STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	**200 FAIRMAN AVENUE WATSEKA, IL 60970**

(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 157 SS=D	Annual Licensure and Certification Survey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 157	Continued From page 1	F 157		

by:
Based on record review and interview, the facility failed to notify family of medication changes for one of 10 residents (R4) reviewed for family notification in the sample of 10.

Findings Include:

R4's MDS (Minimum Data Set) dated 12/14/15 documents moderate cognitive impairment and that R4 has trouble concentrating more than half the time.

R4's Care Plan dated 12/14/15 documents, "(R4) feels restless and anxious...3/10/16 discontinue current Lorazepam {Benzodiazepine} 1 mg (milligram) po (by mouth) at HS (night), start Lorazepam 1 mg po BID (twice a day)...3/27/16 R4 continues on antianxiety medication, no increase in anxiety noted."

R4's POS (Physician Order Sheet) dated 6/1/16 documents an order for: Lorazepam 1 mg po BID. This order was initiated on 3/10/16. The POS dated 3/1/16 documents an order: Lorazepam 1 mg po every HS, which was the original order intiated upon admission on 12/7/15.

R4's Notification/Consent of Psychotropic Medication Use dated 12/10/15 and signed by Z1 (R4's daughter) documents consent for Ativan AKA (also known as) Lorazepam 1 mg every HS.

R4's Nursing Progress Notes dated 3/10/16 to 6/6/16 does not document that R4's family was notified of the medication change.

On 6/6/16 at 4:00 pm, E3 ADON (Assistant Director of Nursing) stated, "when a medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 157	Continued From page 2 like this is increased, the nurse who took the order should call and notify the family and the resident." E3 confirmed that R4's Nursing Progress Notes did not contain documentation that family had been notified of the changes. E3 stated. "if family was notified, it would be documented in the Nursing Notes." On 6/7/16 at 11:10 am, E2 DON (Director of Nursing) stated, when a Psychotropic medication is increased, "family needs notified and consent given before giving the medication", and notification would be documented in the Nursing Notes." The facility's Psychotropic Medication Administration Policy dated 6/5/97 documents, "Before administrating Non-Urgent/Non-Emergency Medications: the nurse must have written informed consent from the resident or guardian. If unable to obtain written consent prior to the administration of medication, the nurse must obtain a verbal consent and follow up with a written consent as soon as possible....A new written consent is required when: a current dose is increased or it exceeds the approved dosage range."	F 157		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 226	Continued From page 3	F 226		

by:
Based on interview and record review the facility Abuse Policy failed to identify reference checks from previous/current employers as part of the screening of new employees. The facility failed to do reference checks from previous or current employers for new employees. This failure has the potential to affect all 29 residents residing in the facility.

Findings include:

1. The facility Abuse Policy dated as reviewed 3/2016 documents, "Conduct pre-employment screenings of employees..." The Hiring Transfers and Promotions policy dated 12/2013 documents "Human Resources will check an applicant's work references, if applicable, before a conditional job offer is made..."

On 6/8/16 at 10:15am E13, Human Resources Director stated we don't do personal or employees reference checks. When asked how they decide whether it's applicable to do a reference check or not, E13 stated, "it's hit or miss, if there's someone we have a question about, we'll do a reference." E13 stated they try to do people working in the nursing home.

On 6/8/16 at 11:40am E1, Administrator stated that reference (employer or personal) checks should be done for new hires.

