STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 Recertification Survey. Federal Oversite/Support Survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 225	Continued From page 1	F 225		

certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to report an allegation of abuse immediately to the Administrator after potential abuse incidents for 2 residents (R11 and R12) reviewed for abuse, in the supplemental sample.

Findings include:

1. Final Incident Investigation Report of an alleged abuse allegation made by R11, not dated, documents R11 made an allegation of abuse by two Certified Nurse Aides (CNA's) on 2/2/13 between 4AM and 4:30AM. R11 accused one of the CNA of punching her in the back. "Staff reported residents statement immediately to Nursing Staff. Nursing staff reported to Admin (Administrator)..."

Typed report by E1 (Administrator), that is not dated, documents, "On 2/2/13 around 08:30 I received a call from E21, nurse, stating resident R11 reported to her that E22, CNA, had punched her in the back and that she was reporting an allegation of abuse to me....Nurse, E21, then stated there was a note addressed to me (the administrator) from night shift Nurse, about something and she wasn't for sure what. See attached #1."

The hand written document "Attached #1" dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2, WINCHESTER, IL 62694

(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 225	Continued From page 2	F 225		

2-3-13 documents, "I didn't call you about this concern." The note documents that R11 reported the CNA's were ruff (rough) with her when they changed her linen...R11 was yelling ... The document is signed by E23, Licensed Practical Nurse (LPN). The document is initialed and dated as received by E1 on 2-2-13 at @ 9:40.

In an interview with E1, on 2/15/13 at 11:25AM, E1 stated R11 has a history of making false allegations against staff and they always have 2 staff to care for her due to allegations. E1 stated she got a note from the Nurse around 8:30AM. E1 confirmed the allegation happened at around 4 - 4:30AM. E1 stated she first learned of the allegation of abuse from E21 when E21 called her on the phone. E1 stated an investigation was conducted with no findings of abuse. E1 stated E23 should have called her when R11 made the allegation around 4 - 4:30AM.

2. Facility INCIDENT REPORT TO IDPH (Illinois Department of Public Health), that is not dated, documents on 10-17-12 at 7AM, a round dime size purple bruising was noted on R12's chin. Report documents E2, Director of Nursing, overheard R12 discussing with daughter and social worker that she was slapped in the face. Investigation was started immediately and there was no staff identified as to who slapped R12.

Record review of R12's Nurses Notes of 10-17-12 documents at 7AM, "During med (medication) pass noted bruising - Will monitor and notify DR (Doctor) family and DON (E2). Nurses note at 9:50AM documents bruising was reported to the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 225	Continued From page 3 Interview with E1, on 2/15/13 at 11:25AM confirmed she was not notified of the bruise until 9:50AM. E1 stated she was contacted about possible abuse because R12's daughter had asked her who hit her. E1 stated a investigation was completed and they could not determine the cause of the bruise.	F 225		
F 226 SS=D	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 record review and interview, the facility failed to revise and operationalize the abuse policy by failing to report allegations of abuse immediately to the Administrator and allowed staff to continue to work with residents once an allegation of abuse was made for 2 residents (R11, R12) in the supplemental sample Findings include: The facility Policy and Procedure for Abuse, Neglect and Mistreatment Prevention Program Facility Procedures documents, "Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, or mistreatment they observe, hear about, or suspect to the administrator or and immediate supervisor who must then immediately report it to the administrator." The policy documents,	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 226	Continued From page 4	F 226		

"Employees accused of possible mistreatment shall not complete the shift as direct care provider to residents." Attached to the policy is The facility Abuse Policy dated 2-5-07 documents. "The facility has always advocated the prevention, reporting of and immediate investigation of allegations of resident abuse, neglect, mistreatment of residents and misappropriations of residents funds or property....If you should have reason to believe any of the above may have occurred or may have the potential to occur to a resident, you are to report it immediately to the Administrator. If the Administrator isn't available, report to the Director of Nursing, Quality Assurance Coordinator, Charge Nurse, or your department supervisor...This form will be placed in your employee file. Please note that you're signing that you understand and acknowledge what is on this page." There is a place for employee and Department Head signature and date on the form. The information on the attached employee signature page that summarizes the Abuse Policy and Procedure conflicts with the Policy for Abuse, Neglect and Mistreatment Prevention Program Facility Procedures in that it does not document that the Director of Nursing, Quality Assurance Coordinator, Charge Nurse or department supervisor should then immediately notify the Administrator.

On 2-15-13, at 9:08AM, E3, Dietary Manager, was interviewed on abuse. E3 stated she would expect her staff to report abuse to her and then they would go to the Administrator. If E3 had a concern of abuse, she stated she would go to E2, Director of Nursing, or E1, Administrator, "Who ever is available."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 226	Continued From page 5	F 226		

On 2-15-13 at 9:10AM, E24, Licensed Practical Nurse (LPN)/Care Plan Coordinator, stated she would report usually to the Administrator.

On 2-15-12 at 9:40AM, E4, Cook, stated she would report abuse to the E3 and if E3 was not available she would go to the Administrator.

On 2-15-12 at 9:40AM, E8, Certified Nurse Aide (CNA) stated she would report abuse to the Nurse, if the Nurse doesn't do anything about it she would go to E2. If E2 was not there she would go to E1.

2. On 2-15-13 at 11AM, E1 stated the last allegation of abuse she had was made by R11. R11 complained two CNA's were abusive with her. This happened on 2/12/13 about 4 - 4:30AM. E1 stated E23, LPN wrote a note about the allegations and left it for E1. E1 stated she was informed of the alleged abuse by E21, LPN, about 8:30AM. E1 stated E23 should have called her once the allegation was made. E1 stated the CNA's were allowed to work the rest of their shift but did not care for R11. E1 stated it is the facility policy that if an allegation of abuse of a staff member, the staff cannot care for that resident, but can care for others. This conflicts with the above Policy and Procedure provided by E1 on 2/13/13.

