STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Annual Licensure and Certification 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 1	F 157		

by:
Based on observation, record review and interview the facility failed to notify the physician of skin impairments/alterations on one of eight residents (R9) reviewed for falls in the sample of 13.

Findings include:

The facility's Skin Impairment policy,dated 8/20/2014, documents, "Practice and procedures: D.) Notify physician of skin impairment. Document any new orders. Document notification in the resident's medical record."

On 2/17/2016 at 9 a.m., R9 had two open areas on the anterior portion of R9's left shin measuring 1 CM (Centimeter) x 0.5 CM with a small amount of serous drainage and reddened surrounding tissue, and 0.5 CM x 0.5 CM scabbed area with reddened surrounding tissue. R9 also had a wound on the posterior portion of the left lower leg, measuring 5 CM x 3 CM with a moderated amount of serous drainage with very red granulated tissue and tan-yellow tissue present with reddened surrounding skin.

R9's Progress Notes, dated 12/3/2015, documents that R9 sustained a skin tear to R9's RLE (Right Lower Extremity). R9's current medical record has no documentation that the physician was notified of R9's skin tear.

R9's Progress Notes dated 12/14/2015 documents that R9 sustained a skin tear on R9's LLE (left lower extremity), superior to the wound on the LLE. R9's current medical record has no documentation that the physician was notified of this skin tear.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 2 R9's Progress Notes dated 12/21/2015 documents that R9 sustained a new open area on old wound (unidentified in the record). R9's current medical record has no documentation that the physician was notified of R9's skin tear. R9's Progress Notes dated 12/30/2016 documents that R9 has a 3.9 CM blister on R9's right calf. R9's current medical record has no documentation that the physician was notified of R9's skin alteration. On 2/18/2016 at 845 a.m., E2 (Director of Nurses) stated, "There is no documentation to show that the physician was notified of the new open areas to the left lower leg. I would expect the nurses to notify physician." On 2/18/16 at 10:10 a.m., Z1 (R9's Advanced Practitioner Nurse) confirmed that Z1 was not notified of R9's skin tears/alterations on 12/3/15, 12/14/15, 12/21/15, and 12/30/15.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, facility staff failed to follow a restraint reduction plan for one of three residents (R2) reviewed for physical restraints in a sample of 13.	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 221	Continued From page 3 FINDINGS INCLUDE: The facility policy, Least Restrictive Positioning Device, dated 11/01/14 directs staff, "Every attempt will be made to maintain a safe environment for all residents utilizing the least restrictive means possible. Orders will be received by the resident's attending physician in utilization of the least restrictive positioning device possible to maintain resident safety." R2's current Physician Order Sheet, dated February 2016 includes the following physician orders: (Padded lap cushion to prevent rising) while up in wheelchair. R2's current Care Plan, dated 01/27/16 instructs staff, "Reduction for (padded lap cushion to prevent rising), please remove when I am in common areas during the day. Close supervision for my safety. I may be receptive to sitting in recliner in sitting room." On 02/16/16 at 9:30 A.M., R2 was in a wheel chair at the South Nurse's Station. A padded lap cushion to prevent rising was across R2's lap. E13/Licensed Practical Nurse, E16 and E17/Certified Nursing Assistants and E18/Activity Director were in sight of R2. At 11:25 A.M., R2 was seated in a wheel chair with a padded lap cushion to prevent rising across (R2)'s lap in the dining room. A family member was seated on either side of R2. Facility staff, including Dietary Staff and Certified Nursing Assistants were present in the dining room. On 02/17/16 at 8:15 A.M., R2 was seated in a wheel chair with a padded lap cushion to prevent	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 221	Continued From page 4 rising across (R2)'s lap in the dining room. A family member was again seated on either side of R2. Certified Nursing Assistants and Dietary Staff were present and assisting residents with the morning meal. At 9:00 A.M. on 2/17/16, R2 was sitting at the South Nurse's Station in a wheel chair with a padded lap cushion to prevent rising across R2's lap. E5, E6 and E13, all Licensed Practical Nurses were present. Upon command from staff, R2 was unable to remove the padded lap cushion from (R2)'s wheel chair. On 02/17/16 at 9:20 A.M., E2/Director of Nurses stated, "When (R2) is up (in the wheel chair), around the nurse's desk, with staff present, it (padded lap cushion) is to be off."	F 221		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to maintain a resident's dignity during toileting for two of 13 residents (R4 and R7) reviewed for dignity in the sample of 13. Findings include: The facility's Patient Rights and Responsibilities/Non-Discrimination policy	F 241		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 5	F 241		

