STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146114	A. BUILDING _____ B. WING _____	C 09/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENA LIVING CENTER	1010 SOUTH LOGAN STREET LENA, IL 61048

(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 Original Complaint Investigation 1413769/IL# 71670 - F441 cited. 1413799/IL# 71701 - F241, F312 cited. 1413865/IL# 71779 - F224, F225, F226, F309 cited. 1413957/IL# 71880 - F224, F241, F309, F441 cited. 1413997/IL# 71928 - F224, F226, F309 cited. A partial extended survey was conducted.	F 000		
F 224 SS=G	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN 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 by: A. Based on interview and record review, the facility neglected to follow their policy and procedure for Accident/Incident Occurrence and their policy on Resident Change in Condition for a resident after a fall. This neglect contributed to a 4 day delay in the identification and treatment of R1's femur fracture which caused excruciating pain and required surgical intervention. This applies to 1 of 6 residents, (R1), reviewed for falls in the sample of 34. The findings include:	F 224		

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

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The facility's policy for Change in Condition, dated 3/5/12, states the licensed nursing staff will: "assess any changes noted through direct observation or through assigned staff...Chart in the nurses notes, assessment data, observations...physician should be updated at least daily, (for a minimum of 48 hours), of the resident's status, including any deterioration or improvement. The facility's policy Accident/Incident Occurrence, (Undated), shows "all accidents or incidents where there is injury or the potential to result in injury," should have interventions initiated. The policy shows all residents that having sustained an injury, or were involved in a fall, should be observed "closely for any change from normal habits that could be an indication that there is an injury not noticed or diagnosed during the initial assessment."

R1's Minimum Data Set (MDS) dated 7/21/14 identified R1 as being able to transfer and/or ambulate with one person limited physical assist. The MDS showed R1's balance as not steady but was able to stabilize without assist.

An incident investigation dated 8/8/14 at 6:15 PM, shows R1 was "observed (on the floor), laying on her left side...with complaints of left knee pain." The nursing note of 8/8/14 at 6:30 PM, shows R1 was non-weight bearing which was not "her usual." The 8/9/14 nursing notes shows R1 was complaining of pain in her left hip when moved and exhibited a decrease in appetite by only eating "a few bites of meal." No nursing entries were made again until 8/11/14 at 12:00 PM which reads, "resident (R1) grabs at left leg when moved. The nursing note dated 8/11/14 at 4:00 PM, shows an order was obtained for an X-Ray of

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R1's left hip. The nursing note written on 8/11/14 at 5:50 PM documents an order was received to send R1 to the local hospital emergency department for evaluation and treatment. The nursing notes show R1 left the facility at 6:45 PM and was admitted to the local hospital with a diagnosis of a left hip fracture. The defination of a hip fracture is a "break in the upper quarter of the femur (thigh) bone.

The Radiology report dated 8/11/14 at 5:26 PM, show R1 with an "acute left intertrochanteric fracture with a near 90 degree angualtion of the fracture fragments."
R1 required surgical intervention on 8/12/14.

On 9/5/14 between 10:35 AM and 2:20 PM, E3, E7, E9, and E11 Certified Nursing Assistant's (CNA's), stated they were aware of R1's fall. All stated they worked with R1 during the 4 days following the fall and noticed her decreased ability to bear weight and an onset of complaints of pain to her left hip area. All stated they reported these findings to the on duty nurses on a daily and every shift basis.

On 9/11/14, E16 (RN) stated R1 "stayed in bed" and "complained of her (R1's) left leg hurting" on 8/9/14. E16 said, "E11 kept telling us, (nurses), (R1) was hurting badly." E16 said "E11 kept insisting R1 was complaining of left hip pain." E16 said, "we, (nurses), need to listen to the CNA's." E16 stated she did not document an assessment/re-assessment on R1 on 8/9/14 when E11 reported the complaints to her. E16 said she really didn't notice anything different because R1 has behaviors and sometimes just stays in bed. E16 stated assessments are to be completed and documented in the nursing notes

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every shift for 3 days following a fall. E16 said "I don't know why, I just didn't document it." E16 stated no new interventions were implemented for R1. E16 said R1 "gets anxious" and "refuses cares," so "I use the topical Ativan ordered to decrease her (R1's) behaviors. It makes her more cooperative."

The nursing notes between 8/8/14 and 8/11/14 show no treatment or interventions were implemented for R1. There was no additional pain medication ordered or given. There was no documentation of re-assessment of R1 despite her noted changes in condition (inability to bear weight, deformity of left leg, decreased in appetite and continual complaints of left hip/leg pain.)

