

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2014	
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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			F 000			
F 242 SS=E	<p>Complaint 1415302/IL73376 - No Deficiencies Cited</p> <p>Complaint 1415313/IL73387 - F242 & F353 Cited</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staff honor resident time preferences for bathing, waking up and going to bed.</p> <p>This applies to 5 of 13 residents (R2, R6, R11, R12 & R13) reviewed for nursing services in the sample of 13.</p> <p>The findings include:</p> <p>On 12/2/14 at 4:30 AM, R11, R12 and R13 were up, dressed and out of their rooms. R11 was seated in a reclining wheel chair at the front of the C wing hallway near the nurses station. R11 was screaming and yelling out. R12 was sleeping in her wheel chair at the front of the A wing hallway near the nurses station. R12 would awaken with the yelling and begin yelling out also. R13 was seated in a wheel chair at the back of the A wing</p>			F 242			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2014
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 242	<p>Continued From page 1 hallway. He was asleep in his wheelchair.</p> <p>On 12/2/14 at 4:50 AM, E5 CNA (Certified Nursing Assistant) stated, R11, R12 and R13 tend to crawl out of bed or have "sundowners" and are difficult to watch/keep safe while tending to other residents. E5 stated for this reason, residents are gotten up and dressed for the day.</p> <p>On 12/2/14 at 5:20 AM, R6 (CNA) stated the night shift is expected to get everyone to bed at night, everyone up in the morning, do scheduled rounds, respond to call lights, pass linens, take out trash, pass water and snacks, meet all resident needs and document on each resident, with minimal staffing. E6 stated the CNA's have to manage their time with the resident's needs.</p> <p>On 12/2/14 at 6:10 AM, R2 stated she prefers bed baths to showers. R2 stated she feels the showers are "unsanitary." R2 said the shower chair hurts her and she yells out and screams during the entire shower. R2 said she has asked for alternatives but "the staff tell me I have to have a shower."</p> <p>On 12/2/14 at 7:00 AM, R6 stated she has some concerns with staff honoring her wishes. R6 stated recently she didn't feel well and didn't want to take a shower. R6 said, "They made me take it anyway."</p> <p>According to the Illinois Department on Aging Residents' Rights pamphlet, given to residents upon their admission to the facility, the facility must "provide services to keep your physical and mental health, and sense of satisfaction with yourself, at their highest practical levels."</p>	F 242			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2014
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353 F 353 SS=F	<p>Continued From page 2</p> <p>483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS</p> <p>The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.</p> <p>The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure staffing was sufficient to meet the residents needs of turning/repositioning, incontinent cares, timely response to call lights, placement and removal of bedpans, and the provision of weekly showers.</p> <p>This has the potential to affect all 76 residents living in the facility.</p> <p>The findings include:</p>	F 353 F 353			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2014
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 3</p> <p>The Facility Data Sheet, completed by the facility on 12/2/14, shows there are currently 76 individuals residing in the facility.</p> <p>On 12/2/14 at 4:30 AM, the facility had 2 RN's (Registered Nurses) and 4 CNA's (Certified Nursing Assistants) on duty with a census of 76 residents. Two call lights were lit on the A Wing. The wait for a CNA response was greater than 20 minutes. Upon answering the call light, the CNA would express she would return as soon as possible. R11, R12 and R13 were up, dressed, and out of their rooms. R11 was seated in a reclining wheel chair at the front of the C wing hallway near the nurses station. R11 was screaming and yelling out. R12 was sleeping in her wheel chair at the front of the A wing hallway near the nurses station. R12 would awaken with the yelling and begin yelling out also. R13 was seated in a wheel chair at the back of the A wing hallway. He was asleep in his wheelchair.</p> <p>On 12/2/14 at 4:30 AM, E3 (RN) was asked about the staffing. E3 stated, "You must be referring to the night of the 24 th (11/24/14). We had two CNA's and were very busy. The nurses were answering call lights, doing bedpans and everything. I believe cares were given but we were late getting people up in the morning."</p> <p>On 12/2/14 at 4:50 AM, E5 (CNA) stated "we are short CNA's on all shifts." E5 said the night shift usually has 3 CNA's but last night E4 came in at 2:00 AM which "helps a lot." E5 stated the residents on the A and B wings are heavy care residents. E5 said she feels sufficient staffing to provide cares would be 4 CNA's minimum on the night shift. E5 stated bed checks, (checking for</p>	F 353			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2014
