DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146078	A. BUILDING ______ B. WING ______	02/06/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PERSHING CONVALESCENT HOME	**3900 SOUTH OAK PARK AVENUE BERWYN, IL 60402**

(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 000	INITIAL COMMENTS Annual Licensure and Certification No extended survey was done.	F 000		
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS AND SERVICES 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 the resident's stay, of services available in the facility and of charges for those services,	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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F 156	Continued From page 1 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 comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These	F 156		

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F 156	Continued From page 2	F 156		

requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

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

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 observations made on 2/6/09 between 9:10 a.m. to 10:40 a.m. during the environmental tour with E9 (Maintenance Director), Z1 (Outside Contracted Environmental Service Manager) and Z2 (Outside Contracted Environmental Service Supervisor), and interview, the facility failed to post a brief synopsis of the Medicare and Medicaid information. The findings include:

1) Upon the tour of the facility, there were no postings for the medicare and medicaid programs. Z1 was asking what is needed to be posted. Surveyor explained that is brief synopsis of the programs and what they offer and how one can apply for the programs. Z1 stated to

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F 156	Continued From page 3 understand and assured that it will be posted. 2) Review of the facility's Oscar 3 (history facility profile) documents that the facility is certified for Medicare and Medicaid.	F 156		
F 167 SS=C	483.10(g)(1) EXAMINATION OF SURVEY RESULTS A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observations made on 2/6/09 between 9:10 a.m. to 10:40 a.m. during the environmental tour with E9 (Maintenance Director), Z1 (Outside Contracted Environmental Service Manager) and Z2 (Outside Contracted Environmental Service Supervisor), and interview, the facility failed to post the plan of correction along with the last annual survey. The findings include: Review of the last annual survey did not have the plan of correction with it. There was other miscellaneous information that was not needed. Z1 assured that the clip board with the past survey would be cleaned up and that the plan of correction would be found and posted along with the deficiencies.	F 167		
F 221	483.13(a) PHYSICAL RESTRAINTS	F 221		

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F 221 SS=D	Continued From page 4 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 observations and medical record review the facility failed to have physician orders, assess or care plan for 4 of 4 residents in the sample with restraints.(R4,R5,R7 and R8) Findings Include: On 2/4/09 R7 was observed on tour in the 1st. floor dining room sitting in a recliner with a lap tray and again on 2/5/09. During the noon meal on 2/5/09 the lap tray was removed for lunch and replaced with an overhead table after lunch. Review of R4's medical record does not indicate R4 had an M.D. order,assessment or care plan for the use of a restraint. On 2/4/09 at 10AM during the initial tour, R4 was observed in her room in a reclining chair with a lap tray and a chair alarm. On 2/5/09 R4 was observed throughout the day at random times in the same position as on 2/4. On 2/5 during lunch at 12:10 PM while being fed by E11 (Rehab Aide), resident was also kept in the same position. The reclining chair was in a slightly reclined position and resident's feet do not touch the floor. On 2/5/09 at 12:30 PM E10 (CNA) stated the resident slips down if there is no tray in front of her. On 2/6/09 from 8:50 AM until 10:30 AM, the resident still remained in the same position as in previous days. R4 was screaming	F 221		

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F 221	Continued From page 5 intermittently throughout the day all throughout the survey. The initial Fall Risk Assessment was done on 12/20/07 and the most recent on 2/5/09 during the survey when surveyors requested to the restraint assessment. There was no physician order for a reclining chair with lap tray. An order was obtained that the resident may be up in a reclining chair on 2/5/09 but still did not indicate the lap tray. Nursing documentation dated 1/31/09 indicated R4 had some bruising. R4 has dementia. The telephone consent to place the resident in a reclining chair was only obtained on 2/5/09 after the surveyors had addressed the issue. There was no care plan to address the use of the reclining chair with lap tray. R8 was observed on 2/6/09 at 10:20 AM in the 1st floor dining room sitting in a reclining chair with a lap tray. No physician order was found for a reclining chair with a lap tray and the telephone consent was only obtained on 2/5/09. On 2/5/09 in the 1st. floor dining room R5 was observed sitting in a recliner with a lap tray. After lunch the lap tray was removed and an overhead table was placed in front of the recliner. Review of R5's medical record in the POS (Physician order sheet) there is no Physician order for a restraint (recliner or lap tray). A restraint assessment could not be found. Review of R5's Minimum Data Set and care plan for a restraint (recliner or lap tray) again was not addressed.	F 221		
F 226 SS=D	483.13(c) STAFF TREATMENT OF RESIDENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