(Revised 11/9/15) documents the following: "While you are a patient, you or your legally designated representative have the right to...Expect an environment that preserves dignity and contributes to a positive self image..."

The facility's Resident Rights for People in Long Term Care Facilities handout (undated) documents the following: "Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care..."

1. R4's Minimum Data Set dated 1/14/16 documents that R4 has severely impaired cognitive skills for daily decision making.

On 2/16/16 at 9:35 a.m., E2, Director of Nursing, stated that R4 is confused and is not a candidate to be interviewed.

On 2/17/16 at 12:30 p.m., R4 was sitting alone on the toilet in the facility's 400 hall common bathroom with R4's pants pulled down at R4's ankles. The door to this bathroom was open and R4 was yelling out incomprehensible sounds. A mechanical lift was positioned in front of R4, and the sling apparatus remained in place around R4's waist and hooked securely to the mechanical lift bar. R4's feet remained in position on the mechanical lift stand platform. At this same time, E12, Certified Nursing Assistant, was assisting R20 with ambulation from the adjoining shower/toilet room. E12 and R20 ambulated past the common bathroom, where R4 was sitting on the toilet in direct view with R4's pants pulled down at R4's ankles.

On 2/17/16 at 12:32 p.m., E12 confirmed that the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 6 door to the 400 hall common bathroom was open, exposing R4 with R4's pants pulled down to R4's ankles to anyone who passed by. 2. R7's current electronic care plan documents the following: "(R7) has severe cognitive impairment and is unable to make (R7's) own major decisions..." On 2/16/16 at 9:35 a.m., E5, Licensed Practical Nurse, stated R7 is confused and not a candidate for interview. On 2/17/16 at 1:31 p.m., R7 was sitting in the facility's 200 hall common bathroom/shower room. E7 and E8, Certified Nursing Assistants, assisted R7 to stand from a wheelchair, pulled R7's pants down to R7's ankles and transferred R7 to the toilet. While R7 was sitting on the toilet, the door to the shower room remained opened, and the privacy curtain in front of the toilet area was not pulled. On 2/17/16 1:35 p.m., E8, confirmed the door to the facility's 200 hall common bathroom/shower room's remained opened and the privacy curtain was not pulled, leaving R7 exposed from the waist down while R7 was sitting on the toilet. On 2/17/15 at 12:30 p.m., E2, Director of Nursing, stated that all facility staff is expected to pull privacy curtains and keep doors closed for privacy/dignity purposes during resident cares at all times.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 279	Continued From page 7 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to develop an individualized care plan with interventions for two of two residents (R9 and R15) reviewed for infections in the sample of 13. Findings include: 1. R15's current electronic diagnoses documents the following diagnoses to include: "Urinary Tract Infection, Urinary Retention, and Resistance to Vancomycin Related Antibiotics..." R15's Admission History and Physical, dated 2/2/16, documents that R15 was admitted to the facility with a primary diagnosis of Urinary Tract	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 279	Continued From page 8 Infection and VRE (Vancomycin-resistant Enterococci) of the urine. On 2/16/16 at 9:30 a.m., a bin containing personal protective equipment was located in the hall just outside of R15's door and there was a sign on R15's door instructing all visitors to check with facility staff prior to entering R15's room. At this same time, E2, Director of Nursing, stated that R15 has an indwelling urinary catheter and is in contact isolation precautions for VRE of the urine. R15's current electronic care plan, dated 2/2/16, does not have a care plan in place addressing R15's contact isolation precautions for VRE of the urine. On 2/17/16 at 12:40 p.m., E3, Care Plan Coordinator, verified that R15 currently has no care plan in place regarding R15's contact isolation precautions for VRE of the urine and stated, "There should have been." 2.) R9's Skin Injury Report Form, dated 12/28/2015, documents R9 has a blood blister to R9's left lower posterior leg, measuring 5 CM (Centimeter) x 4 CM with a bruise surrounding the blister measuring 5.8 CM x 7 CM. R9's Physician Order Sheet, dated 2/1/2016 thru 2/29/2016, documents that on 2/12/2016 a new treatment was started to R9's left lower extremity to apply a medicated ointment to R9's open areas to R9's left lower extremity and wrap with gauze twice a day. R9 also had an order to start Keflex (antibiotic) 250 MG (Milligrams) by mouth every	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 279	Continued From page 9 eight hours for seven days, for diagnosis of Cellulitis to the left lower extremity. R9's care plan, dated 2/2/2016, has no documentation addressing the cellulitis to R9's left lower extremity. On 2/17/2016 at 12:20 a.m., E3 (Care plan Coordinator) stated, "I missed it, I should have care planned the use of the antibiotic for (R9's) cellulitis to (R9's) left lower leg.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure a resident assessed as independent with indwelling urinary catheter care was able to complete cares without cross-contamination and according to facility policies and procedures for one of two residents (R15) reviewed for indwelling urinary catheters in the sample of 13. Findings include:	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 315	Continued From page 10	F 315		