3. Facility INCIDENT REPORT TO IDPH (Illinois Department of Public Health), that is not dated, documents on 10-17-12 at 7AM, a round dime size purple bruising was noted on R12's chin. Report documents E2, Director of Nursing, overheard R12 discussing with daughter and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ____ B. WING ____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 226	Continued From page 6 social worker that she was slapped in the face. Investigation was started immediately and there was no staff identified as to who slapped R12. Interview with E1, on 2/15/13 at 11:25AM confirmed she was not notified of the bruise until 9:50AM. E1 stated she was contacted about possible abuse because R12's daughter had asked her who hit her. E1 stated a investigation was completed and they could not determine the cause of the bruise. On 2/15/13, at 11:25AM, E1 confirmed she was not notified of the bruise when it was first noted. She stated staff did not consider it as possible abuse until R12's daughter asked her who hit her and then E1 was notified. R12's Nurses Notes document, at 7AM, during med pass, the Nurse noted a bruise on R12's chin. Nurses Note of 9:50AM documents E1 was notified.	F 226		
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 interviews, observation and record review, the facility failed to provide adequate pain management including accurate assessments for 2 of 5 residents (R3 and R9) reviewed for pain	F 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 309		F 309		

Continued From page 7
management in a sample of 10.

Findings include:

1. According to the Minimum Date Set (MDS) dated 1/18/13, R9 has no memory or cognitive deficits and requires extensive assist of two staff for most activities of daily living (ADL). The MDS identified pain as frequent which keeps her awake at night and limits her ADLs.

The Physician's Order Sheet (POS) for February 2013 documents R9 receives a Fentanyl Patch 50mcg/hr every 48 hours and Hydrocodone - Acetaminophen 5-325 ii (2) tabs po (per mouth) every 6 hours PRN (as needed). The Pain Assessment is undated and identifies the Fentanyl patch as every 72 hours and not 48 hours as currently ordered for left shoulder down left leg pain. The assessment indicates "everything" increases pain which she identifies as burning, radiating, aching. The pain assessment documents that R9 registers a 9 out of 10 pain scale on a scale of 1=10 with 10 being the worst pain. The Care Plan dated 12/9/12 identifies R9's concern with pain as a radical nephrectomy and demyelinating neuropathy complaining of pain in legs and lower back, and usually rates her pain as 3-7. Interventions includes assessing her pain type, location, duration, and alleviating factors, Have her rate her severity of pain on a scale of 1-10 with 10 being the worse, give pain as needed, report any uncontrolled pain to MD (medical doctor) for possible change in pain medication and/or diagnostic testing, document results of medication and repeat as necessary, and offer her to lay down if she needs to or if in bed change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ____ B. WING ____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2** **WINCHESTER, IL 62694**

(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 309	Continued From page 8	F 309		

of position.

On 2/14/13 at 11:25am, R9 was asked by E14, License Practical Nurse (LPN) if she needed a pain pill during the noon medication pass. R9 stated yes and E14 gave her Norco 5-325 mcg tabs ii. R9 identified her pain as in her legs as she received the pain medication. E14 did not ask R9 where her what her pain level was at the time. At 2:55pm on 2/14/13, R9 was asked about the effectiveness of the Norco she received at 11:25am and stated that it helped. R9 stated at the time that the physician had just increased her patch to 48 hours from 72 hours but she still has to take the norco for breakthrough pain. R9 stated she would rate the pain she had earlier that day at 11:25am when she received the Norco as a "7" on a scale from 1-10.

The Medication Administration Record (MAR) for 2/14/13 for 7-3 shift pain monitoring indicates staff are to assess throughout the shift - has a "3" documented in the space for the shift.. The back of the MAR identifies leg pain as the primary complaint with the result being "better" at 12:20pm on 2/14/13 with no severity rating of the effectiveness of the Norco at the time.

The February 2013 MAR for Pain shows 6 shifts blank for pain assessment even though the documentation for the PRN Norco shows she is taking it between 2-3 times per day for the entire month of February. In addition, the POS show R9's Fentanyl patch was increased from 72 hours to 48 hours on 1/31/12 with no assessment done by nursing prior to that. The nurses notes fail to show any documentation that the pain medication R9 was taking prior to 1/31/13 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 309	Continued From page 9	F 309		

ineffective. The nurses notes for 1/31/12 document that R9 went out to her physician and returned with a new order for the increase. There is no evidence in the nurses notes following the increase that nurses were consistently monitoring R9's pain and medication effectiveness.

Interview with R9 on 2/14/13 at 2:55pm indicates she felt she needed more medication and asked the physician for it when she visited. R9 stated that the increase has helped.

According to the facility's policy on Pain Management dated 3/8/04 indicates the facility will assess resident for pain and appropriately treat residents to help them maintain their optimal level of well being and will achieve that through accurate assessment, encouraging residents to self report and a standard format for assessing, monitoring, and documenting plain will be utilized. The procedure indicates an assessment will be done upon admission, and a re-evaluation will be done quarterly and with significant change which is identified as pain not being controlled while on routine pain medication. The policy continues to indicate that documentation of interventions will be recorded in the medication administration records and/or treatment record and any new pain along with monthly monitoring regarding the pain program and care plan goals documented in a 30 day monthly summary notes as goals met or not met.

2. R3's Minimum Data Set (MDS), dated 11-4-13, documented R3 was an alert resident with frequent moderate pain. R3's Care Plan, problem date 1-25-13, documented, in part, R3 fractured a vertebrae prior to admission resulting in R3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 309	Continued From page 10	F 309		

wearing a cervical collar and pain spasms. It was also noted R3's pain was to be assessed and monitored and that her cervical collar was to be checked for proper application.