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F 226	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to follow their Abuse Protocol for misappropriation of property by failure to interview all parties involved and to report the allegation to the State for 1 (R14) resident, who claimed that his $13 of quarters were missing from his bedside cabinet, out of 10 sampled residents. The findings include: 1) During the resident group interview, R14 stated that $13 dollars of quarters were taken from his bedside cabinet. A police report was made. R12 stated that E13 (Certified Nurse Aide) stated that R12's roommate stole the money. 2) During the abuse prohibition interview with E8 (Assistant Administrator) on 2/6/09 at 10:50 a.m., the alleged theft was reviewed. The alleged theft involved R14, who alleged that someone may have taken his money and it may have been an employee, E13. E13 claimed that she had asked R14 before if she could have candy from his cabinet and he has said "help yourself". On the morning of 12/18/08, R14 was not present but his roommate was in the room when E13 went into R14's room to get more candy. E13 claimed not see any quarters in the cabinet. There was no statement from the roommate as to what he saw. The facility failed to report the allegation because E8 was under the impression that it did not need to be reported if it can not be proved.	F 226		

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F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observations and interview, the facility failed to maintain the facility free of pungent and pervasive urine and fecal odors on all 3 days of the survey. The findings include: 1) Upon entering the building, the pungent urine and fecal odors were noted immediately and throughout the day. Tour of the 1st and 2nd floors were noted with constant smell of fecal odor present at any given time. 2) During the environmental tour on 2/6/09 between 9:10 a.m. to 10:40 a.m. with E9 (Maintenance Director), Z1 and Z2 (Outside Contracted Environmental Service Personnel), E12 (Laundry Staff) was observed to chute loose linen from a soiled linen bin from the 2nd floor. The black plastic (30 gallon size)garbage bag, which was holding the soiled linen, was noted to be re-used. Z1 informed E12 not to re-use the plastic garbage bags. Z2 stated that the janitor was re-using the the garbage bags also. The possible source of the smell within the facility. It was also noted that large container (Industrial size - 30 gallons or more) are being used as trash receptacles on the resident floors. R13 stated that he has asked that the large bin containing garbage could be removed from outside of his room due to the odor and the in frequent disposal of its contents because it can hold so much.	F 253		

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F 253	Continued From page 8 3) During the resident group interview, they stated that the facility is running out of supplies. 4) On the 2nd day of the survey (2/5/09), there was no hand soap available at the 1st and 2nd floor nurses' station hand sinks. This was reported to the administration during the daily status meeting on 2/5/09. The next day, there were disposable hand soap pump containers at the sinks. The wall-mounted soap containers were empty and not in used. When E10 was questioned why the wall-mounted dispenser was not used, he hesitated and was not sure how to answer. The facility is discontinuing service with past supplier and initiating a new contract with the current provider for environmental services per Z1 and Z2.	F 253		
F 323 SS=E	483.25(h) ACCIDENTS AND SUPERVISION 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 observations made on 2/6/09 between 9:10 a.m. to 10:40 a.m. during the environmental tour with E9 (Maintenance Director), Z1 (Outside Contracted Environmental Service Manager) and Z2 (Outside Contracted Environmental Service Supervisor), record review and interview, the facility failed to ensure that the hot water	F 323		

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F 323	Continued From page 9 temperature was not in excess of 110 degrees Farenheit (F.) in 3 of 6 Common Bathrooms, the staff failed to respond to emergency alarms on exterior doors for 2 of 3 doors tested and laundry staff failed to know the correct emergency response to smelling smoke in the Laundry Room. The findings include: 1) The hot water temperature was tested with State Issued Digital Thermometer. The temperatures were found to be 125 degrees F. at the tub and sink in the 1st floor South tub room, 125 degrees F. at the sink in the the toilet room across from the 1st floor nurses' station and 126 degrees F. was observed in the 2nd floor toilet room, at the sink and in the Common Bathroom next to room 8, at the tub and sink. On 2/6/09 at 10:20 a.m., R13 stated that he does use the bathroom adjacent to his room but that the water temperature fluctuates from hot to cold. On 2/5/09 at 8:50 a.m., R15 complained to surveyor that the hot water takes forever to heat up. E9 stated that the hot water temperatures are taken everyday and average between 96 to 106 degrees F. The water log was presented later and confirmed what E9 stated. E9 also stated that the boiler is being replaced today because of low water pressure. E9 stated that maybe the removal of the boiler is affecting the water temperature. There was no urgency on the part of the tour guides to correct the hot water problem. Surveyor had to prompt and cue all 3 tour guides that the water temperature was problem and needed to be adjusted. E9 left to turn down the temperature and Z1 and Z2 were prompted to notify nursing staff and to post signs	F 323		

