STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145426	A. BUILDING _____ B. WING _____	02/05/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OTTAWA PAVILION	800 EAST CENTER STREET OTTAWA, IL 61350

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F 000	INITIAL COMMENTS Annual Certification Survey	F 000		
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that nail care was provided for four of 21 residents (R8, R13, R25, R26) reviewed for grooming in the sample of 24. Findings include: The facility's Shower/Tub Bath procedure (revised 11/2015) documents "Trim the resident's toenails and/or fingernails unless otherwise instructed by your supervisor." On 2/5/16 at 12:20pm, E3, Assistant Director of Nursing, stated (E3) expects residents nails to be checked for cleanliness and length during showers. E3 stated if residents' nails are long, an attempt should be made to trim the nails. 1. R8's Minimum Data Set (MDS) dated 1/13/16 documents R8 is severely cognitively impaired and requires extensive assistance with hygiene cares. R8's Care Plan dated 11/20/15 documents "(R8) is dependent on staff to complete all ADLs	F 312		

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

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F 312	Continued From page 1 (Activities of Daily Living), and "Shower or head to toe bed baths 3 (three) times weekly." On 2/2/16 at 12:05pm, 2/3/16 at 10:00am, 2/4/16 at 12:15pm, and 2/5/16 at 11:45am, R8's finger nails extended one-fourth inch past R8's finger tips and were packed with tan/brown matter. On 2/4/16 at 12:15pm, E8, Certified Nursing Assistant (CNA) confirmed R8's nails were long and dirty. E8 stated residents' nails should be trimmed and cleaned "every couple of weeks by Activities (staff) or CNAs." 2. R13's MDS dated 12/17/2015 documents R13 is severely cognitively impaired requiring extensive assistance with all activities of daily living. R13's care plan dated 12/16/2015 documents R13 is dependent on staff to complete all ADLs, and is to receive a shower or head to toe bath three times a week. On 2/2/2016 at 12:30PM and 2/3/2016 at 10:00 AM, R13 had fingernails measuring one fourth inch over the nail tip on both hands. The right hand's third, fourth and fifth digits were impacted with a dark brown debris under nail as well as the right hand's fifth digit nail was impacted with dark brown debris. On 2/3/2016 at 10:00am, E11 (CNA) stated "(R13) does scratch the rectal area. The dark brown substance appears to possibly be feces. All residents' nails are to be trimmed on shower days." 3. R25's MDS dated 12/18/15 documents R25 is	F 312		

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F 312	Continued From page 2 moderately cognitively impaired and requires extensive assistance with hygiene cares. R25's Care Plan dated 8/18/15 documents staff are to "Check nail length and trim and clean on bath day and as necessary. Requires extensive assistance...with bathing three (3) times per week and as necessary." On 2/4/16 at 12:15pm and 2/5/16 at 11:45am, R25's finger nails extended one-fourth inch past R25's finger tips and were packed with brown matter. On 2/4/16 at 12:15pm, E8, CNA, confirmed R25's nails were long and dirty. 4. R26's MDS dated 12/18/15 documents R26 is severely cognitively impaired and requires extensive assistance with hygiene cares. R26's Care Plan dated 6/30/15 documents R26 "needs extensive assistance for all cares." On 2/4/16 at 12:15pm and 2/5/16 at 11:45am, R26's nails extended one-fourth inch past R26's finger tips and were packed with brown matter. On 2/4/16 at 12:15pm, E8, CNA, confirmed R26's nails were long and dirty. On 2/5/16 at 11:45am, E12, Registered Nurse (RN), confirmed R8, R25, and R26's finger nails were long and packed with brown matter. E12 stated "They (fingernails) look bad." On 2/5/16 at 12:50am, E13, CNA, stated residents' nails are to be cleaned and trimmed or filed on residents' shower days.	F 312		
F 323	483.25(h) FREE OF ACCIDENT	F 323		

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F 323 SS=D	Continued From page 3 HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident 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: Based on observation, interview, and record review the facility failed to implement a fall intervention to prevent falls or injury to one of nine residents (R4) reviewed for falls in a sample of 24. Findings include: The facility's policy Fall Management (dated 5/2015), documents "6. As a fall occurs the nurse on duty will initiate a new intervention to prevent further falls. The plan of care will be updated at this time. The revisions to the fall of care will be monitored for effectiveness and adjustments made as needed." R4's Incident Report documents on 7-16-15 at 9:57 pm that R4 was "Observed on the floor in her room. She attempted to transfer out of bed and her arm was through the assist rail. She had a small reddened area to her arm. Assist rail screening was updated. Assist rails have been removed from her bed." On 2-2-16 at 10:30 am, 2-3-16, at 1:50 pm, and 2-4-16 at 11:30 am there were two half siderails	F 323		

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F 323	Continued From page 4 present on R4's bed. R4's Side Rail Assessments dated 7-16-15, 10-9-15 and 1-4-16, document "The resident has been assessed and it is recommended to use: no assist rails." On 2-4-16 at 3:15 pm and 2-5-16 at 11:10 am respectively, E3, Assisted Director of Nursing (ADON), stated "(R4's) side rails were removed on 7-17-15. I don't know when they were put back on, but we just removed them (again) a little bit ago. I don't know why the side rails were put back on. According to my last assessment I did on her on 7-16-15 she was not supposed to have them." R4's Care Plan, dated 1-15-16, documents an intervention of "May use assist rails when in bed for positioning and bed mobility tasks." R4's Nurse Progress Notes document on 1-17-16 at 11:37 pm, "Skin tear noted to left elbow...(R4) tried to hit aide while doing hs (bedtime) cares and bumped elbow on siderail." R4's skin tear incident report dated 1-17-16, documents "When (R4) attempted to strike the CNA, (R4) bumped her elbow on the side rail resulting in a skin tear. Staff will attempt to reapproach when (R4) is agitated and redirect as necessary." On 2-5-16 at 10:40 am, E14 and E15, CNAs, both concurred that they put R4's siderails in an up position whenever R4 was in R4's bed.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371		

