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	146084	A. BUILDING ______ B. WING ______	01/29/2016

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PLEASANT VIEW REHAB & HCC	500 NORTH JACKSON STREET MORRISON, IL 61270

(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 survey. An extended survey was conducted. An off hours survey was conducted.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F 164		2/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/25/2016

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 164	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure a resident's privacy was maintained during personal care. This applies to 1 resident (R16) in the supplemental sample. The findings include: On January 25, 2016 at 7:25 PM, E8 and E19 CNAs (Certified Nursing Assistant) transferred R16 with a mechanical lift from her wheelchair to the bathroom. E19 removed R16 ' s pants and transferred R16 from the toilet to her bed. E19 left R16's bedside and took the mechanical lift into the hallway, and E8 left R16's bedside to get more linens. R16 was left uncovered from the waist down, and said " brrr, its cold ... I ' m cold, cold; cold ...my toes are terribly cold. " After returning to the room, E19 covered R16, and R16 said she would like covered and " thanks, I was frozen like an icicle. " On January 28, 2016 at 9:05AM, E2 (Director of Nursing - DON) said residents ' should be covered during care, especially if a staff member steps away from the bed. E2 said no one would feel comfortable lying naked without sheets or blankets. At 10:45 AM, E13 and E17 (CNAs) said a resident should be draped or covered during personal care. The 2009 facility Resident ' s Rights for People in Long-term Care Facilities states " Your medical and personal care are private " .	F 164		
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	F 221		2/10/16

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F 221	Continued From page 2 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 ensure a resident ' s lap tray was removed during supper while under the direct supervision of a CNA (Certified Nursing Assistant). This applies to 1 of 3 residents (R1) reviewed for restraints in the sample of 10. The findings include: The January 15, 2016 MDS (Minimum Data Set) shows R1 is cognitively impaired, and requires extensive assistance with transfers, and activities of daily living. R1 ' s January, 2016 POS (Physician Order Sheet) shows an order for " lap tray while up in wheelchair to decrease fall risk " . R1 ' s care plan " Enabler/Physical Restraint " with a start date of July 1, 2014 shows " Remove device during meals when resident is occupied and distracted and visual supervision can be maintained. " On January 25, 2016 at 6:10 PM, R1 was pushed up to the table, in the dining room with a tray across her lap attached to her wheelchair. R1 had her supper in front of her and was running her fingers across her tray. E25 CNA was sitting at the same table, directly across from R1. On January 28, 2016 at 9:05 AM, E2 (Director of Nursing -DON) said R1 ' s lap tray should be removed at meals, and every two hours while she is awake. E2 said if a CNA is at the dining table, and if R1 is under supervision of staff, the lap tray should be off. At 10:45 AM, E13 and E17 (CNAs) said R1's lap tray should be off during meals, and when a CNA is at her table.	F 221		

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F 221	Continued From page 3 The August 18, 2011 facility policy " Physical Restraint/Enabler Policy " states Physical restraints is any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident ' s body, which the individual cannot remove easily and which restricts freedom of movement or normal access to one ' s body. 2. Obtain M.D. order for restraint or adaptive device/enabler. The order must include: specific medical/physical reason, type of restraint/enabler, " release and reposition at least every two hours " and when to be used. 16. Place physical restraint problem on the resident's care plan. The care plan must address the duration, type, and circumstances under which the restraint can be used.	F 221		
F 226 SS=F	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. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to implement and operationalize their abuse policy including timely pre-screening of employees for criminal background checks and obtaining fingerprints for newly hired CNA's (certified nursing assistants). This applies to all 40 residents in the facility.	F 226		2/25/16