2. The undated list of new employees documents the following:

E16, Therapy was hired on 4/13/16.
E14, Food Services was hired on 4/27/16.
E15, Housekeeping was hired on 5/16/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 226	Continued From page 4 E19, Food Services was hired on 5/31/16. On 6/8/16 at 10:15am, E13 verified that no personal or past employer references were checked for E16, E14, E15 and E19. On 6/9/16 at 10:35am E2, Director of Nursing and E1, Administrator verified that E16, E14, E15 and E19 all could potentially work on the unit. E1 stated, E15 no longer works here, but did train on the unit. The Resident Census and Conditions of Residents form dated 6/6/16 documents that 29 residents reside in the facility.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to protect R2's dignity and ensure respect for R19 and R20 when an insulin injection was administered to R2 in a public area. R2 is one of ten residents reviewed for privacy/dignity in the sample of ten. R19 and R20 are two residents on the supplemental The finding includes: On 6-7-16 at 5:05 P.M. E12 (Licensed Practical Nurse) injected insulin into R2's abdomen. E12	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	**200 FAIRMAN AVENUE WATSEKA, IL 60970**

(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 241	Continued From page 5 said to R2 "are you ready (R2)?" R2 nodded R2's head and E12 injected the insulin. R2 was in the dining room for the evening meal. R2 was sitting at the dining room table with R19 and R20. The observation was related to E2 (Director of Nurses) on 6-8-16 at 7:25 A.M. E2 stated E2 would expect the insulin to not be administered in the dining room.	F 241		
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, record review, and interview, the facility failed to maintain hot water temperatures at a safe level so as to not pose a burn hazard. Hot water accessible to residents was found to be excessively hot in three (R4, R5, and R12) of ten sampled residents and three (R7, R8, and R19) supplemental sampled resident's rooms. The finding includes: On 6-6-16 at 11:00 A.M., the hot water temperature at the lavatory in R5 and R7's room was 120 degrees Fahrenheit (F.). On 6-6-16 at 11:05 A.M., the hot water temperature at the	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 323	Continued From page 6 lavatory in R12 and R19's room was 120 degrees. F. On 6-7-16 at 9:35 A.M. the hot water temperature at the lavatory in R4 and R8's room was 120 degrees F. E6, Environmental Service Director stated on 6-7-16 at 1:35 P.M. that water temperatures are taken daily. E6 provided the water temperature logs for review. The documentation revealed that the recorded temperatures were at or below 110 degrees F. The log did not document water temperatures in the sampled locations at 120 degrees F. The sampled locations' water temperatures were retaken with E6. The water temperature rose within three minutes to 120 degrees F. E6 stated that E6 believes that E6's staff was not allowing the water temperature rise to the highest temperature before recording it.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 329	Continued From page 7 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to obtain a consent, assess, and identify non-pharmacological interventions for two of three residents (R12, R4) reviewed with psychotropic medications, on the sample of 10. Findings include: 1. R12's Physician Order Sheet (POS) dated 6/1-6/30/16 documents diagnoses of Insomnia and Cerebral Vascular Accident. The Care Plan dated 5/7/16 does not address R12's insomnia or identify interventions to assist with sleep for R12. On 6/7/16 at 3:30pm E3, ADON (Assistant Director of Nursing) verified the care plan does not address R12's insomnia or identify non-pharmacological interventions to promote sleep. The POS has a Physician's Order dated 4/14/16 for Zolpidem (Ambien, Hypnotic) 5 mg (milligrams) at bedtime as needed for Insomnia. There is no assessment found for the use of the Zolpidem. On 6/7/16 at 2:40pm E2, DON (Director of Nursing) verified that no assessment for the Zolpidem was done for R12.	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 329	Continued From page 8	F 329		

The April, May and June 2016 Medication Administration Record documents that R12 received the Zolpidem starting on 4/16/16 through 6/6/16. R12 received the Zolpidem every night except for two nights in April, six nights in May and one night in June.

2. R4's MDS (Minimum Data Set) dated 12/14/15 documents moderate cognitive impairment and that R4 has trouble concentrating more than half the time.

R4's Care Plan dated 12/14/15 documents, "(R4) feels restless and anxious...3/10/16 discontinue current Lorazepam {Benzodiazepine} 1 mg (milligram) po (by mouth) at HS (night), start Lorazepam 1 mg po BID (twice a day)...3/27/16 R4 continues on antianxiety medication, no increase in anxiety noted."

