STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146134	A. BUILDING _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SALINE CARE CENTER	120 SOUTH LAND STREET, PO BOX 468 HARRISBURG, IL 62946

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F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	Annual Certification Survey 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 check for residual stomach contents prior to administering a tube feeding, failed to provide verbal cueing for meal intake, and/or failed to assess and medicate for pain as indicated in the Care Plans for 3 of 24 residents (R1, R2, and R18) reviewed for Care Plans in the sample of 24. Findings include: 1.R18's Physician's Order Sheet for February, 2015 includes the following orders: a bolus feeding of Glucerna 1.5 Cal liquid three times a day , and to "check for residual prior to feeding." On 2/25/2015 at 2:15 p.m., E9, RN, (Registered Nurse) checked R18's feeding tube for placement by auscultation with a stethoscope, administered a bolus feeding through the abdominal feeding tube, but did not check for residual stomach contents prior to doing so. On 2/25/2015, at 2:35 p.m., E10, RN (Charge Nurse), who was present when E9 administered R18's tube feeding confirmed that a check for residual stomach contents was not done prior to the feeding as ordered on R18's Physician's Order Sheet for February, 2015.	F 282		

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

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F 282	Continued From page 1 2. On 02/22/15 and 02/23/15 from 12pm to 1pm, R1 was observed during lunch service. Staff did not verbally cue the resident to eat during this time, and R1's meal intake was 50% or less. R1's Care plan with a review date of 12/03/14 stated. "Potential for altered nutrition - resident requires verbal cues when eating". On 02/25/15 at 2:15 pm, E11, Executive Director, confirmed the verbal cueing had not been implemented as per the care plan, stated he felt this intervention was ineffective for R1 and should have been removed from the care plan. 3. On 02/24/15 at 1:30 pm, R2 was observed receiving range of motion. Prior to beginning, R2 stated her legs hurt. R2 refused to allow range of motion to her left leg because of complaints of pain. R2's Care Plan with a review date of 12/08/14 identified a problem area of pain, with corresponding interventions of trying non-pharmaceutical strategies such as distraction and massage, and giving Oxycodone-Apap 5/325 milligrams every four hours as needed for pain. R2's Medication Administration Record showed that R2 did not receive this medication at all on 02/24/15. On 02/25/15 at 3pm, E2, Director of Nurses, confirmed that these care plan interventions were not followed.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 2 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, record review and interview, the facility failed to assess pain and offer as needed pain medication or alternative non-pharmaceutical strategies for 1 of 8 residents (R2) reviewed for pain in the sample of 24. Findings include: On 02/24/15 at 1:30 pm, R2 was in her room lying in bed yelling out. E2, Director of Nurses, asked her what was wrong and R2 stated,"My legs hurt ". E2 did not further assess R2's pain, did not ask other staff or check documentation to see when R2 had last received pain medication, did not ask R2 if she was in need of medication for pain, and did not offer any non- pharmaceutical strategies to relieve her pain. E5, Certified Nursing Assistant, proceeded to do range of motion as E2 observed. R2 refused to allow E5 to do range of motion on her left leg, stating, "it hurts too bad." R2's Care Plan with a review date of 12/08/14 listed a problem area of "Frequent intermittent pain". Interventions listed included, "Try non-pharmaceutical strategies that might work for R2 to reduce her pain and enhance comfort; possibilities include distraction and massage." R2's Minimum Data Set (MDS) dated 12/05/14 showed R2 experiences pain 3 to 4 days weekly. The same MDS showed a Brief Interview for Mental Status of 9 which indicated R2 has	F 309		

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F 309	Continued From page 3 moderate impairment in cognition. A February 2015 Medication Record sheet showed that R2 has an order for Hydrocodone Apap 5-325 take one tablet by mouth every four hours as needed for pain. This record further showed that R2 had not received this medication since 02/23/15 at 8:38 am. The diagnoses on R2' s Medication Record sheet include Contractures of feet, lower extremities and hands as well as a history of Cerebral Vascular Incident. A Pain-Clinical Protocol Sheet with a revision date of October 2010 stated, "The nursing staff will identify any situation or interventions where an increase in the residents pain may be anticipated; for example, wound care, ambulation, or repositioning." On 02/25/15 at 3pm, E2 stated that she had followed up with R2's nurse after the range of motion, R2 was found to be in pain, and was given Ibuprofen 400 mg at 2pm when it was due (R2 takes it three times daily). E2 confirmed that on 02/24/15 at 1:30 pm there were no interventions utilized to assess or relieve R2's pain at that time.	F 309		
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	F 425		

