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F 000	INITIAL COMMENTS Annual Licensure and Certification Complaint Investigation # 1415427/ IL 73508 - no citations	F 000		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow its Oxygen Therapy Policy by permitting a Certified Nursing Assistant to turn off and on an oxygen concentrator and remove and replace a nasal cannula. This applies to 1 resident (R20) reviewed for oxygen administration in the supplemental sample. The findings include: On 12/4/14 at 3:25 PM, E3 (Registered Nurse-RN) states, " Dr. Chamberlain ' s written order dated 10/9/14 reads: Oxygen 2L per nasal cannula as needed to keep oxygen saturations greater than 90%. Diagnosis of Congestive Heart Failure. " On 12/1/14 at 2:20 PM, E5 (Certified Nursing Assistant-CNA) turned off R20 ' s oxygen concentrator and removed her nasal cannula from her nose to transfer her to the bathroom. After transferring R20 back to her bed, E5 placed the nasal cannula back into R20 ' s nose and	F 282		

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

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F 282	Continued From page 1 turned the oxygen concentrator back on. On 12/2/14 at 3:45 PM, E1 (Administrator) stated, " The CNAs should not be turning the resident ' s oxygen on and off. " On 12/3/14 at 11:10 AM, E2 (Director of Nursing-DON) stated, " The CNAs have to call the nurse to move the concentrator and should not be turning on or off the resident ' s oxygen. " On 12/3/14 at 11:45 AM, E9 (Licensed Practical Nurse-LPN) stated, " The CNAs are not supposed to do anything dealing with oxygen. " The facility ' s Oxygen Therapy Policy revised on 08/03 states, " Oxygen therapy-responsibility: Licensed nursing personnel. "	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide personal care by not keeping a resident dry and not providing peri care to prevent skin excoriation. This applies to 1 resident (R15) reviewed for incontinence in the supplemental sample. The findings include: On 12/2/14 at 8:50 AM, R15 was in bed saturated with urine and loose watery stools. R15 ' s buttocks and peri area were a bright fiery red. Eighty percent of R15 ' s buttocks were fiery red. While E7 (Certified Nursing Assistant-CNA) and	F 312		

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F 312	Continued From page 2 E6 (CNA) were wiping R15 ' s buttocks and peri area, R15 was saying, " Ouch. " E6 left R15 ' s room to obtain a moisture barrier cream from facility stock. On 12/2/14 at 9:00 am, E7 stated, " R15 has had loose stools for a while. " On 12/2/14 at 9:10 AM, E13 (Licensed Practical Nurse-LPN) stated, " I don ' t know what her order calls for, for her excoriated buttocks. Do moisture barrier for now, we don ' t have an order for Calmoseptine Cream if that ' s what you think she should have. " On 12/3/14 at 11:10 AM, E2 (Director of Nursing-DON) stated, " I am not sure how long R15 ' s peri area has been excoriated. " On 12/3/14 at 12:00 PM, E9 (LPN) stated, " We document abnormal skin findings on the back of the resident ' s treatment record. " On the Physician Order Sheet dated 12/2/14 without a time stated, " Ok to use moisture barrier cream to peri area per protocol. " R15 ' s care plan dated 11/25/14 stated, " Needing increased assistance to reposition every two hours also with increased incontinence needs to be changed with barrier cream applied. " The facility ' s Shower/Abnormal Skin Report dated 12/1/14 stated, " Findings: Patient ' s peri area front and back fire red. " The facility ' s Treatment Record dated 11/01/14-11/30/14 and 12/01/14-12/31/14 stated, " Weekly skin checks. " No abnormalities were documented on the back for R15 ' s buttocks and peri area. The facility ' s Preventative Skin Care policy revised 10/06 stated, " Policy: To provide preventative skin care through repositioning and careful washing, rinsing, drying, and observation of the resident ' s skin condition to keep them clean, comfortable, well groomed, and free from	F 312		

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F 312	Continued From page 3 pressure ulcers. Procedures: Keep incontinent residents clean and dry. " The facility ' s Braden Scale for R15 dated 10/15/14 identified the resident at high risk for pressure ulcers.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on Observation, Interview and Record Review the facility failed to assess, monitor and implement pressure relieving methods to prevent the development of a new pressure ulcer for R9. This failure resulted in R9 developing a suspected deep tissue injury to his left heel. This applies to 1 of 3 residents (R9) reviewed for pressure ulcers in the sample of 13. The findings include: On 12/3/14 at 2:09pm, E9 (Licensed Practical Nurse - LPN) removed the dressing with serousanguinous drainage on it from R9's left heel. R9 had a large open area to the left inner heel with slough present. The surrounding tissue	F 314		

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F 314	Continued From page 4	F 314		

on R9's heel was reddened. E13 (Registered Nurse - RN) stated, "It is unstageable because there is slough and you can't tell what is under it."