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F 226	Continued From page 4 The findings include: On January 27, 2016 at 2:00 PM, the employee background review showed E6 CNA was hired on November 6, 2015 and had no fingerprint background check completed. The record showed the registry check was not performed to check for a fingerprint background check until November 25, 2015 and no fingerprint was initiated as of January 29, 2016. The record for E8 CNA showed a hire date of December 8, 2015 and a fingerprint for background check was not performed until January 5, 2016. The registry check with the fingerprint background check for E8 was printed on January 26, 2016. The record for E12 CNA, documents a hire date of January 8, 2016 and a fingerprint for background check was not done until January 26, 2016. On January 28, 2016 at 7:50 AM, E22 (Business Office Manager) stated she does not have access to the public health portal to run a fingerprint background check. E22 said the office manager at another facility will run the CNA's name through the portal and notify her if the applicant needs to have fingerprints. E22 said if the applicant does have a fingerprint check within the 10 days after hire, they have to be suspended or terminated until the fingerprint is performed. The December 2015 CNA schedule showed E6, E8 and E12 continued to work in December after 10 days when no fingerprint was obtained for a background check. On January 27, 2016 at 2:00 PM the employee records for E7, E9, E10, and E11 (CNA's) document registry checks for the fingerprint background report was not obtained up to 4 days	F 226		

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after hire.

E14 was hired on March 17, 2015 and a fingerprint was obtained on March 26, 2015. The facility did not have a copy of a background check to include results from the fingerprint background check.

The employee record for E15 documents a hire date of April 28, 2015 and check of the registry for a fingerprint background check was done on April 29, 2015. The result of the check shows only a name based check and no fingerprint was on file. No other additional background information was on file. Nursing schedules document E15 had been working since April 28, 2015 without having the fingerprint background check on file.

On January 28, 2016 at 7:50 AM, E22 stated when a person is hired, an employee packet is issued to them including a consent form to perform the background check. E22 said when she has the signed consent she sends the form to another facility and their business office manager will perform the public health portal and send the results to the facility. E22 stated the registry check which were delayed may have been when the other business manager was off or out of the office. E22 said when the other manager is off there is no other means to get the background check.

On January 28, 2016 at 8:15 AM, E1 (Administrator) stated when a CNA is hired, the director of nurses checks the registry to make sure the applicant has a valid CNA certification. E1 said no one in the building has an assigned public health portal access for the background checks and the checks are done at another

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F 226	Continued From page 6 facility. E1 said a fingerprint for a background check should be done within 10 days of hire or they are suspended and have to start over. E1 stated "we do need to get a better system for checking them (fingerprint background checks)." The facility's November 2011 policy for abuse prevention documents prior to a new employee starting a work schedule this facility will: Check the Illinois Health Care Worker Registry on all individuals being hired for a position; and we are required to request a fingerprint based criminal history record check for all non licensed employees.	F 226		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure meaningful activities were provided to a cognitively impaired resident, and failed to ensure a cognitively impaired resident was transported to an activity. This applies to 2 of 10 residents (R2 & R5) reviewed for activities in the sample of ten. The findings include: 1. On January 26, 2016, R2 was observed alone in his room at 9:15 A.M., 9:40 A.M., 10:45 A.M., 1:30 P.M., 2:10 P.M., and 3:00 P.M. without a television or radio on. On January 26, 2016 at	F 248		2/10/16

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F 248	Continued From page 7 7:30 A.M. and 11:00 A.M., R2 was seated in the dining area waiting for the meal to be served. R2 ' s room did not have any books, newspapers, magazines or radio on his side of the room. On January 26, 2016 at 2:00 P.M. there was a live music performance in the activity room and R2 was alone in his room. On January 26, 2016 at 2:15 P.M., E21 (Activity Director) said resident families tell the facility what activities they would like to see the residents active in. E21 said morning activities are geared toward lower functioning residents and afternoons for higher functioning residents. If residents don' t " succeed " in their goal of attending three activities per week they are placed in 1 to 1 activities. On January 27, 2016 at 2:00 P.M., E21 said R2 was involved in " music therapy " on January 26, 2016 at 7:30 A.M. E21 explained that the radio is on while R2 is waiting for his meal and this was his music therapy. On January 27, 2016 at 1:35 P.M., E26 (Certified Nursing Assistant-CNA) said R2 ' s usual routine is to go to breakfast in the morning and then return to his room and sit in the recliner until lunch. He is brought to the dining area for lunch and then lays down for a nap after lunch. On January 28, 2016 at 7:45 A.M.., E1 (Administrator) said it is important to have socialization through activities as it is mentally and emotionally stimulating. If residents are not regularly engaged in activities it may cause isolation, lower cognitive function and an increase in depression. E1 said her expectation is for the activity program to improve and increase resident engagement. E1 said she does not consider being in a room with a radio playing an acceptable music therapy and expects that lower functioning residents are not just invited to activities especially when they are unable to get there on their own or process what	F 248		

