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F 000	INITIAL COMMENTS	F 000		
F 221 SS=D	Annual Licensure and Certification Survey 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 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 release/remove a laptop cushion (lap buddy) restraint as ordered by the physician. This applies to 1 of 1 residents (R4) reviewed for restraints in the sample of 15. The findings include: R4's Physician Order Sheet for April 2016 shows lap buddy when up in the wheel chair, release every two hours and check every 30 minutes. R4's physician telephone orders dated May 6, 2015 shows lap buddy when up in wheel chair as needed, release at least every two hours and at meals/activities. On May 3, 2016 at 11:30 AM, R4 was sitting in front of the lunch table with her lunch tray on the table. Her lap buddy was on. On May 5, 2016 at 10:20 AM, R4 was sitting in the activity kitchen during an activity. R4 had her lap buddy on.	F 221		

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

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F 221	Continued From page 1 On May 6, 2016 at 8:25 AM, R4 was sitting in the dining room for breakfast and had her lap buddy on. On May 6, 2016 at 8:40 AM, E15 Certified Nursing Assistant (CNA) stated, "R4's lap buddy gets removed when we take her to the bathroom or lie her down in bed." 9:05 AM E16 Licensed Practical Nurse (LPN) stated, "R4's lap buddy gets removed at meal times." 9:35 AM E2 Administrator stated, "R4's lap buddy is removed during meal times, during activities, and if she is with a staff member one on one." There was no documentation on the facility's restraint release form for R4 for May 3, 2016 shift 11 PM-7 AM and shift 3 PM-11 PM, May 4-all shifts, May 5 11 PM-7 AM and 3 PM-11 PM, and May 6, 2016-all shifts. There were no documented behaviors for R4 on the facility's behavior tracking sheet for May 2016. R4's Care Plan dated March 15, 2016 shows release lap buddy at every opportunity such as meals, activities, and one on one time. Document the amount of time restraint is released every shift. The facility's Physical Device Assessment dated May 6, 2015 states the lap buddy will be removed for meals and activities, resident is unable to remove the device upon command, and this restraint restricts the residents movement or access to body. R4 Minimum Data Set (MDS) dated March 8, 2016 states R4 uses a physical trunk restraint.	F 221		

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F 314 F 314 SS=G	Continued From page 2 483.25(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 implement planned interventions for a resident with known pressure ulcers, failed to identify a pressure ulcer until it had progressed to a stage 2, failed to perform weekly skin assessments, and failed to identify a resident with incontince and mobility limitations as a high risk for pressure ulcer and implement interventions for prevention of pressure ulcer. These failures resulted with a resident identified at low risk for pressure ulcers to develop a Stage 3 pressure ulcer. This applies to 3 of 5 residents (R3,R10, R11) reviewed for pressure ulcers in the sample of 15. The findings include: 1. The May physician order sheet (POS) for R11 documents she was admitted to the facility on March 22, 2016 following a fall at home resulting in fractured cervical vertebrae. The admission Minimum Data Set (MDS) assessment of March	F 314 F 314		

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29, 2016 shows R11 requires extensive assist with two staff for bed mobility and transfer from bed to chair and standing. The Bladder and Bowel assessment for the MDS documents R11 to be frequently incontinent of urine. The March 22, 2016 and the March 29, 2016 Braden scale for predicting pressure sore risk showed R11 to have a score of 20 and 17, a mild risk for acquiring a pressure ulcer. No further weekly Braden assessments were documented.

The interim care plan for R11 dated March 22, 2016 documents a potential alteration in skin condition and required skin monitoring and to report red/discolored or broken skin, and turn and reposition every two hours and as needed. The March 22, 2016 admission body audit performed by admission nurse documents R11 had no skin breakdown or open areas.

On May 5, 2016 at 3:45 PM, E8 Licensed Practical Nurse (LPN), stated R11 required two assist when she was admitted. E8 said R11 was difficult to keep dry and always seems to have wet incontinence briefs. On May 6, 2016 at 1:00 PM, E9 LPN, stated when R11 was admitted she was unable to move herself in bed and she was always incontinent of urine, she just had no control.

