STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146157	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK FALLS REHAB & HLTH CARE C	430 MARTIN ROAD ROCK FALLS, IL 61071

(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	F 000		
F 157 SS=D	Annual Licensure and Certification Survey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

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F 157	Continued From page 1 by: Based on interview and record review, the facility failed to notify the physician and residents Power of Attorney in a timely manner when the resident had a change in condition. This applies to 1 of 9 residents (R1) reviewed for notification in the sample of 10. The findings include: On August 10, 2016 at 7:55 AM, E3, Licensed Practical Nurse (LPN), E2 (Director of Nursing) and E19 (Social Service Director) were standing at the nurses station. E3 stated R1 was sent to the hospital to be evaluated for a fall that occurred at 1:20 AM. E3 said she called R1's hospice group to inform them of the fall at the time of the incident and sent a fax to R1's primary care physician. E3 stated the physician would not receive the fax until his office practice "opened in the morning." E2 stated Z7 (R1's Power of Attorney) probably should have been called at the time of the occurrence. E19 stated she has a good rapport with R1's POA and knows "she would have wanted (R1) sent out as soon as possible." E3 stated she called E2 for direction regarding notification vs sending R1 to the hospital due to hospice involvement and R2 directed her to wait for hospice's decision. E3 stated she did not notify the POA because she had nothing to report. E3 said, until hospice arrived to evaluate R1 and decide if sending her to the hospital was the next course of action, she didn't see the need to worry the POA. On August 11, 2016 at 9:42 AM, during a phone interview, Z7 stated she was not aware of a delay in treatment for R1 nor of the time the	F 157		

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F 157	Continued From page 2	F 157		

incident occurred. Z7 said she received a call at about 6:00 AM from the hospice nurse (Z6) stating R1 had fallen in the early morning hours. Z7 said Z6 described R1 as being in a lot of pain and asked Z7 if she wanted R1 sent to the hospital. Z7 said "I was confused as to why she was asking me. I told her of course, send her." Z7 said she has been in repeated contact with the facility and R1's hospice service to ensure R1 remains as comfortable and safe as possible during her end stage care. Z7 said it is difficult to be the POA "from 1100 miles away. I have to rely on the information the facility and hospice give me." Z7 said had she been called at 1:20 AM and known that R1 was in so much pain, she (Z7) would have told them to send R1 to the hospital at that time.

On August 11, 2016 at 9:42 AM, Z7 stated she was made aware of R1 ' s coccyx wound " last week. " Z7 said, " it concerned me a little because when they told me, they said she got it while at the hospital, " (two weeks prior to her being notified.)

The nursing notes showed R1 fell at 1:20 AM, was not assessed by Z6 until 5:40 AM. At that time, Z6 called Z7 and arrangements were made to send R1 to the hospital. The facility policy and procedure (undated) titled Notification of Change in Resident Condition or Status showed, the nurse on duty will "notify the resident's attending physician or on-call physician when there has been...an accident or incident involving the resident...a need to transfer the resident to a hospital/treatment center...the resident is involved in any accident or incident that results in an injury including injuries of an unknown source." A notation at the bottom of the policy showed

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F 157	Continued From page 3 documentation which reads: "the policy and procedures of the facility are not intended to replace sound clinical judgment in the deliver of health care and are not intended to replace the prevailing standard of care." The facility policy dated August 14, 2000 titled Responsible Party Notification of Change in a Resident's Condition showed, "A family member or responsible party is made aware of a significant change in a resident's condition by licensed nursing personnel as warranted with in a timely manner."	F 157		
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 coordinate hospice care services and ensure prompt treatment after a resident fall, and failed to have hospice progress notes available to the interdisciplinary team. This applies to 2 of 2 residents (R1 & R4) reviewed for hospice in the sample of 10. The findings include:	F 309		

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On August 10, 2016 at 7:45 AM, R1 was not in her room nor the dining room. At 7:55 AM, E3 Licensed Practical Nurse (LPN) stated R1 was sent to the hospital to be evaluated for a fall that occurred at 1:20 AM. E3 said she called R1's hospice group to inform them of the fall. E3 stated the individual answering the phone said she would pass the message to the nurse on call and they would call the facility with instructions. E3 said at 2:10 AM, Z6 RN (Hospice Registered Nurse) called the facility. E3 stated after listening to the details of R1's fall, Z6 stated R1 should probably be sent to the hospital but this was her second time on call and she wasn't sure if she had to physically assess the resident. E3 said Z6 told her she would find out and call E3 back. E3 said at 2:20 AM, Z6 called back to say that R1 was not to be sent to the hospital until Z6 had a chance to assess R1. E3 said Z6 told her she (Z6) was coming to the facility to evaluate R1. E3 said she asked Z6 how long it would be and she told E3 she was about 1 hour away. E3 said at 4:00 AM, Z6 called her and stated she was lost (gave the name of a city 1.5 hours away from the facility.) E3 stated she corrected Z6 on which city the facility resides. E3 said Z6 arrived at 5:40 AM (more than 4 hours after R1's fall) to assess R1. E3 stated R1 had complained of left hip pain and was yelling out with any movement. E3 explained after Z6 assessed R1, Z6 called Z7 (R1's Power of Attorney) to notify her of R1's condition. At that time, Z7 told Z6 to send R1 to the hospital for evaluation.