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an invitation might imply.
R2 ' s activity care plan shows R2 attends many activity programs. This care plan also shows to provide R2 with a monthly activity calendar and to invite R2 to activities. The care plan also shows to have a radio and television in his room for added stimulation. R2 ' s Minimum Data Set (MDS) dated November 12, 2016 shows it is very important to have books, newspapers and magazines to read and keep up with the news. R2 ' s psychosocial history dated June 20, 2014 shows a history of working as a truck driver and interests in sports, the outdoors and bike riding. R2 ' s Social Service admission assessment dated June 20, 2014 shows leisure time was spent watching television and sports. R2 ' s January 2016 activity participation record shows that he was not involved in any activities regarding the news, television, sports, outdoors or bike riding. The MDS dated November 12, 2015 shows R2 ' s Brief Interview for Mental Status (BIMS) score as 6 which indicates severe impairment in cognition. R2 ' s MDS also shows R2 needs assistance to walk, uses a walker and wheelchair and has a history of falls. The undated facility Activity policy shows they are to provide a program of activities designed to meet (according to the comprehensive assessment) the interests and the physical, mental and psychosocial well being of each resident.

2.
On January 26, 2016, R5 was observed in the dining room waiting for his meal at 7:30 A.M. and 11:30 A.M. On January 26, 2016, R5 was in his room in a chair at 9:15 A.M., 9:40 A.M. and 10:55 A.M. with no television or radio on. On January 26, 2016, R5 was in his room in bed at 1:30 P.M.,

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F 248	Continued From page 9 2:10 P.M. and 3:00 P.M... On January 26, 2016 at 2:15 P.M. E21 (Activity Director) said resident families tell the facility what activities they would like to see the residents active in. E21 said morning activities are geared toward lower functioning residents and afternoons for higher functioning residents. If residents don ' t " succeed " in their goal of attending three activities per week they are placed in 1 to 1 activities. Examples of 1 to 1 activities are " chit chat " ; talking about family and friends or reading books or newspapers to them. . On January 27, 2016 at 1:35 P.M. E26 (Certified Nursing Assistant-CNA) said R5 ' s usual routine is to go to breakfast in the morning and then return to his room and sit in the recliner until lunch. He is brought to the dining area for lunch and then lays down for a nap after lunch. On January 28, 2016 at 7:45 A.M.., E1 (Administrator) said it is important to have socialization through activities as it is mentally and emotionally stimulating. If residents are not regularly engaged in activities it may cause isolation, lower cognitive function and an increase in depression. E1 said her expectation is for the activity program to improve and increase resident engagement. E1 said she does not consider being in a room with a radio playing an acceptable music therapy and expects that lower functioning residents are not just invited to activities especially when they are unable to get there on their own or process what an invitation might imply. R5 ' s Minimum Data Set (MDS) dated December 10, 2015 shows it is very important to R5 to listen to music and is totally dependent on staff to move about the facility. R5 ' s December 10, 2016 Brief Interview for Mental Status (BIMS) score is 5 which indicate severe impairment in cognition. R5 ' s activity care plan shows R5 likes to watch	F 248		

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F 248	Continued From page 10 movies/TV and R5 needs to be brought to activities in the A.M. instead of being put in his chair in his room and to bring R5 to music type activities. R5 ' s activity care plan shows to invite to exercise or active games and his January activity participation record shows he did not participate in or was invited to any. The facility January 2016 activity calendar shows movies as an activity on the 13th, 20th and 27th and the activity participation record shows he did not attend any of these. Music type activities were offered at least 40 times from January 1-27th and R5 ' s participation record shows no 1:1 music activities done.	F 248		
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 assess a resident ' s complaint of pain and failed to implement pain relieving measures for a resident complaining of pain. This applies to 1 of 3 residents (R2) reviewed for pain in the sample of 10. The findings include: On January 25, 2016 at 6:55 P.M., R2 said " ouch " twice during an attempt to transfer R2	F 309		2/10/16