The March 22, 2016 admission nursing assessment for R11 documents she required staff for assist bed mobility and to always need help to move up in bed and to sit up.

On May 5, 2016 at 3:45 PM, E8 stated R11 was a skilled resident and would have had a skin check daily by the nurse and at least twice a week by the aides during her shower. E8 stated R11 was found to have open areas on her buttocks on April 9, 2016.

On May 6, 2016 at 8:00 AM, E3 (Director of Nursing) stated any low risk resident would be

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one who would be able to ambulate on their own and provide their own care and would not require a daily check. E3 stated any resident who is unable to reposition and is incontinent of urine would be considered a high risk for skin breakdown or pressure ulcers. E3 stated any wound should be identified as redness or bruising before it would open and become a Stage 2 or 3.
On May 6, 2016 at 8:10 AM, E4 MDS Coordinator / Registered Nurse (RN), stated she had assessed the wounds on April 10, 2016 and the coccyx was open but would not say the wound was a stage3 but more of a stage 2. E4 stated she should have re-assessed the Braden scale risk assessment weekly after her admission. E4 stated when the wounds were found, R11 was then put on a turn and reposition schedule, but she should have been on a turn schedule prior to the wounds.
On April 9, 2016 the nurse's notes showed R11 to have a slit type open area between the buttocks. The wound documentation progress sheet documents the wound to be 1.2 cm x 0.3 cm (centimeters, length by width). No staging of the wound is documented. A second wound is documented as two irregular shaped areas on the right buttock. No wound measurements or staging is documented. On April 11, 2016 a fax request was sent to the physician's office for a referral to the wound clinic for two open areas at a Stage 2. The physician responded he wound assess the wounds on April 13, 2016.
The April 13, 2016 physician visit dictation notes R11 had complained of some buttock pain but makes no assessment of buttock wounds. The physician order sheet for March 2016 shows an order was written on April 13, 2016 for the wound nurse to evaluate bottom and treat.
The April 14, 2016 wound nurse assessment

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documents R11 to have two stage 3 pressure ulcers. The wound on the coccyx measure 2.0cm x 0.7cm. And the left buttock wound measure 4.5cm x 1.1cm.
On May 6, 2016 at 8:15 AM, E3 stated R11 was working with physical therapy when she was admitted and was very weak. E3 said R11 would refuse to get up and would always want to stay in her room. E3 said the wounds were not open when they were identified but had progressed to stage 3 over the 5 day period.
On May 6, 2016 at 3:15 PM, Z2 (RN) stated she represents Dr. Woods and would respond on his behalf. Z2 stated any resident with incontinence and mobility issues should be considered a high risk for pressure ulcers. And Z2 agreed that with appropriate interventions the wounds could have been avoidable.

2. The March 15, 2016 MDS documents R10 requires extensive assist with 2 staff for bed mobility and is totally dependent upon staff for transferring in and out of bed. The MDS showed R10 to be frequently incontinent of urine. The Braden scale shows R10 to be at a high risk for pressure ulcers. The March 2016 treatment record showed R10 was to have a weekly skin check performed by the nurse on Thursday evening. The record showed no skin check was documented for March 24 or the 31st.
R10's nurse's notes for March 29, 2016 document a newly identified wound on the left lower buttock. The wound measured 3.5 cm x 4 cm x 0.5cm. The notes show barrier cream was applied to the sore. The nurse's note for March 30, 2016 documents an open area on the left buttock and is a dime size bruise. No measurements or description of the wound bed or tissues is documented. The March 31, 2016

