STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146156	A. BUILDING _____ B. WING _____	07/18/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ENFIELD REHAB & HCC	**408 NORTH WILSON STREET ENFIELD, IL 62835**

(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 279 SS=D	Annual Licensure/Certification Survey 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under o483.25; and any services that would otherwise be required under o483.25 but are not provided due to the resident's exercise of rights under o483.10, including the right to refuse treatment under o483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop a comprehensive care plan to address the medical effects of smoking for 1 of 8 residents (R 2) in the sample of 8. Findings include: 1. The 4/15/13 History and Physical form documents R2's diagnosis as acute exacerbation	F 279		

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.

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F 279	Continued From page 1 of chronic obstructive pulmonary disease with hypercapnic respiratory failure, left lower lobe infiltrate suggestive of pneumonia, history of seizure disorder, and schizophrenia. On 3/28/13, R2's physician recommends not to smoke when R2's oxygen saturation is below 92%. R2 was offered nicotine patches and refused. Refusal of Treatment was signed by R2 on 3/28/13 after being informed for the reason to stop smoking. On 7/16/13 at 1:30 PM, E4, (Registered Nurse), during interview stated 2 persons must go with resident when he smokes. He has told too many stories so 2 people is necessary. On 7/15/13 during record review the care plan did not have a plan to monitor for the medical effects of smoking during smoking or the need for 2 persons to be with resident when he smokes.	F 279		
F 283 SS=D	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to provide a summary of the resident's stay for 1 of 8 residents (R8) reviewed for discharges in the sample of 8. Findings include:	F 283		

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F 283	Continued From page 2 1. The face sheet in R8's medical record indicates an admission date of 3/27/10. The Physician Order Sheet documents the diagnosis of Respiratory Failure, History of Bowel Obstruction, Alzheimer's, and Hypertension. During the residents stay R8 received speech therapy to address special feeding needs, restorative program, and a recent hospital stay for Pneumonia. Record review of medical record documents no recapitulation of resident stay to provide necessary information for continued care. On 7/16/13 at 3:30 PM, E1, (Administrator), during interview states the reason the resident transferred to another facility was due to the family wanting R8 to be closer to a hospital. E1 could not find documentation of a discharge plan or summary of stay by nursing staff or social services.	F 283		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to assess, monitor and document condition and treatment of pressure	F 314		

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F 314	Continued From page 3	F 314		

ulcers for 1 of 3 residents (R3) reviewed for pressure ulcers in the sample of 8.

The findings include:

1. R3's admission records and current July physician's orders indicate R3 is an eighty nine year old with multiple diagnoses including: Alzheimers, Hypothyroidism, Chronic Venous Insufficiency and Depression. During the initial tour of the facility on 7/15/13 at 10:30am, R3 was identified by E3 (Licensed Practical Nurse, LPN) to have a Stage III pressure area on her coccyx.

R3's Wound Tracking Report for July (reviewed on 7/15/13), documented R3 had a pressure area last measured on 7/11/13 and found to be a Stage III measuring 2cm x 7cm and .5cm in depth. The report stated the Doctor and family were notified at that time. Nursing notes from 7/12/13 10:00am stated "res wound to coccyx not decreasing in size, notified MD of need for Arginaid daily, awaiting order" There was nothing documented to indicate family was made aware of the enlarged pressure areas.

The facility's cumulative July Wound Tracking report given to surveyors on 7/16/13 indicated that R3 had 1 Stage III and 1 Stage II pressure area to the Right Mid-Buttocks. R3's individual July wound tracking report was resubmitted to the survey staff and found changed from the 7/15/13 documentation stated above. The report from 7/16/13 had removed the 7/11/13 measurements noted above as an error and documented the coccyx wound to measure 1cm x .3 cm and .1 in depth on 7/15/13. However, the

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F 314	Continued From page 4 7/16/13 document had 2 additional pressure areas noted to R3's right buttocks. These entries further indicate the doctor and R3's family were made aware of the two new areas one on 7/15/13 and a second on 7/16/13. Review of Nursing notes find no documentation of doctor or family notification until a note on 7/16/13 at 2100 stating: "n/o arginaid BID, and may have wound consult, dietary notified of n/o, pharm notified, POA called left message." Review of R3's current physician's order sheet and treatment records on 7/15/13 for July failed to find a current order for treatment of R3's pressure area and there was no documentation that any treatment was being provided to the documented coxxyx wound. R3's current orders included only an application of a barrier cream to the buttocks three times a day. This lack of documentation and treatment order was brought to the attention of E3. E3 reviewed R3's record and located a telephone order dated 6/18/13 with a treatment order for R3's Stage III pressure area. E3 stated during an interview at approximately 2:00pm on the 15th, that the current orders and treatment records did not include the treatment order or record of treatment for the entire month of July thus far (1st to 15th) Observation of R3's coccyx area, at 2:45pm on 7/15/13, found an undated dressing in place at that time. E3 stated the night shift normally completed dressing changes. Review of nursing notes for R3 for the month of July found the following notes regarding dressing changes for R3:	F 314		

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F 314	Continued From page 5 7/5/13 0200 Dressing to coccyx changed 7/6/13 0515 Dressing change to coccyx Neither of the above entries describe what treatment was provided to R3's wound. There is no further documentation available to detail how R3's wound was treated. Observation of R3's wound care, on 7/16/13 at 3:45pm, found R3 to be incontinent of stool and 1 stage III and 2 Stage II wounds to be present and treated. A review of R3's care plan dated 7/3/13 for "Impaired Skin integrity due to: Stage II (R) inner buttock" fails to include the Stage III wound to the coccyx and the newly acquired Stage II areas (2) to the right mid buttock. The approaches for the care plan include: "Provide treatment as ordered". The specific treatment is not included in this comprehensive plan of care.	F 314		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and observation the facility failed to give medication as ordered by the physician, with 2 medication errors out of 28 opportunities for error, resulting in a 7.14 % medication error rate for 1 of 8 sampled resident (R5) and 1 resident (R9) in the supplemental.sample	F 332		