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F 309	Continued From page 11 from the wheelchair to the toilet by E18 CNA (Certified Nursing Assistant). E18 asked R2 if he was having pain and R2 responded " yes " . E18 asked R2 where his pain was and he did not answer. E18 asked R2 if the pain was on his butt he said " yes " . E18 said she would tell the nurse about his pain. R2 said " ouch " again. On January 25, 2016 at 7:20 P.M., R2 yelled " ouch " as E18 and E12 (CNA) continued their attempt to transfer R2 to the toilet and again yelled " ouch " as E12 was washing his buttocks. On January 26, 2016 at 10:35 A.M., E15 (CNA) and E13 (CNA) assisted R2 to stand so E24 (Licensed Practical Nurse-LPN) could assess his bottom. R2 said " ouch, ouch " . E15 said R2 ' s bottom hurts sometimes. On January 26, 2016 at 2:00 P.M., E27 (LPN) said she was never told on January 25, 2016 that R2 was experiencing pain and did not give him anything for pain. R2 ' s MAR (Medication Administration Record) showed R2 did not receive any pain medications January 26th after two CNA ' s and an LPN heard R2 yell ouch twice. E27 said R2 ' s order is for ibuprofen 200mg. and that won ' t do anything so said she would contact the doctor. On January 27, 2016 at 9:55 A.M., E2 (Director of Nursing-DON) said if a resident is saying " ouch " the nurse should be notified of the resident ' s complaint and assess and treat the resident to make them comfortable. E2 said if a nurse is present when a resident yells " ouch " the nurse should assess and treat the pain. E2 said if a resident's pain is not relieved their condition may deteriorate, behaviors may increase and they may refuse care to avoid untreated pain. R2 ' s January 2016 had no record any pain medications had been given to R2 on January 26, 2016. R2 ' s new Norco medication card showed	F 309		

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F 309	Continued From page 12 a dose was administered at 8:30 P.M. on January 26, 2016, over 24 hours after R2 ' s first complaint of pain. Norco is available in the facility ' s convenience box which can be utilized when medicine is not immediately available. R2's BIMS (Brief Interview for Mental Status) shows he has severe impairment in cognition. R2 ' sMDS (Minimum Data Set) dated November 12, 2015 shows R2 had difficulty communicating the presence of pain but was able to give verbal clues such as " ouch " and facial expressions to indicate pain. This Pain Assessment on R2 ' s MDS shows R2 experienced pain 3 to 4 days out of 5. R2 does not have a pain care plan. R2 ' s MDS dated November 12, 2015 shows R2 is always incontinent of bowel, has a history of Crohn ' s Disease and has moisture associated skin damage to his buttocks.The facility ' s June 25, 2014 Pain Prevention and Treatment policy shows the purpose of the policy is to enhance the quality of life by assessing for and reduce the incidence of and the severity of pain. This policy shows assessment of pain will be completed with self reporting of pain or evidence of behavioral cues indicative of the presence of pain.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		2/10/16

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F 315	Continued From page 13	F 315		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to provide catheter care to prevent contamination and infection, and the facility failed to keep a urinary drainage bag off the floor.
This applies to 2 of 3 residents (R5 & R4) reviewed for catheters in the sample of 10.
The findings include:
1. On January 25, 2016 at 9:45 P.M.,E8 (Certified Nursing Assistant-CNA) hung R5 ' s urinary drainage bag from side of bed and looped the tubing around the side rail causing the uncovered tip to rest against the wall. E8 then washed R5 ' s groin first (dirty) and then the catheter at the urethral opening (clean) without changing gloves. E8 unplugged the urinary leg bag from the catheter and plugged the urinary drainage bag tip (which was resting against the wall) into the catheter tubing all without changing the gloves worn during the care of the groin and catheter.
On January 28, 2016 at 9:55 A.M., E2 (Director of Nursing-DON) said staff should use separate washcloths for cleaning the groin and providing catheter care. Proper catheter care would include washing from a clean area to a dirty area and the catheter bag tips should not come in contact with any surfaces to prevent contamination and infection.
R5 ' s progress note from a local medical clinic shows a history of recurrent UTI ' s (urinary tract infections) with an indwelling foley catheter. The facility ' s December 8, 2010 Catheter Care Policy shows to wash the catheter tubing from the opening of the urethra outward four inches or farther if needed and to remove gloves and wash

