's wheelchair foot rests spread out, half of the left foot rest cushion was missing. R8's wheel chair is too small for R8's height. R8 continued to sit on the wheelchair with both of R8's legs on the wheel chair seat and propel the wheelchair with his hands in and out of the facility on all days of the survey.<br><br>R8's 2003 admission information sheet showed R8 has Multiple Sclerosis, Legally Blind and has Osteoporosis.<br><br>On 10/21/15 at 11:45 AM E3 said R8 refused to have a different chair, but was unable to show documentation if R8 or guardian was given information of risks involved in declining to have proper fitting chair. At 12:52 E3 presented a note dated 10/21/15 indicating the facility called R8's insurance to evaluate R8 for customized wheelchair and also called R8's family to help convince R8 to comply with having a customized chair. | F 318 | | |
| F 328 SS=D | 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS<br><br>The facility must ensure that residents receive proper treatment and care for the following special services: | F 328 | | |

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| F 328 | Continued From page 7<br>Injections;<br>Parenteral and enteral fluids;<br>Colostomy, ureterostomy, or ileostomy care;<br>Tracheostomy care;<br>Tracheal suctioning;<br>Respiratory care;<br>Foot care; and<br>Prostheses.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to ensure nursing competency in the process of IV (Intravenous) antibiotic infusion through a PICC (Peripherally Inserted Central Catheter).<br><br>This applies to one of one resident (R7) reviewed for IV infusion in a total sample of 28 residents.<br><br>The findings include:<br><br>On 10/22/15 at 2:00 PM, E4 primed R7's IV antibiotic then inserted the end port into the higher port without cleaning it. E4 stated R7 had a PICC line inserted while in the hospital. E4 irrigated one port of the PICC line and did not check for a blood return to confirm patency and placement of the PICC line. E4 connected the tubing to the PICC line port and attempted to feed the tubing through the IV pump but was having difficulty. E4 continued for approximately 10 minutes to put the tubing in the pump. When questioned if E4 was familiar with this IV pump and E4 stated she was. The pump beeped occlusion and E4 pulled the IV tubing out of the pump and noted an air bubble. E4 then disconnected the tubing from the PICC line and | F 328 | | |

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| F 328 | Continued From page 8<br>left the tip of the tubing that connects to the PICC line open to air and in the process of removing the tubing from the pump the exposed end of the tubing was touching the pump and E4's gloved hand potentially contaminating the end of the tubing. E4 opened the clamp of the IV and let medication free flow out of the tubing into the garbage to release the air bubble. An unknown amount of medicine was released into the garbage can.<br><br>E4 spent another 10 minutes trying to put the rate and volume information into the pump. E4 was asked again if she was familiar with this pump and she stated she was. E4 had put in 100 milliliter (ml) / hour as the rate with a volume of 60 ml. The antibiotic was labeled 100 ml to infuse over one hour. E4 was questioned about her input numbers and stated it was right because it is running over 60 minutes. E4 then realized she had put the volume in wrong and changed the 60 ml to 100 ml so the antibiotic would infuse over one hour.<br><br>On 10/22/15 at 3:00 PM, E2 (DON) stated E4 was familiar with the IV pump infusion, but would be retrained and the physician was notified that R7 was shorted some of the antibiotic dose. | F 328 | | |
| F 469 SS=E | 483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM<br><br>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.<br><br>This REQUIREMENT is not met as evidenced | F 469 | | |

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by:
Based on observation, interview and record review the facility failed to have an effective plan for pest control and failed to follow their policy on Bed Bugs and Scabies.

This applies to 3 of 3 residents (R2, R3, R4) reviewed for pest control in the sample of 28 residents and one resident (R32) in the supplemental sample.

The findings include:

During a tour of the facility on 10/20/15, R2 was observed lying on his bed sleeping with no shirt on. R2 had visible red marks to his upper torso. R2's chart showed an order from the dermatologist dated 10/21/15 for a medication to treat scabies, Ivermectin 3 milligrams, 5 tabs today, repeat in one week. E2, DON (director of nursing) was asked on 10/23/15 if R2 has scabies. E2 said R2 does not have scabies but if he did he would be in isolation and the doctor has not written the diagnosis in the record yet. R2 shares his room with one other resident. The facility's policy for Scabies states to isolate the resident on the day resident is suspected of scabies and wash all clothing in hot water. The facility did not initiate their scabies policy.

R4 was also observed during the tour of facility on 10/20/15. R4 stated she has been getting bitten and they sprayed her room today for bed bugs. R4 said she had to stay out of her room for 3 hours. E1 provided pest control documentation showing R4's room had been treated for bed bugs. Two more receipts were provided showing inspections of the rooms on either side of R4 with no bed bugs found. However, those two rooms

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were not treated. R2's room which is 2 rooms away from R4 was not inspected for bed bugs.

On 10/21/15 R3 said a couple weeks ago she found a bed bug crawling across her wheelchair arm. R3 said she showed the bug to the nurse at the nurses station. R3 also stated she knows what a bed bug looks like because she is a city girl. When E1 (administrator) was asked about the situation he provided receipts from the pest control company. The receipt noted that R3's room was inspected for bed bugs on 09/29/15. There was no bed bug activity noted and no treatment applied. Another receipt dated 10/07/15 showed a repeat visit by pest control to R3's room. This time a treatment was applied to the room. On 10/14/15 a second treatment was applied to R3's room.

On 10/30/15 R32 complained of getting bitten. The pest control company was called and R32's room was inspected. No bedbugs were noted and R32's room was not sprayed.

E10 (maintenance director) stated on 10/22/15 he is in charge of inservicing the staff on identifying and reporting pests. E10 showed a book that is kept at the nurses station for staff to write down where and when they see a pest. E10 said he does the inservicing verbally and does not use written material. E10 provided an inservice sign-in sheet with the title "pest control log book" with no summary of subject matter discussed.

The facility's policy on bed bugs notes that residents, family and staff are to be educated about bed bugs and their habits. Various staff members were asked on 10/22/15 about their training on pest control and specifically bed bugs.

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| F 469 | Continued From page 11<br><br>E11 (Certified Nurse Aide - CNA) stated she has worked at the facility for 8 years and has never been told anything about pests or bedbugs.<br><br>E12 (CNA) stated, "We are supposed to look for little bugs on the bed sheets or wheelchairs; I don't know what rooms were treated."<br><br>E13 (Licensed Practical Nurse - LPN) stated, "We didn't see the bed bugs, there aren't any bed bugs, no training on bed bugs."<br><br>E14 (Registered Nurse - RN) stated there has been no education from the facility.<br><br>The facility policy on Bed Bugs indicated the bed bugs are out at night in dark and live on human blood sucking. The facility had no surveillance plan for monitoring bed bugs at night in the dark. | F 469 | | |