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OTTAWA PAVILION	**800 EAST CENTER STREET OTTAWA, IL 61350**

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F 000	INITIAL COMMENTS Annual Licensure and Certification Complaint#1521915/IL#76378 - F323 Federal Oversight and Support Survey	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during	F 156		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.

The facility must furnish a written description of legal rights which includes:
A description of the manner of protecting personal funds, under paragraph (c) of this section;

A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.

A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.

The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.

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The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility failed to ensure that contact information regarding the State Agency's Nursing Home Hotline was available and easily accessible in the facility. This has the potential to effect all 124 residents in the facility.

Findings include:

On 4/20/15 from 1:25 p.m. to 1:56 p.m., a facility-wide tour was conducted. No information regarding contacting the State Agency's Nursing Home Hotline was able to be located.

On 4/21/15 at 10:50 a.m., all residents in attendance during the group interview, R34-R39, were not aware of the Nursing Home Hotline, or how to obtain its contact information. R34-R39 were unaware of any accessible postings for the Hotline in the facility.

On 4/22/15 at 2:38 p.m., E13, Certified Nursing Assistant Coordinator, was unable to locate information anywhere in the facility regarding the Nursing Home Hotline and verified that this information was not accessible for the facility's

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F 156	Continued From page 3 residents. The Centers for Medicare and Medicaid Services (CMS) Resident Census and Conditions of Residents form dated 4/20/15, and signed by E1, Administrator, documents that 124 residents are currently residing at the facility.	F 156		
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, the facility failed to document a medical symptom for the use a restraint and failed to follow a physician order for release of a restraint for one of three residents (R19) reviewed for restraint use in the sample of 24. FINDINGS INCLUDE: The facility policy titled," Physical Device/Physical Restraint Program" dated (03/11) directs staff, "Physical restraints/physical devices will be used by this facility only when it is determined that they are required to treat a resident's medical symptoms...as ordered by a physician...The informed consent will authorize the use of a physical restraint/device for a period not to exceed one year." R19's Physician Order Sheets dated April 2015 includes the following diagnoses: Psychoses, Constipation, Dementia, Anxiety, Alzheimer's Disease, Cataract, hypertension, Osteoarthritis	F 221		

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F 221	Continued From page 4 and Osteoporosis. R19 has the following physician's order, dated 10/19/12, "Soft lap belt per POA (power of attorney) request." And the following order dated 10/23/12, "Clarification of order: May use self release alarmed lap (cushion) when up in wheel chair and remove at mealtime, toileting and when supervised by staff." R19's current Care Plan, dated 12/10/15 includes the following approaches: "Lap (cushion) for positioning. Remove for all meals and repositioning." On 4/20/15 at 12:35 P.M., R19 was seated in a wheelchair, in the Unit dining room, with a lap cushion buckled to R19's wheelchair, covering (R19)'s lap. R19's wheelchair was positioned at a horseshoe-shaped assisted dining table. Facility staff were feeding R19 the noon meal. On 4/20/15 at 1:10 P.M., R19 remained seated at the assisted feeding table with a lap cushion secured in place while being fed the noon meal. On 4/20/15 at 1:25 P.M., R19 remained seated at the assisted feeding table with a lap cushion secured in place, while facility staff continued to feed R19 the noon meal. On 4/20/15 at 1:55 P.M., E9 Certified Nursing Assistant stated, "That's (R19)'s lap (cushion). It's so (R19) doesn't try to get up out of (R19)"s chair. I think (R19)'s niece wants (R19) to have it. I don't know why it wasn't off at lunch time today." On 4/20/15 at 5:45 P.M., R19 was seated in a wheelchair in the Unit dining room, with a lap cushion buckled to R19's wheelchair, covering (R19)'s lap. R19 was being fed the evening meal by facility staff. On 4/21/15 at 10:00 A.M., E8 Registered Nurse/Restorative Nurse stated, "(R19) has had it (lap Cushion) prior to two years. (R19) is unable to remove it. It's (lap cushion) is supposed to be	F 221		