R3 was observed, on 2-13-13 beginning at 11:45a.m. and 2-14-13 beginning 8:30a.m., not wearing her cervical collar during dining and ambulation. R3 held her head down during dining and ingested her meal without completely swallowing her food and liquids. R3 ambulated with her head down without full vision of her ambulatory path.

Interview of R3, on 2-14-12 at 11:00a.m, R3 stated, in part, that she was in constant pain since her fracture, she could not sleep at night due to pain and staff did not timely provide night time pain medication causing her to lose her balance during self ambulation. R 3 also stated that her cervical collar was too tight and that it was difficult for her to eat and ambulation without her cervical collar in place.

R3's PRN (as needed) Medication Information sheets, dated 2-1-13 to 2-18-13, documented she was administered "Norco 7.5/325mg" and/or "Tylenol Ex-Str 500mg" for pain. The effectiveness of the administered pain medications were not documented on 2-2-13, 2-4-13 (three times), 2-5-13, 2-6-13 (three times), 2-9-13 (twice), 2-10-13 (three times), 2-12-13 and 2-13-13.

R3's current face sheet documented R3 was admitted on 10-24-12. R3's record did not document that a pain assessment had been completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 309	Continued From page 11 Interview of E13, Wound Nurse, and E2, Director of Nursing (DON), on 2-14-13 at 2:40p.m. and 2:50p.m., E13 stated R3 did not have a pain assessment. E13 also stated, on 2-14-13 at 2:55p.m, that R3's cervical collar was not monitored. Interview of E1, Administrator, on 2-19-13 at 10:20a.m., E1 stated that only the cleanliness of R3's cervical collar was monitored and not the placement. E1 also stated that R3 did not have a pain assessment. The facility's Pain Management Policy and Procedure, dated 3-8-04, documented, in part, "All residents have the right to pain relief. Our policy is to assess residents for pain and appropriately treat residents to help them maintain their optimal level of well being. A standard format for assessing, monitoring and documenting pain will be utilized."	F 309		
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:	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 314	Continued From page 12 Based on observation, record review, and interview, the facility failed to provide timely turning and repositioning and heel protection according to their pressure ulcer prevention plans for 3 of 6 residents (R1, R5, and R8) reviewed for pressure ulcers in a sample of 10. Findings include: 1. The Minimum Data Set (MDS) dated 1/7/13 identifies R1 as requiring minimal assist of one staff for most Activities of daily living including mobility. According to the Braden Scale dated 1/7/13, R1 is assessed to be at mild risk for skin breakdown although the facility's current pressure ulcer list identifies her to have a stage II ulcer on her coccyx. The Physician's Order Sheet (POS) for February 2013 documents an order for Granulex spray to coccyx three times a day (TID.) and Arginaid Lab results dated 10/24/13 show normal levels of Total Protein, Albumin, and BUN/Creatinine. The care plan dated 1/18/13 includes interventions to assist to bathroom every 2 hours and as needed, turn/reposition every two hours and as needed, and heelbos in bed. The care plan identifies the stage II to coccyx on 9/21/12 which measured 1.6cm x 1.2cm. The weekly skin report dated 2/4/13 identifies it as a stage II "pink", not opened. On 2/13/13 at 11:23am, R1 was observed in bed with no heelbos on according to her preventative plan. Following lunch on 2/13/13, R1 was transferred directly back to bed without being toileted and/or offered the toilet. According to the Certified Nurses Aide (CNA), E15 and E16,	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2** **WINCHESTER, IL 62694**

(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 314	Continued From page 13	F 314		

present at the time, R1 is continent.

E1, Administrator on 2/19/13 at 3:10pm, confirmed the facility determined R1's pressure ulcer as unavoidable but agreed the interventions of every two hours for toileting and repositioning is standard practice in the facility for anyone at risk. When asked why the facility wouldn't have determined her to be in need of more frequent toileting and/or repositioning since the pressure ulcer was assessed to be caused primarily by her incontinence and immobility, E1 stated it may be avoidable.

2. The MDS, dated 01/07/13, identifies R5 as having short and long term memory deficits and requires assistance of at least one staff member for bed mobility, transfers, ambulation, toilet use, personal hygiene, bathing and is incontinent of bladder. The MDS also identifies R5 as being at risk for pressure ulcers. On 01/07/13, R5's Braden Scale for pressure ulcers score was 15, which puts R5 at moderate risk for developing pressure ulcers.

The Care Plan, dated 01/14/13, identifies R5 as having communication deficits due to short and long term memory deficits and being hard of hearing. The Care Plan also identifies R5 as requiring assistance with all activities of daily living and is incontinent of both bowel and bladder. Also, it identifies R5 as being at risk for pressure ulcers requiring assistance to the restroom and turning and repositioning every two hours and as needed.

On 02/13/13 from 9:30 AM to 11:50 AM, R5 was observed in her wheelchair in her room and in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 314	Continued From page 14	F 314		

Continued From page 14

common area in facility. At 11:50 AM, R5 was taken via wheelchair to the dining room. No offer from staff to toilet R5 or check for incontinence before she was taken to the dining room. R5 stayed seated in her wheelchair during the lunch meal time. At 1:10 PM, R5 was taken to the common area. R5 was taken via wheelchair to dining room for Bingo activity. At 3:00 PM, R5 was taken via wheelchair to common area. At 3:20 PM and 3:50 PM, R5 was observed sitting in her wheelchair in the same position in the common area watching television.

3. The MDS,dated 01/17/13, identifies R8 as requiring assistance of one to two staff members for bed mobility, transfers, dressing, eating, personal hygiene, toilet use, bathing and is incontinent of both bowel and bladder. It also identifies R8 as being at risk for pressure ulcers. On 01/07/13, the Braden Scale for pressure ulcers score was 13, which puts R8 at moderate risk for developing pressure ulcers.

