STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145836	A. BUILDING _____ B. WING _____	07/08/2016

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SHELBYVILLE REHAB & HLTH C CTR	2116 SOUTH 3RD DACEY DRIVE SHELBYVILLE, IL 62565

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Licensure Survey For Subpart S:SMI	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to make State Survey and Certification Agency survey results readily available for two substantiated complaint investigations and also failed to ensure survey results were easily accessible to residents. This has the potential to affect all 35 residents in the facility. Findings include: On 7/8/2016 at 9:30 AM, annual survey results were displayed in the facility living room in a binder. The survey results only documented the last annual survey from 6/18/2016 with the facility's Plan of Correction. No other surveys were included with the annual survey.	F 167		

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

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F 167	Continued From page 1 On 7/8/2016 at 9:45 AM, E1 (Administrator) acknowledged not knowing that substantiated complaint investigation surveys are required to be posted in the survey binder. The facility had substantiated complaint investigation surveys with findings on 9/26/2015 and 12/17/2015. On 7/8/2016 at 9:30 AM, survey results were displayed in a binder in the facility living room entertainment center. The binder was located 60 inches from the floor and was not within easy reach for all residents. The Resident Census and Condition of Residents Report dated 7/5/2016 documents 34 residents residing in the facility.	F 167		
F 354 SS=F	483.30(b) WAIVER-RN 8 HRS 7 DAYS/WK, FULL-TIME DON Except when waived under paragraph (c) or (d) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. Except when waived under paragraph (c) or (d) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced	F 354		

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F 354	Continued From page 2 by: Based on observation, record review, and interview, the facility failed to utilize the services of a registered nurse for eight consecutive hours per day, and failed to designate a registered nurse to serve as a full time director of nursing. These failures have the potential to affect all 35 residents residing in the facility. Findings include: On 7/5/16 at 9:30 am, E2, Minimum Data Set Coordinator/ Care Plan Coordinator/ Licensed Practical Nurse, stated, "We do not have a Director of Nursing right now." The Facility Roster form revised March 2006, completed by E1, Administrator, on 7/5/16, documents the absence of a name for a Director of Nurses and the absence of a name for an Assistant Director of Nurses. Throughout the entire course of the survey, there was no Director of Nurses present at the facility. The facility's posted Daily Staffing confirms there was not a registered nurse on duty for the entirety of the survey. On 7/8/16 at 10:50 am, E1, Administrator, stated, "The last day our Director of Nurses worked was May 18, 2016 so we have not had a Director of Nursing since May 19th." On 7/6/16, E1 provided a staffing spreadsheet for the two week period of 6/17/16 through 6/30/16. This spreadsheet documents a Registered Nurse was not working in the facility on the following dates:	F 354		

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F 354	Continued From page 3 6/17/16 through 6/21/16, 6/23/16, 6/24/16, 6/26/16, 6/28/16, and 6/30/16. This same spreadsheet documents a registered nurse worked one hour on 6/22/16, and five hours on 6/25/16. This spreadsheet also documents the facility has a daily average skilled census of 3.43 residents. On 7/8/16 at 10:50 am, E1, Administrator stated, "The staffing spreadsheet is accurate and complete. I based the spreadsheet on the actual time clock punches." The facility's Staff Schedule for the month of June 2016 documents, with the exception of E1, Administrator/Registered Nurse, who worked in direct care for one and one-half hours on 6/10/16, and E3, Corporate Registered Nurse who worked eight hours on each of 6/7/16, 6/15/16, 6/16/16, 6/27/16, and 6/29/16, there was not a registered nurse scheduled to work in the facility, nor was there a Director of Nurses scheduled to work in the facility. The facility's Staff Schedule for the month of July 2016 documents, with E1's, Administrator's daily schedule, there was not a Registered Nurse scheduled to work in the facility, nor was there a Director of Nurses scheduled to work in the facility. The facility's Resident Census and Conditions of Residents report dated 7/5/16 documents 35 residents reside in the facility.	F 354		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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F 441	Continued From page 4 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 Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility	F 441		

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F 441	Continued From page 5 failed to maintain a sanitary environment while performing incontinence care for one resident (R15) out of three residents reviewed for incontinence care in the sample of ten residents. Findings include: R15's Physician Order Sheet dated 7/1/16 documents medical diagnoses including Clostridium Difficile (C-Diff), Cecal Mass (colon cancer), Prostate Cancer, Colitis, and Chronic Kidney Disease. R15's Minimum Data Set dated 6/24/16 documents R15 is frequently incontinent of bowel, requires assistance of 2 staff members for bed mobility, and is totally dependent upon 2 staff members for toileting. On 7/5/16 at 12:45 pm, R15's water pitcher, 8 ounce glass of tea, and 8 ounce glass of water were sitting on R15's overbed table. On 7/6/16 at 12:12 pm, R15's meal tray was sitting on R15's overbed table. A bureau was sitting outside R15's room which contained isolation gowns and gloves for use when facility staff performed direct care for R15 (due to the C-Diff diagnosis). On 7/6/16 at 3:30 pm, E5 and E6, Certified Nursing Assistants (CNA's), performed incontinence care for R15. After donning clean gloves, E5 placed a stack of white linen washcloths into the handwashing sink (not a clean vessel) and turned on the water faucets handles (not clean fixtures). E5 then manipulated the cranks (not clean fixtures) to lower the foot end of R15's bed. E5 then returned to the handwashing sink and wrung out the washcloths, and placed the washcloths onto a clean field set	F 441		

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F 441	Continued From page 6 up on R15's bedside bureau. E5 wore the same gloves throughout this entire process. E5 and E6 both placed clear plastic bags on R15's overbed table. E5 had placed a clean white linen towel on one-half of the overbed table onto which E5 placed one plastic bag. E6 placed the second plastic bag directly on R15's overbed table surface. The plastic bag placed by E5 was used to dispose of soiled linen washcloths used to perform incontinence care for R15. R15 was incontinent of frank, visible, dark unformed stool. The plastic bag placed by E6 was used to dispose of a blue and white disposable incontinence pad which was underneath R15. The blue and white disposable incontinence pad was also smeared with the stool as described. Upon completion of performing incontinence care for R15, neither E5 nor E6 cleaned R15's overbed table. On 7/6/16 at 3:45 pm, E6 stated, "We do have basins we can use to put washcloths into." On 7/6/16 at 4:10 pm R15's water pitcher was sitting on the overbed table. On 7/7/16 E7, Maintenance/ Housekeeping/ Laundry Supervisor, stated, "The majority of our room cleaning is performed on the day shift. No, (R15's) room would not have been cleaned between the hours of 3:00 pm and 5:00 pm on 7/6/15."	F 441		
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	F 458		

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F 458	Continued From page 7 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 80 square feet of floor space per resident bed. This affects one resident (R9) in the sample of 10 and 28 residents (R1, R3, R5-8, R10, R12-14, R16, R19-33, R35-36) in the supplemental sample. The findings include: Historical room size documentation and actual measurements demonstrate that the facility has 32 resident rooms that do not provide 80 square feet per bed. Resident rooms 101-111 and 201-210 provide 73 square feet per bed. Rooms 301-311 provide 78 feet per resident. According to the Room Roster dated 7-5-16, R1, R3, R5-8, R10, R12-14, R16, R19-33, and R35-36 reside in the undersized resident rooms. On 7/8/2016 at 9:35 AM, E1 (Administrator) acknowledged these 32 resident rooms are certified for Title 19 Medicaid.	F 458		