The Nurses Notes for R9 showed, "10/13/14 at 2:15am - Called to resident room by staff. Large flap of soft skin hanging loose from the left heel. Large amount of serousanguinous drainage noted. Skin approximated and steri strips applied. The area was cleansed with normal saline. A non-adherent pad was applied. Dry gauze was applied and wrapped with gauze; 10/14/14 - R9 resting quietly with dressing to left foot due to a large amount of drainage; 10/15/14 at 7:00am - Skin to R9's left heel was peeled back, moderate serousanguinous drainage present to dressing and sheets; 10/15/14 at 1:00pm - Spoke with physician, ordered a hydrogel dressing to left heel and referred R9 to the wound clinic."

On 12/3/14 at 2:09pm, E13 stated, "I removed the steristrips from R9's heel and did the dressing the doctor ordered. There were a couple of black areas to his heel."

The facility's Weekly Wound Tracking for R9 showed, "Area - Left heel; Date assessed - 10/13/14; Type - pressure; Length x Width - 10.5cm x 9.4cm; Depth - unable to determine." The facility's Weekly Wound Tracking for R9's left heel dated 10/13/14 did not show any staging of the wound.

The Physician's Progress Note for R9 showed, "10/13/14 - Open wound to the left heel due to a blister that broke. R9 is at risk for a deep tissue injury. Keep pressure off the left heel at all times. Pressure relieving boot to left foot if needed to keep pressure off of it. Wound care per wound

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F 314	Continued From page 5 care team; 10/20/14 - Open wound to left heel with probable necrotic areas due to a blister that broke. Suspect deep tissue injury. Nurse practitioner ordered an off loading boot on 10/19/14. R9 has a wound clinic appointment on 10/22/14 per staff." On 12/3/14 at 11:20am, E2 (Director of Nursing - DON) stated, "I guess I am over the wound care program. The nurses on the floor do the treatments and a weekly measurement. The Certified Nursing Assistant (CNA) tells the nurse about any skin problem. The nurse does an assessment and measurement. The Admission Assessment dated 10/7/14 for R9 doesn't have it documented that he came in with the pressure ulcer, it happened here." The facility's Decubitus Care/Pressure Areas policy (5/07) showed, "To ensure a proper treatment program has been instituted and is being closely monitored to promote the healing of any pressure ulcer, once identified. Complete all areas of the treatment administration record. Document size, stage, site, depth, drainage, color, odor and treatment. Document the stages of the pressure ulcer as follows: Suspected deep tissue injury: purple or maroon localized area of discolored intact skin or blood filled blister due to damage of underlying soft tissue from pressure and/or shear."	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough	F 322		

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F 322	Continued From page 6 alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to check placement on a Percutaneous Endoscopic Gastrostomy tube (PEG) per facility procedure prior to administering medications and a bolus feed. This applies to 1 of 1 residents (R12) reviewed for tube feeding in the sample of 13. The findings include: R12's November, 2014 Physician Order Sheet shows an order for tube feeding bolus of Nutren 2.0 250 ml scheduled at 8, 12, 5, and bedtime. R12's diagnoses include Dysphasia and Anorexia. On 12/3/14 at 11:25 AM, E9 (Licensed Practical Nurse-LPN) checked R12 for residual and did not get any. E9 did not instill air into the PEG tube and then administered medications and a bolus feeding to R12. On 12/3/14 at 2:25 PM, E15 (Registered	F 322		

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F 322	Continued From page 7 Nurse-RN) stated, " I only check placement by aspirating, we don ' t really instill air anymore. " The facility ' s Administration of Medication Via a Feeding Tube policy revised 1/8/14 states, " Check for tube placement by checking for residual if no residual is aspirated, verify tube placement by placing a stethoscope over the stomach and instilling approximately 30cc of air. Listen for air instillation, proceed if heard. " The facility ' s Enteral Tube Feeding Bolus Procedure policy dated 4/07 states, " Check for residual gastric content by aspirating stomach secretions and measuring the amount of fluid. If unable to aspirate stomach contents, place stethoscope on stomach, insert approximately 30cc of air. Listen for air instillation, proceed if audible. "	F 322		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on Interview and Record Review the facility failed to ensure R7 was given the correct dose of sliding scale insulin from 5/1/2014 through 12/1/2014. This applies to 1 of 1 residents (R7) reviewed for insulin in the sample of 13. The findings include: The Medication Administration Record for R7 dated 9/1/14 through 9/30/14 showed he has	F 333		

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F 333	Continued From page 8	F 333		

regular insulin ordered per sliding scale and was given 4 units of insulin instead of the ordered 6 units 5 times at 6:00am; 12 times at 11:30am; once at 5:30pm and 3 times at 8:00pm.

