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	145536	A. BUILDING _____ B. WING _____	08/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE OUR LADY OF VICTORY	20 BRIARCLIFF LANE BOURBONNAIS, IL 60914

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey.	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to coordinate communication between facility staff, hospice and the Medical Doctor, when discontinuing antiepileptic medications. This applies to 1 of 4 residents (R15) reviewed for hospice care in the sample of 19. The findings include: On August 15, 2016 at 10:20am during the initial tour with E3 (Assistant Director of Nursing - ADON), R15 was in her room sitting in her high back wheelchair. R15 was groaning loudly. E3 went into R15's room. R15 stopped groaning. From the hallway, R15 was seen to be shaking at first and then she had a stiff posture. E3 came out stating the resident had a grand mal seizure lasting a few minutes and it is over now. On August 15, 2016 at 11:20am, Z3 (Hospice Nurse) stated she asked for the order to stop the	F 309		

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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seizure medications because R15 had been frequently refusing medications and she felt it was a comfort measure to stop the oral medications because she wasn't getting any benefit from the medication anyway. Z3 stated there had been no seizures for "a couple of months." Z3 stated the seizure medication was replaced with a suppository to be used when R15 had a seizure.

R15 was admitted to the facility on August 6, 2011 with diagnoses including Epilepsy according to the POS (Physician Order Sheet) dated August 2016. The POS dated August 2016 also shows a physician's order dated August 6, 2011 to administer Phenytoin Sodium (antiepileptic medication) Extended Release 100 mg (milligram) twice a day at 8:00 am and 8:00 pm. The same POS also showed a physician's order dated June 15, 2012 to administer Phenytoin 50 mg Infatab one tablet at 12:00 noon. The same POS also showed a physician's order dated August 12, 2016 to discontinue Phenytoin.

The drug inserts for both Phenytoin (Dilantin) under the subheading of "Warning" documented "Effects of Abrupt Withdrawal - Abrupt withdrawal of phenytoin in epileptic patients may precipitate status epilepticus. When, in the judgment of the clinician, the need for dosage reduction, discontinuation, or substitution of alternative antiepileptic medication arises, this should be done gradually."

On August 18, 2016 at 9:26am, Z1 (Medical Doctor) stated he stopped the seizure medication after Z3 called and a told him R15 "had been rejecting medication" for some time and was getting nothing from it. Z1 stated further he had

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F 309	Continued From page 2 understood "the family was concerned with oral meds, but I didn't talk with the family." On August 16, 2016 at 11:49am, E8 (Licensed Practical Nurse) stated R15 didn't refuse medications. E8 stated R15 didn't like getting medications early in the morning, but would accept them later in the morning. E8 stated R15 didn't really have any trouble with taking her medications. On August 15, 2016 at 1:35pm, E9 (Licensed Practical Nurse) stated she works with R15 frequently and she has no problem giving R15's medications. E9 said R15 doesn't like to be given medication before 9:00am, but will take them if you come back at 9:00am or sometimes later. E9 further stated on August 12, 2016, Z3 did witness R15 refusing her morning medications. E9 stated she was able to give the medication a little later, and the order to stop the medication arrived just after that. The review of MAR (Medication Administration Record) for June, July and August 2016 showed R15 refused medication only once (in July). The seizure medication was restarted after the seizure on August 15, 2016 and R15 has not refused the medication any since then. Laboratory results dated May 14, 2016 are the latest record in R15's clinical record showing the Phenytoin to be in a therapeutic level. No subsequent laboratory values were in the record.	F 309		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of	F 363		

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F 363	Continued From page 3	F 363		

residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow recipes and failed to serve correct pureed meat portion sizes for lunch meal service. This applies to 5 of 16 residents (R6, R8, R10, R14, R16) reviewed for pureed diets in the sample of 19 and 7 residents (R20 through R26) in the supplemental sample. The findings include:
On August 16, 2016 at 10:20AM , E4 (cook) was preparing the pureed meal. The menu included pork stir fry as the main entrée and beef tips in gravy as the alternate choice. E4 stated that she was preparing 14 pureed portions. E4 put unmeasured cooked pork (about a third of 1/8th pan) and chicken broth into a blender and pureed it. E4 added thickener using a gray scoop (4 oz) to the mixture & pureed it again. This was transferred to a 1/8th pan. When asked how much pork was pureed, E4 was not able to answer. E4 started to add unmeasured ground beef into the rinsed blender but E5 (Dining Service Director) interrupted her and pointing to the recipe told her to puree 4 cups beef tips & gravy instead. This was in turn transferred into a 1/8th pan.
On August 16, 2016 at 12:15PM, the lunch meal was served by E4 in the Gent dining room. E4 used two #16 scoops (equivalent to 4 oz) to serve the pureed pork. E4 used #12 scoop (2.67 oz) to serve the pureed beef tips.