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F 221	Continued From page 5 off for meals and toileting. I feel it (lap cushion) is a comfort for (R19). (R19) rests (R19)'s arm on it. (R19) likes to play with the strap." On 4/21/15 at 10:35 A.M., E2 Director of Nurses stated, "Lap (cushions) are to be removed at meal times and during activities."	F 221		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		

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F 225	Continued From page 6	F 225		

representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to ensure that an allegation of physical abuse was immediately reported to the Administrator, failed to investigate to determine the root cause of three reports of injury of unknown origin and failed to notify the State Agency immediately and in five days of three reports of injury of unknown origin for two of 24 residents (R6 and R23) reviewed for abuse on the sample of 24 and one resident (R32) on the supplemental sample.

Findings include:

R32's Preliminary 24-Hour Incident Investigation Report dated 2/18/15 documents that on 2/15/15, an unidentified facility staff member observed Z1, R32's family member, grabbing and holding R32's arm while Z1 and R32 were arguing.

On 4/22/15 at 2:23 p.m., E1, Administrator, verified that E1 was not immediately notified of the above incident regarding R32 and Z1, and therefore an investigation was not initiated until 2/18/15, three days after the incident occurred.

R32's Skin Tear/Bruise/Abrasion/Scrape of Unknown Origin Investigation Form dated 1/23/15 documents a bruise was present on R32's left

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foot. This same report does not include documentation of the root cause that was determined for the bruising.

R6's Skin Tear/Bruise/Abrasion/Scrape of Unknown Origin Investigation Form dated 3/30/15 documents that R6 had a "C" shaped skin tear present to the lateral (outside) aspect of R6's right antecubital (region of arm in front of the elbow). This same report does not include documentation of the root cause that was determined to cause the injury.

R23's Skin Tear/Bruise/Abrasion/Scrape of Unknown Origin Investigation Form dated 3/31/15 documents that bruising and a small skin tear was present on R23's left 3rd toe. This same form does not include documentation of the root cause that was determined to cause the injury.

On 4/22/15 at 2:28 p.m., E1, Administrator, stated the above injuries of unknown origin regarding R32, R6 and R23 were not investigated as allegations of abuse, and therefore the State Agency was not notified and a root cause was not determined. E1 then stated, "It was a lack of understanding on my part. I didn't look at (R32, R6 and R23's injuries of unknown origin) as an abusive act. I felt it wasn't purposeful."

F 226 SS=D

483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

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F 226		F 226		

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This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to follow operational policies and procedures regarding immediately reporting an allegation of abuse to the Administrator, investigation of injuries of unknown origin, and State Agency notification of injuries of unknown origin for two of 24 residents (R6 and R23) reviewed for abuse on the sample of 24 as well as one resident (R32) on the supplemental sample. The facility also failed to fully develop and implement its Abuse Policy regarding procedures for screening and reporting, which has the potential to effect all 124 residents in the facility.

Findings include:

The facility's Abuse Policy dated November 2013 documents the following: "...Any individual observing an incident of resident abuse or suspecting resident abuse must immediately report such incident to the Administrator or Director of Nursing or Social Services...Injury of unknown source is defined as an injury that meets both of the following: The source of the injury was not observed by any person or the source of the injury cannot be explained by the resident; and the injury is suspicious because of the extent of the injury; the location of the injury; the number of injuries observed at one particular time; or the incidence of injuries over time...All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management...The Administrator will provide a written report of the accusation of abuse and the preliminary action

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F 226	Continued From page 9 taken to (State Agency), as soon as possible but within 24 hours of the reported incident...The Administrator will provide a written report of the results of all abuse investigations and appropriate action taken to the State Agency...as soon as possible but within 5 working days of the reported incident..." R32's Preliminary 24-Hour Incident Investigation Report dated 2/18/15 documents that on 2/15/15, an unidentified facility staff member observed Z1, R32's family member, grabbing and holding R32's arm while Z1 and R32 were arguing. On 4/22/15 at 2:23 p.m., E1, Administrator, verified that E1 was not immediately notified of the above incident regarding R32 and Z1, and therefore an investigation was not initiated until 2/18/15, three days after the incident occurred. R32's Skin Tear/Bruise/Abrasion/Scrape of Unknown Origin Investigation Form dated 1/23/15 documents a bruise was present on R32's left foot. This same report does not include documentation of the root cause that was determined for the bruising. R6's Skin Tear/Bruise/Abrasion/Scrape of Unknown Origin Investigation Form dated 3/30/15 documents that R6 had a "C" shaped skin tear present to the lateral (outside) aspect of R6's right antecubital (region of arm in front of the elbow). This same report does not include documentation of the root cause that was determined to cause the injury. R23's Skin Tear/Bruise/Abrasion/Scrape of Unknown Origin Investigation Form dated 3/31/15 documents that bruising and a small skin tear	F 226		