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F 323	Continued From page 10 by faucets alerting them to the extreme hot water temperatures until the system could be purged. 2) When the exterior door on the 1st floor South was tested, there was no response from the facility staff. The alarm was tested again to ensure it was audible and was observed to work. The facility intercom system also announced that the door should be checked. E10 (Certified Nurse Aide) stated that she heard the alarm twice but turned it off. Fellow State surveyor also confirmed that the alarm was heard and shut off by staff. The alarm on the 1st floor West exterior door was tested and E10 responded to the area. E10 was slow moving to approach the area. E10 was instructed to do what she normally would do. She approached the door and looked outside the window of the door. E10 failed to open and look out the door to ensure no one had left the facility. There was no intercom announcement to check the door. The alarm on the 2nd floor West exterior door was tested and no staff responded. There also was no intercom announcement for staff to check the door. All three exterior doors lead to the outside. The facility is on a corner of a busy intersection. On 2/6/09 at 10:40 a.m., E8 stated that there are no in-services to present on staff's emergency response to alarms on exterior doors. This has been a past citation for this facility. 3) In the Laundry Room, E12 (Laundry Staff) was asked what she has been instructed to do when she smells smoke in the laundry room. E12 was not not sure what to do before she left the area.	F 323		
F 356 SS=C	483.30(e) NURSE STAFFING The facility must post the following information on	F 356		

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a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observations and interview, the facility failed to post all pertinent information for the nurse staffing on 2 of 2 days of the survey. The finding include:

1) On the first two days, the nurse staffing that was posted was observed to have the staff's

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F 356	Continued From page 12 names, their titles and the date. The posting did not have the facility's name, the census, or the actual hours worked. 2) During the Daily Status Meeting on 2/5/09, the administration staff (E2 and E8) stated that they would ensure the required information would be there but thought what was posted was okay.	F 356		
F 364 SS=D	483.35(d)(1)-(2) FOOD Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation of the noon meal distribution on 2/5/09 in the kitchen the facility failed to maintain the temperature of the corned beef served at the noon meal at 138 degrees Fahrenheit or higher. Findings Include: On 2/5/09 during the noon tray line observation plates of resident food was observed sitting on a counter uncovered. the temperature of the mechanical diet corned beef was 98 degrees and the regular diet corned beef was 120 degrees. The food was not reheated and was sent to the floor and served to the residents.	F 364		
F 371 SS=C	483.35(i) SANITARY CONDITIONS The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local	F 371		

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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 371	Continued From page 13 authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observations made on 2/4/09 and 2/5/09 in the kitchen the facility failed to: 1.) wear gloves and/or wash hands vs licking potatoes off thumb while placing food on plates during resident tray line preparation 2.) properly store an oven mit that fell onto the floor during the noon meal tray line. 3.) date bags of vegetables as to when they were delivered. Findings Include: On 2/5/09 E4 was observed not wearing gloves while handling resident plates and placing food onto the plates. A small portion of boiled potatoes attached to E4's thumb. E4 licked the potatoes off her thumb wiped her thumb onto her apron and continued placing food onto resident plates without washing her hands or wearing gloves. On 2/5/09 E4 dropped an oven mit onto the floor while placing food onto resident plates for the noon meal. E4 picked up the oven mit and placed in onto the clean food prep table where the pureed food was served. E4 did not wash her hands after picking up the oven mit off the floor. The oven mit remained on the clean food prep counter throughout the noon meal preparation and after.	F 371		

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	146078	A. BUILDING ______ B. WING ______	02/06/2009

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F 371	Continued From page 14 On 2/4/09 4 bag of frozen peas and 4 bags of frozen Italian vegetables were observed without dates as to when they were delivered.	F 371		
F 431 SS=E	483.60(b), (d), (e) PHARMACY SERVICES 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. 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.	F 431		

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F 431	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that medications are 1) stored under proper temperature to preserve their integrity and in accordance with the manufacturer's specifications and 2) label medications when it was opened Findings include: On 2/4/09 at 10:50 AM, E7 (Nurse) was requested to open the 2nd floor medication refrigerator in the medication room. The following were observed: 1) An unopened container labeled Emergency Box which contained : 1 vial of Humulin, 1 vial of Human Insulin Regular, 1 vial of Lorazepam and 1 vial of Lantus insulin was found directly stored underneath the freezer section. The freezer had ice build-up and was touching the emergency box. The box had chunks of ice that formed inside the box. The box had a label documented, "Keep in Refrigerator. Do not freeze." 2) The following insulins that belonged to 2 different residents were opened without the date of when it was opened: - 1 vial of Humalog - 1 vial of Novolin R E6 confirmed the emergency medications should not be frozen. On 2/6/09 at 10:10 AM, E5 (Nurse) stated the refrigerated emergency medications are kept in	F 431		