On 9/5/14 between 9:45 AM and 2:45 PM, E5, E7, E8, E9, and E11, (CNA's) were interviewed. All stated they do not feel the nursing staff takes their observations and concerns seriously when presented. All stated they feel there are many times when there are significant, (several days), delays in getting residents sent out for evaluations.

On 9/11/14 at 11:50 AM, E19 (LPN) stated she was the nurse on duty when R1 fell on 8/8/14. R1 was found on the floor on her left side. E19 stated she helped staff "roll R1 to her back and R1 complained of "pain to her left knee and began grabbing at it." E19 stated she didn't notice any shortening or rotation. E19 said R1 was uncooperative with a (mechanical lift) transfer which is the standard for lifting people following a fall. For this reason, E19 stated the staff used a 3 person assist to get her up into her wheelchair because she would not bear weight. E19 said she had the CNA's take R1 to her room

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and transfer her to the bed so "I could re-assess her." E19 said "She (R1) kept rubbing her left leg" but "I didn't see anything different, (besides not bearing weight)." E19 said she was off for the next 3 days but when she returned on Monday, 8/11/14, R1 was still "acting like something was hurting." E19 said because R1 was still hurting, "I called the doctor to get an order for an X-Ray."

B. Based on observation, interview and record review, the facility neglected to follow their policy and procedure for Accident/Incident Occurrences after an allegation of theft was reported. This neglect resulted in a cash loss of greater than $200.00 for R3, and the loss of personal property for R8, R9.

This applies to 3 of 14 residents (R3, R8, R9) reviewed for neglect/theft in the sample of 25.

The findings include:

The facility's policy Accident/Incident Occurrence, (undated), states, interventions are to be initiated for "Allegations of mistreatment, neglect, or misappropriation of resident property registered by residents, visitors, or others." Incidents that "involve mistreatment, neglect, or abuse, injuries including injuries of unknown origin and misappropriation of resident funds . . . b) the facility must have evidence that all alleged violations are thoroughly investigated and must prevent further potential abuse while the Investigation is in progress, c) the facility must ensure that any incident, related investigations, and corrective actions taken are reported immediately to the Administrator of the facility;

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and to other State Survey/licensing/certification officials in accordance with State Law, within 5 working days of the incident, utilizing established procedures."

On 9/5/14 at 8:25 AM, R3 stated he has had money stolen from him on several occasions. R3 likes to have about $200.00 cash on hand to take family and/or friends out on the weekends. R3 said the facility provides the use of a locked dresser drawer in his room. R3 used to put his cash in his billfold and place it in the locked drawer in his room until he had the money stolen from his drawer. R3 stated he placed his billfold in his locked drawer and placed the drawer key in his trouser pocket. At bedtime, R3's trousers were hung in his closet with the key in the pocket. The next morning, the key was gone and so was the billfold and cash. R3 said he reported the theft of the theft of over $200.00 to the administrative personnel. R3 was not aware of any investigation or any efforts made to locate the missing money. R3 was told that he could place his money in the front office to be locked up. R3 expressed concerns that if he were to use the front office lock up, he would not be able to have access to his money from Friday evening until Monday. R3 added, "the missing key" to his locked drawer "mysteriously returned" to his room several days later. R3 said, with no other options, he began placing his cash in a "waterproof" envelope and taping it to his abdomen. R3 said this method seemed to be working until recently, (7/18/14). R3 shared that while he was in the shower, (on 7/18/14), "the envelope had at least $200.00" and it "disappeared" from the seat of his walker. R3 stated when he undressed, he placed the envelope on the seat of his walker and covered the envelope with paper napkins. R3

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was able to give details of the events that occurred during the shower and verbalized his belief that it was taken by E4 (CNA). R3 reported the money missing. R3 said "this time they must have called the local sheriff's department because they showed up." On 9/12/14 at 10:25 AM, R3 stated he has money stolen at 3-4 month intervals. R3 said, "I keep telling them and reporting it but it keeps happening. Will you be able to keep this from happening to others here?"

On 9/5/14 at 12:35 PM, E8 (CNA) stated, on 7/18/14, after lunch, R3 was to be given a shower. E8 asked E4 to sit with R3 while she obtained some clean clothes from his room. Upon returning to the shower room, E8 said E4 had already showered R3 and was drying him off. E8 said E4 "left the shower room when I returned." E8 said 30-45 minutes later, R3 returned to the shower room stating his money/envelope was missing.

R3 lost more than $200.00 with the event of 7/18/14. Grievance logs for the past 3 months showed R8, R9 and R25 all reported personal items missing with no investigation initiated/completed and no alternatives for protection of personal property provided.