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was present on R23's left 3rd toe. This same form does not include documentation of the root cause that was determined to cause the injury.

On 4/22/15 at 2:28 p.m., E1, Administrator, stated the above injuries of unknown origin regarding R32, R6 and R23 were not investigated as allegations of abuse, and therefore the State Agency was not notified and a root cause was not determined. E1 then stated, "It was a lack of understanding on my part. I didn't look at (R32, R6 and R23's injuries of unknown origin) as an abusive act. I felt it wasn't purposeful."

The facility's Abuse Policy dated November 2013 does not include information regarding screening of new hires and obtaining information from previous employers and completing checks with appropriate licensing boards and registries. This same policy does not include the following information regarding reporting: how the facility will report to the State Nurse Aide Registry or licensing authorities any knowledge it has of any actions by a court of law that would indicate an employee is unfit for service. The policy also does not specify that all allegations of abuse, neglect, injuries of unknown origin and misappropriation of property must be immediately reported to the Administrator.

On 4/22/15 at 2:34 p.m., E15, Nurse Consultant, verified the above mentioned information is not included in the facility's Abuse Policy and stated, "It (facility's Abuse Policy) is not sufficient."

On 4/22/15 at 3:45 p.m., E1, Administrator, stated the facility revised their abuse policy in January 2015, but E1 had not yet pulled the revised policy from E1's email.

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F 226	Continued From page 11 The Centers for Medicare and Medicaid Services (CMS) Resident Census and Conditions of Residents form dated 4/20/15, and signed by E1, Administrator, documents that 124 residents are currently residing at the facility.	F 226		
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 observation, interview and record review, the facility failed to ensure the dignity of a resident by allowing residents confidential care information posted at the bedside for one of ten residents (R19) reviewed for incontinence care in the sample of 24. FINDINGS INCLUDE: The facility policy titled, "Quality of Life-Dignity" dated (revised 11/2013) instructs staff, "Signs indicating the resident's clinical status or care needs shall not be openly posted in the resident's room...Discreet posting of important clinical information for safety reasons is permissible (e.g.,taped to the inside of the closet door)." On 4/20/15 at 1:50 P.M., multiple signs displaying R19's care information were posted above R19's bed, on R19's bulletin board, on R19's closet and on the shared bathroom door in R19's room. R19's care information posted in R19's room included: "Do not put diapers on (R19) at any time." Also,"(R19) is to lay down after each meal	F 241		

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F 241	Continued From page 12 and is to be gotten up at 4:30." Also, "Do not use any products on (R19)'s body except what is in (R19)'s drawers. (R19) has a rash." On 4/20/15 at 1:55 P.M., E9 (CNA) stated, "(R19)'s niece puts all of those signs up for us to follow." On 4/21/15 at 10:35 A.M., E2, Director of Nursing (DON) stated, "All of those signs in (R19)'s room should be posted on the inside of (R19)'s closet."	F 241		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to revise a resident	F 280		