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 4</p> <p>incontinence, turning/repositioning, toileting, etc.) are to be completed at 12:00 AM, 2:00 AM and 4:00 AM. E5 said due to people climbing out of bed, needing toileted, and other things that occurred during the night, "it is almost 5:00 AM and I haven't even started by 4:00 bed checks." E5 acknowledged residents may be laying in their beds after being incontinent due to being unable to get to them in a timely manner. E5 said "people just have to wait to be cleaned up if they are incontinent." E5 said the night shift does not do showers, but she is aware that residents are not receiving their scheduled showers because the first and second shifts are "short staffed too." E5 said the night shift used to start "get up" between 5:00 AM and 5:30 PM but due to the minimal staffing and increased care requirements of residents, "we get people up earlier." Especially if they are restless or climbing out of bed." E5 said cares provided are "minimal and quick."</p> <p>On 12/2/14 at 5:20 AM, E6 (CNA) stated he usually has 15-18 hours of overtime just to help cover the staffing concerns. E6 stated "adequate" staffing for nights would be 4 CNA's, (one for each wing), and "ideal" would be to have a 5th CNA to float and help with the heavy care residents. E6 stated the A and B wings have 28-30 residents each and are given 1 CNA per wing. E6 said he was currently assigned the C and D wing. E6 said D wing has 10 residents and C wing has 16 residents. E6 said because that totals 26, "I guess they think it is the same as working either the A or B wing." E6 said things don't get done because you "can't be on both wings at the same time." E6 gave an example of, "If I am toileting a resident on one wing, and an alarm goes off on the other wing, what am I</p>	F 353			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2014
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 5</p> <p>supposed to do? Drop the resident I am toileting to answer it?" E6 said some residents are confused or have "sundowners" and are ambulatory. E6 said I have been in a room on one wing assisting a resident and (resident's name) will wander out into the hallway or even outside with no clothes on."</p> <p>On 12/2/14 at 5:50 AM, E7 (CNA) stated, "Staffing is not the greatest. We usually only work with 3 (CNA's) on nights and sometimes just 2 (CNA's). Tonight we actually had 4 (CNA's) after 2:00 AM." E7 said the night shift needs 1 CNA per hallway at a minimum and should have 1 CNA to "bounce between the A and B wings because they are such heavy care residents." E7 said, due to not having enough staff, "A lot of baths don't get done, lights go off longer, especially when assigned two halls and we rush to get things done so sometimes things get missed. We forget more. Repositioning gets missed and cleaning cares are not as thorough as we would like."</p> <p>On 12/2/14 at 6:55 AM, R1 stated she had been at the facility more than a month and has only had 2 showers. R1 said it takes "a long time" for staff to answer the call lights. R1 said, "I understand they answer them in the order they came on but my roommate (R2) has been left on the bedpan so long she has an impression left on her butt." Review of R1's medical records showed she was admitted to the facility on 10/23/14. The nursing note of 11/28/14 documents R1 received a shower. Review of the November shower sheets showed R1 received a shower on Saturday 11/29/14.</p> <p>On 12/2/14 at 6:10 AM, R2 stated, "It takes a long</p>	F 353			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2014
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 6</p> <p>time to answer call lights." R2 stated the PM and Night shifts are the worst. R2 said, "I don't know exactly how long but I can tell you I can put the light on and wait so long I fall asleep. Then, I wake up and it is still on." E2 said she has wet and defecated in her bed waiting for a response to the call light but that it is because there "isn't enough staff. Most of the staff do their best but there are not enough."</p> <p>On 12/2/14 at 5:35 AM, E2 (Director of Nursing) stated during interview, "Staffing is not at it's best. We need to hire CNA's and Nurses." E2 said the decline in staffing makes repositioning more difficult. On 12/2/14 at 5:45 AM, E1 (Administrator) stated the facility follows minimum staffing guidelines which consists of 9 CNA's on the first shift, 7 CNA's on the second shift and 3-4 CNA's on the third shift. E1 said "Typically we have been working close to or at the minimum by utilizing overtime." On 12/2/14 at 6:50 AM, E8 (Social Service Designee) stated, call light response times are always an issue with the residents. On 12/2/14 at 6:35 AM, E9 (RN-Clinical Services) said the "staffing has been up and down but the staff we do have are willing to pitch in and help."</p> <p>Review of the November Shower sheets showed residents were waiting 2-4 days after their scheduled day to receive showers. R7 is scheduled to receive showers on Fridays. The shower sheets showed R7 declined a shower on 11/21/14 and has not been offered one, (due on 11/28/14) up to the present (12/2/14). This is a minimum of 18 days since her last shower. R8's scheduled shower day is on Sunday's. R8 declined a shower on 11/23/14 and has not been offered another shower, (due 11/30/14) to the</p>	F 353			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 146114	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/03/2014
NAME OF PROVIDER OR SUPPLIER LENA LIVING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 353	<p>Continued From page 7</p> <p>present (12/2/14). This is a minimum of 16 days since her last shower. R9 has Monday's as her scheduled shower days. R9 declined her shower for 11/24/14 and was not offered her shower for 12/1/14. This is a minimum of 15 days since her last shower. On Sunday, 11/30/14, R10's shower sheet documents she was given a bed bath "due to low staff."</p> <p>Review of the staffing schedules from November 9, 2014 to December 1, 2014 showed on November 15, 2014 (Saturday), November 16, 2014 (Sunday), and November 24, 2014 (Monday), the night shift was staffed with only 2 CNA's for the 12 hour shifts. Many other times on the scheduled it was shown that CNA's were doing overtime/mandation. The overtime varied between 4 hours and 12 hours resulting in CNA's working 12-16 hours a day.</p>	F 353			