The investigation file for the allegation of theft dated 7/18/14 showed no resident interviews were conducted. No report was submitted to the Public Health Department and no further interventions were implemented/offered to ensure the safety of R3's money in the future. On 9/5/14 at 1:30 PM, E1 (Administrator) stated a summary of the investigation for 7/18/14 was not completed until today, (9/5/14), by E12 (Human Resources). This report was written 7 weeks after the

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F 224	Continued From page 7 allegation was initially reported. All investigations completed and submitted to the Department of Public Health from February 2014 to the present, (7 months) were reviewed. There were no allegations of theft investigated by the facility or reported to the Public Health Department. Between 9/5/14 and 9/12/14, interviews were conducted with E1, E2 (Acting Director of Nursing), E3, E6, E7, E8, E9, E11 (CNA's), and E27 Licensed Practical Nurse (LPN). All stated they were aware R3 had issues with money stolen/missing over the course of his stay. All stated there had been allegations of theft in the past. All were aware that R3 was taping the money to his abdomen in an effort to prevent future loss/theft.	F 224		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225		

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misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to initiate and thoroughly investigate allegations of theft, failed to complete investigations in a timely manner and failed to report the allegations to the State Agency. These failures contributed to recurrent loss of money, in $200.00 increments, for R1 with the most recent occurrence being 7/18/14.

This applies to 1 of 14 residents, (R3), reviewed for neglect/theft in the sample of 34.

The findings include:

The Mininimum Data Set dated 8/15/14 showed R3 as having a Brief Intervew for Menal Status

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score of 15, (No cognitive impairment.) On 9/5/14 at 8:25 AM, R3 stated he has had money stolen from him on several occasions. R3 explained that he owns a business in town which his sons now run. R3 likes to have about $200.00 cash on hand to take family and/or friends out on the weekends. On occasion, R3 accompanies his sons to Rockford to obtain "parts" needed for the company. During these trips, R3 wants to have enough money available to pay for the part. R3 said the facility provides the use of a locked dresser drawer in his room. R3 used to put his cash in his billfold and place it in the locked drawer in his room until he had the money stolen from his drawer. R3 stated "a while back (6-12 months ago)," he placed his billfold in his locked drawer and placed the drawer key in his trouser pocket. At bedtime, R3's trousers were hung in his closet with the key in the pocket. The next morning, the key was gone and so was the billfold and cash. R3 said he reported the theft of the approximately $230.00 to the administrative personnel. R3 was not aware of any investigation nor any efforts to locate the missing money. R3 was told that he could place his money in the front office to be locked up. R3 expressed this as not being a viable alternative for him because if he were to use the front office lock up, he would not be able to have access to his money from Friday evening until Monday. R3 verbalized the missing key to his locked drawer mysteriously returned to his room several days later. R3 said, with no other options, he began placing his cash in a "waterproof" envelope and taping it to his abdomen. R3 opened his shirt to show this surveyor an envelope in a plastic covering taped to his abdomen. R3 said this method seemed to be working until recently (7/18/14). R3 was in the shower and "the

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envelope had at least $200.00." R3 said the enveleope disappeared from the seat of his walker. R3 explained that when he undressed, he placed the envelope on the seat of his walker and covered the envelope with paper napkins. R3 was able to give details of the events that occurred during the shower and stated he felt E4 (CNA) had taken the money. R3 reported the money missing. R3 said "this time they must have called the local sheriff's department because they showed up." On 9/12/14 at 10:25 AM, R3 stated he had money stolen at about every 3-4 month intervals. R3 said, "I keep telling them and reporting it but it keeps happening. Will you be able to keep this from happening to others here?" R3 continued to make statements regarding the theft of his money. R3 stated he is constantly thinking about how to prevent it, (theft), from happening again. R3 re-emphasized how he thought taping the money, (in an envelope), to his abdomen was the answer, but now, R3 worries about how to keep his money safe while he is in the shower. R3 expressed frustration with the repeated thefts and voiced it as being "a big concern."

On 9/11/14 at 1:20 PM, E1 (Administrator) stated R3 had reported allegations of theft in the past. E1 stated he has been offered to place in money in the front office to be locked up for safe keeping. E1 stated no staff have the key to the front office. E1 said on the weekends, if someone wanted money from the front office lock up, staff would need to call her to come to the facility to procure it for the resident.