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F 332	Continued From page 6 Findings include: 1. R9 has a physician order for Insulin Novolog sliding scale. Blood Sugar is 168 and requires 2 units of Novolog as per order. On 7/16/13 at 11:40 AM, E 4 Registered Nurse obtained Novolog Insulin pen, placed needle on Insulin pen, dialed 2 units for administration. E4 administered 2 units without preparing the Insulin pen first. Insulin Pen Instructions for Use obtained from E2, (Director of Nurses) on 7/16/13 at 3:45 PM, documents to avoid injecting air and ensure proper dosing: apply needle, turn dose selector to 2 units, pressure the push button all the way in until the dose selector is back to 0. Turn the dose selector to the number of units you need to inject. On 7/16/13 at 3:45 PM, E 4, (Registered Nurse), stated during interview that she was unaware of the procedure to flush the needle before injecting residents. 2. R5 has a physician order for calcium 600 milligrams with vitamin D 400 units two times a day with food. On 7/15/13 at 2:35 PM, E3, (Licensed Practical Nurse) administered calcium 600 milligrams with vitamin D 400 units with out food.	F 332		
F 387 SS=E	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.	F 387		

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F 387	Continued From page 7 A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure physician visits are timely for 1 of 4 residents (R5) reviewed for timely visits by Z1, (Physician), in the sample of 8 and 3 residents (R12, R15 and R19) in the supplemental sample. Findings include: 1. The face sheet in R5's record indicates an admission date of 10-21-11 under the medical care of Z1, (Physician). Diagnoses noted includes Diabetes Mellitus, Dialysis, and Left Below the Knee Amputation. The last Physician's progress note available from Z1 is dated 9-3-12. The medical record included hospital information noting medical visits 4-30-13, 6-28-13 and 7-4-13. A 90 day visit from Z1 was due in 12-12 and 3-13. 2. The face sheet in R12's record indicates an admission date of 2-4-13 under the medical care of Z1. Diagnoses noted includes Parkinson's Disease and Hypertension. R12 fractured their hip in the facility and required surgical repair on 2-23-13. Progress notes from Z1 are available for 2-7-13 and 7-2-13. At 3:15PM on 7-18-13, E4, (Registered Nurse), stated R12 saw an orthopedic physician out of the facility on 5-31-13. Review of R12's record indicated no progress note was available for this visit. There was no visit by Z1 for March or April 2013 to	F 387		

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F 387	Continued From page 8 meet the requirement of every 30 days for the first 90 days after admission. 3. The face sheet in R15's record indicates an admission date of 5-30-02 under the medical care of Z1. Diagnoses noted includes Schizophrenia, Anemia, and Chronic Obstructive Pulmonary Disease. Review of physician visits by Z1 indicates progress notes for 9-3-12, 2-7-13 and 7-2-13. Progress notes are missing for 90 day visits in 12-12 and between 2-7-13 and 7-2-13. 4. The face sheet in R19's record indicates an admission date of 4-10-07 under the medical care of Z1. Diagnoses noted includes Cerebral Vascular Accident, Chronic Obstructive Pulmonary Disease and Anemia. Progress notes by Z1 are available for 9-3-12, 2-7-13 and 7-2-13. Progress notes are missing for 90 day visits in 12-12 and between 2-7-13 and 7-2-13. E2, (Director of Nursing), during interview stated at 8:50AM on 7-18-13, progress notes have been obtained for any visits made by Z1. E2 noted facility staff are aware of untimely visits by Z1.	F 387		
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431		

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F 431	Continued From page 9 Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, interview and record review the facility failed to provide proper storage and elimination of expired medications. This has the potential to effect all 18 resident in this facility. Findings include: The Resident Census and Condition of Residents dated 7/15/13 documents the facility has a census of 18 residents.	F 431		

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F 431	Continued From page 10 1. On 7/16/13 at 10:00 AM, in the medication room was a red emergency drug box on the floor, no coved mop baseboard, applesauce in the medication refrigerator, dirty electric shavers on the counter, dirty thumb splint on counter belonging to a discharged resident, and the medication room is in general disarray. 2. On 7/16/13 at 3:30 PM, in the medication cart was one bottle of aspirin 325 milligrams that expired 3/13. 3. On 7/16/13 at 10:00 AM, in the medication room on the top shelf of the bulk medication shelf was 4 bottles of zinc sulfate that expired 3/13. E4, (Registered Nurse), stated during interview that she could not believe that there were expired medications since the pharmacist checks for outdates monthly.	F 431		
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide the required 80 square feet per resident in all 23 of 23 multiple resident bedrooms. This has the potential to affect all 18 residents living in the facility. The findings include:	F 458		

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F 458	Continued From page 11 The facility's Resident and Census and Condition of Residents form, dated, 7/15/13 documented the facility had a census of 18 residents. 1. An interview with E1 (Administrator), on 7/17/13 at 4:00pm, found all the multiple resident bedrooms in the facility are Medicare / Medicaid Certified and measure 72 square feet per bed. These waivered rooms were occupied by residents R1 - R7 and R9 - R20. There were no negative resident interviews or affects noted to the health and safety of the 18 residents who reside in the waivered rooms. Review of Resident Council notes and facility incident reports found no issues related to room size.	F 458		