The Care Plan, dated 01/14/13, identifies R8 as having cognitive loss due to Alzheimer's type Dementia, being hard of hearing and short term memory deficit. The Care Plan also identifies R8 as requiring assistance with all activities of daily living. Also, the Care Plan identifies R8 as being at risk for pressure ulcers requiring assistance with toileting and turning and repositioning every two hours and as needed.

On 02/13/13 at 12:10 PM, R8 was observed to be sitting in her wheelchair in the dining room sleeping. At 1:10 PM, R8 was taken via wheelchair to the common area and transferred via mechanical lift to a reclining chair. At 1:50 PM,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 314	Continued From page 15 R8 was sleeping in the recliner. At 3:35 PM, staff woke up R8 to give a cup of water. R8 drank the water and went back to sleep. No offer by staff at that time to toilet or to reposition. On 02/14/13 at 8:45 AM, R8 was sitting in her wheelchair at the dining room table sleeping. Approximately 50% of the breakfast food had been consumed. At 8:55 AM, R8 was taken via wheelchair by staff to the common area. No offer to toilet or checking for incontinence was done at this time by staff. At 10:00 AM, 10:35 AM and 10:55 AM, R8 remained in the same position sleeping in the common area. At 11:15 AM, R8 was observed in her wheelchair at the dining room table sleeping. On 02/14/13 at 12:45 PM, R8 was taken from the dining room to her room via wheelchair. R8 was observed during transfer via mechanical lift by E8 and E19, CNA's, from the wheelchair to the bed. R8's incontinent pad was observed to be saturated with urine and her buttocks were heavily creased and red. On 02/14/13 at 12:55 PM, E8, CNA, stated that the night staff got R8 up in the wheelchair before 5:00 AM, when E8 began her shift.	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	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 315	Continued From page 16 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, record review and interview, the facility failed to provide timely toileting/incontinent care, to provide complete catheter care and to encourage fluids for a resident with a catheter and history of UTI (Urinary Tract Infection) for 3 of 7 residents (R5, R6 & R8) reviewed for incontinent/catheter care in the sample of 10. Findings include: 1. R6's Minimum Data Set (MDS), dated 12-3-12, documented extensive assistance of one person physical assist with toileting and indwelling catheter. R6's Care Plan, goal date 3-3-13, documented, in part, to check the placement of R6's indwelling catheter, assure the cathter was patent at all times and to provide catheter care every shift and as needed. R6's Urinalysis, dated 7-28-12, documented R6 was positive for a Urinary Tract Infection, Proteus Mirabilis. R6's Urinalysis, dated 10-11-12, R6 was positive for a Urinary Tract Infection, Escherichia Coli. During observation of R6's indwelling catheter care, on 2-13-13 at 11:30a.m., E18 and E19, Certified Nursing Assistant's (CNA,s) did not offer R6 fluids after providing care.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ____ B. WING ____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 315	Continued From page 17	F 315		

During observation of R6's noon meal, on 2-13-13 at 11:45a.m., R6 did not drink her red drink, tea or water.

During interview of E13, Treatment Nurse, on 2-20-13 at 1:30p.m., E13 stated she would expect fluids would be offered to R6 with care.

On 2/13/13 at 3:12pm, E6 and E5, CNA's, assisted R6 to the toilet because her catheter bag had leaked causing her pant leg to have a wet spot visible just above the knee on her left leg. The CNA's removed her wet pants and failed to provide any cleansing to her leg where her skin would have been in contact with urine although cleansing clothes were brought into the room. R6's leg bag was full and had slid down to her knee area causing the catheter to be pulled taut down the side of her leg. There was no other strap present to prevent her bag from pulling on the catheter tubing if it slipped down. Neither CNA's moved the bag up but prepared to empty the bag, After a few minutes, R6 reached down and pulled the bag up above her knee so the catheter tubing was no longer taut.

Interview of E1, Administrator, on 2-19-13 at 10:25a.m., E1 stated inservice on toileting and catheter care had been done in the past but needed to re-inservice staff now.

2. The MDS, dated 01/07/13, identifies R5 as needing assistance of at least one staff for bed mobility, transfers, ambulation, dressing, toilet use, personal hygiene and bathing. It also identifies R5 as being frequently incontinent of bladder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ____ B. WING ____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 315	Continued From page 18	F 315		

Continued From page 18

The Care Plan, dated 01/14/13, identifies R5 as requiring assist with all activities of daily living. Staff approaches/interventions include, in part, incontinent care done as needed at least two hours.

On 02/13/13 from 9:30 AM to 11:50 AM, R5 was observed in her wheelchair in her room and in the common area in facility. At 11:50 AM, R5 was taken via wheelchair to the dining room. No offer from staff to toilet R5 or check for incontinence before she was taken to the dining room. R5 stayed seated in her wheelchair during the lunch meal time. At 1:10 PM, R5 was taken to the common area. No offer from staff to toilet R5. At 1:55 PM, R5 was taken via wheelchair to dining room for Bingo activity. No offer from staff to toilet. At 3:00 PM, R5 was taken via wheelchair to common area. No offer from staff to toilet. At 3:20 PM and 3:50 PM, R5 was observed sitting in her wheelchair in the same position in the common area watching television.

3. The MDS, dated 01/17/13, identifies R8 as needing assistance of at least one staff member for bed mobility, transfers, dressing, personal hygiene, toilet use and bathing. It also identifies R8 as being frequently incontinent of both bowel and bladder.