The facility's Isolation Precautions policy dated 5/6/14 documents the following: "Contact Isolation...wear gloves during the course of providing care...change gloves after having contact with infective material that may contain high concentrations of microorganisms...wash hands immediately with an antimicrobial agent..."

The facility's Catheter Care policy (Revised 6/12/12) documents the following: "Wash hands and apply gloves...gently separate the labia, wash down one side then the other- always from front to back to prevent contamination...cleanse area well at insertion...cleanse catheter tubing approximately 4 inches from insertion...wash hands..."

The facility's Incontinence Care/Perineal Care policy dated 8/9/15 documents the following: "Wash hands...Put on disposable gloves...Remove soiled clothing...Remove gloves. Wash hands. Replace gloves...Gently separate labia, wash down on one side then the other (always from front to back to prevent contamination). Remember to change sections of the washcloth with every stroke...wash anal area going in direction away from genital area..."

R15's current electronic diagnoses documents the following diagnoses to include: "Urinary Tract Infection, Urinary Retention, and Resistance to Vancomycin Related Antibiotics..."

R15's Admission History and Physical dated 2/2/16 documents R15 was admitted to the facility with a primary diagnosis of Urinary Tract Infection and VRE (Vancomycin-resistant Enterococci) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 315	Continued From page 11	F 315		

the urine. This same form also documents R15 has an indwelling urinary catheter.

On 2/16/16 at 9:30 a.m., E2, Director of Nursing, stated R15 was recently admitted from an assisted living facility with an indwelling urinary catheter in place and performs all of (R15's) own cares.

R15's current care plan dated 2/8/16 documents R15 has, "severe cognitive impairment with short term memory problems and is unable to make major decisions..." This same care plan also documents R15 has an indwelling urinary catheter and, "performs toileting independently."

R15's Brief Interview of Mental Status dated 2/8/16 documents a score of 7, indicating severe cognitive impairment.

