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	145248	A. BUILDING _____ B. WING _____	01/15/2015

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MORTON VILLA HLTH & REHAB CTR	190 EAST QUEENWOOD ROAD MORTON, IL 61550

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F 000	INITIAL COMMENTS	F 000		
F 314 SS=D	Annual Licensure and Certification 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	F 314		

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, interview, and record review the facility failed to follow a physician's order for prevention and treatment of pressure ulcers for one of three residents (R6) reviewed for pressure ulcers in a sample of 16.

Findings include:

A Weekly Pressure Sore log dated 1/06/15 documents R6 has a Stage III pressure ulcer to the Right Ischium and a Stage III pressure ulcer to the Coccyx.

R6's Physician's Orders Sheet (POS) Dated 1/01/15 to 1/31/15 documents R6 is to, "Limit sitting to 60 minutes."

On 1/13/15 at 11:17a.m. R6 was sitting in a wheelchair in R6's room. During continuous observations between 11:17a.m. to 1:20p.m. R6

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

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F 314	Continued From page 1 remained sitting up in the wheelchair. On 1/14/15 at 9:00a.m. E4 (Wound Nurse) verified R6's POS orders state, "Limit sitting to 60 minutes," for pressure ulcer treatment/prevention. E4 stated R6 should not have been up in the wheelchair for more than one hour on 1/13/15.	F 314		
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 observation, interview, and record review, the facility failed to keep a urinary drainage bag off the floor and bed for one of four residents (R11) reviewed for catheters in the sample of 16. Findings include: Facility's Urinary Catheter Care policy, dated October 2010, documents, "Be sure the catheter tubing and drainage bag are kept off the floor." R11's Physician's Order Sheets, dated 1/2015, documents that R11 has a 16 french/5-10 milliliter	F 315		

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F 315	Continued From page 2 suprapubic catheter. On 1/13/15 at 9:50 a.m., E10 (Certified Nursing Assistant) and Z1 (Hospice Registered Nurse) lifted R11 from the bed using the mechanical lift, and while moving R11 across the bed to wheelchair R11's urinary drainage bag drug across the bed and landed on the floor. On 1/13/15 at 11:00 a.m., E10 stated, "Normally during a mechanical lift transfer I would hook the catheter bag to me or hold it low during the transfer, not let it drag across the bed and drop on the floor." On 1/14/15 at 11:30 a.m., E2 (Director of Nursing) stated, "With a mechanical lift transfer from the bed to the wheelchair, the staff should hang the urinary drainage bag somewhere on the resident below the bladder. Proper procedure would not be to let the urinary drainage bag drag across the bed and hit the floor."	F 315		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not	F 329		

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given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility failed to perform scheduled psychotropic drug assessments for one of six residents (R11) reviewed for psychotropics in sample of 16.

Findings include:

R11's Physician's Orders, dated 1/2015, documents that R11 has an order for Risperdal 0.5 milligrams by mouth twice daily, and that R11 has a diagnosis of Psychotic disorder.

R11's Abnormal Involuntary Movement Scale (AIMS) documents that R11's last AIMS assessment was completed on 6/2/14.

R11's Antipsychotic Medication Quarterly Evaluation documents that R11's last assessment was completed on 9/5/14.

On 1/14/15 at 11:30 a.m., E2 (Director of Nursing) stated, "Psychotropic assessments are done quarterly, and the AIMS are done quarterly but are only required to be done every six months.

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F 329	Continued From page 4 (R11's) AIMS and Psychotropic assessment should have been done in December 2014." Drug Information Handbook for Nursing, dated 2007, documents that Risperdal may cause extrapyramidal symptoms, including pseudoparkinsonism, acute dystonic reactions, akathisia, and tardive dyskinesia. Facility's Antipsychotic Medication Use Policy, dated April 2007, documents that AIMS evaluations are completed consistent with federal guidelines.	F 329		
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. 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.	F 431		

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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 observation, interview, and record review the facility failed to ensure employee food products are not stored in designated refrigerator for resident storage of medication and biological products. This failure has the potential to affect all 79 residents in the facility.

Findings include:

On 1/12/15 at 1:30p.m. in the facility medication room refrigerator, an employee water bottle filled with liquid, was found.

On 1/14/15 at 9:05a.m. E7 (Registered Nurse) stated "No employee items should be kept in the residents' refrigerator. This is the the facility policy."

On 1/15/15 at 10:25a.m.E7 stated, " The nurses use both medication rooms when assigned to a unit."