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(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 280	Continued From page 13 care plan to show a decrease in passive range of motion for one resident of 15 residents (R11) reviewed for care plans in a sample of 21. Findings Include: On 4/22/2015 at 10:15AM, E11, Certified Nursing Assistant, performed PROM (passive range of motion) to evaluate R11's range of motion for R11's to upper and lower extremities. R11's care plan titled, Passive Range of Motion Care Plan dated 6/4/2014 documents, "Resident has decreased passive range of motion/Potential for decreased range of motion d/t CVA (Cerebral vascular accident) with left sided effect. Goal: Resident will not have any further ROM (Range of motion) deficits, continue 2/5/2015." R11's Range of Motion/Contracture Screening documents an 11/11/2014 assessment indicated R11's fingers to be assessed at "1" (i.e., range of motion within functional/normal range). On 2/5/2015, R11's assessment indicates R11's left fingers to demonstrated a change from 1 to "2" (i.e., mild, 75% of normal range). On 4/22/15 at 1:00 p.m., E8 RN (Registered Nurse-Restorative) stated, "I understand the care plan should have been changed to show a change in R11's reduction of PROMS.	F 280		
F 323 SS=G	483.25(h) FREE OF ACCIDENT 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.	F 323		

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F 323		F 323		

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This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility to provide supervision to one of four residents (R1) reviewed for falls in the sample of 24. This failure resulted in R1 sustaining a left forehead laceration from a fall that required the placement of 9 sutures at a local hospital.

Findings include:

1. R1's Fall Risk Assessments dated 2/15/15, 2/19/15 and 4/3/15 document that R1 is at high risk for falls.

R1's Accident/Incident Report dated 2/15/15 documents that R1 fell from R1's wheelchair and obtained a right forearm skin tear. This same report documents the following intervention was initiated: "Keep in visibility when up in wheelchair..."
R1's current fall care plan has this same intervention documented.

R1's Accident/Incident Report dated 4/3/15 documents that R1 had an unwitnessed fall and was observed face down on the floor at the bottom of the facility's 800 hall ramp. This same report documents that R1 sustained a laceration to R1's left forehead, and was sent to a local hospital, where R1 had sutures placed to repair the laceration.

R1's local hospital emergency room records dated 4/3/15 document the following: "...presents to the emergency department with complaint of fall and forehead laceration...(R1) was in (R1's) wheelchair and fell face first out of the

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F 323	Continued From page 15 wheelchair...(R1) with pain to head...pain has been constant since the injury...3.5 centimeter laceration to left forehead T-shaped...nine 5-0 Nylon sutures required to close laceration..." On 4/20/15 at 9:56 a.m., 4/21/15 at 10:15 a.m., and 4/22/15 at 10:17 a.m. and 12:00 p.m., R1 was sitting alone up in R1's wheelchair in R1's room. On 4/22/15 at 10:35 a.m., E8, Restorative Nurse, verified that R1's fall on 4/3/15 was unwitnessed and therefore R1 was not in staff visibility at the time of R1's fall. E8 also stated that facility staff should not be leaving R1 sitting up in R1's wheelchair alone in R1's room. On 4/23/15 at 12:30 p.m., E1, Administrator, stated that R1's fall on 4/3/15 occurred at approximately 7:00 p.m. E1 then stated, "At this time of the evening, staff may be busy toileting or providing cares to others, so (R1) may have been out of facility staff's visibility.	F 323		
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	F 329		

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F 329	Continued From page 16 who have not used antipsychotic drugs are not 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 attempt a gradual drug reduction for psychotropic medication and failed to provide medical justification for the continued use of a psychotropic medication for R19. R19 is one of six residents reviewed for psychotropic medications in the sample of 24. FINDINGS INCLUDE: The facility policy titled, "Resident's with a Dementia Diagnosis Using Psychoactive Drugs" dated (revised 11/2013) directs staff, "If a resident has a dementia diagnosis, anti-psychotics should only be used under the following circumstances: the behavioral symptoms result in presenting a danger to self or others or results in distress or impairment in functional capacity. Residents with dementia must be assessed for the appropriate use of anti-psychotic medication. All behavior must be quantitatively and objectively documented to determine if the behavioral symptom is transitory or permanent." R19's Physician Order Sheet dated April 2015 includes the following diagnoses: Dementia,	F 329		