On 2/17/16 at 12:10 p.m., R15 was sitting in a recliner near the facility's north nurse's station. E12, Certified Nursing Assistant, and E11, Licensed Practical Nurse, assisted R15 up from the recliner, and R15 ambulated to R15's room with a wheeled walker. R15 then entered R15's bathroom to perform perineal care and indwelling urinary catheter care. R15 pulled R15's pants down, and a urine leg bag was attached to R15's left leg. R15 twisted the urine leg bag's drainage valve and emptied the contents into the toilet. While the urine drainage bag was draining, the contents of the bag trickled down R15's left leg and saturated an area of R15's pants. At this time, E11 stated, "It's (R15's urine) running down (R15's) leg. E12 and E11 prepared a basin of soap and water for R15. R15 performed perineal care, wiping R15's left and right groin with a washcloth using repeated strokes. R15 then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 315	Continued From page 12 rinsed the soiled washcloth into the basin of soap and water, and wiped several times from R15's buttocks and anal area toward R15's indwelling catheter insertion site. R15 did not cleanse R15's indwelling urinary catheter. R15 then pulled up R15's soiled pants, exited R15's bathroom and sat in a recliner in R15's room. R15 did not apply gloves before or throughout performing R15's cares, nor change R15's soiled pants. R15 then stated, "I wash up every morning and that's how I always do it." On 2/17/16 at 12:20 p.m., E12, verified that R15 did not apply gloves or perform hand hygiene before, during or after R15 performed R15's cares. E12 then stated, "(R15) performs (R15's) own cares. (R15) usually performs (R15's) cares in the sink. (R15) empties (R15's) leg bag independently. (R15) has her own routine. We have no idea when (R15) is doing these things." On 2/18/16 at 10:20 a.m., E2, Director of Nursing, stated that residents providing their own cares should follow the facility's policies and procedures. E2 then stated, "(R15) is still new to the facility and getting used to us. (R15) is so used to doing things herself. (R15) has always done (R15's) cares independently." E2 then stated that E2 could not provide documentation of education administered to R15 regarding contact isolation precautions or documentation of R15 performing return demonstration of knowledge of the facility's policies regarding self administration of R15's cares.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13	F 323		

environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Facility non-compliance resulted in three deficient practices:

A. Based on observation, record review and interview, the facility failed to investigate, monitor, and implement interventions to prevent further injuries (skin tears/skin impairments) for one of eight residents (R9) reviewed for falls in the sample of 13. This failure resulted in R9 subsequently sustaining multiple skin tears/skin impairments and cellulitis of the left lower extremity.

B. Based on interview, observation and record review, the facility failed to maintain a functioning bed alarm to prevent further falls for one of eight residents (R7) reviewed for falls in the sample of 13.

C. Based on interview, observation and record review, the facility failed to provide supervision while using a mechanical lift for one of eight residents (R4) reviewed for falls in the sample of 13.

Findings Include:

A. The facility's Skin Impairment policy, dated 8/20/2014, documents, "Practice/Procedure: B.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14	F 323		

All skin tears, bruises, hematomas, lacerations, blisters, and abrasions will be assessed using the skin injury form with input from the direct care nurse responsible for that resident. Immediate interventions will be put into place.... Follow up will be documented at least weekly in the resident's record."

On 2/17/16 at 9:00 a.m., R9 had two open areas to the anterior portion of the left lower leg measuring: 1 CM x 0.5 CM (Centimeters) with a small amount of bloody drainage and red tissue surrounding the area; and a 0.5 CM x 0.5 CM scabbed area with surrounding red tissue. R9 also had an open area to the posterior calf of the left leg measuring 5 CM x 3 CM, with a moderate amount of bloody drainage. Its wound bed being very red with a small amount of yellow tissue present, with a reddened surrounding area. E14 (Registered Nurse) verified the surrounding skin for all of these open areas was warm to the touch.

R9's Skin Injury Report Form, dated 12/28/2015, documents that R9 sustained a bruise and blood blister to the posterior left lower extremity. The bruise around the blood blister measures 5.8 CM x 7 CM and the blister measures 5 CM x 4 CM. The Skin injury report also documents it is unknown if the injury was sustained during transfer, dressing, fall, bath,mechanical lift lift or ambulation, other contributing factors, and R9 stated, "Must be that d--- wheelchair."

R9's Progress Notes, dated 12/3/2015, documents that R9 sustained a skin tear to R9's right lower extremity.

R9's Progress Notes, dated 12/14/2015,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15	F 323		

documents that R9 has a 1 CM x 1 CM skin tear on the left lower extremity, superior to the wound on the left lower extremity.

R9's Progress Notes, dated 12/21/2015, documents that R9 sustained a new open area on an old wound (not identified in the record), and steri strips were applied.

R9's Progress Notes, dated 12/28/2015, documents that R9 sustained a discoloration on the left lower extremity measuring 5.8 CM x 7 CM , with a blood blister in the center that measures 5 CM x 4 CM.