The Medication Administration Record for R7 dated 10/1/14 through 10/31/14 showed he has regular insulin ordered per sliding scale and was given 4 units of insulin instead of the ordered 6 units 5 times at 6:00am; 8 times at 11:30am; 4 times at 5:30pm and 5 times at 8:00pm.

The Medication Administration Record for R7 dated 11/1/14 through 11/30/14 showed he has regular insulin ordered per sliding scale and was given 4 units of insulin instead of the ordered 6 units 6 times at 6:00am; 7 times at 11:30am; 5 times at 5:30pm and twice at 8:00pm.

The Laboratory Report dated 11/21/14 for R7 showed his hemoglobin A1c was high at 8.7 (normal range is 4.6 - 6.2) and stated, "A1c levels of less than 7.0 percent indicates good diabetes control as recommended by the American Diabetes Association."

On 12/1/14 at 3:05pm, E2 (Director of Nursing - DON) reviewed R7's Physician Order Sheet (POS) dated 12/1/14 and stated, "This says R7 is getting sliding scale insulin for these ranges, a blood sugar of 150 - 249 is 4 units and 200 - 249 is 6 units. These sliding scales overlap. This must be an error. I think it should be 150 - 199 and 200 - 249."

On 12/1/14 at 3:39pm. E2 stated, "The April 2014 POS for R7 was still correct (for the sliding scale ranges) 150 - 199 is 4 units and 200 - 249 is 6 units. In May 2014 the POS changed and it was

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F 333	Continued From page 9 150 - 249 is 4 units and 200 - 249 is 6 units and that is incorrect." E2 stated R7's POS has had incorrect parameters for sliding scale insulin for 7 months (May 2014 to December 2014). The facility's Medication Administration policy (dated 7/3/13) showed, "Medications must be identified by using the six (6) rights of administration: Right resident, right drug, right dose, right time, right route and right documentation."	F 333		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by:	F 425		

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F 425	Continued From page 10 Based on Interview and Record Review the facility failed to provide services that ensured the accuracy of reconciliation and administration of sliding scale insulin. This applies to 1 of 1 residents reviewed (R7) for sliding scale insulin in the sample of 13. The findings include: A note from E2 (Director of Nursing - DON) dated 12/1/14 showed, "It was brought to my attention that the sliding scale for R7 was incorrectly changed on the Physician Order Sheet (POS) and Medication Administration Record (MAR). In April 2014 it was correct at 150 - 199 = 4 units, 200-249 = 6 units, 250 - 299 = 8 units, 300 - 349 = 10 units and greater than 350 call the physician. On the May 2014 POS/MAR for R7 it was wrong and there were no orders to change the sliding scale. I called our pharmacist, Z1, and he was not sure how come it was changed like that." On 12/2/14 at 10:15am, E1 (Administrator) stated, "E2 checks the POS' every month and the physicians sign them. I am not sure if pharmacy checks every POS each month. We contacted our pharmacist, Z1, yesterday and he doesn't know what happened,. The nurses should be checking the POS' and MARs." The Medication Administration Record for R7 dated 9/1/14 through 12/1/14 showed he has regular insulin ordered per sliding scale and was given 4 units of insulin instead of the ordered 6 units 16 times at 6:00am; 27 times at 11:30am; 10 times at 5:30pm and 10 times at 8:00pm. The facility's Medication Administration policy	F 425		

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F 425	Continued From page 11 (7/3/13) showed, "Drug administration shall be defined as an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from previously dispensed, properly labeled container, verifying it with physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given."	F 425		
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 12 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 prevent cross contamination by not washing hands/changing gloves when going from dirty to clean surfaces and the facility failed to clean soiled surfaces. This applies to 3 of 12 residents (R4, R11, R12) reviewed for infection control in the sample of 13 and 3 residents (R15, R21, R20) in the supplemental sample. The findings include: 1. On 12/1/14 at 2:20 pm, E5 (Certified Nursing Assistant-CNA) transferred R20 from the bed to the bathroom. E5 removed R20 ' s incontinence brief that was saturated with urine and wet clean wash cloths then placed them in the sink to shut of the call light all without changing gloves or washing hands. E5 provided peri care while R20 was sitting on the toilet and then placed the wash cloths in the sink, placed new incontinence brief and slacks around R20 ' s lower legs and stood R20 up. E5 used one cloth to remove stool and a second one for peri care without changing gloves or washing hands. E5 pulled R20 ' s incontinence brief and slacks up and transferred her back into	F 441		