Between 9/5/14 and 9/12/14, interviews were conducted with E1, E2 (Acting Director of Nursing), E3, E6, E7, E8, E9, E11 Certified

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F 225	Continued From page 11 Nursing Assistants (CNA's), and E27 Licensed Practical Nurse (LPN). All stated they were aware R3 had issues with money being stolen/missing over the course of his stay. All stated there had been allegations of theft reported by R3 in the past. All were aware that R3 was taping the money to his abdomen in an effort to prevent future loss/theft. None of these issues were identified or addressed in R3's care plan or medical record. The investigation file for the allegation of theft dated 7/18/14 showed no resident interviews were conducted. No report was submitted to the Public Health Department and no further interventions were implemented/offered to ensure the safety of R3's money in the future. On 9/5/14 at 1:30 PM, E1 (Administrator) stated a summary of the investigation for 7/18/14 was not completed until today, (9/5/14), by E12 (Human Resources). This report was written 7 weeks after the allegation was initially reported. All investigations completed and submitted to the Department of Public Health from February 2014 to the present, (7 months) were reviewed. There were no allegations of theft investigated by the facility or reported to the Public Health Department.	F 225		
F 226 SS=F	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.	F 226		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to follow it's policy and procedure for initiating, investigating and reporting the misappropriation of resident funds and protection of the residents when an allegation is reported.

This applies to all 78 residents residing in the facility.

The findings include:

The facility data sheet completed by the facility on 8/30/14, identified 78 residents currently live in the facility.

The Mininimum Data Set dated 8/15/14 showed R3 as having a Brief Intervew for Menal Status score of 15, (No cognitive impairment.) On 9/5/14 at 8:25 AM, R3 stated he has had money stolen from him on several occasions. R3 explained that he owns a business in town which his sons now run. R3 likes to have about $200.00 cash on hand to take family and/or friends out on the weekends. R3 said the facility provides the use of a locked dresser drawer in his room. R3 used to put his cash in his billfold and place it in the locked drawer in his room until he had the money stolen from his drawer. R3 stated he placed his billfold in his locked drawer and placed the drawer key in his trouser pocket. At bedtime, R3's trousers were hung in his closet with the key in the pocket. The next morning, the key was gone and so was the billfold and cash. R3 said he reported the theft of the approximately $230.00 to the administrative personnel. R3 was not aware of any investigation nor any efforts

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made to locate the missing money. R3 was told that he could place his money in the front office to be locked up. R3 expressed this as not being a viable alternative for him because if he were to use the front office lock up, he would not be able to have access to his money from Friday evening until Monday. R3 said, with no other options, he began placing his cash in a "waterproof" envelope and taping it to his abdomen. R3 opened his shirt to show this surveyor to show an envelope in a plastic covering taped to his abdomen. On 7/18/14, R3 was in the shower and "the envelope had at least $200.00." R3 said the envelope disappeared from the seat of his walker. R3 explained that when he undressed, he placed the envelope on the seat of his walker and covered the envelope with paper napkins. R3 was able to give details of the events that occurred during the shower. R3 reported the money missing. On 9/12/14 at 10:25 AM, R3 stated he has money stolen at about every 3-4 month intervals. R3 said, "I keep telling them and reporting it but it keeps happening. Will you be able to keep this from happening to others here?" R3 stated he is constantly thinking about how to prevent it, (theft), from happening again. R3 re-emphasized how he thought taping the money, (in an envelope), to his abdomen was the answer, but now, R3 worries about how to keep his money safe while he is in the shower. R3 expressed frustration with the repeated thefts and voiced it as being "a big concern."

The facility's abuse Prevention Program, dated December 2013, documents "Any incident or allegation involving abuse, neglect, mistreatment or misappropriation of resident property will result in an investigation. . .The appointed investigator will, at a minimum, attempt to interview residents

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to whom the accused has regularly provided care. . . The investigator will report the conclusions of the investigation in writing to the administrator or designee within five working days of the reported incident. . . The administrator or designee is then responsible for forwarding a final written report of the results of the investigation and of any corrective action taken to the Department of Public Health within five working days of the reported incident. . . When an allegation of abuse, neglect, mistreatment or misappropriation of resident property has occurred, the resident's representative and the Department of Public Health's Regional office shall be informed immediately by telephone or fax. . . Within five working days after the report of the occurrence, a complete written report of the conclusion of the investigation, including steps the facility has taken in response to the allegation, will be sent to the Department of Public Health. The facility shall also immediately contact local law enforcement authorities...when there is a reasonable suspicion that a crime has been committed in a facility by a person other than a resident."

Between 9/5/14 and 9/12/14, interviews were conducted with E1, E2 (Acting Director of Nursing), E3, E6, E7, E8, E9, E11 Certified Nursing Assistants (CNA's), and E27 Licensed Practical Nurse (LPN). All stated they were aware R3 had issues with money being stolen/missing over the course of his stay. All stated there had been allegations of theft reported by R3 in the past. All were aware that R3 was taping the money to his abdomen in an effort to prevent future loss/theft. None of these issues were identified or addressed in R3's care plan or medical record.

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The investigation file for the allegation of theft dated 7/18/14 showed no resident interviews were conducted. No report was submitted to the Public Health Department and no further interventions were implemented/offered to ensure the safety of R3's money in the future. On 9/5/14 at 1:30 PM, E1 (Administrator) stated a summary of the investigation for 7/18/14 was not completed until today, (9/5/14), by E12 (Human Resources). This report was written 7 weeks after the allegation was initially reported.