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F 363	Continued From page 4 The facility menu spread sheet for week 2 Tuesday showed to use #6 scoop(6 oz) for pureed pork and #10 scoop(3.2oz) for pureed beef tips and gravy. The facility recipes used at the time of pureed prep called for 25, 40, 60 and 75 servings for Beef tips in gravy and Pork stir fry with vegetables. The recipe for pureed beef tips was listed in gallons and the recipe for pureed pork with vegetables was listed in pounds. Neither of the recipes were followed. On August 17, 2016 at 2:15 PM, E6 (Clinical Nutrition Manager) stated that the correct scoop portions as listed on the menu spread sheet should be used and the recipe must be followed. The facility presented a list of residents on pureed diet which included R6, R8, R10, R14, R16, and R20 through R26.	F 363		
F 365 SS=E	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide mechanically altered diet to residents. This applies to 6 of 16 residents (R6, R8, R9, R10, R14 and R16) observed during meal in the sample of 19 and 8 residents (R20 through R27) in the supplemental sample. The findings include: On August 15, 2016 at 12:30PM in the main	F 365		

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dining room, R27 was served very dry ground chicken kebab in small and large (about 1 inch) clumps. R27 stated " I need to have it in small pieces or I'll choke."
On August 15, 2016 at 12:45PM, E5 (Dining Service Director) stated that ground meat must be finely ground and moist before it comes out of the kitchen to the service area. On
On August 16, 2016 at 10:20AM during pureed meal prep, E4 (cook) pureed pork stir fry, beef tips in gravy, stir fry vegetables, and fried rice separately in a blender. The pureed beef tips had strands of beef that needed to be chewed. The pureed rice had whole pieces of cooked rice grains that was scraped in from the edge of the blender. The pureed vegetables had strands of carrot and small pieces of fibrous vegetables that needed to be chewed. E4 did not taste the final product. When asked how she would know that the right consistency was served, E4 stated that she does not taste the pureed but only the regular foods prepared.
On August 16, 2016 at 12:20PM during lunch meal, R9 was served regular consistency pork stir fry. Meal ticket and physician order showed ground meats.
On August 16 at 12:55PM, E6 (Clinical Nutrition Manager) stated that the pureed items were not the right consistency.
The undated facility policy guidelines titled " Dysphagia Diets " showed that mechanically altered meats must be " Moist,-ground or minced, tender cooked meat with no larger than ¼ " pieces ." For pureed consistency " Foods are totally pureed. No coarse textures or lumps of any sort are allowed. "
The facility presented lists of residents on Pureed diet and mechanical soft/ground diet. these lists included R6, R8, R9, R10, R14, R16 and R20

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F 365	Continued From page 6 through R27	F 365		
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 This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to follow sanitary practices in the kitchen and during meal service. This applies to all 93 residents receiving meal in the facility. The findings include: On August 15, 2016 at 9:55 AM, during the kitchen tour with E5 (dining service director), washed dishes used for meals were stacked wet on far end of the dish machine station as they got pulled out of the dish machine after being sanitized. These dishes were about 6 inches away from the hand sink where there was potential for water to be splashed onto the dishes during hand washing. Multiple soup bowls and dessert plates still wet in between were stacked on a rack next to the dish machine. Some bowls and dessert plates had remnants of food particles on them. Multiple fruit flies were seen flying from the drain of the dish machine. In the walk in cooler, a tray containing multiple individual	F 371		