On 2/17/2016 at approximately 1:00 p.m., R9 stated, "These open areas started out as skin tears caused by hitting the back of my wheelchair pedals. I have asked repeated times for the wheelchair pedals and frame to be padded for protection. The (facility) still has not padded pedals or frame."

R9's Minimum Data Set, dated 1/21/16, documents that R9's BIMS score, (Brief Interview for Mental Status) is 15/15, indicating that R9 is not cognitively impaired.

On 2/17/16 at 1:00 p.m., there were no padded areas present on R9's wheelchair frame or foot pedals.

R9's Care plan, dated 5/15/2015, documents, "R9 has an actual skin impairment to skin integrity related to fragile skin LLE (left lower extremity) with open areas anterior and posterior. Intervention: 1.) Follow facility protocols for treatment of open areas. 2.) Monitor/document location, size and treatment of skin wound.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 Report abnormalities, failure to heal, sign and symptoms of infection, maceration to MD (Doctor). R9's Physician Order Sheet, dated 2/1/2016 thru 2/29/2016, documents that on 2/12/2016 a new treatment was started to R9's left lower extremity to apply a medicated ointment to R9's open areas to R9's left lower extremity and wrap with gauze twice a day. R9 also had an order to start Keflex (antibiotic) 250 MG (Milligrams) by mouth every eight hours for seven days, for diagnosis of Cellulitis to the left lower extremity. On 2/17/2016 at 11:00 a.m., E14 (Wound Nurse) stated, "There are no interventions put into place for the bruise/blister to the posterior left lower leg. that was sustained on 12/28/2015. I do think that (R9) hit left leg on wheelchair pedals and sustained the injuries." On 2/18/2016 at 8:50 a.m., E14 verified, there is no Skin Injury reports for R9's open areas to the anterior portion of the left lower leg, and interventions were not put in place for each skin tear/ impairment. E14 also verified there is no weekly monitoring of each open area sustained to the left lower leg. On 2/18/2016 at 8:45 a.m., E2/DON (Director of Nurses) stated, " I have no idea how (R9) sustained the open areas to the anterior and posterior left lower leg. There is no documentation to support that the skin tears/ skin impairments on left lower legs were investigated." On 2/18/2016 at 10:10 a.m., Z1 (R9's Advance Practice Nurse) stated, " I examined resident (R9) on 2/12/2016 , because she came to me about	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17	F 323		

her wounds on the left lower extremity. I noticed (R9) had an increase in redness and edema, so I started (R9) on an oral antibiotic and a medicated ointment to be applied to the wounds on the left lower extremity due to cellulitis...The areas could be caused by (R9) bumping (R9's) legs on (R9's) wheelchair pedals."

B. The facility's Fall Prevention policy (Revised 4/1/14) documents the following: "Interventions will be implemented to minimize the risk of resident falls...a 'blue falling star' will be placed on the doorframe alerting staff of a recent fall."

R7's fall care plan, dated 12/16/15, documents that R7 is at risk for falls and includes the following fall intervention: "Replace bed alarm if indicated."

The facility's undated fall log documents R7 fell at the facility on the following dates: 5/26/15, 12/7/15 and 2/16/16.

R7's Post Fall Assessment Form dated 12/7/15 documents that R7 was found on the floor on a safety mat in R7's room. This same form documents that R7 had a bed alarm in place, and the alarm was not sounding at the time of R7's fall.

R7's Post Fall Assessment Form dated 2/16/16 documents that R7 had an unwitnessed fall and was found on the floor in R7's room. This same form documents that R7's bed alarm was not sounding at the time of R7's fall.