During interviews conducted between 9/5/14 at 8:00 AM and 9/11/14 at 6:30 PM, E7, E11 and E27 all stated they were not aware of any interventions/precautions the facility implemented to identify and/or prevent theft. All stated there is no inservicing being done in the facility. E27 said they are handed a sheet of paper to sign stating they were inserviced. E27 said, "it is just assumed we will read about it." E7 stated the staff "have suspicions" as to who is stealing. E11 said there is one person always on duty when items come up missing.

All investigations completed and submitted to the Department of Public Health from February 2014 to the present, (7 months) were reviewed. There were no allegations of theft investigated by the facility or reported to the Public Health Department. Facility Grievance Logs dated 6/10/14, 8/4/14 and 8/26/14, showed R9, R25 and R8 respectfully, reported missing personal items and/or money. No investigations were initiated and no alleged perpetrators were removed from duty to protect other residents from potential harm/loss.

On 9/11/14 at 9:30 AM, Z2 (R18's daughter), said

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F 226	Continued From page 16 her mother has had many items come up missing and they are never recovered or replaced. Z1 and Z2, (R18's daughters), both denied being aware any investigation occurred when the items were reported missing. Both state they have never been offered any type of alternative or preventative interventions to ensure their mother's possessions are safe. Z2 said "they, (facility), will take her jewelery and lock it up but then there is no access to it."	F 226		
F 241 SS=E	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, interview and record review the facility failed to respect residents dignity by not offering assistance with dining and not covering residents while providing care. This applies to 4 of 8 residents (R16, R18, R20 & R23) reviewed for dignity in the sample of 34. The findings include: 1. On 8/30/14 at 7:05 AM, R16 was seated in the dining room for breakfast. R16 was given her breakfast of sausage, eggs and a cinnamon roll. The cinnamon roll was not cut up or prepared for R16 and she began eating the roll with her fingers. R16 picked up the cinnamon roll and was attempting to take a bite of the whole roll. E17 (Dietary Aide) approached R16's table and stated "Good Morning pretty lady. You have got silverware for a reason. " E17 then left the table	F 241		

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without offering R16 assistance getting her silverware or to cut up the cinnamon roll. R16 then began to reach for her silverware which was wrapped in a napkin. R16 displayed difficulty in removing the silverware from the napkin and staff at no time offered to assist. At 7:50 AM, R16 remained at the table and eating her eggs with her fingers and the silverware remains in the napkin.
On 8/30/14 at 7:20 AM, E17 (Dietary Aide) stopped and stood at the side of R20 and gave her 2 bites of her eggs and one sip of water.
On 8/30/14 at 7:40 AM, R23 stated to E5 CNA (Certified Nursing Assistant) that she did not care for her breakfast. E5 stated in a loud and aggressive manner " If you don ' t like it, then don't eat it! " R23 placed her clothing protector over her breakfast plate and ambulated out of the dining room without breakfast.
On 8/30/14 at 11:15 AM, E2 DON (Director of Nursing) stated the aides should be seated when feeding the residents and they should be spoken to in a respectful manner.
On 9/11/14 at 9:30 AM, Z1 and Z2 stated the dining hall is very noisy and the aides are always on their phones instead of paying attention to the residents. Z1 stated she began to take her mother to the lounge to eat because it was much quieter. Z2 stated the staff are not very helpful or friendly and they could use a different tone or demeanor when speaking to the residents.
The facility ' s undated policy titled Feeding Residents, states the staff are to position serving pieces on the table so resident can reach the food and sit in a chair to feed the resident.
2. On 9/12/14 at 10:15 AM, E19 LPN (Licensed Practical Nurse) and E7 CNA, removed the sheet from R18 and then removed her incontinence brief. E19 and E7 rolled R18 over, provided peri

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F 241	Continued From page 18 care, and changed a dressing on her buttocks. During cares, no attempt was made to cover R18 ' s private areas. R18 remained exposed to this surveyor and her daughters who were in the room. On 9/11/14 at 9:30 AM, Z1 and Z2, (R18's daughters), stated their mother always cleaned her dentures in the evening and wore them during the night. The facility would not allow her to wear them. Z1 said not being able to wear her dentures all the time was disturbing to R18. The facility ' s undated dressing change policy titled Dressing Change-Clean Technique, states the area to be dressed should be exposed and privacy should be provided.	F 241		
F 309 SS=G	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 interview and record review, the facility failed to provide the necessary care and services by not re-assessing and providing treatment for a resident with an acute change in condition following a fall. The facility also failed to assess a residents need for pain management. These failures contributed to R1 not obtaining pain medication or evaluation and treatment for a fractured femur for 4 days.	F 309		

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This applies to 1 of 6 residents (R1) reviewed for falls in the sample of 34.