R4's POS (Physician Order Sheet) dated 6/1/16 documents an order for: Lorazepam 1 mg po BID. This order was initiated on 3/10/16. The POS dated 3/1/16 documents the original order: Lorazepam 1 mg po every HS, which was order upon admission on 12/7/15.

R4's Notification/Consent of Psychotropic Medication Use dated 12/10/15 and signed by Z1 (R4's daughter) documents consent for Ativan AKA (also known as) Lorazepam 1 mg every HS. There is no other Psychotropic Medication Consent in R4's medical record.

R4's Nursing Progress Notes dated 3/10/16 to 6/6/16 does not document that R4's family gave consent for an increase in Lorazepam.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 329	Continued From page 9 On 6/6/16 at 4:00 pm, E3 ADON (Assistant Director of Nursing) stated, "when a medication like this is increased, the nurse who took the order should call and notify the family or resident and get a verbal consent for the changes, then (E8 RN (Registered Nurse)) is responsible for getting the actual consent form signed." E3 confirmed that R4's medical record did not contain any updated Psychotropic Consents and that the Nursing Progress Notes did not contain documentation that family had given consent. On 6/7/16 at 11:10 am, E2 DON (Director of Nursing) stated, when a Psychotropic medication is increased, "family needs notified and consent given before giving the medication", and it would be documented in the Nursing Notes." The facility's Psychotropic Medication Administration Policy dated 6/5/97 documents, "Before administrating Non-Urgent/Non-Emergency Medications: the nurse must have written informed consent from the resident or guardian. If unable to obtain written consent prior to the administration of medication, the nurse must obtain a verbal consent and follow up with a written consent as soon as possible....A new written consent is required when: a current dose is increased or it exceeds the approved dosage range."	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 371	Continued From page 10 (2) Store, prepare, distribute and serve food under sanitary conditions	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to ensure that food was protected from potential contamination. This failure has the potential to affect all 29 residents.

The findings include:

1. The manual table mounted can opener was not clean on 6-7-16 at 11:25 A.M. The can opener had a heavy accumulation of moist black residue and a large amount of metal filings present. The residue was on the blade, in the gears, around blade and gear housing, and on the can opener table brace. E7, Dietary Coordinator was shown the can opener on 6-7-16 at 11:25 A.M. and E7 stated that it is to be cleaned daily. E7 acknowledged that it has been more than a day since it was cleaned. The can opener is to be cleaned after each different food.

2. On 6-7-16 at 11:25 A.M., a heavy accumulation of burnt on food and grease residue was on the range top, the grill and the range back splash. The underneath side of the shelf attached to the back splash of the range had accumulated food and grease splatters that could fall into food that was prepared on the range. Uncovered food was present under the shelf.

3. On 6-6-16 at 9:20 A.M., the open metal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 371	Continued From page 11 shelves inside the two walk in refrigeration units were not clean. A brown greasy residue was on the top of the open metal shelves. The accumulated residue could be removed by friction and fall onto food. According to the facility's Resident Census and Conditions of Residents report dated 6-6-16, 29 residents reside at the facility.	F 371		
F 441 SS=E	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 - (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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	**200 FAIRMAN AVENUE WATSEKA, IL 60970**

(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 441	Continued From page 12 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, record review and interview, the facility failed to prevent cross-contamination and potential spread of infection by failing to correctly handle/disinfect the glucometer and case, failure to remove gloves during resident care when indicated, and failure to effectively disinfect the whirlpool bather tub. These failures have the potential to affect six residents (R4, R5, R11, R13, R15, R16) in the sample of 10 and 13 residents in the supplemental sample (R1, R6, R8 - R10, R18 - R21, and R24 - R27). Findings include: 1. On 6/6/16 at 3:20pm, E12 (Licensed Practical Nurse/LPN) performed blood glucose testing on R15. In doing so, E12 took the plastic case containing the glucometer, lancets, alcohol wipes and cotton balls into the room, along with the container of quaternary ammonia based disinfectant wipes, and set them on the overbed table. E12 did not have the medication cart. After obtaining the blood sample from R15, E12 placed the glucometer back onto the case until the blood glucose results registered on the meter. E12	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 441	Continued From page 13	F 441		

then picked up the meter and wiped it with a disinfectant wipe for approximately 10 seconds, returned the meter to the case and closed the case.

