STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14G003	A. BUILDING _____ B. WING _____	R 03/01/2016

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BELLWOOD DEVELOPMENTAL CENTER	**105 EASTERN AVENUE BELLWOOD, IL 60104**

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{W 000}	INITIAL COMMENTS 2ND FOLLOW UP TO ANNUAL SURVEY OF 10/26/15	{W 000}		
{W 104}	483.410(a)(1) GOVERNING BODY The governing body must exercise general policy, budget, and operating direction over the facility. This STANDARD is not met as evidenced by: REPEAT Based on observations, record review and interview, the facility failed to: 1) Ensure that governing body created and implemented a policy and procedure to address Scabies; and 2) Ensure that Rooms 35 and 36 as well as wheelchairs are free of strong urine smell potentially affecting 78 of 78 clients residing in the facility (R1 through R78). Findings include: 1) When surveyors started the survey on 2/23/16, facility informed surveyors that they currently have two clients (R1 and R10) just recently diagnosed with Scabies. Observations were conducted by surveyors in the facility. At approximately 12:21pm, R10 was observed crawling out of his bedroom and stood up then ambulated in the hallway towards the greatroom. R10's record was reviewed and a dermatology consult dated 2/22/16 noted that R10 currently is	{W 104}		

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

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{W 104}	Continued From page 1 diagnosed with Norwegian crusted scabies. E1, Administrator, was interviewed on 2/23/16 at 1:04pm. E1 stated, "No internal policy regarding scabies, we just follow the IDPH (Illinois Department of Public Health) guidelines." E1 clarified that following the guidelines includes reporting the incident to the state health department and Cook County health department and that families are notified." E2, was interviewed on 2/25/16 at approximately 9:00am. E2 stated that the facility had a scabies outbreak in late 2014 or early 2015. Prior to that interview on 2/23/16, E2 informed surveyors that the facility had a scabies outbreak sometime around 2012. 2) Observations were conducted in the facility on 2/24/16 at around 11:48am. Surveyor entered rooms 35 and 36 and noted a very strong urine smell in both rooms. E2, Director of Nursing, was interviewed on 2/24/16 at 12:10pm. E2 stated, "Yes you are right (regarding the strong urine smell). I will call the housekeeper." 3) Observations were conducted in the facility on 2/23/16 at approximately 1:50pm. Walking in the hallway a strong smell of urine was detected between bedroom 10 and bedroom 21. At 1:54pm E6 (Lead Staff) was present in the hallway and verified there was a strong smell of urine. Surveyor observed wheelchairs lined up in the hallway at this time and the following was noted: - R31's wheelchair the molded seat was dirty and debris was observed on the sides of the	{W 104}		

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{W 104}	Continued From page 2	{W 104}		

wheelchair. R31's arm rest was observed to be cracked.
- R54's wheelchair was observed to have a dirty and stained seat cushion.
- R9's wheelchair was observed to have a torn seat cover and the left arm rest was torn.
- R67's foot bucket on the wheelchair was observed to have debris in the bottom of the bucket. The bucket was torn on the left side and the zipper on the back of the wheelchair was torn.
- R71's wheelchair was noted to emit a strong urine smell. R71's wheelchair had a torn armrest and crusted debris was observed on the leg rest.
- R40's wheelchair was observed to have padding on the left and right side of the foot bucket that was dirty and there was debris in the bucket.
- R21's wheelchair was observed to have torn molding on the upper and back of the seat.
- R58's wheelchair was observed to have a dirty and discolored seat cushion cover. The cover cushion was worn out and the fibers from the elastic visible. Food and debris were observed on the frame of the wheelchair and the foot bucket was dirty.

E1 (Administrator) was present on 2/23/16 at 1:59pm and verified that R71's wheelchair emitted a strong urine smell.

On 2/24/16 at 8:10am R19's wheelchair was observed in the hallway. R19's wheelchair did not have a seat cushion and the arm rests were missing.
E6 was present at 8:12am and verified that R19's wheelchair lacked a seat cushion and arm rests. E6 stated that he has no answer as to why R19's wheelchair has no arm rests. E6 stated that R19 does not have a seat cushion due to his PICA