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F 425	Continued From page 4 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: Based on observation, interview and record review the facility failed to assure the accurate documentation of the administration of pain medication as per the Administering Pain Medication policy for two of 12 residents (R7 and R14) reviewed for pain in a sample of 24. The findings include: The Administering Pain Medication Policy with a revision date of October 2010, states to "Document the following in the resident's medical record: results of the pain assessment; medication; dose; route of administratonm and results of the medication (adverse or desired)." 1. On the January 1, through 31, 2015 and February 1 through 28, 2015 Physician's Order Sheet (POS), R14 has Hydrocodon-APAP 5/325 milligrams (mg) 1 or 2 orally every 4 hours as necessary (prn) ordered. On the front of R14's Medication Administration Record (MAR) for January and February, 2015, Hydrocodone 5/325 mg is listed and initialed as being given twice on January 4, 2014, and February 15th and once on January 7, 12, 13, 15, 16, 20, 22, 23, 24, 25, 28, 30, February 1, 2,	F 425		

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F 425	Continued From page 5 3, 5, 9, 11, 12, 17, 18, 19, 20, and 21, 2015. The back of the MAR has an area to include "explain the date and hour the medication was given, medication and dosage, reason, results, and initials of nursing staff completing." The back of the MAR does not include Hydrocodone being given on January 4, 2015, twice on January 15, none on January 20, 23, or 30, twice on February 11, and none on February 18 and 20th, 2015. On R14's Individual Resident's Controlled Substance Record (NARC sign out sheet) for Hydrocodon - APAP 5-325 mg there are discrepancies with the dates and times the Hydrocodon was signed out of R14's medication stock as being given when compared to the dates and times of the MAR (as above) as follows: three times on January 13, 2015, twice January 15, 2015, once January 19, none on January 23, three times on February 11, none on February 15, and three times on February 21, 2015. On February 23, 2015 at 11:45 AM, E6, (Licensed Practical Nurse) stated when PRN pain medication is given " the nurses initial the MAR on the appropriate date, document on the back of the MAR the date, time, name of the medication being given, for what reason, if the pain medication is effective, the initials of the nurse giving the pain medication and then the nurse signs out the medication on the NARC sign out sheet. " On February 22, 2015 at 1:10 PM R14's Hydrocodone card had 18 left on the card and according to the NARC sign out sheet there was supposed to be 18 left indicating the NARC sign out sheet was correct. 2. On February 1 through 28, 2015 POS, R7 had Hydrocodone - APAP 5-325 mg 1 tablet orally every 4 to 6 hours as needed for pain ordered.	F 425		

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F 425	Continued From page 6 On the front of R7's MAR there are initials that show Hydrocodone being given once on February 3, 8, 12, 19, twice on 21, and twice on February 22, 2015. On the back of R7's MAR for February 1 through 28, 2015, Hydrocodone was documented as being given three times on February 21, 2015. On R7's NARC sign out sheet for Hydrocodone - APAP 5-325 mg there are discrepancies with the dates and times the Hydrocodon was signed out of R7's medication stock as being given when compared to the dates and times of the MAR (as above) as follows: Once on February 1st, twice on the 2nd, once on the 5th, twice on the 8th, once on the 9th, 10th, 11th, and the 13th of February, 2015. On February 26, 2015 at 8:25AM R7's Hydrocodone card had 7 left on the card and according o the NARC record there was supposed to be 7 left indicating the NARC record was correct.	F 425		
F 458 SS=B	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide the required 80 square feet of floor space per resident bed for 2 multiple resident rooms on Side 1 and 32 multiple resident rooms on Side 2. This affects 6 of 6 residents (R3, R4, R12, R15, R17, R21) reviewed for adequate room size who occupy	F 458		

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F 458	Continued From page 7 these rooms in the sample of 24 and 65 residents (R25 through R77 and R80 through R93) in the supplemental sample. Findings include: On 2/23/2015 at 2:15 p.m., E11, (Executive Director), stated rooms 108 and 109 on Side 1 and rooms 3 ,6, 8, 9, 11, 12, 15-20, 22-27, 29-31, 34, 35, 38, 39, 41, 42, and 44-48 on Side 2, provide less than 80 square feet of floor space per resident. E11 further stated that these rooms are furnished with two beds and that rooms 108 and 109 are Medicare and Medicaid certified and that all the waivered rooms on Side 2 are Medicaid certified. The room roster for residents presented by the facility on 2/22/2015 lists the following residents as occupants of these rooms: R3, R4, R12, R15, R17, R21, R25 - R77 and R80 - R93. E11 verified on 2/23/2015 at 2:15 p.m. that this roster is current and correct. Observations of these rooms during the initial tour of the facility on 2/22/2015 at 9:15 a.m., found no negative environmental concerns regarding the undersized rooms. During the course of the survey, there were no negative interviews with residents or the families of residents who reside in these rooms	F 458		