STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	Annual Licensure & Certification survey 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		6/25/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 07/07/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 157	Continued From page 1	F 157		

by:
Based on interview and record review, the facility failed to notify the physician regarding a significant weight loss for one of two residents (R1) reviewed for weight loss in the sample of 10.

Findings Include:

R1's Physician Order Sheet dated 5/16/15 - 6/15/15 list the following Diagnoses: Chronic Obstructive Pulmonary Disease, and status post Fracture of the Left Hip.

The facility Monthly Weight (wt) Grid dated 7/14 - 6/15 documents the following wt for R1: 9/14 - 137 pounds (lb), 10/14 - 138 lb, 11/14 - 143 lb, 12/14 - 144 lb, 1/15 - 149 lb, 2/15 - 139 lb, 3/15 - 139 lb, 4/15 - 133 lb, 5/15 - 121 lb, 6/15 - 121 lb. This weight loss calculates to the following significant wt loss: 18.79% in 180 days (1/15 - 6/15), 12.95% in 90 days (3/15 -6/15), and 9.02% in 30 days (4/15 - 5/15).

No documentation is found in R1's medical record from 1/15 - 6/15 that Z1 (R1's physician) was made aware of R1's wt loss.

Dietary Notes dated 5/6/15 by Z2 (Registered Dietician) documents a significant wt loss with no new recommendations made, "intakes 25 - 75 % of meals...(R1) to take food and drinks as he desires and can tolerate." Dietary Notes dated 6/3/15 by Z2 documents a significant wt loss with no changes with diet, "intakes 50 - 75% of most meals."

On 6/15/15 at 3:45 pm E2 Director of Nursing confirmed that Z1 had not been notified of R1's significant wt loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 157	Continued From page 2 On 6/16/15 at 9:20 am R1 stated, "I have lost right at 60 lb over the last year or so...I had lost wt immediately after I broke my hip, then gained some of it back but now I'm back to losing it." The facility Resident Weight Monitoring Policy dated 10/14 documents, "if there is an actual wt change, the residents Healthcare Power of Attorney/family/guardian, physician and dietitian are notified. The physician shall be notified using the MD notification of wt change form."	F 157		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of	F 164		6/27/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 164	Continued From page 3	F 164		

the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to protect the identity of two residents (R1, R6) reviewed for privacy and confidentiality in the sample of 10.

The findings include:

1. On 6/17/15 at 12:45 pm the facility Survey Binder containing the results of the most recent survey conducted by the Illinois Department of Public Health was reviewed. The book contained the Statement of Deficiencies (HCFA-2567) from the Licensure and Certification survey from 5/30/14 and the Plan of Correction.

The Survey Book is located on a wall shelf in the living area by the Administrators office for viewing by the residents and the public. As part of the evidence for the Plan of Correction, the facility had included a copy of a Self Administration of Medication Assessment dated 5/8/14 for R1 that had the resident's name and medical assessment. It also included a Physical Restraint/Enabler Assessment dated 5/23/14 for R6 that included the residents name, diagnoses as well as a Physician's Telephone Order for restraint use with R6's name and diagnoses dated 5/28/14.