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nurses note documents R10 had a stage 2 pressure ulcer on her left buttock and measured 3cm x 2 cm with drainage. The weekly wound documentation was initiated on March 31, 2016 with the wound as a stage 2.
On May 6, 2016 at 10:30 AM, the left buttock wound was observed to be a small open area with pink skin around the wound. No drainage noted, and no odor. E9 noted a new open area on R10's coccyx. E9 stated it was a new area since she had no current treatment orders for this wound. E9 measured the wound as an open stage 2 wound 0.5cm x 0.5 cm. E9 stated this area has opened and closed before and now it has re-opened. E17 Certified Nursing Assistant (CNA) stated she had been putting barrier cream on R10's bottom and she should be turned every 2 hours.
On May 6, 2016 at 8:30 AM, E3 stated the buttock was more of a pink area and it was not opened and cannot believe in one day the area opened and had drainage. E3 stated she cannot say the nursing documentation was incorrect. E3 stated the nurse with the initial documentation did not complete a weekly wound sheet as required per protocol.
The facility policy for Prevention and Treatment of Skin Breakdown documents the facility's policy is to properly identify and assess residents whose clinical conditions increase the risk for impaired skin integrity ad pressure ulcers; to implement preventative measures. Procedure: Prevention of Pressure Ulcers 1. Braden scale will be done upon admission and weekly for the first 4 weeks post admission. 2. Monitoring of skin integrity: b. Weekly skin audits on the bath/shower day will be performed by the Licensed Nurse in conjunction with the nursing assistant. If there is development of a pressure ulcer the following

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procedure is to be implemented: 10. Initiate weekly wound documentation progress sheet which will include: type of wound, location, date, stage (pressure ulcer only), length, width and depth.

3. March 1, 2016 MDS shows R3's admission date to be February 22, 2016. The same MDS shows R3 to have a diagnosis to include psychotic disorder with delusions, anxiety, diabetes, and history of cerebral vascular accident (CVA). The April 15, 2016 nursing progress notes shows R3 had a open area on his left and right inner buttocks. On April 16, 2016 a blister on his right heel measuring 10 cm (centimeters) was discovered and categorized as unstageable.

On May 5, 2016 at 9:00 AM R3 was restless and getting up as soon as the CNA, assisted him in sitting. E16 (LPN) said he (R3) has a stage 2 pressure ulcer on either side of his buttocks. On the same date and time R3 was seen leaning over in his wheelchair and leaning forward, putting pressure on his arms in an effort to relieve pressure off his bottom. On May 3, 2016 at 2:00 PM, E16 LPN applied barrier cream to a stage 2 pressure ulcer that measured approximately 8cm X 3cm on the right side of the buttocks and 5cm X 4cm on the left side of the buttocks. No visible drainage was seen. R3 had a 4cm in diameter blister on his right heel. On May 3, 2016 at 3:30 PM while in bed R3's heels were not being floated. On May 4, 2016 at 9:21 AM R3's heels were not being floated. On May 5, 2016 at 8:15 AM R3 was in bed with heels not floated. On May 4, 2016 at 12:24 PM, E3 said, if R3's Physician's orders say to float R3's heels while in bed, then it should be done. On May 4, 2016 at

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9:30 AM R3 was in his wheelchair without his seat cushion. On May 4, 2016 at 12:24 PM, E3 DON said, his (R3) seat cushion not being on his wheelchair was my fault. I transferred R3 into the wheelchair and forgot to put the cushion on.

On May 3, 2016 at 9:00 AM R3 said my butt hurts if I sit on it. On May 4, 2016 at 1:48 PM R3 stated, "did you know about my back side? My butt really hurts, I have a sore." On May 5, 2016 at 9:14 AM R3 said my butt hurts. On May 4, 2016 at 10:00 AM, E11 RN said she did not assess R3's pain yet and did not give any medication for pain. On May 5, 2016 at 10:00 AM E18 CNA said she did not realize that R3's heels should be floated while in bed. We get information on resident's care in daily report and on communication sheets and floating heels was not on my communication sheet. On May 4, 2016 at 12:24 PM E3 said we are trying to make positive changes in the way information is being passed down to the CNA's after there is a change in care for the residents. On the same date and time E3 said that a pain assessment should be done upon admission and when there is a change in the resident's condition. E3 said a pressure ulcer is a change in condition. R3 had one pain assessment sheet in his chart dated February 2, 2016, but none after that. E3 said weekly wound reports should be completed weekly. R3's buttocks wound was assessed on April 15, 2016 with no other weekly wound reports completed. R3's right heel wound was assessed on April 16, and April 23, 2016 with no other wound reports completed.