E3 said she sent a fax to R1's primary care physician at the time of the incident. E3 stated the physician would not receive the fax until his office practice "opened in the morning." E2

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F 309	Continued From page 5 (Director of Nursing) stated Z7 probably should have been called at the time of the occurrence. E19 stated she has a good rapport with R1's POA and knows "she would have wanted (R1) sent out as soon as possible." E3 stated she called E2 for direction regarding notification vs sending R1 to the hospital due to hospice involvement and R2 directed her to wait for hospice's decision. E3 stated she did not notify Z7 because she had nothing to report. E3 said, until hospice arrived to evaluate R1 and decide if sending her to the hospital was the next course of action, she didn't see the need to worry Z7. On August 11, 2016 at 9:42 AM, Z7 was interviewed via phone. Z7 stated she had no idea R1 fell at 1:20 AM. Z7 said she was called at about 6:00 AM and told it was "early morning hours" and therefore was thinking just prior to 6:00 AM. Z7 said "I was told she fell and hospice came right away and called me." Z7 did state she was a little concerned that hospice asked her (Z7) about sending R1 to the hospital because she (Z6) was describing R1 as being in horrible pain. Z7 said R1 does have a fractured left hip that at this point she has elected to forego surgical intervention. Z7 said the facility has seemed to "be able to keep my Aunt from falling. She has fallen 4 times in the past few weeks and had a right hip surgery just 3 weeks ago." Z7 said it is difficult for her to direct R1's care from 1100 miles away so she has to rely on the facility and hospice group to keep her informed on R1's condition. Z7 said she became aware there was some communication concerns between the facility and the hospice group 3 weeks ago. Z7 said R1 fell and broke her right hip. The facility sent R1 to the hospital and surgical invention was done. Z7 said, because the hospice was not	F 309		

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notified prior to her admission, for payment reasons R1 needed to be removed from hospice care. Z7 said she understood and that was not a problem as they could put R1 back on palliative care after her discharge. Z7 said when the hospice group called me on August 10, 2016, "I thought good, they are finally communicating." Z7 said she has been in repeated contact with the facility and R1's hospice service to ensure R1 remains as comfortable and safe as possible during her end stage care. Z7 said had she been called at 1:20 AM and known that R1 was in so much pain, she (Z7) would have told them to send R1 to the hospital at that time.

On August 10, 2016 at 8:27 AM, Z1 (Hospice Director of Nursing) was interviewed via phone conversation. Z1 stated the hospice group is to be called when a change in condition occurs with their clients. Z1 said their hospice group procedure is to have a nurse from their group go to the facility to assess the resident and then call the resident's family/POA to discuss options/recommendations. Z1 said, if the family is called and wishes for the resident to be sent to the hospital, there is no need for the hospice group nurse to come to the facility and assess the resident. Z1 said the facility should comply with the family/POA's wishes. Z1 stated their nursing staff will write a note after the visit and send a copy of the record to the facility for the residents medical record.

On August 11, 2016 at 9:00 AM, E2 said the hospice groups utilized are to leave notes on each visit at the facility for the residents medical record. E2 said some groups will leave a brief handwritten note and send/fax the typed note in "a timely manner." E2 expressed surprise that

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there were no hospice nursing visit notes in R1's or R4's medical records. Both R1 and R4 receive care from different hospice groups. E2 stated she would call the hospice centers and have then send the notes. Upon receipt of the hospice records for R1, there were no notes prior to her July 7, 2016 fall with a right hip fracture and no notes regarding the visit for the fall that occurred on August 10, 2016.