The Director of Nurse's E2 was shown the documents on 6/15/15 at 12:50 pm. E2 stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 164	Continued From page 4 that the resident information should not have been include as it was a HIPPA (Health Information Protection and Portability Act) violation. The facility "Residents' Rights for People in Long-term Care Facilities" brochure from the Illinois Department on Aging dated 6/09 states "Privacy -Your medical record and personal care are private...Your facility may not give information about you or your care to any unauthorized persons without your permission."	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to document a medical symptom to justify the use of physical restraints and failed to ensure resident safety while wearing a restraint for one of three residents (R6) reviewed for restraints in the sample of 10. Findings include: R6's June 2015 Physician Order Sheet (POS) documents diagnoses that include Schizophrenia, Anxiety Disorder due to Schizophrenia, Arthritis and Dementia. R6's POS documents an order for a Restraint/Enabler, "May apply pelvic restraint when up in chair-release minimum of every two	F 221		7/10/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 221	Continued From page 5 hours and ambulate to toilet and meals related to unsteady gait and potential for falls, diagnoses Dementia with poor cognition and safety awareness." R6's Minimum Data Set (MDS) dated 4/23/15 documents R6 is extensive assist of one person for ambulation and does not identify a trunk restraint as being used. R6's Care Plan dated 12/3/14 documents, "..Resident has been known to attempt to get up from chair unattended....and has been known to attempt to get out of bed unattended... Maintain pelvic restraint when in chair at all times.....Release every two hours, at meal times when attended, during one to one activities and PRN (as needed)." On 6/15/15 at 11:03 AM R6 was seated in a dining room chair at the table with a pelvic restraint tied around the back of the chair. The restraint was untied during the meal. After R6 was finished eating, E8 Certified Nursing Assistant (CNA) applied the gait belt around R6 and walked with R6 down the hall to R6's room. R6 was steady walking and E8 had E8's hand on the gait belt on R6's back. E8 and E11 CNA assisted R6 to the toilet. R6 pulled R6's own slacks and incontinent brief down while standing with E8 having E8's hand on the gait belt. R6 displayed no balance issues while sitting on the toilet. R6 attempted to rise from the toilet one time and E8 asked R6 to sit back down and R6 sat back on the toilet. On 6/15/15 at 12:27 PM R6 was alone in R6's bathroom standing at the sink washing R6's hands while the pelvic restraint was still around R6 and tied to the wheelchair.	F 221		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 221	Continued From page 6	F 221		

On 6/15/15 at 2:01 PM R6 was in the dining room for an activity in a wheelchair with the pelvic restraint tied behind the wheelchair. At 2:28 PM R6 was still participating in the activity while remaining in the wheelchair with the restraint tied behind wheelchair. E12, Activity Director/Social Service Director was present during the activity. At 2:53 PM R6 remained in the activity room in the wheelchair with the restraint tied behind the wheelchair sleeping. E12 was still present in the room.

On 6/16/15 at 11:08 AM R6 was in the dining room in a dining chair being fed lunch by E9 CNA. The pelvic restraint remained tied behind the chair. R6 was in the same position with the restraint tied during the meal at 11:17 AM, 11:23 AM. At 11:32 AM E9 removed the restraint and walked R6 back to R6's room. R6 walked upright with minimal assistance to the bedroom with E9 just holding the gait belt at the back.

At 12:35 PM E8 entered R6's room and said, "(R6) what have you done!" R6 was in the bathroom on the toilet with the pelvic restraint entangled tightly around R6's thighs and R6's left leg could not touch the floor as the restraint was too tight. R6 had transferred self to the toilet while wearing the pelvic restraint that was still attached to the wheelchair. E8 stated, "I saw the bathroom door open and did not see (R6) so I came in and found (R6) on the toilet. I have never seen (R6) do this before. (R6) will stand up at the sink to wash (R6's) hands with the restraint on but never this." E8 asked R6 if R6 needed to have a bowel movement and R6 said, "yes."

On 6/17/15 at 9:56 AM there was no documentation in R6's Nurses Notes about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 221	Continued From page 7	F 221		

self transfer to the toilet with restraint entrapment the day before. E6 Licensed Practical Nurse (LPN) stated that the CNA told (E6) that (R6) tried to transfer but E6 was unaware that R6 completed the transfer. E6 stated, "It's a good thing (R6) had the pelvic restraint on, (R6) could've fallen."

On 6/17/15 at 9:50 AM E2, Director of Nursing stated that R6 has not had a recent therapy evaluation and stated therapy did not tell them to put the restraint on. E2 stated, "(R6) walks well. (R6) just falls."

R6's Restraint Reduction Flow Record documents quarterly attempts at restraint reduction on 9/1/14, 11/20/14, 2/5/15 and 4/22/15. The restraint attempt each time was the alarming seat belt and pressure alarm. There was no documentation available of any other interventions, devices, or reductions attempted. Each time it is documented that R6 had a "failed attempt."

R6's Physical Restraint Elimination Assessment documents for 11/20/14, 2/5/15 and 4/23/15 that R6 is a good candidate for restraint reduction.