The Care Plan, dated 01/14/13, identifies R8 as requiring assistance of at least one staff member for all activities of daily living. Staff approaches/interventions include, in part, incontinent care after each incontinent episode and at least every two hours; encourage to change positions every two hours.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 315	Continued From page 19	F 315		

On 02/13/13 at 12:10 PM, R8 was observed to be sitting in her wheelchair in the dining room sleeping. At 1:10 PM, R8 was taken via wheelchair to the common area and transferred via mechanical lift to a reclining chair. No offer by staff to toilet or to check for incontinence. At 1:50 PM, R8 was sleeping in the recliner. At 3:35 PM, staff woke up R8 to give a cup of water. R8 drank the water and went back to sleep. No offer by staff at that time to toilet or to reposition.

On 02/14/13 at 8:45 AM, R8 was observed to be sitting in her wheelchair at the dining room table sleeping. Approximately 50% of the breakfast food had been consumed. At 8:55 AM, R8 was taken via wheelchair by staff to the common area. No offer to toilet or checking for incontinence was done at this time by staff. At 10:00 AM, 10:35 AM and 10:55 AM, R8 remained in the same position sleeping in the common area. At 11:15 AM, R8 was observed in her wheelchair at the dining room table sleeping.

On 02/14/13 at 12:45 PM, R8 was taken from the dining room to her room via wheelchair. R8 was observed during transfer via mechanical lift by E8 and E19, CNA's, from the wheelchair to the bed. R8's incontinent pad was observed to be saturated with urine and her buttocks were heavily creased and red.

On 02/14/13 at 12:55 PM, E8, CNA, stated that the night staff got R8 up in the wheelchair before 5:00 AM, when E8 began her shift.

4. The Resident Census and Conditions of Residents, CMS-672, dated 02/13/13, documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 315	Continued From page 20 that 24 residents are occasionally or frequently incontinent of bladder and 13 are occasionally incontinent of bowel. It also documents that the facility currently has no urinary or bowel toileting programs.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure adequate nutrition to prevent weight loss was provided for 1 of 1 residents (R7) reviewed for unplanned weight loss in the sample of 10 and 1 resident (R14) in the supplemental sample. Findings include: 1. R7's Physician Order Sheet (POS) of February 2013 documents R7 is on a Regular Pureed Diet with Nectar thick liquids, (supplement) BID (twice a day) and chocolate pudding at lunch and supper. R7 has an order for weekly weight.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 325	Continued From page 21 R7's Minimum Data Set (MDS) of 1/14/13 documents R7 requires extensive assistance of 1 for eating. R7 was observed on 2-14-13 to receive a noon meal of 1/2 cup pureed potato casserole, 1/3 cup of pureed peas, a serving of pureed peas, 1/2 cup of chocolate pudding. R7 did not receive a (supplement) or Pureed Buttered Bread. E4, the cook, was observed on 2/14/13 at 10:15AM to puree the tator tot potato/hamburger casserole and peas. E4 stated there were 2 residents in the facility that received pureed diets so she was making 2 servings of each item . She did not measure amount of liquid added to puree the food and the pureed food was runny consistency. She did not add bread and margarine to the peas as per recipe and did not dish up consistent amount of meat when portioning for the pureed potato/hamburger casserole. She did not puree buttered bread or serve as per menu. After serving the meal, there was 1/2 cup pureed potato casserole and 1/2 cup pureed peas as leftovers. This would reflect R7 received less calories and protein as per recipes and menu. R7 also did not receive the (supplement). On 2/15/13 at noon meal R7 did not receive Chocolate pudding or (supplement). Interview with E20, cook, and E12, dietary aide, on 2-15-13 at 1:10PM, both state R7 should have gotten Pudding and (supplement) at noon meal. E20 looked at where R7 had been sitting and stated he didn't get it and E12 stated she forgot to give it to him. Both confirmed (supplement) is given at meals and not in between stating they had no residents getting supplements in between meals. Interview with E19, Certified Nurse Aide (CNA) at	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 325	Continued From page 22	F 325		

1:05PM, E19 stated R7 does not get supplement between meals. Interview with E17, Registered Nurse (RN) at 12:30PM, E17 stated there are no weekly weights documented for R7.

R7 was observed to be fed both meals and ate less than 50%.

R7's Dietary Progress note of 1-14-13 documents he is 64 inches tall, weighs 145 lbs (pounds) with an Ideal Body Weight (IBW) range of 117 - 143 lbs. Intake is fair at 53% of 3 meals. Note of documents to add (supplement) BID. Dietitian Progress Note of 2-9-12 document R7 has had a weight change. Weight 142 lbs 2/13 down 14 lbs in 3 months and down 16 lbs in 6 months (10.1%). Weight loss is undesired. Appetite is fair to poor per Nursing Notes. ...Will ask Physician if there is a medication that would be appropriate to stimulate appetite. R7's POS shows an order on 2-11-13 for Megace 400 mg daily for 1 month.

2. Record review of R14's February 2013 POS documents R14 was admitted to the facility on 1/7/13 and is on a pureed diet. R14 has an order of 2/18/13 for a supplement drink between meals as needed. R14's weight records document R14 weighed 110 lbs when admitted there was no weight documented for February 2013. Interview with E17, RN, on 2-19-13 at 9AM, E17 stated R14's February weight was 106.4 lbs.