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F 371	Continued From page 5 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 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure pans and sugar dispensers were air dried, failed to ensure the mixer, stove, and ovens were in clean condition to prevent cross contamination. These failures have the potential to affect all 120 residents residing at the facility. Findings include: The facility policy "Infection Control Guidelines for the Dietary Department" documents " Food Equipment- #1d- Are thoroughly cleaned as required between food preparation, #3c- Dishes and utensils are air dried, #3d-Dishes are stored dry, covered or upside down." On 2/2/2016 at 9:30AM, eight, one third size pans were stacked right side up together with water standing on the cooking surfaces stored on the clean storage rack. There were also two full size pans stacked up side down with water on the cooking surface. On 2/2/2016 at 9:31AM, three, clean, empty sugar dispensers with lids on had standing water	F 371		

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F 371	Continued From page 6 inside the glass dispensing jar placed on the shelf in the storage area for clean dishes. On 2/2/2016 at 9:32AM, E9 (Dietary Aide) stated " The clean sugar dispensers are to be air dried upside down with the lids off, not on." On 2/3/2016 at 10:00AM E4 (Dietary Supervisor) stated, "All dishes and pans are to be air dried, upside down to prevent contamination." On 2/2/2016 at 9:35AM, the black mixer had white splatters of food debris on the underside of the neck of the mixer where the beater attaches over the mixing bowl. The empty mixing bowl was covered with plastic wrap. On 2/2/2016 at 9:37AM, E9 (Dietary Aide) stated, "This means the mixer was cleaned, but that is whipping cream sprayed all over the mixer stand. I do not consider the mixer cleaned. All surfaces must be wiped down and free of any food debris after each use." On 2/2/2016 at 9:38AM, both ovens had large amounts of thick brown food debris on the top, sides, and bottom of the oven as well as the oven racks. The stove top also had brown food debris on the top and burner surfaces. On 2/2/2016 at 9:40AM, E9 stated, "I'm not sure when the last time the ovens were cleaned." On 2/3/2016 at 10:20 AM, E4 (Dietary Manager) stated, " I don't have a specific cleaning schedule or policy regarding cleaning of the oven." The Census and Conditions of Residents Report dated 2/2/2016 documents a census of 120.	F 371		

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F 441 SS=D	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 professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to practice good hand hygiene for two of 11 residents (R13 and R21) reviewed for incontinence care in a sample of 24. Findings include: The facility's policy Personal Protective Equipment - Using Gloves, dated 01/2014, documents "Purpose: 1. To prevent the spread of infection. Miscellaneous: 4. Use non-sterile gloves primarily to prevent the contamination of the employee's hands when providing treatment or services to the patient and when cleaning contaminated surfaces. 5. Wash hands after removing gloves." The facility's policy Incontinence Care dated 6/05, documents "1. Gloves must be worn whenever there is potential for exposure to feces. 2. If hands or skin are exposed to feces, the area must be washed as soon as practical." 1. On 2-2-16 at 1:30 pm, E6 and E7, Certified Nursing Assistants (CNA), performed incontinence care for R21. With gloved hands, E6 cleansed feces from R21's rectal area, then assisted R21 to roll over, touching R21's clothed shoulder and hip with the same soiled gloves. E6 changed gloves without performing hand hygiene, removed R21's incontinent brief soiled with feces then wiped more feces from R21's rectal area. With the same soiled gloves, E6 cleansed R21's perineal area. R21 was incontinent of urine and stated "I just peed." E6 re-gloved, tucked urine soaked incontinent pad under R21, re-placed with a clean incontinent pad, and cleansed urine from	F 441		

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F 441	Continued From page 9 R21's rectal area. With the same soiled gloves, E6 touched R21's right bare thigh and blouse to roll R21 while E7 cleansed R21's rectal area and removed the soiled incontinent pad. With the same soiled gloves E7 placed R21's right assist rail up. E6 cleansed R21's perineal area, placed clean incontinent pad under R21, and put R21's left assist rail up. On 2-2-16 at 1:54 pm, E6, CNA, stated "I should change gloves after wiping dirty and before going to clean areas or wiping the front. I normally wash in between glove changes but I didn't do that today." On 2-2-16 at 1:58 pm, E7, CNA stated "I usually change gloves after I wipe and before touching clean." 2. On 2/3/2016 at 10:00AM, E10 (Restorative Nurse) and E11 (Certified Nurses Aide) provided incontinence care for R13. After R13 was incontinent of urine, E10 cleansed the groin area as well as the buttocks while wearing the same pair of gloves. E10 removed the gloves, pulled up the covers on R13's bed , positioned R13's pillow under R13's head with no hand hygiene performed after glove removal. On 2/5/2016 at 12:12PM, E2 (Director of Nursing) stated, "After the care is completed, the staff should remove their gloves, wash hands, and then pull up covers or redress a resident."	F 441		