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F 431	Continued From page 16 the 2nd floor medication refrigerator. She stated the 1st and 2nd floor share the same refrigerated emergency medications.	F 431		
F 442 SS=D	483.65(b)(1) PREVENTING SPREAD OF INFECTION When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that staff followed the isolation procedures and requirements for 2 of 10 sampled residents who are in contact isolation (R1, R4). Findings include: 1) R1 has a diagnoses that includes ESBL (Extended Spectrum Beta Lactamase) in urine. R1's room is on the first floor of the facility. On 2/5/09 at 9:45am surveyor went to the first floor nurses station to wash my hands. There was no soap available to do so. On 2/5/09 at 9:55am surveyor observed E3 (Licensed Practical Nurse)LPN gathering supplies to do R1's dressing changes. On 2/5/09 at 10:00am outside of R1's room E3 stated R1 was on contact isolation. E3 took gloves and a red isolation bag from the dresser outside of R1's room containing isolation supplies. E3 did not wear an isolation gown and	F 442		

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F 442	Continued From page 17 walked into R1's room. R1 was observed with an indwelling urinary catheter. E3 placed gloves on a and began removing R1's sacral dressing. The front of E3's top was observed touching R1's linens. A large amount of green drainage was noted on the outside of R1's old dressing. R1 now began having a stool. E3 changed her gloves and applied a clean dressing. E3 changed gloves without washing her hands and began removing the dressing from R1's hip. E3 changed gloves and applied a clean dressing to R1's hip. There was no sink or soap in R1's room for E3 to wash her hands. After doing R1's hip dressing E3 stated she ran out of gloves and would surveyor get more gloves for her. Surveyor went outside of R1's room and brought E3 more gloves. E3 changed gloves and did the third dressing change. After the 3rd. dressing change E3 left and said she was going to get a basin of water to clean R3. After 5 minutes E3 had not returned and surveyor left R1's room. E3 was not seen in the hall. Review of facility policy for isolation for resistant bacteria judged to be of special significance reads handwashing should be done before entering room,after touching infected material and after leaving room. Anyone with the likelihood of soiling clothes should wear a gown. E3 did not wash her hands nor did she wear a gown. Interview with E2 (Director of Nurses) on 2/6/09 at 10:45 am in the Rehabilitation room stated, " Staff should mostly wear gloves when changing dressing. She (R1) has ESBL in her urine and was placed on Levaquin on 2/2/09. There was no soap in the facility yesterday only waterless hand sanitizer."	F 442		

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F 442	Continued From page 18 2) R4 has the diagnoses including Cancer of the Uterus, Dementia, Diabetes Mellitus, Dementia and Psychosis. The Microbiology Report of the urine specimen collected on 1/21/09 documented R2 has ESBL (Extended Spectrum Beta Lactamase) of urine. There was an order in the Physician Order (POS) dated 1/29/09 for antibiotic therapy but there was no documented order found to place the resident in contact isolation. On 2/4/09 at 10:00 AM during the initial tour with E7 (Nurse) R4 was sitting by herself in her room in a reclining chair with a laptop tray screaming. The door had a sign to notify the nurse before entering and a dresser outside the room containing an unopened package of disposable gowns, garbage bags and 3 disposable gloves. E7 stated she thinks the resident had ESBL. On 2/5/09 at 12:10 PM, R4 was observed in her room sitting in a reclining chair. E11 (Rehab Aide) was sitting beside R2 and was feeding the resident. E2 was not wearing disposable gloves or gown. On 2/5/09 at 12:20 PM, E10(CNA) was observed going in R4's room without gown or gloves. On 2/6/09 at 10:45 AM, E2 (Director of Nursing) confirmed there was no physician order found to place resident in contact precaution and should have been obtained. Nurses notes and the Psychotropic Drug Reaction notes (being used by nurses as nurse's notes) from 12/11/08 through end of nursing documentation 1/31/09 had no documentation to indicated that R4 is on contact	F 442		

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F 442	Continued From page 19 isolation. The Interdisciplinary Plan of Care did not address infection control. Review of the facility policy on contact isolation precaution documented, mask should be worn by anyone in close contact with the resident, gown and gloves should be worn with likelihood of soiling or touching infective materials.	F 442		
F 458 SS=B	483.70(d)(1)(ii) RESIDENT ROOMS Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: * Based on observations, measurements and interview, the facility failed to provide the required square footage of 80 square feet (Sq. Ft.) per bed for the multi-bed rooms in 8 of 24 resident rooms. The finding include: 1) In the 2 bed rooms, room 2 and 3 provide 71.5 sq. ft. per bed. In room 4, 72 sq. ft. per bed. In rooms 21 and 28 provide 76 sq. ft per bed. In room 22, provides 70 sq. ft. per bed. 2) In the 4 bed rooms, rooms 24 provides 68.25 sq. ft per bed and room 31 provides 63 sq. ft. per bed. 3)During the environmental tour, residents were asked about the size of their rooms and they stated it was okay but one can always use more space. 4) There were no observations of compromised	F 458		

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F 458	Continued From page 20 care due to space.	F 458		