2. On 6/6/16 at 3:23pm, E12 donned gown and gloves from the isolation station and entered R11's room, carrying the case with the meter and the container of disinfectant wipes. E12 placed the case and the container directly on the overbed table with no towel or clean surface. E12 then proceeded to prepare and perform the glucose test on R11. After obtaining the blood sample, E12 placed the meter directly on the counter next to the sink, while waiting for the blood sugar results. E12 then removed her gloves and washed her hands. When the test was completed, E12 picked up the meter with her bare hands and placed it into the case and closed the case. E12 removed the gown and exited the room. At the isolation station, E12 wiped the meter with the disinfectant wipe for approximately 15 seconds and returned it to the case.

Laboratory results for urine culture dated 5/30/16 shows R11's urine positive for VRE (vancomycin resistant enterococcus).

3. On 6/6/16 at 3:27pm, E12 donned gloves from the isolation station and entered R13's room with the case and a disinfectant wipe. E12 placed the case and glucometer on the first bed's overbed table, without towel or clean surface. E12 took the blood sample and placed the meter on R13's overbed table. When the test was completed, E12 wiped the meter with the disinfectant wipe for approximately 10 seconds and returned it to the case and closed the case. E12 then removed her gloves and washed her hands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 441	Continued From page 14	F 441		

At that time E12 stated that this was the only glucometer for the facility as the other one was broken. When asked regarding the cleaning procedure for the meter, E12 stated, "It takes a minute to dry."

Laboratory results for stool culture dated 6/5/16 shows R13 is positive for Clostridium Difficile (C-diff). The Physician's order dated 6/5/16 orders Flagyl (antibiotic) for C-diff.

4. On 6/6/16 at 3:33pm, E12 took R5 to the common bathroom to do the blood glucose testing. E12 took the case with the glucometer and the container of disinfectant wipes. E12 donned gloves and did the glucose test, returning the meter to sit on the case while waiting for the results. When the test was completed, E12 wiped the meter for approximately 10 seconds, returned to it to the case and closed the case.

Again when asked regarding cleaning the meter, and the directions that state for the surface to be wet for one minute, E12 stated, "it takes a minute to dry."

The directions on the label of the disinfectant wipes used state under Cleaning Directions and Contact Time for use as a disinfectant, "Thoroughly wet surface with a . . . towelette. Repeated use of the product may be required to ensure that the surface remains visible wet for 1 minute. . ." The product insert information dated 2014 also states that disinfection is only ensured with a one minute wet time. The label and product information also lists the organisms against which this solution is effective. C-diff is not listed on the "Proven 1-Minute Efficacy" list.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 441	Continued From page 15	F 441		

The facility policy dated 3/15 for Blood Glucose Monitoring for the brand of glucometer used states the following: "After use or prior to the next patient, clean the outside of the monitor thoroughly with {quaternary ammonia wipes}. Do not use bleach or hydrogen based cleaners unless the patient is being tested for or has confirmed clostridium difficile infection."

The facility policies for Infection Control dated 2/07 address the use of disposable thermometers and using blood pressure cuffs and stethoscopes to be left in the resident room. The policy for Standard Precautions states, "Ensure that reusable equipment is not used for the care of another patient until it has been cleaned and reprocessed appropriately."