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F 315	Continued From page 14 hands when done. R5 ' s October 11, 2015 physician order sheet shows an order for an antibiotic to treat a UTI. R5 ' s urine culture results show greater than 100,000 colonies of Escherichia coli and greater than 100,000 colonies of proteus mirabilis growing in the urine specimen. 2. On January 25, 2016 at 9:35 PM, R4 was in bed sleeping and her urinary drainage bag and tubing were lying directly on the floor. At 9:40 PM, E27 (Licensed Practical Nurse - LPN) said it should not be touching the floor. E27 looked at the bed and said there was no hanger for the bag and placed the bag face down back on the floor. At 9:42, E12 CNA picked the bag up off the floor and attached it to a piece of metal on the bed frame. The bottom of the urinary drainage bag and tubing were resting directly on the floor. At 9:50 PM, E27 said the Director of Nursing told her to put a privacy cover on the urinary drainage bag. On January 28, 2016 at 9:05 AM, E2 (Director of Nursing- DON) said a urinary drainage bag should have a privacy cover over it, and drainage bag and tubing should not directly touch the floor to maintain infection control. At 10:45 AM, E13 (CNA) said if a urinary drainage bag cannot hang from a bed frame, the bag should have a cover on it, and should be placed in a basin on the floor to keep it from touching the floor. The January 01, 2002 facility " Urinary Drainage Collection Unit " shows " Hang the urinary drainage unit below the bladder level, not touching the floor. "	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		2/10/16

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F 323	Continued From page 15 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: The facility failed to ensure safety interventions were implemented to prevent resident injury, failed to ensure a lap tray was in place and secured to prevent a resident from falling, and failed to ensure a resident's safety alarm was engaged. This applies to 2 of 10 resident (R1, R5) reviewed for safety in the sample of 10. The findings include: 1. The January 15, 2016 MDS (Minimum Data Set) shows R1 is cognitively impaired, and requires extensive assistance with transfers, and activities of daily living. The MDS shows R1 ' s balance is unsteady, and R1 wanders throughout the facility and is at significant risk of getting to a potentially dangerous place. R1's fall assessment dated January 24, 2016 shows R1 is at a high risk for falls. R1's January, 2016 Physician Order Sheet (POS) shows diagnoses to include a history of falls, and an order for " lap tray while up in wheelchair to decrease fall risk " . R1's care plan dated October 5, 2015 shows " has a history of wandering throughout the facility due to medical diagnoses of dementia " and " will wander safely within environment with no falls. " R1's fall care plan has an intervention dated November 17, 2015 " to have tray attached to	F 323		

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F 323	Continued From page 16 wheelchair for safety related to resident ' s previous history of falls, due to lack of safety awareness and advanced Alzheimer ' s. " R1's Fragile Skin care plan shows and intervention dated November 11, 2015 to ensure protective sleeves are on daily. On January 27, 2015 at 8:50 AM, E11 and E17 (CNAs) transferred R1 from her wheelchair to her bed with a mechanical lift. E11 and E17 removed R1's pants, and R1 had a large brown/orange/yellow bruise to her right thigh. The bruise was approximately 2 inches above her knee, and extending just below her groin. R1 also had multiple bruises to her right hand, and both arms. R1 did not have protective sleeves on. E11 said she has seen R1 with sleeves on before but she did not have them on now, and E17 looked for the sleeves and found them in R1's drawer. At 12:10 PM, R1 was sitting in the dining room without protective sleeves to her arms and hands, and at 12:45 PM, R1 was sitting outside the north hall nurse station in a wheelchair with a lap tray extending across her lap, unattended by staff, without protective sleeves on. On January 28, 2016 at 8:15 AM, R1 was in a wheelchair with a lap tray across the top. R1 was using the hands rails to propel herself down the hallway. R1's nurse notes show R1 slid out of a chair on May 9, 2015, and had " fallen backwards " in her wheelchair on June 28, 2015. R1's nurse notes dated January 24, 2016 shows R1 fell and " resident had taken/pushed tray from wheelchair " four times and " resident pushed tray off and leaned forward causing her to fall to her knees. " The January 25, 2016 nurse notes show the pins that were needed to lock R1's wheelchair in place were missing on January 24, 2016. R1's nurse	F 323		