On 2/17/16 at 9:00 a.m., a picture of a blue star was posted on R7's doorframe, indicating R7 had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 recently fallen. On 2/17/16 at 10:40 a.m., E2, Director of Nursing, stated, "(R7's) bed alarm wasn't sounding when (R7) fell on 12/7/15 and 2/16/16. E2 then stated, "They (bed alarm wires) become loose sometimes and can be very touchy." On this same date at 12:30 p.m., E2 stated that the facility does not have a policy in place regarding the use of bed alarms. E2 stated that facility staff checks residents' bed alarms weekly, but cannot provide any documentation, "We (facility staff) don't log the checks. It just seemed like another piece of paper." C. The facility's sit-to-stand mechanical lift's Operating and Product Care Instructions manual (undated) documents the following: "(Sit-to-stand mechanical lift) shall always be handled by a trained caregiver, continuously attending to the resident..." R4's Minimum Data Set dated 1/14/16 documents that R4 has severely impaired cognitive skills for daily decision making. This same form also documents that R4 is not steady, and can only stabilize with staff assistance while moving on and off the toilet. R4's Fall Risk Assessment dated 1/19/16 documents a score of "8," indicating R4 is at moderate risk for falls. On 2/17/16 at 12:30 p.m., R4 was sitting on the toilet in the facility's 400 hall common bathroom and was yelling out incomprehensible sounds. A sit-to-stand mechanical lift was positioned in front of R4, and the sling apparatus remained in place	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19 around R4's waist and hooked securely to the mechanical lift bar. R4's feet remained in position on the mechanical lift stand platform. R4 was sitting alone with no facility staff present. On 2/17/16 at 12:33 p.m., E12 verified that R4 was sitting alone secured in a sit-to-stand mechanical lift in the facility's 400 hall common bathroom. On 2/18/16 at 9:40 a.m., E10, Certified Nursing Assistant, was standing in the facility's north nurse's station and stated, "(R4) is on the toilet and (R4) is going to be transferred in just a minute when (R4) is finished." Approximately two minutes later, E10 and E6, Licensed Practical Nurse, approached the facility's 400 hall common bathroom, and pulled back the privacy curtain. R4 was sitting alone on the toilet with a sit-to-stand mechanical lift positioned in front of R4, and the sling apparatus remained in place around R4's waist and hooked securely to the mechanical lift bar. R4's feet remained in position on the mechanical lift stand platform. On 2/17/16 at 12:30 p.m., E2, Director of Nursing, stated the facility does not have a policy in place regarding the use of mechanical lifts. E2 then stated that two staff members must be present when a resident is being transferred with a sit-to-stand mechanical lift. E2 also stated if a resident is transferred onto a commode with a sit-to-stand mechanical lift and remains secured in mechanical lift while sitting on the commode, then one staff member should remain with the resident to supervise while the resident uses the restroom.	F 323		
F 332	483.25(m)(1) FREE OF MEDICATION ERROR	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 332 SS=D	Continued From page 20 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 observation, record review and interview, the facility failed to give medications as ordered by the physician to two residents (R8 and R10) of five residents on the sample of thirteen and five residents on the supplemental sample reviewed for medication pass. This failure resulted in two errors out of twenty six opportunities for a 7.7% medication error rate. FINDINGS INCLUDE: The facility policy, dated 08/01/15 directs staff, "Administer medications as ordered by the physician. Medications may be administered one hour prior to the scheduled medication time and up to one hour after the scheduled medication time." 1. On 02/17/16 at 11:30 A.M., E5/Licensed Practical Nurse (LPN) prepared to administer medications to R8. E5 LPN instilled one drop of Artificial Tears in R8's left eye, then instilled one drop of Artificial Tears in R8's right eye. R8's Physician Order Sheet, dated February 2016 includes the following medications, Artificial Tears Drops instill one drop in the left eye, four times daily.	