The June 15, 2012 prevention and treatment of skin breakdown policy and procedure shows when there is a development of a new pressure ulcer the following procedures will be

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F 314	Continued From page 9 implemented; #5 notify therapy department for seating surface evaluation and possible treatment interventions in other interdisciplinary team members as appropriate. #7 initiate Braden Scale form. #9 update nursing assistant profiles with skin concerns, appropriate risk factors, turning intervals and interventions as appropriate. #11 when a pressure ulcer is present, daily wound monitoring should include; A. An evaluation of the ulcer. E. whether pain is being adequately controlled. The April, 2016 POS shows on April 16, 2016 to float heels in bed and monitor every shift. The TAR (treatment administration record) for May, 2016 shows that heels are to be elevated in bed with no documentation for first shift on the 2, 3, 4, and 5 of May.	F 314		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure staff do not reuse disposable wipes during incontinence care to prevent infection related to cross-contamination.	F 315		

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This applies to 1 of 13 residents (R7) reviewed for incontinence in the sample of 15.

The findings include:

R7's hospital visit note with a discharge date of February 10, 2016, dictated by Z1 (Medical Doctor) shows an urinary tract infection as a diagnosis.

On May 3, 2016 at 12:10 PM, E19 Certified Nursing Assistant (CNA) provided perineal (pubic area to buttock) care to R7. R7 had stool in her pubic and buttock area. E19 used a disposable wipe and wiped R7's front side. There was visible stool on the disposable wipe and E19 folded the wipe in half and then proceeded to wipe R7's front side again. E19 then turned R7 on her side, using a new disposable wipe, wiped from front to back. The disposable wipe had visible stool on it. E19 folded the disposable wipe and wiped using the same wipe from front to back.

On May 6, 2016 at 8:40 AM, E15 CNA stated, "If I noticed stool on the wipe, I would get a clean wipe." at 9:35 AM E3 Director of Nursing stated, "A new cloth is needed if it is soiled. The cloths should not be folded. The cloths are permeable and the stool could have gotten back on her skin. The stool could cause a urinary tract infection."

R7's Minimum Data Set dated March 1, 2016 shows R7 requires a one person extensive assist with personal hygiene and toilet use. R7 is frequently incontinent of urine. Active diagnosis in the last 30 days includes a urinary tract infection.

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F 315	Continued From page 11 The facility's Perineal Care policy with a revised date of January 9, 2014 shows to use separate corners of the washcloth for each fold in the perineal area. Assist the resident to turn on her side and clean the anal area with toilet tissue, before washing the area if necessary.	F 315		
F 373 SS=D	483.35(h) FEEDING ASST - TRAINING/SUPERVISION/RESIDENT A facility may use a paid feeding assistant, as defined in §488.301 of this chapter, if the feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents; and the use of feeding assistants is consistent with State law. A feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN). In an emergency, a feeding assistant must call a supervisory nurse for help on the resident call system. A facility must ensure that a feeding assistant feeds only residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. The facility must base resident selection on the charge nurse's assessment and the resident's latest assessment and plan of care. NOTE: One of the specific features of the	F 373		

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regulatory requirement for this tag is that paid feeding assistants must complete a training program with the following minimum content as specified at §483.160:
o A State-approved training course for paid feeding assistants must include, at a minimum, 8 hours of training in the following:
Feeding techniques.
Assistance with feeding and hydration.
Communication and interpersonal skills.
Appropriate responses to resident behavior.
Safety and emergency procedures, including the Heimlich maneuver.
Infection control.
Resident rights.
Recognizing changes in residents that are inconsistent with their normal behavior and the importance of reporting those changes to the supervisory nurse.