The findings include:

R1 has diagnoses to include Dementia and Hypertension according to the Physician Order Sheet (POS) dated 8/14. The Minimum Data Set (MDS) dated 7/21/14 identifies R1 as being able to transfer and/or ambulate with one person limited physical assist. The MDS showed R1's balance as not steady but able to stabilize without assist.

On 9/5/14 at 2:00 PM, E9, Certified Nursing Assistant (CNA), stated she (E9) "heard" R1 fall on 8/8/14, on the second shift. E9 said R1 was sitting on the floor in front of her wheelchair. E9 said "I could tell something was wrong because she, (R1) didn't bear any weight when I picked her up and she usually walks." E9 said R1 was complaining of pain while E9 was rolling her in the wheelchair down the hall to her room. E9 said R1 can be difficult to understand because R1 speaks several languages, but R1 was "clearly" complaining of pain. (R1's care plan of 7/14/14 showed R1 does speak multiple languages.)

On 9/5/14 at 10:35 AM, E3 (CNA) stated she and E7 (CNA) worked with R1 on 8/11/14. E3 stated R1 was non-weight bearing at that time which is not "her usual." E3 stated E7 had told her she was aware of R1's decline in condition and had been reporting those changes to the nursing staff for the past two days. E3 stated she went with E7 to report it again on 8/11/14.

On 9/5/14 at 11:00 AM, E7 stated she was aware

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of R1's fall. E7 said it took the facility (nurses) "about a week" to send her out to get checked. E7 said she is unaware of why it took so long but that the "nurses just don't listen to the CNA's." E7 said "I told them I thought she, (R1) had a fracture because she would not bear weight and was walking prior to her fall." E7 said she reported it daily until R1 was sent out.

On 9/5/14 at 12:35 PM, E8 (CNA) stated she worked the day after R1 fell, (8/9/14). E8 stated she reported to the nurse on duty that R1 was not "acting right." E8 said R1 refused to get out of bed and her left leg was "bowed out." E8 stated she was unaware of when R1 was sent to the hospital for evaluation and treatment but is aware it was longer than two days because she reported R1's change in condition for two days.

On 9/5/14 at 2:20 PM, E11 (CNA) stated she worked 4 evenings in a row starting the night R1 fell. E11 stated she began her routine bed checks when she noticed "a large bump on (R1's) left leg, it was rotated out and when I went to touch it she yelled out in pain." E11 stated she had E26 (Wound Nurse) come to R1's room to assess it. E11 said E26 looked at it, stated "It's not broken." and left the room. E11 said the CNA's were "pad rolling" R1 because she was in "excruciating pain" when moved. E11 stated she also reported her concerns related to R1's change in condition to E16 Registered Nurse, (RN), and E27 LPN. E11 said it was 4 days after R1's fall before she (R1) was given an X-Ray and sent out for treatment.

On 9/11/14, E16 (RN) stated R1, "stayed in bed" and "complained of her (R1's) left leg hurting" on 8/9/14 and 8/10/14. E16 said, "E11 kept telling

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us, (nurses), (R1) was hurting badly." E16 said "E11 kept insisting R1 was complaining of left hip pain." E16 said, "we, (nurses), need to listen to the CNA's." E16 stated she did not document an assessment/re-assessment on R1 when E11 reported the complaints to her. E16 said she "really didn't notice anything different" because R1 "has behaviors and sometimes just stays in bed." E16 stated assessments are to be completed and documented in the nursing notes every shift for 3 days following a fall. E16 said she "I don't know why, I just didn't document it." E16 stated no new interventions were implemented for R1 after her fall. E16 said R1 "gets anxious" and "refuses cares," so "I use the topical Ativan ordered to decrease her (R1's) behaviors. It makes her more cooperative."

The nursing notes between 8/8/14 and 8/11/14 verify no treatment nor interventions were implemented for R1. There was no additional pain medication ordered or given. There was no documentation of re-assessment of R1 despite her noted changes in condition (inability to bear weight, deformity of left leg, decreased in appetite and continual complaints of left hip/leg pain.)

On 9/5/14 between 9:45 AM and 2:45 PM, E5, E7, E8, E9, and E11, (CNA's) were interviewed. All stated they do not feel the nursing staff takes their observations and concerns seriously when presented. All stated they feel there are many times when there are significant, (several days), delays in getting residents sent out for evaluations.

