PRINTED: 08/06/2014 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		145518	B. WING	D WING		C	
NAME OF I	PROVIDER OR SUPPLIER	143316	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	07/	31/2014
MARKA	NURSING HOME				201 SOUTH 10TH STREET		
WATTRA	NOTIONA FIOME			Λ	MASCOUTAH, IL 62258		ı
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ΓS	F 0	000			
F 274 SS=D	Minimum Data Set 483.20(b)(2)(ii) COI AFTER SIGNIFICA	MPREHENSIVE ASSESS	F 2	274			
	assessment of a re facility determines, that there has been resident's physical opurpose of this secondant a major decresident's status that itself without further implementing standinterventions, that hone area of the resirequires interdisciplicare plan, or both.)	uct a comprehensive sident within 14 days after the or should have determined, a significant change in the or mental condition. (For tion, a significant change line or improvement in the at will not normally resolve intervention by staff or by lard disease-related clinical has an impact on more than ident's health status, and linary review or revision of the					
	by: Based on interview failed to ensure Mir (MDS) accurately re						
	The findings are:						
	a fall at the facility of Nurses Notes and of Investigation dated to the hospital on 1,	Fracture of the Right Hip from on 1/4/14 as noted in the on a facility Incident 1/4/14. R33 was discharged /4/14 and returned to the noted in the Nurses Notes.					
I ARORATOR'	V DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	JATURE		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.

Facility ID: IL6005748

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED	
		145518	B. WING	B. WING		C 07/31/2014	
	PROVIDER OR SUPPLIER NURSING HOME			201 SOUT	DDRESS, CITY, STATE, ZIP CODE IH 10TH STREET UTAH, IL 62258	1 017	31/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL ROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 274	was reviewed and of completed after the Quarterly MDS also from supervision to of the Activities of E gone from supervision activity not occurring showed that a signification was not done and a construction on 5/13/14, was concontinued to show the and balance problem the 12/3/14 MDS. E4, MDS Coordinate pm that a significant completed as requifications. The Resident Assertation	ated 12/3/14, prior to the fall, compared with a 2/24/14 MDS, fall, which was coded as a b. R33 was noted to have gone extensive assist in 4 areas's Daily Living Section G, and ion for ambulating in room, to g at all. These changes ficant change MDS should ed within 14 days, once the d a significant change. This additionally an MDS completed ded as an Annual. This MDS the need for extensive assist ms that were not present on tor, verified on 7/31/14 at 3:00 at change MDS was not red by the Resident	F 2	74			
	is a decline or impro that will not normall than one area of the The RAI manual also change in status as when: When there significant change in his/her baseline has comparison of the remost recent compro subsequent quarter	ovement in resident's status y resolve itselfimpacts more e resident's health status" so states, "A SCSC (significant issessment) is appropriate is a determination that a n a resident's condition from a soccurred as indicated by resident's current status to the ehensive assessment and anyty assessments; and the is not expected to return to					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145518		B. WING		C 07/31/2014	
NAME OF	PROVIDER OR SUPPLIER	140010	1	STREET ADDRESS, CITY, STATE, ZIP CO	I DDE	07/3	51/2014
MAR KA	NURSING HOME			201 SOUTH 10TH STREET MASCOUTAH, IL 62258			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD E	BE	(X5) COMPLETION DATE
F 274	of decline." 2. R54 sustained a from a fall at the factor a fall at the factor and convestigation dated to the hospital on 1 facility on 1/10/14 a quarterly MDS was documented chang Section G- Activitie mobility going from transfer changing from the decision of the facility inconting the facility had iden Director of Nurses, R54 was admitted to 2/4/14. E2 verified to assessment should after return from the 483.20(g) - (j) ASSI ACCURACY/COOF The assessment maresident's status.	Fracture of the Right Hip cility on 1/5/14 as noted in the on a facility Incident 1/5/14. R54 was discharged /5/14 and returned to the is noted in the Nurses Notes. A completed on 2/2/14 which es in 2 or more areas of s of Daily Living, with bed extensive to total assist, rom limited assist to total assist for ambulating in room in H- Bladder and Bowel 54 had changed from always incontinent. These hat a significant change MDS completed within 14 days, once tified a significant change. E2, stated on 7/31/14 at 5 pm that it in facility Hospice care on that a significant MDS have been completed for R54 e hospital. ESSMENT RDINATION/CERTIFIED ust accurately reflect the	F 2				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		COMPLETED	