At noon meal on 2-14-13 at 11:30AM, R14 was given 1 #8 scoop of pureed potato casserole, a #12 scoop of peas and a serving of pureed cake along with juice and water. R14 did not receive any pureed bread and butter as per menu and the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 325	Continued From page 23 portions for the pureed potato/hamburger casserole and peas were inadequate. At noon meal on 2-15-13, R14 received pureed meat balls, pureed broccoli rice casserole and pureed cookie and ate 100%. E1, Administrator, stated on 2/15/13 at 4PM, E1 stated that R14's son had expressed concerns that R14 stated she was receiving small portions of food at meals.	F 325		
F 332 SS=E	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 interview, observation and record review, the facility failed to ensure a medication error rate of less than 5%. Of 42 opportunities, 5 errors were identified resulting in an 11.9% medication error rate for 1 of 10 residents (R1) on the sample of 10 and three residents, (R15, R16, R14) in the supplemental sample. Findings include: 1. On 2/14/13 at 12:10am, E14 Licensed Practical Nurse (LPN) gave R1 Novolog 20 units subcutaneous while R1 was in her room. The Physicians Order Sheet (POS) for February 2013 documents R1's Novolog is ordered to be given with meals. R1 was not served her meal until 11:55am. This error was confirmed in interview	F 332		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ____ B. WING ____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 332	Continued From page 24	F 332		

with E14 at 3:30pm on 2/14/13 who confirmed in interview that the order was for the insulin to be given with meals which she did not do.

2. During observation of a medication pass, on 2-15-13 beginning 11:30a.m, E17, Registered Nurse (RN), did not timely administer the following medications:
1) R14's physician ordered "Aleve 1 tablet" was administered at 12:50a.m. R14 was served lunch at 12:05p.m. According to the Geriatric Dosage Handbook, 13th Edition, Aleve should be administered with food, milk or antacids to decrease GI (gastrointestinal) adverse reactions.
2) R15's physician ordered "Reglan 5mg" was served with his noon meal and not 30 minutes before he was served his noon meal as recommended by the manufacturer.

3. On 02/14/13 at 11:39 AM, E17, LPN, was observed during a medication pass to administer Metoclopramide (Reglan) 5 mg tablet to R16 during the lunch meal time. R16 was observed to be eating lunch and E17 gave the tablet with a spoonful of applesauce and water.

The POS, dated 02/04/13, documented "Metoclopramide (Reglan) 5 mg tablet take 1 tablet by mouth 30 minutes before meals and at bedtime." The orders are to give at 7:30 AM, 11:30 AM, 4:30 PM and 9:00 PM.

The Medication Administration Record documented from 02/04/13 to 02/14/12, the 11:30 AM doses were initialed by staff as given. The lunch meal time service is 12:00 PM.

On 02/19/13 at 9:30 AM, during an interview with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 332	Continued From page 25	F 332		

Z1, Registered Pharmacist (RPh) she stated that the manufacturer's guidance for the medication Metoclopramide (Reglan) would be the same guidance used in the Nursing Drug Handbook. Z1 further stated that this drug is recommended to be given 30 minutes before meals to help decrease the effects of Gastroesophageal reflux disease.

4. On 02/14/13 at 11:41 AM, E17, LPN, was observed during a medication pass to administer Metoclopramide (Reglan) 5 mg tablet to R15 during the lunch meal time. R15 was observed to be eating lunch and E17 gave the tablet whole with water.

The POS, dated 09/03/12, documented "Metoclopramide (Reglan) 5 mg tablet take 1 tablet by mouth 3 times daily." The orders are to give at 6:00 AM, 12:00 PM and 5:00 PM.

The Medication Administration Record documented for the months of December, 2012 and January, 2013 and February, 2013, the 12:00 PM doses were initialed by staff as given.

F 363 SS=D — 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED — F 363

Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.

This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ____ B. WING ____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

(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 363	Continued From page 26	F 363		

Based on observation, interview and record review, the facility failed to follow the recipes and menu for 1 of 1 residents (R7) reviewed for pureed diet in the sample of 10 and 1 resident R14 in the supplemental sample.

Findings include:

The facility Diet Spreadsheet for the pureed menu on 2-14-12 documents at noon meal, residents are to receive a #8 scoop (1/2 cup) of pureed potato casserole, a #12 scoop (1/3 cup) of pureed peas, a # 20 scoop (little less than 1/4 cup) of pureed buttered bread, and #10 scoop (2/5 cup) pureed frosted cake.

E4, cook, was observed on 2/14/13 at 10:15AM to puree the potato casserole and peas. E4 stated she had 2 residents in the facility on a pureed diet. E4 scooped two # 8 scoops of potato casserole into a blender. The first scoop was mostly mashed potatoes with approximately 2 tablespoons of meat and cheese. Which would make the portion deficient in protein. The second scoop was more evenly portioned with meat and potatoes. E4 added milk to the blender and proceeded to puree the casserole and add milk until it was of a cream soup consistency. E4 stated she doesn't measure the amount of milk she uses. E4 then was observed to puree peas. E4 put two 1/2 scoops peas into the blender and added broth to the peas. E4 did not measure amount of liquid used to pureed the peas. The peas were a thin runny consistency.

At noon meal on 2-14-13 at 11:30AM, R14 was given 1 #8 scoop of pureed potato casserole, a #12 scoop of peas and a serving of pureed cake

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 363	Continued From page 27 along with juice and water. R14 did not receive any pureed bread and butter. At 11:50AM R7 was served his pureed diet. R7 received 1 #8 scoop of potato casserole, 1 #12 scoop pureed peas a serving of pureed cake and liquids. R7 did not received pureed buttered bread. At 11:55AM, E4 took left over pureed potato casserole and pureed peas from the steam table and into the kitchen. E4 was asked to measure the left overs and measured 1/2 cup pureed potato casserole and 1/2 cup pureed peas. This would reflect R7 and R14 received approximately 1/3 less a serving of pureed potato casserole and 1/3 less of pureed peas than as per menu and no pureed buttered bread. The (Potato) casserole recipe documents recipes for 15 servings, 25 servings and 50 servings. There is no recipe for 2 servings. The portion size after pureed is documented as #8. The recipe for pureed peas document serving for 15, 25 and 50 servings. The recipe calls for adding bread and margarine to the peas and then puree until smooth. E4 did not add bread or margarine to her peas. The portion size is documented as #12 (1/3 cup).	F 363		
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	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 371	Continued From page 28	F 371		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to ensure: there is a system in place to ensure food is stored, cooled and prepared in a manner which prevents potential contamination; and there is a cleaning schedule to ensure food contact surfaces and equipment are clean. This has the potential to affect all of the 38 residents living in the facility.