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notes from March, 2015 through January 26, 2016 show R1 had multiple bruises to her upper and lower extremities, and face, and scratches/skin tears to her upper and lower extremities.
On January 28, 2015 at 9:05 AM, E2 (Director of Nursing -DON) said R1's lap tray is used to prevent her from falling, and should be put on correctly, with two pins to secure the tray in place. E2 said R1's pins were missing, and R1 should have been supervised within reach, while up in her wheelchair until the pins were found. E2 said R1 has bruises to her arms and hands and some of the bruises were caused because the height of her dining table was too high, and when the staff pushed her up to the table, the table hit her hands. E2 said R1 is supposed to have protective sleeves to her arms and hands when she is up to protect her arms and hands from injury. E2 said R1 will pull at the sleeves sometimes, but cannot get both sleeves off.
On January 28, 2015 at 10:45 AM, E13 (CNA) said R1 should have protective sleeves on all day except when she is in bed.
The September, 2015 facility " Fall Prevention " program states " to provide for resident safety and to minimize injuries related to falls; decrease falls ... "
" All staff must observe residents for safety. "
2. On January 25, 2016 at 6:55 P.M., E18 CNA was transferring R2 from the wheelchair to the toilet and noticed that the seat belt alarm was not properly engaged to alert staff if R2 attempted to get up without assistance. E18 said she just got to work at 6:00 P.M. and is not sure who did not correctly apply the device to R2.
On January 28, 2016 at 7:45 A.M. E1 (Administrator) said she expects staff to make sure residents are safe and the CNA ' s and

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F 323	Continued From page 18 nurses are responsible to ensure resident safety equipment is properly implemented. E1 said residents can fall and be injured if fall prevention intervention equipment is not used properly. R2 ' s January 13, 2016 Fall Risk Assessment score is 29 which indicates a high risk for falls. R2 ' s undated face sheet shows a diagnosis history of traumatic brain injury, seizures, cerebral hemorrhage. R2 ' s June 20, 2014 Social Service Admission Assessment shows R2 wears a helmet to protect his head due to a seizure disorder. R2 ' s nurse ' s notes show falls on December 25, 2015, January 4, 13th, and 25th, 2016. R2 ' s January 10, 2016 nurses note shows R2 attempted to stand and self-transfer without assistance six times. R2 ' s January 21, 2016 nurses note shows R2 attempted to get up twice without help. R2 ' s fall care plan starting December 8, 2015 shows to use a self releasing seat belt for the wheelchair to alert staff and reduce risk of falls and injury and to educate staff to check alarms before leaving patient and make sure it is on.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to administer medications without a timing or administration error. There were 40 opportunities with 6 errors	F 332		2/10/16

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F 332	Continued From page 19 resulting in a 15% error rate. This applies to 2 of 6 residents observed in the medication pass. The findings include: On January 27, 2016 at 7:50 AM, E24 LPN (Licensed Practical Nurse) was preparing medications for R2. E24 placed three Depakote ER 500mg (Extended Release seizure medication), Trileptal 300mg tablet (seizure medication) into a cup and crushed the medication and mixed it with pudding. E24 then opened Omeprazole DR (Delayed Release for gastric reflux) 20 mg capsule, opened Zonisamide 100mg (seizure medication) three capsules, and opened Pentasa CR (Controlled Release Crohns disease) 500mg four capsules. E24 mixed all of the crushed and opened medications with pudding and administered to R2 while he was eating breakfast. On January 27, 2016 at 8:05 AM, E24 administered famotidine 20mg tablet, for gastric reflux disease, to R15 while he was eating breakfast. On January 27, 2016 at 2:20 PM, E23 stated extended release, controlled release and delayed release medications should not be crushed. E23 stated if a resident is unable to swallow the medication a new order can be obtained from the physician to something that can be crushed or have in liquid form. E23 stated famotidine (pepcid) and Omeprazole (prilocec) should be given on an empty stomach or at bedtime. E23 stated these medications should not be given with food.	F 332		