		145518	B. WING _		07	C // 31/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE 201 SOUTH 10TH STREET MASCOUTAH, IL 62258		701/2011
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	assessment is come Each individual who assessment must so that portion of the auxiliary and knowing false statement in a subject to a civil most subject subje	must sign and certify that the apleted. o completes a portion of the sign and certify the accuracy of assessment. In Medicaid, an individual who agly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who agly causes another individual and false statement in a ant is subject to a civil money than \$5,000 for each	F 27	78		
	by: Based on interview failed to ensure Minaccurately reflected 22 residents (R4, Freviewed for accurate sample of 22. Findings include: 1. A Physician's O 6-15-14 documented Urinary Tract Infection the medication Ceptwo times daily. A	NT is not met as evidenced v and record review, the facility nimum Data Set assessments d residents' status for seven of 822, R25, R27,R33, R35, R46) acy of assessments in a rders Sheet (POS) dated and R22 had a diagnosis of tion (UTI) and was prescribed chalexin 500 mg (milligrams) nurse's note dated 6-12-14 was complaining of urgency				

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	IPLE CONSTRUCTION NG	CON	(X3) DATE SURVEY COMPLETED	
		145518	B. WING _			C / 31/2014
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 201 SOUTH 10TH STREET MASCOUTAH, IL 62258		70172314
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 278	culture and sensitive documented R22's the bacteria Esche R22's Minimum Dadated 6-16-14 doesno Diagnosis, the diagnosis, the diagnosis, the diagnosis, the diagnosis, the diagnosis assessment Coord the Resident Assessment Coord the Resident Assessments. A RAI (Resident Assessments. A RAI (Resident Assessments. A RAI (Resident Assessments. The UTI has a locative disease instate following are most in the following are most in the following are most included urinary symptoms or may not include urinary symptoms sensation, frequence pain or tenderness in mental status, chees.	ng urination. A laboratory vity report dated 6-15-14 urine culture was positive for richia Coli. Ita Set (MDS) assessment is not include in section I Active process of Urinary Tract In p.m. E4 (Minimum Data Set linator) stated the facility uses is sement Instrument (RAI) user's ey for ensuring accurate if Minimum Data Set Its sessment Instrument) Manual ter 3 Item I2300 Urinary tract is estates, ok-back period of 30 days for ead of 7 days. Code only if all et in practitioner, physician il nurse specialist or other id staff as permitted by state law	F 2'	78		
	attending physiciar significant laborato a culture should be	should determine the level of ry findings and whether or not				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED			
		145518	B. WING	B. WING		C 07/31/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH 10TH STREET MASCOUTAH, IL 62258	<u> </u>	51/2014	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED CORRECTION OF THE AP	LD BE	(X5) COMPLETION DATE	
F 278	the last 30 days.' On 7-31-14 at 5:05 Assessment Coord diagnosis of Urinary been added to R22 Diagnosis. 2. A Physician's Or 6-30-14 document include the antipsyc two times each day R46's Minimum Da N0300 Medications antipsychotic medic during the the date prior to the assessr On 7-31-14 at 5:00 Assessment Coord the Resident Asses manual as it's polic coding of residents assessments. A RAI (Resident As dated 4/2012 section says, "Record the re antipsychotic medic resident at any time period (or since adr than 7 days)." On 7-31-14 at 5:05 Minimum Data Set 6-29-14 should hav	o.m. E4 (Minimum Data Set inator) verified R22's y Tract Infection should have 's 6-16-14 MDS under Active ders Sheet dated 4-01-14 to R46 has medications which chotic Seroquel which is taken of the MDS or the six days ment reference date. o.m. E4 (Minimum Data Set inator) stated the facility uses sment Instrument (RAI) user's y for ensuring accurate Minimum Data Set inator) accurate Minimum Data Set instrument of days an eation was received by the enduring the 7-day look-back mission/entry or reentry if less on. E4 verified that R46's assessment (MDS) dated e indicated R46 received eations during the last seven	F 2	78			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILD		(X3) DATE SURVEY COMPLETED			
		145518	B. WING				C 31/2014