On 9/11/14 at 11:50 AM, E19 (LPN) stated she was the nurse on duty when R1 fell on 8/8/14. E19 said R1 was "found on the floor on her left

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side." E19 stated she helped staff "roll R1 to her back." E19 said R1 complained of "pain to her left knee and began grabbing at it." E19 stated she didn't notice any shortening or rotation. E19 said R1 was "uncooperative with a (mechanical lift) transfer" which is the facility practice for lifting people following a fall. E19 stated the staff used a "3 person assist" to get her, (R1) up into her wheelchair because she, (R1) would not bear weight. E16 said she told the CNA's to take R1 to her room and transfer her to the bed so "I could re-assess her." E16 said "She (R1) kept rubbing her left leg" but "I didn't see anything different, (besides not bearing weight)." E16 said she was off for the next 3 days but when she returned on Monday, 8/11/14, R1 was still "acting like something was hurting." E16 said because R1 was still hurting, "I called the doctor to get an order for an X-Ray."

An incident investigation dated 8/8/14 at 6:15 PM, documented R1 was "observed (on the floor), laying on her left side...with complaints of left knee pain." The nursing note of 8/8/14 at 6:30 PM, described R1 as currently non-weight bearing, (a change in resident's condition.) The 8/9/14 nursing note showed R1 was complaining of "pain in her left hip when moved" and exhibited a decrease in appetite by only eating "a few bites of meal." There were no other entries made until 8/11/14 at 12:00 PM which read, "resident (R1) grabs at left leg when moved." The nursing note dated 8/11/14 at 4:00 PM, shows an order for an X-Ray for R1's left hip was obtained (4 days after R1's fall). The nursing note written on 8/11/14 at 5:50 PM, shows an order was received to send R1 to the local hospital emergency department for evaluation and treatment. The nursing notes show R1 left the facility at 6:45 PM and was

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F 309	Continued From page 23 admitted to the local hospital with a diagnosis of a left hip fracture. The defination of a hip fracture is a break in the upper quarter of the femur (thigh) bone. The Radiology report dated 8/11/14 at 5:26 PM, showed R1 with an "acute left intertrochanteric fracture with a near 90 degree angulation of the fracture fragments." R1 required surgical intervention on 8/12/14. The facility's policy for Change in Condition, dated 3/5/12, states the licensed nursing staff will: "assess any changes noted through direct observation or through assigned staff...Chart in the nurses notes, assessment data, observations...physician should be updated at least daily, (for a minimum of 48 hours), of the resident's status, including any deterioration or improvement. The facility's policy Accident/Incident Occurrence, (Undated), shows "all accidents or incidents where there is injury or the potential to result in injury," should have interventions initiated. The policy shows all residents that having sustained an injury, or were involved in a fall, should be observed "closely for any change from normal habits that could be an indication that there is an injury not noticed or diagnosed during the initial assessment."	F 309		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to assist or position residents to maximize independent feeding in the dining room.
This applies to 6 of 6 residents (R1, R12, R16, R20, R21, R22) reviewed for dining assistance in the sample of 34.
The findings include:
On 8/30/14 at 7:05 AM, R12 was sitting in a chair at the breakfast table. R12 had her eyes closed and was leaning to the right. R12's breakfast plate was located on the table. Multiple dietary staff and aides passed the table and told R12 to wake up and eat. No staff stopped at the table to offer any assistance. At the same table R20 was sitting in her wheel chair approximately 10 inches back from the table. R20 reached the table and picked up her bowl of eggs and then reached for her fork. R20 rested the bowl on her stomach area and attempted to eat the eggs with the fork. As R20 began to eat, with each bite, the eggs fell off of the fork onto the floor or the clothing protector. R20 continued this process until nothing was left in the bowl and then put the bowl to her mouth in an attempt to get food. R20 placed the bowl on the table and reached for the bowl of fruit and continued with the same pattern of dropping each bite of food before getting it into her mouth. No staff stopped to assist R20 with eating or to place her closer to the table. At 8:10 AM, an aide approached R20, removed her clothing protector full of food and removed her from the dining room.
At 7:30 AM, R1 was sitting with her breakfast tray at the table. Multiple staff walked past R1 but did not offer assistance. E31 (Housekeeping)

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	146114	A. BUILDING _____ B. WING _____	C 09/19/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENA LIVING CENTER	1010 SOUTH LOGAN STREET LENA, IL 61048