Findings include:

1. During initial tour of the kitchen on 2/13/13 there were 2 containers of oatmeal in the refrigerator. The larger container was put in the refrigerator at 7:20AM, per interview with E4, Cook. At 9:58AM the oatmeal had a temperature of 80 degrees F. (Fahrenheit) and at 11:50AM the oats were 66 degrees F. The smaller pan was put into the refrigerator at 8:15AM, per interview with E4. At 9:58AM the oatmeal had a temperature of 102 degrees F and was 72 degrees F at 11:50AM.

The refrigerator also contained foods not labeled properly with date and time. There was tomato juice labeled 3-8 and ham and ground ham labeled 3-10 with no time documented that it was put into the refrigerator. There was cooked left over sausage patties, and apple crisp dated 2/12 with no time on the label. There was left over red beans dated 2/8 with no time. Left over sausage

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 371	Continued From page 29 gravy dated 2/10 with no time on the label. On 12/20/13 at 11:45PM, E3, Dietary Manager stated that the label for the tomato juice and ham dated 3-8 and 3-10, should have been 2-8 and 2-10, E4 accidently documented the wrong month. 2. During initial tour of the kitchen on 2/13/13 the small chest freezer had spilled food in the bottom, there was an open drink not labeled or covered in the freezer and no thermometer. 3. Record review of the TEMPERATURE CHART for the freezers and reach in cooler and walk in cooler documents lack of documentation that temperatures are checked on a daily basis. The January and February 2013 TEMPERATURE CHART documents there is no recorded temperature for the reach in cooler for January and only 1 time in February which was February 13 the day of the survey. There is no temperature documented for the walk in cooler or the store room freezer for January or February 1-13, 2013. The Freezer #2 (kitchen chest freezer) had temperature documented only 3 days in January and no temperature documented February 1-13, 2013. According to the facility Policy and Procedure for Cooler and Freezer Temperatures, that is not dated, "The temperatures of the coolers and freezers will be recorded twice a day. The temperature will be recorded on the temperature log..." Interview with E3, Dietary Manager, on 2-20-13 at 11:45AM, E3 stated the Policy and Procedure	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 371	Continued From page 30	F 371		

was implemented prior to her being Dietary Manager and stated she had not enforced the policy.

4. The reach in freezer in the outside storage building was soiled with frozen pink substance and dried food debris on the bottom of the freezer.

5. On 2/14/13 at 9:40AM, there was a bottle of water sitting on the tray for the meat slicer. The garbage can was overflowing with garbage on top of the lid. The meat slicer, storage containers for sugar and flour, the microwave and the can opener were greasy and sticky. The uncovered, unlabeled drink was still in the freezer. E4 stated it was a left over milkshake belonging to R14.

6. On 2/14/13 at 9:55AM, E3 was informed of the concern of lack of cleanliness of the kitchen equipment and stated she had not been enforcing a cleaning schedule and had just today implemented a cleaning schedule that staff will have to sign off when they do the cleaning. E3 was told of the concern of cooling foods down properly and stated the facility did not have a system in place to ensure foods are cooled down properly.

7. On 2/14/13 at 10:15AM, E4 was observed to puree hamburger/potato casserole. E4 removed the pan of casserole from the oven to get portions for the pureed diets. She placed the lid from the hamburger/potato casserole into a sink that was soiled with food debris. After portioning purees, E4 placed the lid back onto the casserole and put it into the oven.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 371	Continued From page 31 8. On 2/14/13 at 11:10AM, the microwave in the Dining Room by the steam table was soiled inside and outside with dried food debris. 9. The facility's Resident Census and Conditions of Residents CMS 672, dated 02/13/13, documented that the facility has 38 residents living in the facility.	F 371		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility's pharmacist failed to evaluate each resident's drug regimen and make any necessary recommendations for 1 resident (R15) reviewed for medication in the supplemental sample. Findings include: 1. During a medication pass on 02/14/13 at 11:41 AM, E17 was observed to give R15 Metoclopramide (Reglan) 5mg by mouth while R15 was eating lunch.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	**RURAL ROUTE 2 WINCHESTER, IL 62694**

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F 428	Continued From page 32	F 428		

The Physician's Order Sheet (POS), dated 02/01/13, documented Metoclopramide (Reglan) 5 mg 1 tablet by mouth 3 times daily that had an original order date of 09/03/12. The Medication Regimen Review sheet had been signed as reviewed by the facility's pharmacist monthly since April, 2012 through January 31, 2013.

On 01/31/13, the Consultation Report by the facility's pharmacist made a recommendation to discontinue the Metoclopramide (Reglan) given for GERD and initiate Omeprazole 20 mg, a proton-pump inhibitor. The Consultation Report further explains that "Metoclopramide (Reglan) is considered unacceptable for the treatment of GERD in nursing facility individuals because there are no definitive data showing that it promotes esophageal mucosal healing, and because of its many undesirable side effects (such as dyskinesias, hallucinations, drowsiness, tremor and restlessness.)"

The facility's Pharmacy Recommendation Policy, dated April 28, 2010, documented under, "Procedure: 1. Once the Pharmacy Consult has provided the Director of Nursing with the recommendations that have been made: c. The original recommendations will then be mailed out to the Physician's...a copy is placed in a file to assure that all sent out are then received..."