	PROVIDER OR SUPPLIER NURSING HOME			201	EET ADDRESS, CITY, STATE, ZIP CODE SOUTH 10TH STREET SCOUTAH, IL 62258	1 011	51/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 278	3. A 4/28/14 Nurses was admitted to the urosepsis. The Hos dated 4/27/14 docu complaint was UTI altered mental statu on 5/2/14 as noted documentation that antibiotic for a UTI. A quarterly Minimum on 5/19/14 does not the UTI even thoug during the 30 day to in Section I of the Normal completed on 6/2/1 presence of the UTI diagnosis during the this MDS. E4, MDS Coordinate pm that the MDS has to an oversight. 4. A 5/2/14 11:30 at that R33 was yelling hitting at staff. A 7:0 documented that at R33's physician to culture and sensitive 5/3/14 urinalysis and than 100,000 Esche Practical Nurse, stawas not normal behavior and UTI on 5/5/201	s Note documented that R27 hospital with a diagnosis of spital History and Physical mented that R27's chief (Urinary Tract Infection) and us. R27 returned to the facility in the Nurses Notes with R27 was receiving an material Data Set (MDS) completed to the diagnosis ook back time frame required MDS 3.0. A discharge MDS 4 also did not document the Which was still an active e 30 day look back period for the tor verified on 7/31/14 at 3:00 and been coded incorrectly due on Nurses note documented gat another resident and D0 pm Nurses Note order was obtained from obtain a urinalysis with a wity (C&S) if indicated. The lad C&S report indicated greater erichia Coli. E5, Licensed ated that the yelling and hitting navior for R33, and a UTI was gan an antibiotic for treatment	F 2	278			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (Y1) PROVIDED (STATEMENT OF DEFICIENCIES (Y1) PROVIDED (STATEMENT)

C 07/31/2014
(X5) COMPLETION DATE

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145518	B. WING			C	
NAME OF F	PROVIDER OR SUPPLIER	143310	3	STREET ADDRESS, CITY, STATE, ZIP CODE	07/	/31/2014	
	NURSING HOME			201 SOUTH 10TH STREET MASCOUTAH, IL 62258			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X (EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 278	Manual for coding of E4, stated on 7/31/2 of the discharge, shaware of the diagnost a modification of the done when the diagnost facility. 7. R25's June 2014 indicated that R25 medication Abilify a least last Decembe Administration Record R25 had received the 6/15/14, which was the MDS completed 6/15/14 MDS was of R25 did not received during the look back 7/31/14 at 3:00 pm 483.75(o)(1) QAA COMMITTEE-MEM QUARTERLY/PLAN A facility must main assurance committed nursing services; a facility; and at least facility's staff. The quality assess of committee meets a issues with respect and assurance acting develops and imple control of the diagram o	sident Assessment Instrument of Section J on the MDS 3.0. 2014 3:00 pm that at the time he had not yet been made used fracture and verified that he discharge MDS was not gnosis was reported to the section of the management of th	F 2				
	action to correct ide	entified quality deficiencies.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		145518		B. WING		C 07/31/2014	
	PROVIDER OR SUPPLIER			S1 20	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH 10TH STREET IASCOUTAH, IL 62258	<u> </u>	31/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			X	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 520	disclosure of the reexcept insofar as a compliance of such requirements of this Good faith attempt and correct quality a basis for sanction. This REQUIREME by: Based on record refailed to have a quisystem in place to Minimum Data Set This has the potentiving in the facility. The findings are: 1. R33 sustained a a fall at the facility Nurses Notes and Investigation dated to the hospital on 1 facility on 1/8/14 as A Quarterly MDS also from supervision to of the Activities of I gone from supervision to gone from supervisions.	eretary may not require ecords of such committee such disclosure is related to the non-committee with the is section. It is section. In the section is section is section. In the section is section is section. In the section is section is section is section. In the section is section is section is section. In the section is section is section is section is section. In the section is section. In the section is section is section is section is section is section. In the section is section is section is section is section is section. In the section is section is section is section is section is section is section.	F	520			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				(X3) DATE SURVEY COMPLETED		
145518		B. WING	B. WING			C 07/31/2014		