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 332	Continued From page 21 2. On 02/17/16 at 1:45 P.M., E6/Licensed Practical Nurse (LPN) prepared to administer medications to R10. E6 LPN placed Thermo Tabs, one tablet, into a medication cup with vanilla pudding. E6 placed the mixture in R10's mouth and then handed R10 a cup of water. E6's Physician Order Sheet, dated February 2016 includes the following medications, ThermoTabs one three times daily with meals (8:00 A.M., 12:00 P.M. and 5:00 P.M.), for diagnosis: Liver Cirrhosis. On 02/18/16 at 10:50 A.M., E2/Director of Nurses (DON) confirmed facility staff are to follow physician's orders when administering medications, including administering medications one hour before or one hour after they are ordered by the physician.	F 332		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced	F 354		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(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 354	Continued From page 22 by: Based on record review and interview the facility failed to have eight consecutive hours per day of Registered Nurses for two sampled dates. This has the potential to affect all 52 residents who reside in the facility. Findings include: The facility's Nurses Schedule, dated 2/2016, documents that on 2/7/16 no RN was scheduled to work, and on 2/13/16 E15 (RN) worked for four hours. On 2/16/15 at 11:45 a.m., E4 (Scheduler) stated, "On 2/7/16, there was no RN coverage in the building...On 2/13/16, (E15) was four hours of RN coverage. We did not have any other RN coverage...I don't know how many RN hours are needed in the day." On 2/17/16 at 2:05 p.m., E1 (Administrator) stated, "I am aware that we are under the required RN hours." The Center for Medicare and Medicaid Services form 672 Resident Census and Condition of Residents form dated 2/16/16 and signed by E2, Director of Nursing, indicates that 52 residents currently reside in the facility.	F 354		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 23 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation and interview, the facility failed to discard one unopened and one opened, plastic jar of bottled food product within a specified timely manner. This failure has the potential to affect all 52 residents in the facility. Findings include: The facility's undated Food Storage policy states:"Expiration dates printed by the manufacturer apply until the product is opened; Once opened, use these time limits unless the manufacturer's date is earlier. All unopened canned, carton boxed or bottled goods" are to be used "within one year of delivery, or the manufacturer's expiration date, if sooner". The facility's undated Food Storage Chart states that food products including syrups, sauces, ketchup, and barbecue sauce are all to be discarded 60 days after opening and honey is to discarded 6 months after opening. On 2/16/16 at 9:30a.m., one unopened one-gallon plastic jar of molasses and one half-empty opened one-gallon plastic jar of molasses, both dated 8/29/2013 on the caps, were present in the facility kitchen's dry food storage area The opened jar of molasses had an sticker on the jar identifying the opened date as "6/25", with no year documented. No	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 24 manufacturer's expiration date was present on either jar of molasses. On 2/16/16 at 9:30a.m., E19, Dietary Manager verified that the two jars of molasses had dates on the caps which were the received date (8/29/2013); and there was no expiration date found on either jar. E19 stated that both jars should have been discarded. E19 also verified the opened jar of molasses was inaccurately dated, omitting the year the jar was opened. E19 verified that there are no residents receiving tube feedings, and all 52 residents' meals are prepared using food products found in the facility's Kitchen/Dietary Department. The Center for Medicare and Medicaid Services form 672 Resident Census and Condition of Residents form dated 2/16/16 and signed by E2, Director of Nursing, indicates that 52 residents currently reside in the facility.	F 371		
F 441 SS=F	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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 25 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 infection. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure contact isolation precautions were maintained and failed to ensure a resident assessed as independent with indwelling urinary catheter care was able to complete cares without cross-contamination for one of two residents (R15) reviewed for infections in the sample of 13. This has the potential to affect all 52 residents in the facility. Findings include: The facility's Isolation Precautions policy dated 5/6/14 documents the following: "Contact	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 26	F 441		