The facility was unable to provide any documentation or agreement in which hospice was required to evaluate a resident before emergency care interventions were implemented. The front of the hospice chart for R1 showed instructions which showed they (hospice) was to be notified "immediately" if there is a "change in resident's condition, resident fall...request for transfer." On August 11, 2016 at 1:40 PM, E2 stated the facility had located another book (involving R1's hospice group) located in the MDS (Minimum Data Set) MDS office. E2 acknowledged the book would be inaccessible to staff after the MDS office closed. E2 was unable to identify R1's hospice group physician. E2 could not identify when a physician (hospice or primary care) should be notified for any given circumstance. The facility/hospice contracts/agreements were reviewed with no findings that residents care is to be held based on a hospice assessment.

The policy and procedure dated September 7, 2009 titled Emergency Care showed emergency care is to be provided to preserve life, prevent worsening of the situation and to promote recovery. The procedures listed include, the nurse "shall attend to the resident's need for emergency treatment within his/her scope of

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F 309	Continued From page 8 capabilities and per facility protocol to stabilize the resident' condition; Notify the physician of the need for emergency care and scope of care provided; Notify the Director of Nursing and the Medical Director should the primary physician or on-call physician not respond to the facility's call for assistance in a timely manner."	F 309		
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 thorough incontinence care and wash a residents hands after actively participating in toileting. This applies to 1 of 9 residents (R1) reviewed for incontinence care in the sample of 10. The findings include: On August 9, 2016 at 11:30 AM, E17 and E18 CNA's (Certified Nursing Assistant's) provided R1 use of the commode before being taken to lunch. E17 and E18 took R1 to the common bathroom in the hallway. E17 and E18 used a gait belt pivot transfer to move R1 from her low center of gravity relining chair to the commode. R1 was able to assist by reaching for the grab bars next to the commode and lowering herself to the stool. R1's	F 312		

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hands were reaching at her clothing, the gait belt and near her perineal (peri)area. E18 removed the soiled incontinent brief and handed it to E17 to discard in the trash. E18 removed the gloves and put on a new pair without washing or sanitizing hands. E17, still wearing the gloves used to remove the soiled brief, applied a clean incontinent brief then assisted R1 to a standing position. R1 held the grab bars as E18 began to provide incontinence care. E18 reached through R1's legs from behind and made several swipes using several different washcloths. At no time was R1's inner thighs or buttocks cleaned where the incontinent brief touched her skin. Upon completion of the incontinence care, R1 was gait belt pivot transferred back to her low center of gravity chair. At that time, both CNA's removed their gloves and washed their hands. E17 wheeled R1 out to the dining room for lunch without washing R1's hands. At 12:18 PM, E17 was seated in the dining room to assist residents with their lunch. E17 stated the (brand name) sanitizing cleanser should be used between glove changes and to cleanse resident hands.

On August 10, 2016 at 1:32 PM, E14 CNA, stated that hands should be washed or sanitized between each glove change. E14 stated gloves should be changed after possible contamination (touching soiled incontinent brief) before touching anything else (clean incontinent brief.) E14 stated when providing incontinent care, all areas touched by the brief should be washed. E14 verbalized, the stomach, inner thighs, whole backside including the buttock cheeks. On August 10, 2016 at 1:55 PM, E11 and E12 CNA's also stated gloves are to be changed between soiled and clean area uses with sanitizing or handwashing completed with each

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F 312	Continued From page 10 glove change. Both also stated if a resident was wearing a wet or soiled incontinent brief, the stomach, inner thighs and buttock cheeks should be washed. "All areas of the brief that touch the skin of may have been exposed to leaking." E11, E12 and E14 all stated they complete peri care by washing outer to inner areas (lateral to medial or dirty to clean). When technique was discussed, all agreed they had been taught to go from clean to dirty (medially to lateral or inner to outer). The facility policy dated December 2009 titled Standard Precautions showed staff are to wash hands "when touching blood, body fluids, secretions, excretions and contaminated items whether or not gloves are worn. Wash hands immediately after gloves are removed between resident contacts and when otherwise indicated to avoid transfer of microorganism to other residents or environments. It maybe necessary to wash hands between tasks and procedures on the same resident to prevent cross-contamination of different body sites." The facility policy dated September 21, 2010 titled Perineal Cleansing showed the technique for cleansing is to "wash pubic area including upper inner aspect of both thighs and frontal portion of perineum. Use long strokes from the most anterior down to the base of the labia. After each stroke, refold the cloth to allow use of another area...remove gloves and wash hands with soap and water, cleansing gel or (brand name gel). Apply new incontinent product, clothes or repositioning comfortably."	F 312		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards	F 323		

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as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to apply a gait belt in a manner to safely transfer a resident without discomfort.

This applies to 1 of 9 residents (R1) reviewed for transfers in the sample of 10.