Facility policy Storage and Expiration of Medications, Biological, Syringes and Needles dated 1/01/13 states, "Facility should ensure that

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F 431	Continued From page 6 food is not to be stored in the refrigerator...where medications and biological's are stored." A "Resident Census and Condition of Residents" report on 1/12/15, signed by E2 (Director of Nurses), documents a resident census of 79 residents at the time of the survey.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted	F 441		

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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 observation, interview, and record review the facility failed to perform hand hygiene following resident cares for four of 13 residents (R6, R8, R9, R11) reviewed for infection control practices on the sample of 16, and seven residents (R22, R23, R24, R25, R26, R28, R29) on the supplemental sample.

Findings include:

1. On 1/13/15 at 9:37 a.m.. E6 (Certified Nurse Aide) was providing perineal cleansing/catheter care to R6. E6 applied gloves then washed and dried R6's catheter tubing and perineal area. E6 removed the soiled gloves, then without performing hand hygiene, E6 touched R6's clothing, bed linens, and repositioned R6's pillow.

On 1/13/15 at 10:00 a.m.. E6 stated E6 should have performed hand hygiene after assisting R6 with perineal/catheter care and before touching R6's clothes and bed linens.

2. On 1/12/15 from 11:20 a.m.-12:20 p.m. E7 (Licensed Practical Nurse) did not perform hand hygiene when passing medications to R22, R23, R8, R24, R11, R25, R26, R9, R28, and R29. At 11:30 a.m., E7 administered artificial tears eye

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drops to R23's bilateral eyes and E7 did not perform hand hygiene prior to or after the administration of eye drops. At 11:40 a.m., E7 administered an Albuterol nebulizer treatment to R8 who had a harsh productive cough, and E7 did not perform hand hygiene following this administration. At 12:10 p.m., E7 crushed Dilantin and Sulfazine and mixed them with applesauce. E7 then administered them to R9 and did not perform hand hygiene following this administration. At 12:20 p.m., E7 crushed Hydrocodone/Acetaminophen, opened Ferrex and Gabapentin capsules, and added applesauce to them then administered the mixture to R29. E7 did not perform hand hygiene before or after this administration.

On 1/12/15 at 12:20 p.m., E7 stated, "Handwashing/sanitizing should be done between each resident's pill pass."

On 1/14/15 at 11:30 a.m., E2 (Director of Nursing) stated, "During medication pill pass they should sanitize in between residents."

3. On 1/13/15 at 10:45 a.m., E11 (Licensed Practical Nurse) removed R11's ostomy wafer and ostomy bag and cleaned feces from R11's colostomy with a dampened rag. E11 proceeded to apply a new ostomy wafer and ostomy bag to R11's colostomy without changing E11's gloves or washing/sanitizing E11's hands. E1 (Administrator) was present during the procedure.

On 1/13/15 at 10:55 a.m., E11 stated, "I wasn't aware that I was suppose to change my gloves. I would change my gloves if it was a wound, but it's a colostomy and I cleaned the feces and there's going to be more feces present with the new

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F 441	Continued From page 9 ostomy wafer and bag. So I don't see why I would need to change my gloves." On 1/13/15 at 11:05 a.m., E1 stated, "After (E11) removed the ostomy wafer and cleansed the ostomy site (E11) should have changed (E11's) gloves before applying the new ostomy wafer and bag." Facility's Colostomy/Ileostomy Care Policy, dated 10/2010, documents "Remove drainage bag. Remove gloves, wash hands, put on clean gloves." A Handwashing/ Hand Hygiene policy dated 8/2012 states, "Employees must wash their hands...before and after direct resident contact. Before and after assisting a resident with personal care. After handling soiled or used linens, dressings, bedpans, catheters and urinals."	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review,the facility failed to provide a sanitary environment for residents and staff. This failure has the ability to affect all residents in the facility. Findings include:	F 465		

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F 465	Continued From page 10 On 1/12/15 at 10:30a.m. in the soiled linen laundry room there were six open barrels with soiled linen and clothing. One barrel was overflowing with clothing, touching the wall in this area. A strong odor was noted in the soiled linen laundry room. On 1/12/15 at 10:40a.m. E8 (Laundry Supervisor) stated "These containers are not covered while in the soiled linen room. We used to cover them with a sheet but we don't do that anymore." A facility policy "Laundry and Bedding, Soiled", dated 8/2009 documents "Soiled laundry/bedding shall be handled in a manner that prevents gross microbial contamination of the air and persons handling the linen." A "Resident Census and Resident Condition" report on 1/12/15, signed by E2 (Director of Nurses) documents resident census of 79 residents at time of survey.	F 465		