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F 329	Continued From page 17 Anxiety, Unspecified Psychosis, Hypertension, Osteoarthritis and Osteoporosis. R19's Physician Order Sheet also lists the following medications: Risperidone 0.25 MG (milligrams) one tablet daily and Lorazepam 0.5 MG one tablet twice daily. The facility form, titled "Medication Consent Form" includes the following medication, "Risperdal 0.25 MG one daily" and is signed by R19's Power of Attorney on 06/13/13. R19's "Care Plan" dated, October 2013 includes the following problems: "Currently taking Risperdal for the following behaviors, biting, hitting, screaming aloud, pinching and scratching." R19's Care Plan also lists the following approaches: " Take me [R19] to a quieter area to see if behavior decreases and encourage redirection of thoughts onto something else such as: folding laundry, taking care of a baby doll, food, drink or laying down. Assess me [R19] for pain, illness or other possible reasons. I [R19] will be given redirection as often as it is needed. I [R19] will be able to voice my needs, complaints and have someone listen to me with sincerity." R19's "Behavioral Tracking" dated 4/1/14 to 4/21/15 documents three episodes of behavior, including: "7/19/14 at 2:30 A.M. Resident refused help with eating and refused help with personal hygiene"; "8/17/14 at 7:15 A.M. Resident tried to bite staff during A.M. (morning) care" and; "8/29/14 at 4:15 P.M., Resident screaming." R19's" Physician Progress Notes", dated 3/27/15 includes the following note: "Dementia; Alzheimer's Disease. Unchanged," and another progress note dated 1/17/15 includes the following note: "Dementia; Alzheimer's Disease. Stable." R19's "Psychiatric Progress Notes" dated 3/19/15 documents," Pt (patient) was seen with staff.	F 329		

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F 329	Continued From page 18 (R19) continues to be stable. (R19) pinches once in a while. (R19) is not acting out like before. Medication Reduction: contraindicated, family refusal." R19's "Pharmacy Consultation Report" dated 3/5/15 documents the following," (R19) has dementia and receives an antipsychotic, Risperdal 0.25 MG every morning since at least 6/13/2013. Please consider reducing the dose of Risperdal. An FDA (Food and Drug Administration) boxed warning identifies an increased risk of mortality in elderly individuals receiving an antipsychotic for behavior or psychiatric symptoms of dementia. Family refuses reduction" On 4/21/15 at 9:45 A.M., E7 Registered Nurse/ Psychotropic Nurse stated, " We are monitoring (R19) for pinching staff and refusing care. Those are the only behaviors (R19) has. (R19)'s diagnosis is Dementia with Psychosis. (R19) has been receiving the same dose of Risperdal since 2013, (R19)'s niece refuses to allow us to reduce it (Risperdal)." On 4/21/15 at 10:35 A.M., E2 Director of Nurses stated, " (R19)'s diagnosis for the Risperdal is Dementia. (R19) tries to pinch or slap the staff. (R19) still pinches once in awhile. (R19)'s family refuses to allow us to reduce the Risperdal."	F 329		
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 under sanitary conditions	F 371		

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F 371	Continued From page 19	F 371		

This REQUIREMENT is not met as evidenced by:
Based on interview, observation and record review, the facility failed to ensure that the chlorine sanitizing solution measured the recommended concentration. This has the potential to affect all 124 residents in the facility.

Findings include:

On 4/20/15 at 9:41 a.m., a red bucket of solution containing a wash cloth was sitting on the food preparation island in the facility's kitchen. E12, Dietary Director, stated the bucket contained chlorine sanitizing solution, and the facility uses this solution to clean all surfaces in the kitchen. E12 then tested the concentration of the solution with a chlorine concentration testing strip, and the chlorine concentration of the strip read 0 parts per million. E12 then tested the chlorine concentration of a second red bucket of solution that was sitting on the kitchen's three compartment sink's countertop, and the chlorine concentration testing strip read 10 parts per million.

On 4/20/15 at 9:44 a.m., E12 verified that the concentration of the chlorine solution used to clean surfaces throughout the facility's kitchen was not measuring at the recommended concentration. E12 then stated that the concentration of the chlorine solution should measure at least 50 parts per million.