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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 441	Continued From page 13	F 441		

bed. E5 placed clean linens over R20 and replaced oxygen nasal cannula to R20 ' s nose still wearing the same gloves.
2. On 12/1/14 at 10:25 AM, E4 (CNA), wearing gloves, transferred R21 from the bed to the bathroom. R21 ' s bed pad, gown, t shirt, and socks were saturated with urine. E4 removed R21 ' s gown, t shirt, and socks and placed them in a plastic bag. E4 handed R21 a wet wash cloth to wash her face and E4 washed R21 ' s back with a wet wash cloth. E4 placed a new t shirt on R21 and placed stocking hose without washing R21 ' s feet. E4 put an incontinence brief and shoes on R21 and tied them without changing her gloves or washing her hands. E4 provided peri care with the same two wet washcloths and put a clean incontinence brief then a pair of dry underwear on top up.
3. On 12/2/14 at 8:50 AM, E7 (Certified Nursing Assistant-CNA) provided peri care to R15 after being incontinent of liquid stool and urine. E7 removed pads saturated with urine and stool and placed new pads underneath R15 and did not change gloves or wash her hands. E6 (CNA) provided peri care to the front of R15 which had liquid stool residue and then pulled the clean pad in between R20 ' s legs. E7 did not wash her hands or change her gloves.
4. On 12/3/14 at 11:25 AM E9 (Licensed Practical Nurse-LPN) administered medications and a bolus feeding to R12 and did not wear gloves.
On 12/3/14 at 11:10 AM, E2 (Director of Nursing-DON) stated, " The CNAs should wash their hands before care, between gloves changes, and after care. Or when they come in to contact with soiled items.
On 12/3/14 at 11:45 AM, E9 stated, " We should wash our hands before and after cares, in between glove changes, and after handling soiled

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145727	A. BUILDING _____ B. WING _____	12/04/2014

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F 441	Continued From page 14 items. " On 12/2/14 at 12:50 PM, E12 (CNA) stated, " I wash my hands before and after cares. I also wash my hands and put new gloves on before and after clean a resident after a bowel movement. I wash my hands and put new gloves on before I put barrier cream on. " On 12/3/14 at 2:25 PM, E14 (RN) stated, " We wear gloves when giving medications or feeding through a PEG tube. The facility ' s policy on Handwashing revised 12/08 states, " All staff will wash hands after resident contact and after contact with blood, body fluids, secretions, excretions, and equipment or articles contaminated by them. " The facility ' s policy on Standard Precautions revised 12/09 states, " Wash hands after touching blood, body fluids, secretions, excretions, and contaminated items. Wash hands immediately after gloves are removed between resident contacts. It may be necessary to wash hands between tasks and procedures on the same resident to prevent cross contamination of different body sites. Put on clean gloves just before touching mucous membranes and non intact skin. Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after use, before touching noncontaminated item and environmental surfaces. 5. On 12/1/14 at 1:36 PM, E4 and E6 (both Certified Nursing Assistant-CNA) assisted R4 from the wheelchair to the bedside commode using a mechanical stand lift. R4 stood upright and started to urinate. The urine landed on her wheelchair cushion pad. E8 wiped the urine using a dry paper towel. E8 stated, " I suppose we don	F 441		

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F 441	Continued From page 15 ' t have any wipes. " R4 was placed back on the same wheelchair cushion pad. 6. On 12/2/14 at 11:30 AM, E7 and E8 (both Certified Nursing Assistant-CNA) were providing incontinence care for R11. A soiled washcloth with stool was on the floor. E8 picked up the soiled washcloth with a trash bag. Stool was observed on the floor after the washcloth was picked up. E8 did not clean the floor with disinfectant or notify housekeeping to clean the floor. On 12/3/14 at 10:15 AM, E7 stated, " Dirty washcloths go in a linen bag. E7 put the dirty washcloth on the floor, I ' m not gonna lie. " The facility ' s Standard Precautions Policy dated December 2009 states, " Environmental Control: Ensure that the facility has adequate procedures for the routine cleaning and disinfection of environmental surfaces..bedside equipment..and ensure these procedures are being followed. "	F 441		