A facility must maintain a record of all individuals used by the facility as feeding assistants, who have successfully completed the training course for paid feeding assistants.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to ensure a resident with difficulty swallowing and a pureed diet was not fed by a paid feeding assistant.
This applies to 1 of 7 residents (R7) reviewed for hydration/swallowing in the sample of 15.
The findings include:
On May 4, 2016 at 8:10 AM, E14 (Activity Aide/Paid Feeding Assistant) was seated at the Zone 3 activity/dining table next to R7 feeding her

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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 373	Continued From page 13	F 373		

a pureed diet. All three of the facility nurses working were in the main dining room passing medications (approximately 168 feet away and not in direct view-see facility map).
On May 4, 2016 at 8:30 AM, E20 (Activity Aid/Certified Nursing Assistant) said she would run to the main dining room for help if there was an emergency with a resident choking in the Zone 3 dining area. On May 4, 2016 at 8:25 AM, E14 said she would yell for help if R7 began to choke while she was feeding her. On May 4, 2016 at 11:15 AM, E14 said she did not know she was not supposed to feed R7. On May 4, 2016 at 10:30 AM, E10 RN (Registered Nurse) said she couldn't tell me where to locate a list of residents the paid feeding assistants are approved to feed. E10 said she was not aware a paid feeding assistant was feeding R7 in her assigned zone while she was in the main dining room passing medications. On May 4, 2016 at 10:34 AM, E9, Licensed Practical Nurse (LPN) said there was no list readily available to show which residents were approved to be fed by paid feeding assistants. On May 4, 2016 at 10:35 AM, E8 LPN said she could not tell me where to locate a list of residents that could be fed by paid feeding assistants. On May 4, 2016 at 10:55 AM, E11 RN said she had no idea where to find a list of residents that may be fed by non-certified staff (paid feeding assistants). On May 4, 2016 at 11:00AM, E3 (Director of Nursing) said the facility does not use paid feeding assistants. On May 6, 2016 at 12:35 PM, E3 said resident aspiration and choking are potential outcomes that may occur if paid feeding assistants were to feed a resident with swallowing difficulty and would expect nursing supervision of these residents.
The facility's Resident Attendant (Feeding Only) policy dated November 11, 2016 shows the RA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146177	A. BUILDING _____ B. WING _____	05/10/2016

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RESTHAVE HOME-WHITESIDE COUNTY	408 MAPLE AVENUE MORRISON, IL 61270

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F 373	Continued From page 14 (Resident Attendant) will not feed residents with " complicated " feeding challenges such as difficulty swallowing, the RA is supervised by a nurse and an updated list of residents the RA may feed will be kept updated. The facility's list of residents that may be fed by a Paid Feeding Assistant did NOT include R7. R7's March 1, 2016 Minimum Data Set (MDS) shows R7 requires extensive assistance to eat. R7's Nutrition Care note dated March 8, 2016 shows problems swallowing and a pureed diet. A March 8, 2016 fax communication with R7's physician shows a report of difficulty swallowing and a pureed diet. R7's swallowing evaluation dated February 9, 2016 shows significantly delayed swallows indicative of a heightened possibility of aspiration.	F 373		
F 425 SS=D	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.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 425	Continued From page 15	F 425		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review the facility failed to have pharmaceutical services to ensure expired medications are disposed of and not administered to residents. The facility failed to ensure staff label insulin with an expiration date after opening.

This applies to 1 of 15 residents (R3) reivewed for medications in the sample of 15 and 2 residents (R18, R19) in the supplemental sample.

On May 4, 2016 at 11:30 AM, an insulin vial of Levemir for R3 had an open date of March 25, 2016 (11 days passed the discard date), and R18's lantus vial had an open date of March 5, 2016 and was still being actively used (63 days passed the discard date). On the same date and time, R19's novolog insulin vial was opened without an open date.

On May 4, 2016 between 10:00 AM and 12:00 PM E4 & E10 Registered nurse (RN) said insulin vials should be dated when opened, and the insulin should be discarded after 28 days.

The October 17, 2015 insulin storage policy and procedure #5 shows when a vial of insulin is opened it should be dated. #6 shows the insulin vial in use and dated should be discarded as her manufacturers instructions. The manufactures instructions for Lantus and Levemir shows it should be discarded after 28 days from opening.