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portioned juices and shakes were stored on the bottom shelf, right next to the uncooked sausage in a pan.
On August 15, 2016 at 12:43 PM, during tray line service in the Gent (small) dining room, E4(cook) was observed plating food items. E4 had gloves on which were dripping with meat sauce from the lasagna, and proceeded to pick up pieces of garlic bread and place it on plates as ordered. The gloves touched various other surfaces, such as steam table, trays, lids and scoops during multistep meal service. E4 also touched her eye glasses and chin with the same gloves. Gloves were not changed for the entire meal service.
On August 16, 2016 at 10:20 AM during pureed meal prep, E4 was using her gloved hands to scrape the pureed beef tips from the blade of the food processor and back into the pureed mixture inside the food processor. This procedure was repeated during the pureeing of the rice. Other items pureed using the same gloves, were stir fried vegetables and pork. E4 had the same gloves on as she walked about the kitchen doing various tasks such as, rinsing the food processor in between purees, getting broth from across the kitchen to puree the vegetables, handling various pans and scoops and getting milk from the cooler to add to the pureed rice. During the meal prep, flies were seen in the kitchen landing on the food preparation area.
On August 16, 2016 at 12:05 PM during tray line service in the Gent dining room, E4 was plating food items. E4 had gloves on that had gravy on it. With the same gloves, E4 adjusted the vegetables on some of the plate after scooping it onto the plate. E4's gloves had touched multiple surfaces such as, steam table, trays, lids and scoops. Gloves were not changed for the entire meal service.

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F 371	Continued From page 8 Flies were observed landing on top of the steam table, clean plates and other surfaces in the dining room. Flies were also observed landing on plated food. This was brought to the attention of E4 and other nursing staff. E4 continued to use the plate to serve residents food and the nursing staff continued to serve the plated food. The CMS 672 Form titled " Resident Census and Conditions of Residents " , dated August 15, 2016, shows facility census of 93 residents.	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	F 441		

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F 441	Continued From page 9 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 observation, interview and record review, the facility failed to ensure that handwashing was performed during wound care for residents and failed to ensure the isolation carts of infected residents contained personal protective equipment. This applies to 4 of 6 residents (R10, R11, R4, R16) reviewed for wound care and infection control practices in the sample of 19 and 2 residents (R23, R28) in the supplemental sample. The findings include: 1. R10 was readmitted on March 11, 2015 with diagnoses including hepatic encephalopathy, dementia, atrial fibrillation, and chronic obstructive pulmonary disease, according to the August 2016 physician orders (POS). The August 2016 POS showed a telephone order on August 8, 2016 to clean the sacrum with normal saline and apply Duoderm every three days.	F 441		

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F 441	Continued From page 10 On August 17, 2016 at 1:40 PM, E12 (Licensed Practical Nurse/LPN) was observed for wound treatment on R10. E12 was assisted by E13 (Certified Nursing Assistant). R10 was positioned on her left side while held by E13. E12 said the wound dressing was removed after R10 had a bowel movement. E12 washed her hands, donned on gloves, and sprayed and cleansed the sacral wound with normal saline. E12 changed her gloves without handwashing. E12 dabbed the wound with dry gauze, and changed gloves without handwashing. The right hand glove ripped at the wrist and a strip was left hanging while E12 was putting on the glove. E12 did not change the right hand glove and the strip was touching the buttock. E12 finished applying the Duoderm. 2. On 8/17/16 at 1:45pm, E15 (Wound Treatment Nurse) provided wound care for R11. Wearing gloves, E15 removed the old dressing and cleansed the wound per the physician's order. E15 then changed her gloves without washing her hands, followed by measuring the wound. E15 then changed gloves again without washing her hands, then proceeded to place the new dressing on the wound. At that time, E15 stated, " Oh, yeah, I should have washed my hands, even though I was wearing gloves." The facility policy titled, "Non-Sterile Dressing Change" revised March 31, 2013, requires, "X. Remove gloves, wash hands, apply new gloves." 3. On August 15, 2015 at 11:15 AM, during the initial tour of the D Wing with E10 (Nurse), E10 stated there were three residents (R4, R16, R28) on contact isolation in the D Wing. It was noted that there was one isolation cart being shared by	F 441		

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F 441	Continued From page 11 all three residents. In the process of going into R28's room, it was discovered that there were no isolation gowns in the isolation cart. E10 stated she has sent someone to get some gowns. R28 was on contact isolation for methicillin resistant staphylococcus aureus (MRSA) in the abdominal wound. Upon entering R28's room, when asked, R28 stated staff members do not usually put on their gowns when they enter her room. On August 15, 2016 at 11:00 AM, during the initial tour of the E Wing with E11 (Care Plan Coordinator), it was observed that R23 was on contact isolation for Clostridium difficile. On opening the isolation cart by R23's room, there were no isolation gowns in the cart. E11 stated she will inform staff to put gowns in the cart. The facility policy titled, "Transmission-Based Precautions," revised June 21, 2013, requires, "D. Gather equipment. 1. Obtain cabinet and cart for a 24 hour supply of gloves, gowns, etc needed to maintain precautions."	F 441		