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F 332	Continued From page 20 E23 shows R2's medication administration record has the omerprazole order to be given before breakfast. E23 stated R2 takes his medications whole with a cup of water and at no time should his medications need to be crushed. The facility's October 2006 policy for crushing medication shows only those medication which can be crushed are, and only with a physician's order.	F 332		
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, interview, and record review the facility failed to ensure a pan of ham and beans were cooled to prevent food borne illness. This applies to all 40 residents reviewed for food safety. The findings include: The Resident Census and Conditions of Residents federal form dated January 25, 2016 shows there are 40 residents that reside in the facility. On January 25, 2016 at 6:15 PM, E28 cook, took	F 371		2/10/16

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a pan of ham and beans off the serving line and dumped the content into a rectangular, deep sided container and placed it into the refrigerator. On January 25, 2016 at 6:20 PM, E28 said, the ham and beans don ' t need to be tracked for cooling temperature (temps), because tracking was just for leftover meat, plus " no dietary staff is here at night " .

On January 26, 2016 at 9:00 AM the container of ham and beans was in the refrigerator with no temperature sticker on it. E5 Dietary Manager said, there was no temp log on the ham and beans because she didn ' t think foods like that needed to be tracked for cooling.

On January 26, 2016 at 9:00 AM, guidance in the form of a piece of paper, attached to the refrigerator door, with the heading of " Cooling requirements for all Potentially hazardous Foods. " The guidance included; food should be cooled within two hours from 140 degrees Fahrenheit (F) to 70 degrees F, within four hours from 70 degrees F to 41 degrees F,

- Cool in pans less than 4 " deep (preferably 2 " deep).
- Cut large items, such as roasts, into quarters or smaller in needed.
- Do not cover tightly, to allow heat to escape.
- Label date and time prepared.
- Document time and temperature at 2 and 4 hour intervals.
- If time/temperature ranges are not met, you may reheat 1 time and try cooling by a different method or discard product.

The April 2012 policy for Hazard Analysis Critical Control Point, shows, 9. Rapidly cool all cooked foods to an internal temperature of 70 degrees Fahrenheit or below within two (2) hours and 41 degrees Fahrenheit or below within four (4) hours. Label all cooling foods with appropriate log

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F 371	Continued From page 22 record to track cooling procedure.	F 371		
F 431 SS=C	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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		2/10/16

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F 431	Continued From page 23 This REQUIREMENT is not met as evidenced by: The facility failed to ensure medications were dated after opening. This applies to all 40 residents in the facility. The findings include: The Resident Census and Conditions of Residents federal form dated January 25, 2016 shows there are 40 residents that reside in the facility. On January 27, 2016 at 1:30 PM, E24 LPN (Licensed Practical Nurse) unlocked the medication cart on the north hallway. An open bottle of Tussin cough syrup, antacid tablets, Geri-lanta , anti-diarrheal pills, and Melatonin were inside the cart without a date the bottles were opened. The medication refrigerator had an open bottle of lorazepam mg/ml concentrated drops that did not have a date of when it was opened. E24 said all open medications should be dated when they are opened, and all the medications except the lorazepam were floor stock medications that were used for any resident who had an order for the medication. On January 28, 2015 at 8:50 AM the south hall medication cart had an opened bottle of Banophen antihistamine, milk of magnesia, and calcium antacid tablets. Each bottle did not have a date to identify when it was opened. The medication refrigerator had 2 bottles of lorazepam concentrated drops and a bottle of Haldol concentrated drops. Each bottle did not have a date to identify when it was opened. E29 (LPN) said the banophen, milk of magnesia, and calcium antacids were floor stock, and used for all residents who had an order for them. E29 said the medications should be dated when opened. On January 28, 2015 at 10:50 AM, E2 (Director of Nursing - DON) said all opened medications	F 431		

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F 431	Continued From page 24 should be dated when they are opened. The October, 2006 facility policy " Procurement and Storage of Medications " policy states " all medication containers shall be labeled with the date opened by the person breaking the container seal. "	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441		2/10/16