	PROVIDER OR SUPPLIER			STREET ADDRESS, 201 SOUTH 10TH MASCOUTAH, II		1 017	01/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	(EACH CC	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOUL FERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 520	showed that a signi have been complet facility had identified was not done and a on 5/13/14, was concontinued to show that and balance problethe 12/3/14 MDS. E4, MDS Coordinate pm that a significant	ficant change MDS should ed within 14 days, once the d a significant change. This additionally an MDS completed ded as an Annual. This MDS the need for extensive assist ms that were not present on our or, verified on 7/31/14 at 3:00 at change MDS was not red by the Resident	F	20				
	is a decline or improthat will not normall than one area of the The RAI manual also change in status as when: When there significant change in his/her baseline has comparison of the most recent comprosubsequent quarter resident's condition baseline within two appropriate is there of decline." 2. R54 sustained a from a fall at the fact Nurses Notes and convestigation dated to the hospital on 1.	ssment Instrument Manual states, "A significant change ovement in resident's status y resolve itselfimpacts more e resident's health status" so states, "A SCSC (significant isessment) is appropriate is a determination that a n a resident's condition from a cocurred as indicated by resident's current status to the enensive assessment and any ray assessments; and the is not expected to return to weeksA SCSA is are either two or more areas are either two or more areas are facility Incident 1/5/14. R54 was discharged /5/14 and returned to the s noted in the Nurses Notes. A						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED	
		145518		B. WING		C 07/31/2014	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 201 SOUTH 10TH STREET MASCOUTAH, IL 62258		75172014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 520	documented changes Section G- Activities mobility going from transfer changing from the too cocumented that Roccasionally inconturinary catheter and being continent to a changes showed the should have been of the facility had iden Director of Nurses, R54 was admitted 2/4/14. E2 verified assessment should after return from the 3. A Physician's On 6-15-14 documented Urinary Tract Infect the medication Cept two times daily. And documented R22 wand frequency during culture and sensitive documented R22's the bacteria Escheller R22's Minimum Dadated 6-16-14 does Diagnosis, the diagraphics of the diagraph	completed on 2/2/14 which les in 2 or more areas of s of Daily Living, with bed extensive to total assist, rom limited assist to total assist for ambulating in room on H- Bladder and Bowel 54 had changed from inent to using a indwelling d Bowel had changed from always incontinent. These hat a significant change MDS completed within 14 days, once tified a significant change. E2, stated on 7/31/14 at 5 pm that to in facility Hospice care on that a significant MDS I have been completed for R54 to hospital. I ders Sheet (POS) dated end R22 had a diagnosis of ion (UTI) and was prescribed on the complaining of urgency in gurination. A laboratory rity report dated 6-15-14 urine culture was positive for	F 5	20			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		` '		SURVEY PLETED
145518		B. WING			C 07/31/2014		
NAME OF PROVIDER OR SUPPLIER MAR KA NURSING HOME				2	STREET ADDRESS, CITY, STATE, ZIP CODE 101 SOUTH 10TH STREET MASCOUTAH, IL 62258		,, = 0.1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	520			

,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	CON	(X3) DATE SURVEY COMPLETED	
		145518	B. WING _			C / 31/2014	
NAME OF PROVIDER OR SUPPLIER MAR KA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP COL 201 SOUTH 10TH STREET MASCOUTAH, IL 62258		70172011	
(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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 520	N0300 Medications antipsychotic medic during the the date prior to the assession on 7-31-14 at 5:00 Assessment Coord the Resident Assessments. A RAI (Resident Assessments. A RAI (Resident Assessments. A RAI (Resident Assessments. A RAI (Resident Assessments. On 7-31-14 at 5:05 Minimum Data Set 6-29-14 should have antipsychotic medic days prior to the assessments. 5. A 4/28/14 Nurseswas admitted to the urosepsis. The Host dated 4/27/14 docucomplaint was UTI altered mental state on 5/2/14 as noted documentation that antibiotic for a UTI.	ta Set dated 6-29-14 section is, does not indicate cations were administered of the MDS or the six days ment reference date. p.m. E4 (Minimum Data Set linator) stated the facility uses is ment Instrument (RAI) user's y for ensuring accurate 'Minimum Data Set 'Minimum Data Set 'Sessment Instrument' Manual on N0410A, Antipsychotic number of days an cation was received by the eduring the 7-day look-back mission/entry or reentry if less p.m. E4 verified that R46's assessment (MDS) dated re indicated R46 received cations during the last seven sessment. So Note documented that R27 to hospital with a diagnosis of spital History and Physical imented that R27's chief (Urinary Tract Infection) and us. R27 returned to the facility in the Nurses Notes with R27 was receiving an	F 52				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