On 6/8/16 at 3:30pm, E2 (Director of Nursing) stated that the case and glucometer should not be put down in the resident's room, that they should be kept on the medication cart. "The meter should be cleaned correctly before returning it to the case." The list provided by E2 of residents who receive blood glucose monitoring includes R9, R17, R11, R15, R5, R18, R2, R19 and R13.

5. According to the Minimum Data Set dated 5/30/16, R11 is occasionally incontinent of urine and currently has a Urinary Tract Infection (UTI). The careplan dated 5/27/16 states R11 is on Contact Isolation Precautions for UTI. Laboratory results for urine culture dated 5/30/16 shows R11's urine is positive for VRE (vancomycin resistant enterococcus).

On 6/6/16 at 1:30pm, E17 and E18 (Certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	200 FAIRMAN AVENUE WATSEKA, IL 60970

(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 441	Continued From page 16	F 441		

Nurse Aides/CNA) donned gown and gloves to change and reposition R11. R11 was first positioned on her back and then on her left side while E18 pulled down R11's brief and cleaned the front and then the backside with disposable wipes. E18 then removed and replaced her gloves before assisting with repositioning onto R11's right side. Then E17 finished removing R11's wet brief and pad, and started cleaning R11's buttocks with a wipe. E17 stopped cleaning momentarily and lowered the siderail on E17's side with the same gloves, then resumed cleaning R11. With the same contaminated gloves, E17 pulled up the siderail, and continued assisting with repositioning R11, holding R11's hands at times to help in turning. E17 handled the siderails several more times, held R11's hands and adjusted pillows and bed covers, all with the same gloves on. When used supplies were gathered and bagged, E17 and E18 removed their gown and gloves and washed hands.

The facility policy for Standard Precautions dated 8/2009 states to "Perform hand hygiene after touching. . .body fluids. . .excretions and contaminated items whether or not gloves are worn . . . Change gloves between tasks and procedures on the same patient after contact with material that may contain high concentrations of microorganisms. Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces. . . ."

6. The facility's whirlpool bathing tub was observed on 6-6-16 at 3:55 P.M. and E20 (Certified Nurse Assistant) was interviewed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	**200 FAIRMAN AVENUE WATSEKA, IL 60970**

(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 441	Continued From page 17 regarding the cleaning of the tub. E20 stated that the resident is removed from the area. The interior of tub is sprayed with liquid disinfectant. The tub is filled with water just at the whirlpool jets level. The whirlpool jets are turned on and ran for 10 minutes. After 10 minutes, the water is drained, rinsed and ready for the next resident. The disinfecting procedure was posted on the cabinet beside the whirlpool bathing tub. E20 followed the posted procedure. The procedure does not account for the additional gallons of water filled into the tub to bring the water level to the jets. No additional disinfectant is added to the water. With the addition of water, the disinfectant concentration potentially falls below the concentration for effective disinfection. E2, Director of Nurses provided a list of residents that receives whirlpool baths. Two (R4 and R16) of ten sampled residents and 13 additional residents (R1, R6, R8, R9, R10, R18, R19, R20, R21, R24, R25, R26, and R27) bathed in the whirlpool tub.	F 441		
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that the camera and monitoring system was maintained to ensure proper function. The cameral was not rotating as designed to	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146049	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
IROQUOIS RESIDENT HOME, THE	**200 FAIRMAN AVENUE WATSEKA, IL 60970**

(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 456	Continued From page 18 ensure visual control of two resident rooms (R21 and R22) on the supplemental sample and the activity room. The finding includes: The facility has one resident room and activity area that cannot be seen from the nurse's station without a camera and monitoring system. According to the facility room roster, R21 and R22 reside in the room. The facility has a camera and monitor for those areas on the north end of the facility. The camera does not rotate as it was designed to provide visual control the north end of the facility. E11, Unit Secretary stated on 6-8-16 at 1:35 P.M. that the camera did rotate providing visual control for R21 and R22's room and the activity room, and "years ago it stopped working."	F 456		