Isolation...wear gloves during the course of providing care...change gloves after having contact with infective material that may contain high concentrations of microorganisms...wash hands immediately with an antimicrobial agent..."

The facility's Catheter Care policy (Revised 6/12/12) documents the following: "Wash hands and apply gloves...gently separate the labia, wash down one side then the other- always from front to back to prevent contamination...cleanse area well at insertion...cleanse catheter tubing approximately 4 inches from insertion...wash hands..."

The facility's Incontinence Care/Perineal Care policy dated 8/9/15 documents the following: "Wash hands...Put on disposable gloves...Remove soiled clothing...Remove gloves. Wash hands. Replace gloves...Gently separate labia, wash down on one side then the other (always from front to back to prevent contamination). Remember to change sections of the washcloth with every stroke...wash anal area going in direction away from genital area..."

R15's current electronic diagnoses document the following diagnoses to include: "Urinary Tract Infection, Urinary Retention, and Resistance to Vancomycin Related Antibiotics..."

R15's Admission History and Physical dated 2/2/16 documents that R15 was admitted to the facility with a primary diagnosis of Urinary Tract Infection and VRE (Vancomycin-resistant Enterococci) of the urine. This same form also documents that R15 has an indwelling urinary catheter.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 27	F 441		

On 2/16/16 at 9:30 a.m., a bin containing personal protective equipment was located in the hall just outside of R15's door and there was a sign on R15's door instructing all visitors to check with facility staff prior to entering R15's room. At this same time, E2, Director of Nursing, stated R15 was recently admitted from an assisted living facility with an indwelling urinary catheter in place and performs all of her own cares. E2 also stated that R15 is currently in contact isolation precautions for VRE of the urine.

R15's current care plan dated 2/8/16 documents R15 has, "severe cognitive impairment with short term memory problems and is unable to make major decisions..." This same care plan also documents R15 has an indwelling urinary catheter and, "performs toileting independently."

R15's Brief Interview of Mental Status dated 2/8/16 documents a score of 7, indicating severe cognitive impairment.

On 2/17/16 at 12:10 p.m., R15 was sitting in a recliner near the facility's north nurse's station. E12, Certified Nursing Assistant, and E11, Licensed Practical Nurse, assisted R15 up from the recliner, and R15 ambulated to R15's room with a wheeled walker. R15 then entered R15's bathroom to perform perineal care and indwelling urinary catheter care. R15 pulled R15's pants down, and a urine leg bag was attached to R15's left leg. R15 twisted the urine leg bag's drainage valve and emptied the contents into the toilet. While the urine drainage bag was draining, the contents of the bag trickled down R15's left leg and saturated an area of R15's pants. At this time, E11 stated, "It's (R15's urine) running down (R15's) leg. E12 and E11 prepared a basin of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 28	F 441		

soap and water for R15. R15 performed perineal care, wiping R15's left and right groin with a washcloth using repeated strokes. R15 then rinsed the soiled washcloth into the basin of soap and water, and wiped several times from R15's buttocks and anal area toward R15's indwelling catheter insertion site. R15 did not cleanse R15's indwelling urinary catheter. R15 then pulled up R15's soiled pants, exited R15's bathroom and sat in a recliner in R15's room. R15 did not apply gloves before or throughout performing R15's cares, nor change R15's soiled pants. R15 then stated, "I wash up every morning and that's how I always do it."

On 2/17/16 at 12:20 p.m., E12, verified that R15 did not apply gloves or perform hand hygiene before, during or after R15 performed R15's cares. E12 then stated, "(R15) performs (R15's) own cares. (R15) usually performs (R15's) cares in the sink. (R15) empties (R15's) leg bag independently. (R15) has her own routine. We have no idea when (R15) is doing these things."

On 2/17/16 at 1:30 p.m., R15 was standing in the doorway to R15's room. R15 ambulated down the hall and seated herself in a recliner in the resident sitting area near the facility's north nurse's station.

On 2/17/16 at 3:15 p.m., E2, Director of Nursing, stated that R15 is on contact isolation precautions for VRE of the urine, but since R15 has an indwelling urinary catheter, the organism is contained. E2 then stated, "(R15) is able to leave (R15's) room. (R15) ambulates independently with a wheeled walker and since it's contained (R15) can go anywhere in the facility."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146138	A. BUILDING _____ B. WING _____	02/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GENESIS SENIOR LIVING, ALEDO	309 N W 9TH AVENUE ALEDO, IL 61231

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 29 On 2/18/16 at 10:20 a.m., E2, Director of Nursing, stated that residents providing their own cares should follow the facility's policies and procedures. E2 then stated, "(R15) is still new to the facility and getting used to us. (R15) is so used to doing things herself. (R15) has always done (R15's) cares independently." E2 then stated that E2 could not provide documentation of education administered to R15 regarding contact isolation precautions or documentation of R15 performing return demonstration of knowledge of the facility's policies regarding self administration of R15's cares. The Center for Medicare and Medicaid Services form 672 Resident Census and Condition of Residents form dated 2/16/16 and signed by E2, Director of Nursing, indicates that 52 residents currently reside in the facility.	F 441		