(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 312	Continued From page 25	F 312		

stopped at the table and gave R1 one bite of food and walked away from her to assist others to eat. R21 was sitting in her wheelchair approximately 10 inches away from the table. R21 held up each bowl as she was eating as she was unable to reach the table.
R22 was sitting in her wheelchair at the table. She was holding onto a bowl of pureed food and the contents were spilling out of the bowl onto her clothing protector. Staff in the area made no attempt to assist.
On 8/30/14 at 7:05 AM, R16 was seated in the dining room for breakfast. R16 was given her breakfast of sausage, eggs and a cinnamon roll. The cinnamon roll was not cut up or prepared for R16 and she began eating the roll with her fingers. R16 picked up the cinnamon roll and was attempting to take a bite of the whole roll. E17 (Dietary Aide) approached R16's table and stated " Good Morning pretty lady. You have got silverware for a reason. "E17 then left the table without offering R16 assistance getting her silverware or to cut up the cinnamon roll. R16 then began to reach for her silverware which was wrapped in a napkin. R16 displayed difficulty in removing the silverware from the napkin and staff at no time offered to assist. At 7:50 AM, R16 remained at the table and eating her eggs with her fingers and the silverware remains in the napkin.
On 8/30/14 at 11:15 AM, E2 DON (Director of Nurses) stated the aides should be seated when feeding the residents and they should offered help if they need assistance.
The facility ' s undated policy titled Feeding Residents states, when a resident cannot feed himself/herself, nursing staff will feed the resident. 4. Assist the resident to a comfortable position at assigned table. 9. Position serving

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F 312	Continued From page 26 pieces on the table so resident can reach the foods.	F 312		
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 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	F 441		

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infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure handwashing and glove use was performed to prevent cross-contamination. The facility failed to ensure clean dressings were applied to wounds.

This applies to 4 of 4 residents (R1, R8, R14, R18) reviewed for dressing changes in the sample of 34.

The findings include:

On 8/30/14 at 9:45 AM, E19 LPN (Licensed Practical Nurse) and E18 RN (Registered Nurse), stated R8's dressing needed to be changed to her legs because it was not done on the night shift as scheduled. E19 stated this was the second day in a row the dressing had to be done on day shift. E19 removed the visibly soiled dressings from R8's calves. With the same contaminated gloves, she grabbed the bottle of saline to flush the wound. Without any protection under the leg, E18 began to flush the wound, with drainage leaking onto the blanket below. After placing a collection pad under the leg, E18 began to flush the wound again, patting the wound dry with dry gauze. With the same contaminated gloves, E18 then put the wound ointment over the wound bed and surrounding skin.

On 8/30/14 at 10:15 AM, E18 and E19 removed a dressing from R14's wound. With gloves on, E18 irrigated the wound bed with saline and

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gauze. With the same soiled gauze, E18 cleaned the surrounding skin. E18 cleaned the wound from dirty to clean (outward to inward). Without changing gloves, E18 packed the wound with a cotton tipped applicator and applied a bandage with the same contaminated gloves.

On 9/11/14 at 10:10 AM, E32 LPN, donned gloves and removed R1's sock and soiled dressing. With the same gloved hands, E32 cleansed the wound bed, removed the medicated cream from a plastic bag, placed the cream on clean gauze and placed the dressing over the wound. Without changing her gloves, E32 placed a kerlix around the foot. Still wearing the same soiled gloves, E32 began to remove the soiled dressing from the other foot and began to clean that wound. E32 placed the medicated cream on the gauze, applied it to R1's heel and wrapped the foot with kerlix. E32 performed the dressing changes to both heels without changing her gloves.

On 9/11/14 at 10:15 AM, E19 removed R18's soiled dressing on the left buttock. E19 cleansed the wound with normal saline. E19 placed the lid back onto the bottle of normal saline and patted the wound dry with gauze. This was done while still wearing the soiled gloves used to remove the soiled dressing and clean the wound. E19 then placed the medicated ointment onto clean gauze and the gauze is then placed over the wound with contaminated gloves. After completing care, E19 placed the soiled gloves into the soiled incontinence brief under R18.

On 9/11/14 at 1:00 PM, E19 stated that gloves should be changed during dressing changes, when they become soiled.

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F 441	Continued From page 29 On 9/11/14 at 1:50 PM, E27 LPN, stated the nurses in the facility do not receive any training on how to perform dressing changes. E27 stated there have been no in-services or meetings about dressing changes or infection control. E27 stated the facility would just have you sign a paper to say they had a meeting or in-service but they did nothing. E27 stated she was told by supplies that it was necessary to reuse some of the dressings because there was no supply of new dressings. The facility's undated policy for Dressing Change-Clean Technique states 9. Put on gloves 10. Remove soiled dressings and place in a plastic bag. 11. Remove soiled gloves and place gloves in a plastic bag. 12. Wash hands 13. Put on gloves 14 Cleanse open areas from top to bottom or from inside out. The facility undated policy titled Handwashing, states proper handwashing is essential to aid in the prevention of the transmission of microorganisms. The Policy states, all staff must wash their hands immediately after coming in contact with each resident and after contact with material which may be contaminated and /or potentially infectious. Also after a source of body fluids, mucous membranes, and removing gloves.	F 441		