The facility's undated Manual Sanitizing policy

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F 371	Continued From page 20 documents, "...the recommended sanitation concentrations are as follows: Chlorine 50-100 parts per million minimum..." The Resident Census and Conditions of Residents form dated 4/20/15, and signed by E1, Administrator, documents that 124 residents are currently residing at the facility.	F 371		
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	F 441		

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F 441	Continued From page 21 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 perform hand hygiene during preparation of thickened liquids and protein supplements, and while performing passive range of motion. The facility also failed to ensure that indwelling urinary catheter tubing was kept from dragging across the floor for three of 24 residents (R22, R23, and R29) reviewed for infection control practices in the sample of 24 as well as three residents (R30, R31 and R33) on the supplemental sample. Findings include: 1. The facility's Hand Washing policy, undated, documents "Hand washing must be performed under the following conditions: Before preparing or handling medications...Before preparing or handling food." R30's Physician Orders Sheet, dated 4/1/15 through 4/30/15, documents R31's diet as general/pureed//honey thick liquids. On 4/20/15 at 12:20pm, E5, Registered Nurse, removed a scoop from a multiple use can of thickening powder, retrieved two scoops of the powder to mix R31's honey thick liquid. E5 then returned the scoop to the multiple use container without cleaning the scoop or washing E5's hands or applying gloves before E5 touched the scoop	F 441		

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F 441	Continued From page 22 inside the multiple use container of thickening powder. On 4/21/15 at 11:45am, E5, Registered Nurse, verified that E5 should have washed E5's hands and applied gloves before touching the scoop in the multiple use container. On 4/20/15 at 12:25pm, E3, Certified Nursing Assistant, removed two scoops of thickening powder from the multiple use container for R31's liquid. E3 did not wash E3's hands or apply gloves before handling the scoop from the multiple use container of thickening powder. E3 then placed the scoop back inside the multiple use container without cleaning the scoop. On 4/21/15 at 11:15am, E3, Certified Nursing Assistant, verified that E3 did not wash E3's hands or apply gloves prior to handling the scoop inside the multiple use container of thickening powder. R30's Physician Order Sheet, dated 4/1/15 through 4/30/15, documents for a protein supplement powder, one scoop to be mixed in a beverage of choice, to be taken two times a day. On 4/21/15 at 8:25am, E4, Licensed Practical Nurse, removed the scoop from the inside of a multiple use container of a protein supplement. E4 scooped out one scoop of the protein supplement for R30, and returned the scoop to the multiple use container. E4 did not apply gloves prior to touching the scoop inside the multiple use container. E4 then confirmed that the multiple use container of protein supplement is also used for R22 and R29. On 4/21/15 at 11:05am, E4 verified that E4 did not apply gloves prior to touching the scoop in the multiple use container when obtaining R30's protein supplement. E4 also verified that E4 did not clean the scoop prior to returning the scoop into the multiple use container.	F 441		

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F 441	Continued From page 23 On 4/21/15 at 2:00pm, E1, Administrator, verified that E1 expects facility staff to perform hand hygiene and apply gloves prior to touching the scoops in the multiple use containers. On 4/22/15 at 10:30 AM, E6 (Certified Nursing Assistant) performed Passive Range of Motion (PROM) to R23's right hand and R23's right leg. E6 did not perform hand hygiene prior to performing R23's PROM. E6 also did not perform hand hygiene after completing R23's PROM. On 4/22/15 at 10:40 AM, E6 (Certified Nursing Assistant) confirmed that E6 did not perform hand hygiene prior to beginning or after completing R23's PROM. The facility's Range of Motion Exercises policy (revised 11/2013) documents the following: ..."Wash your hands thoroughly before beginning the procedure... Wash and dry your hands thoroughly (when finished with range of motion)." 2. On 4/21/2015 at 8:40AM, R33's indwelling urinary catheter bag tubing was hanging down from R33's wheelchair touching the floor. On 4/21/2015 at 8:41AM, E4, Licensed Practical Nurse, confirmed that R33's indwelling urinary catheter bag tubing was dragging on the floor and was not hanging properly. The facility's policy titled Catheter Care,Urinary, dated 11/2013, documents the following: "...Be sure the catheter tubing and drainage bag are kept off the floor..."	F 441		