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F 441	Continued From page 25 (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 infection control guidelines were followed for a resident on isolation precautions, failed to change gloves after touching soiled incontinent briefs before handling a clean cloth to wash a resident ' s face and failed to wash a resident's hands after having a bowel movement. This applies to 3 residents (R15, R16 & R17) in the supplemental sample. The findings include: 1. On January 25, 2016 at 8:15 P.M., E12 touched the total lift and bedrails with ungloved hands and left R17 ' s room without washing her hands. On January 25, 2016 at 8:30 P.M., E8 pulled R17 ' s dressing back (area of potential infection) using the same gloved hands and touched bed linens and the total mechanical lift. On January 25, 2016 at 6:40 P.M., E29 (Licensed Practical Nurse-LPN) said we don ' t know why she is on isolation, R17 has something on her back and the cultures have been negative. On January 25, 2016 at 8:10 P.M., E8 (Certified Nursing Assistant-CNA) said she does not know what kind of isolation R17 is on. (The top of the isolation cart says Contact Isolation). On January 25, 2016 at 8:15 P.M., E12 (CNA) said word is R17 has shingles and we don ' t have any masks. On January 27, 2016 at 9:55 A.M., E2 (Director of	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146084	A. BUILDING ______ B. WING ______	01/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 26 Nursing-DON) said when a resident is on contact isolation (or standard precautions) and the staff touches potentially infectious material, gloves should be worn and removed and hands should be washed before touching any other surfaces. If this procedure is not followed the spread of infection and cross contamination would be possible. R17 ' s Minimum Data Set (MDS) dated January 8, 2016 shows R17 is totally dependent on staff for mobility, hygiene and all ADL's (activities of daily living). The facility May 2007 Infection Control Policy shows the facility will monitor for compliance with work practices. The facility December 2009 Contact Precautions policy shows to use contact precautions for residents suspected to be infected with microorganisms that can be transmitted by direct contact with the resident or indirect contact (touching with environmental surfaces or resident care items in the resident environment). The policy also shows to change gloves after having contact with infective material that may contain high concentrations of microorganisms. The facility ' s December 2008 Hand washing Policy shows all staff will wash hands after resident contact and after contact with body fluids, secretions, excretions, and equipment or articles contaminated by them. 2. On January 25, 2016 at 9:20 P.M., E18 (CNA) removed a soiled incontinent brief from R15 and tossed it in the garbage. With the same gloved hands, E18 removed R15 ' s clothing and put on a gown. E18 then (without changing gloves) filled a basin with water, placed wash cloths in the water and handed R15 a wet wash cloth to wash his face. E18 changed her gloves, performed perineal/incontinent care for R15 then (without	F 441		

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F 441	Continued From page 27 removing gloves) touched a wheelchair. On January 25, 2016 at 9:20 P.M., E 18 said yes R15 ' s incontinent brief was wet when it was removed. On January 27, 2016 at 9:55 A.M., E2 (Director of Nursing-DON) said when a resident is on contact isolation (or standard precautions) and the staff touches potentially infectious material, gloves should be worn and removed and hands should be washed before touching any other surfaces. If this procedure is not followed the spread of infection and cross contamination would be possible. R15 ' s undated face sheet shows current diagnosis are: dementia, urinary incontinence and anxiety. R15 ' s MDS (Minimum Data Set) dated December 3, 2015 shows a BIMS (Brief Interview for Mental Status) which indicates moderate cognitive impairment. The MDS shows R15 requires extensive assistance with bathing, bed mobility and is totally dependent on staff to use the toilet. 3. On January 25, 2016 at 7:25 PM, E8 and E1 CNAs (Certified Nursing Assistant) transferred R16 with a mechanical lift from her wheelchair to the bathroom. E8 and E19 entered the bathroom and R16 was wiping her bottom with toilet paper after having a bowel movement. E8 and E19 removed R16's pants and transferred R16 from the toilet to her bed. E8 and E19 undressed R16, and provided peri-care. E8 and E19 did not offer for R16 to wash her hands, and did not assist R16 with washing her hands after she used the toilet. On January 28, 2016 at 9:05 AM, E2 (Director of Nursing-DON) said residents ' hands should be washed after toileting and should be washed with soap and water if the resident had a bowel movement	F 441		