The Consultation Report was signed without a date and returned to the facility. The physician's response was marked: "I accept the recommendation above, please implement as written." The order for Metoclopramide (Reglan) was not discontinued until 02/19/13. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ____ B. WING ____	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 428	Continued From page 33 Medication Administration Record, dated February, 2013, documented that R15 had received Metoclopramide (Reglan) as scheduled three times per day each day.	F 428		
F 441 SS=F	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. (c) Linens	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 34 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 interview, observation and record review, the facility failed to establish and/or maintain an Infection Control Program that identifies, controls and investigates infections, failed to maintain a current record of incidents and corrective actions related to infections, failed to wash hands when appropriate and failed to properly clean the glucometer after use. This has the potential to affect all 38 residents residing in the facility. Findings include: 1. The facility failed to maintain an infection control program that includes identifying infections timely enabling the facility to determine patterns and trends. On 2/13/13 a current Infection Control Log was requested. The Administrator, E1, identified two residents recently hospitalized in the past two days for upper respiratory infections (URI) and one resident, R20, currently in house with a URI. At 10:55am, a January 2013 log was provided by E1 which included no documentation or evidence showing the facility analyzed the data to determine patterns and trends for January. E1 stated at the time that the facility did not have the February Log completed yet and asked if we wanted them to do it early. E1 identified E2,	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 35 Director of Nursing (DON), as the Infection Control Designee and explained that E2 would not complete the log until the end of the month when they get the lists from pharmacy on antibiotics and lab results. On 2/14/13 at 10:25am, a request for the February Infection Control Log was again made to E1. E1 stated in interview that she would have E2 work on it. A short while later, a handwritten list of residents was provided by E1 that included only names, sources of infections and dates. In addition, E1 stated she did not inform or notify the department or local health department of any of the URI's and did not realize she needed to with 2-3 residents exhibiting the same symptoms. On 2/15/13, the newly completed February log was provided. In review of the January log, the facility identified 5 residents, R17 - R21, with URI's between 1/29/13 and 1/31/13. According to the February 2013 log, there were 4 residents, R5 (x 2), R16, R23, R22 identified with URI's between 2/1/13 and 2/9/13. No evidence was presented that showed the facility effectively identified a cluster of URI's at the end of January and no documentation was provided that showed a preventative plan to control URI's in other residents at the time of the infections was developed and implemented. Interview with the Administrator on 2/14/13 at 2:15pm indicates that she did not realize that the facility had a "cluster" until she looked at the log and stated "that is why it is so important to keep the log up daily.' According to the facility policy entitled "Infection Control Committee Policy & Procedure" documents under #4 "The Committee shall	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 36	F 441		

monitor the health and environmental aspects of the facility to include the development, implementation, and at least yearly revision of policies and procedures related to the prevention and control of infections, maintenance of sanitary environment, techniques and systems for identifying infections within the facility, and with procedures for reporting to appropriate government agencies, which are consistent with the most up-to-date Centers for Disease Control and Preventions publications." There is no evidence the facility is monitoring infections in a ongoing manner in an effort to identify infections timely for control and prevention purposes since they only complete the data collection on a monthly basis. There is also no documentation that the facility identifies patterns and trends and sets a plan of correction in place to address these infections on the previous logs provided.

2. On 2/14/13 at 11:05am, E14 Licensed Practical Nurse did an blood glucose check on R1 in her room using a glucometer. E14 then returned to the medication cart, removed a (sanitizing/disinfecting) cloth from the dispenser on top of the cart, wiped the glucometer for 10 seconds and left it to air dry. According to the manufacturers directions for use on the container, "surface must remain visibly wet for a full 2 minutes. Use added cloths to keep wet 2 minutes." This was confirmed in an interview with E14 on 2/14/13 at 1:10am who stated she was unaware of the time frame required to properly disinfect the glucometer after use and was unsure as to how she was going to keep the surface wet for a full 2 minutes.

The facility policy entitled "Procedure for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 37	F 441		

disinfecting Blood Glucometer Monitors" dated 12/14/10 documents disinfecting guidelines indicate a bleach solution of 10% is to be used but a "(sanitizing/disinfectant) wipes can be used, as they are equivalent to the 10% bleach solution recommended by the CDC for healthcare settings." and "After cleaning/disinfecting your monitor wait 2 minutes before using that monitor on another resident.'

3. On 2/13/13 at 3:12pm, E6 and E5 Certified Nurses Aides (CNA) toileted R6 who had a catheter leg bag on that had leaked. R6 ambulated to the toilet and pulled down her pants which were wet where the bag rested at her knee area. Both CNA's touched the catheter/bag as the bag was emptied and without removing their soiled gloves and washing their hands, handled her clean pants, touched her shoulder as they assisted her up from the toilet.

The facility policy entitled "Handwashing" identifies its purpose as preventing cross contamination and control infection using soap and running water to wash hands when soiled.

4. On 02/14/13 at 11:19 AM, during a medication pass, E17, Registered Nurse (RN), was observed checking a blood glucose level on R5. After performing the procedure of the blood glucose level, E17 cleansed the blood glucose machine with a (sanitizing/disinfecting) cloth for approximately 5 seconds and sat the machine directly on the medication cart. Approximately one minute later, E17 put the machine in the top drawer of the medication cart.

At 11:45 AM, E17 stated that she normally wipes

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146106	A. BUILDING ______ B. WING ______	02/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SCOTT COUNTY NURSING CENTER	RURAL ROUTE 2 WINCHESTER, IL 62694

(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 38 the machine down thoroughly with the (sanitizing/disinfecting) wipe and lets it dry a minute or two before putting in away. The Facility's Resident Census and Conditions of Residents CMS 672, dated 2/13/13, documented the facility has 38 residents living in the facility.	F 441		