The findings include:

On August 9, 2016 at 11:17 AM, R1 was being assisted to her low center of gravity wheel chair from a low bed. R1 was identified as a two person assist gait belt transfer with pivot assist. E17 CNA (Certified Nursing Assistant) applied the gait belt to R1. The gait belt was placed across R1 ' s left breast and tightened. R1 was using her left hand to tug at the gait belt and pulling it in a downward motion. E17 and E18 CNA were asked about the positioning of the gait belt. E18 stated it should not be placed across the breast. E18 said it should be applied below the breast or higher above the breasts. E18 removed the gait belt and repositioned it below R1 ' s breasts at the waist. R1 stopped reaching for the belt. Review of R1 ' s medical record showed she has a history of a right breast mastectomy.

Review of the undated policy titled Transfer Belts/Gaitbelt Policy, showed " Gait belt is placed

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F 323	Continued From page 12 around the resident ' s waist over clothing. Gait belts may also be applied around the upper chest just below the axilla (armpit) area if client complains of being uncomfortable with the gait belt around waist. Gait belts should never be applied directly over bare skin. "	F 323		
F 431 SS=D	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	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146157	A. BUILDING _____ B. WING _____	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ROCK FALLS REHAB & HLTH CARE C	430 MARTIN ROAD ROCK FALLS, IL 61071

(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 431	Continued From page 13 quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to label multiple dose vials with open dates. This applies to 3 residents (R3, R4, R19) reviewed for medication labeling. The findings include: On August 10, 2016 at 11:00 AM R3's multiple dose bottle of liquid Ativan had a broken seal, but no open date on the bottle. On the same date and time R19's multiple dose bottle of liquid morphine had a broken seal, but no open date on the bottle. Both bottles were 3/4 full. On August 11, 2016 at 10:20 AM, R4's multiple dose of liquid morphine had a broken seal, but no open date on the bottle. On the same date and time, E21 RN (Registered Nurse) said, that she had opened R4's morphine at 10:00 AM, but did not put an open date on the bottle. E21 said that all multiple dose bottles of medication should have a date on the bottle/vial to indicate when it was opened. On August 10, 2016 at 11:40 AM, E7 LPN (licensed practical nurse) said when multiple dose medications are opened, they should have an open date written on the bottle. On August 11, 2016 between 10:30 AM and 11:15 AM, E2 DON (director of nursing), and E22	F 431		

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 431	Continued From page 14 Corporate RN (registered nurse) said, multiple dose bottles/vials should be labeled with an open date when opened. The Procurement and Storage of Medications policy revised on October, 2006 shows, #7. 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	F 441		

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F 441	Continued From page 15 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 ensure urine was cleaned in a manner to prevent cross-contamination. This applies to 1 resident (R17) in the supplemental sample. The findings include: The MDS (Minimum Data Set) of June 20, 2016 shows R17 is totally dependent on two staff for transfers and toileting, and is frequently incontinent of urine. On August 10, 2016 at 8:45 AM, E11 and E12 CNA (Certified Nurse Assistants) raised R17 to a standing position with a mechanical lift. R17 said "I'm leaking" and urine dripped from her saturated pants to the floor. R17's wheelchair had urine pooled on the seat. E11 and E12 transferred R17 to the toilet and E12 was stepping in the urine. This surveyor pointed out that E12 was stepping in the urine, and also pointed out the urine on R17's wheelchair seat. E12 grabbed paper towel, and sprayed sanitizer directly on the urine on the	F 441		

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F 441	Continued From page 16	F 441		

seat of the wheelchair. E12 used the paper towel to wipe off the urine. E12 then sprayed the inside sides of R17's wheelchair, and with the same wet/contaminated paper towels, wiped the side of the chair. E12 then sprayed the sanitizer directly on the urine on the floor, and with the same wet/contaminated paper towels, wiped the floor. E12 did not clean the bottom of her shoes.

On August 11, 2016 at 10:55 AM, E11 (CNA) said a clean cloth should be used for each area when cleaning up urine.

On August 11, 2016 at 11:00 AM, E2 DON (Director of Nursing) said urine should be wiped up before a disinfectant spray is put on it. E2 said the same cloth used to wipe up the urine should not be used to disinfect with. E2 said if shoes come in contact urine, they should be cleaned.

The undated facility "Implementation Schedule and Methodology" policy states
"All blood or other body fluids and material contaminated with body fluids shall be considered infectious regardless of the perceived status of the source individual."
"Employees have been instructed on decontamination procedures. Decontamination of surfaces and devices shall be achieved through a one to ten dilution of house hold bleach to water."