145518		B. WING			C 07/31/2014		
NAME OF PROVIDER OR SUPPLIER MAR KA NURSING HOME				S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE 01 SOUTH 10TH STREET IASCOUTAH, IL 62258	<u> 0775</u>	31/2014
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 520	the UTI even thoug during the 30 day lo in Section I of the M completed on 6/2/1 presence of the UT diagnosis during the this MDS. E4, MDS Coordinat pm that the MDS had to an oversight. 6. A 5/2/14 11:30 are that R33 was yelling hitting at staff. A 7:0 documented that are R33's physician to culture and sensitive 5/3/14 urinalysis and than 100,000 Esche Practical Nurse, stawas not normal behavior and the UTI on 5/5/201. An annual Minimum on 5/13/14 does not the UTI even thoug during the 30 day lo in Section I of the ME4, MDS Coordinat pm that the MDS had to an oversight. 7. R35 was diagnost Infection on 5/8/201.	t document the presence of h it was an active diagnosis ook back time frame required MDS 3.0. A discharge MDS 4 also did not document the I which was still an active e 30 day look back period for or verified on 7/31/14 at 3:00 ad been coded incorrectly due on Nurses note documented gat another resident and nother resident and nother was obtained from obtain a urinalysis with a city (C&S) if indicated. The d C&S report indicated greater erichia Coli. E5, Licensed ated that the yelling and hitting navior for R33, and a UTI was gan an antibiotic for treatment 4.	F 5	520			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED	
		145518	B. WING _		07	C // 31/2014
NAME OF PROVIDER OR SUPPLIER MAR KA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP COL 201 SOUTH 10TH STREET MASCOUTAH, IL 62258		70172014
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 520	noted on a 5/6/201 note and a 5/8/201 R35 began treatments 5/8/2014 as noted Order Sheet. An Initial minimum 5/09/14 does not dutled UTI even though it the 30 day look back section I of the ME completed on 5/14 document the presecontinued as an accompleted on 3/19/14 and documentation on Investigation dated was completed on transferred to the harmonia of a supplementation on Investigation dated was completed on transferred to the harmonia of a supplementation of the 3/20/14 as noted in the Resemblem Major Injury which as noted in the Resemblem Manual for coding E4, stated on 7/31/0f the discharge, saware of the diagnal a modification of the done when the diagnal facility.	nalysis with C&S ordered, as 4 Nurse Practioner progress 4 physician telephone order. In with an antibiotic on on the May 2104 Physician Data Set (MDS) completed on ocument the presence of the was an active diagnosis during the time frame required in 0S 3.0. Subsequent MDS's 1/14 and 5/29/14 also did not ence of the UTI which the diagnosis during the 30 me for each of these. Fracture of the Right Cheek fiter a fall, as noted in the the facility Incident 13/20/14. A Discharge MDS 3/19/14 when R4 was nospital. R4 returned on the Nurses Notes with a cture to the Right Cheek Bone. does not code the injury as a is required for bone fractures, sident Assessment Instrument of Section J on the MDS 3.0. (2014 3:00 pm that at the time he had not yet been made osed fracture and verified that he discharge MDS was not gnosis was reported to the	F 52	20		
	indicated that R25	was receiving the antipsychotic and had been receiving since at				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DAT	(X3) DATE SURVEY COMPLETED	
145518			B. WING			C 07/31/2014	
NAME OF PROVIDER OR SUPPLIER MAR KA NURSING HOME				STREET ADDRESS, CITY, STATE, ZIP C 201 SOUTH 10TH STREET MASCOUTAH, IL 62258		/31/2014	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 520	least last Decembe Administration Reconstruction Reconstruction Reconstruction Reconstruction R25 had received the MDS completed 6/15/14 MDS was constructed R25 did not received during the look bacconstruction R25 did not received the received R25 did not received the received R25 did not received R25 did not received the received R25 did not received the received R25 did not received the	r 2013. The Medication ord for June 2014 verified that he Abilify from 6/9/14 thru the 7 day look back period for 3 on 6/15/14. Section N of the coded 0, which indicated that an antipsychotic medication k period. E4 verified on that this was a coding error. Foort dated 7/30/14 documents sus was 53. Ferified at 6:15 pm on 7/31/14 not have a program in place to y of the MDS assessments. or stated on 7/31/14 at 5:00 completed using the RAI Manual (Resident	F 5	20			