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{W 104}	Continued From page 3 behavior. E6 stated that R19 will pick at the cushion. E6 then stated that R19's wheelchair seat cushion is in the laundry room. At approximately 8:19am E6 went into the laundry room and could not locate R19's seat cushion, however a seat cushion cover was found. At 8:21am E6 found a torn blue covered seat cushion and stated this was for R19's wheelchair. Then another staff stated they had found R19's wheelchair seat cushion. Both seat cushions were torn and or stained. 4) An environmental tour was performed on 2/23/16, beginning at 1:45pm. E6(Staff Lead) and E1(Acting Administrator) were both present for this tour. Wheelchairs were observed lined up against the wall in the hallway. A strong smell of urine was detected at this time. The following was observed: * R18's wheelchair molded seat cushion was observed to be frayed, and her left armrest pad was missing. * R70's wheelchair had a strong smell of urine, and was dirty with debris. * R77's wheelchair was missing a right armrest pad. * R11's wheelchair had a torn right armrest. * R14's wheelchair was missing a cover to his cushion, and per E1 is waiting to have his wheelchair repaired. * R50's wheelchair had a torn boot case and armrest, and was soiled. * R63's wheelchair had torn right and left armrests, and her head rest was loose, compromising proper head support. During an interview with E1 at this same date and	{W 104}		

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{W 104}	Continued From page 4 time, E1 stated that there is a cleaning schedule for the wheelchairs, but obviously, the schedule is not working. E1 also confirmed that he smelled the urine from the wheelchairs as well.	{W 104}		
{W 331}	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to: 1) Ensure that the Do Not Resuscitate orders for 1 of 1 client (R79), was followed when R79 was found unresponsive in his room; 2) Ensure that 1 of 1 client diagnosed with scabies (R8) on 1/12/16 had his follow up appointment scheduled and completed within a month as per recommendations from the dermatologist; and Findings include: 1) A resident discharge summary signed by the Medical Director on 1/11/16 was reviewed. It includes: "date of discharge: 12/23/15 time: 6:30am reason for leaving: 80 year old elderly male resident was noted on 12/22/15with poor appetite, and at 10:00pm with an emesis of undigested food particles. Abdomen distended and firm (checked for impaction, no stool noted at base of rectum. Bowel sounds were auscultated in all quadrants, and vital signs were WNL (within normal limits). Medication was administered for bowel movement promotion per record order. Ongoing monitoring checks revealed no further	{W 331}		

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{W 331}	Continued From page 5	{W 331}		

emesis and steady vital signs at 1:45am. Resident was noted on 12/23/15 that at approximately 6:30am staff notified Nursing of resident with unresponsiveness. Vital signs unattainable - 911 was notified and per verbal report CPR (cardiopulmonary resuscitation) was initiated. Resident was pronounced expired via telemetry to a hospital physician by 911 responders."

R79's Physician Orders Sheet for the period of 12/15/15 - 1/14/15. Under code status it stated; " DO NOT RESUSCITATE".

E2, Director of Nursing, was interviewed on 2/24/16 at 9:05am. E2 stated, "I remembered receiving a call from the nurse and she told me she started CPR. " E2 added, "The nurse, was a brand new nurse." E2 then verified that R79 had a DO NOT RESUSCITATE order. E2 then stated, "The nurse should have double checked R79's code status. It's in the clients charts and a list is posted in the nurses station." Surveyor asked what the facility did to address this issue. E2 stated, "I don't have any documented training regarding the code status of the clients."

2) R8's medical chart was reviewed. R8's Dermatology report from 1/12/16 states that R8 has Scabies, with linear burrows located on his right hand. A Scabies prep was performed on his right hand, and R8's caregiver was counseled that Scabies is very contagious. Household contacts should be treated, and clothing should be isolated for 72 hours, and washed and dried on high heat. R8 needs to be seen in one month(2/12/16) for a focused follow up visit. There is no other Dermatology report in R8's chart, indicating that R8 was seen on 2/12/16 for

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{W 331}	Continued From page 6 his follow up visit. R8's nursing notes were reviewed. On 2/16/16, there is a nursing entry that states R8 will have a follow up appointment with Z1 on 3/1/16 at 2:45pm. During an interview with E2(Director of Nursing) on 2/25/16 at 9:30am, E2 was asked if R8 had his follow up appointment on 2/12/16, as ordered by Z1 on 1/12/16. E2 stated that E11(Assistant Director of Nursing) makes all of the follow up appointments, and stated that R8 is behind in his follow up appointment for Scabies. E2 explained that E11 did not call for the appointment until 2/16/16. During a telephone interview with Z2(Dermatology nurse) on 2/25/16 at 12:26pm, Z2 confirmed that R8 is behind in his one month follow up appointment.	{W 331}		