R6's Physician Progress Notes for 1/5/15 and 3/2/15 document, "According to the nurse, (R6) is a high risk for falls and needs restraint when sitting up on the wheelchair." R6's Progress Note for 4/1/15 documents, "(R6) needs restraint when sitting up on the wheelchair." Z1, R6's Physician, signed the Progress Notes dated 1/5/15, 3/2/15 and 4/1/14.

The facility's undated Physical Restraint/Enabler Policy documents, "To allow residents to be free

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	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 221	Continued From page 8 of physical restraints which are not required to treat the resident's medical symptoms or as a therapeutic intervention. Physical restraints shall not be used for the purpose of discipline or convenience....Definition of Physical Restraint is any manual method or physical or mechanical device..or equipment attached or adjacent to the resident's body which the individual cannot remove easily and which restricts freedom of movement or normal access to one's body. They include, but are not limited to..soft waist restraints, lap cushions, vest restraints.."	F 221		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED 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: Based on observation, record review and interview the facility failed to ensure that residents on Mechanical Soft diets and Pureed diets received the planned amount of protein by failing to prepare food according to the menu. This affected four residents (R3, R6, R10, R11) reviewed for nutrition in the sample of 10 and three residents (R15, R16, R17)in the supplemental sample. The findings include: The menu for the 6/15/15 lunch meal planned for	F 363		6/25/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 363	Continued From page 9	F 363		

residents on Regular Diets to receive one serving of Chicken Cordon Bleu, residents on Mechanical Soft Diets to receive ground Chicken Cordon Blue with sauce and residents on Pureed Diets to receive a #8 Scoop (4 ounces) Pureed Chicken Cordon Blue.

On 6/15/15 at 9:30 am there was a sheet pan of Chicken Cordon Blue on the stove top ready to be baked. It was comprised of breaded Chicken Patties with a slice of ham and a slice of Swiss cheese on top.

On 6/15/15 at 9:35 am Cook E4 prepared two servings of Pureed Chicken Cordon Blue. E4 had breaded frozen chicken patties boiling on the stove. E4 put two boiled chicken patties and a cup of broth into the food processor and blended till smooth. E4 did not add ham or Swiss cheese to the mixture.

On 6/15/15 at 9:40 am Cook E4 stated E4 was preparing 6 servings of Chicken Cordon Blue. E4 put 6 boiled chicken patties in the food processor with broth and ground them. E4 did not add ham or cheese to the mixture.

On 6/15/15 during the lunch meal from 11:00 am -11:20 am E4 served residents with diet orders for Mechanical Soft diets (R3, R10, R11, R15-17) a three ounce volume dipper of ground chicken patty.
E4 served the one resident on a Pureed Diet a #6 dipper of pureed chicken patty.
There was still one serving of mechanical chicken left over, even though all six resident had been served.

On 6/15/15 E4 weighed the ground chicken patty

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	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

(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 10 left in the pan and it measured 3.25 ounces which meant that each resident received a half ounce less than a full serving of the plain ground chicken. A regular Chicken Cordon Blue patty prepared with ham and Swiss cheese weighed 4.25 ounce. On 6/15/15 at 11:20 am R3 had consumed 100 percent of the ground chicken. The recipe for the Chicken Cordon Blue was reviewed with Dietary Manager E3 and Cook E4. The recipe stated to use a breaded chicken patty with a .4 ounce slice of ham and a slice of Swiss cheese per serving. The menu stated "each chicken cordon blue =22 grams protein (7 grams = 1 ounce protein)from chicken patty and cheese." Based on this information the residents with Mechanical soft diets received approximately 1.5 ounces less protein than planned. R6 with a Pureed diet received a 1/2 ounce less protein, due to not having the slice of ham and cheese added. E3 confirmed on 6/15/15 at 11:30 am that the ham and Swiss cheese should have been included in the ground and pureed chicken. The Diet Report dated 6/9/15 documents R3, R10, R11, R1-17 with Mechanical Soft diets and R6 with a Pureed Diet.	F 363		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system	F 431		7/24/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 11 of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to lock the medication cart to secure the safety of the medication when out of visual control and failed to maintain controlled drugs in a separately locked,	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 12	F 431		

permanently affixed compartment for nine residents (R1-R4, R6, R10-13) reviewed for medications in the sample of 10 and 9 residents (R5, R15-17, R19, R20, R22-R24) in the supplemental sample.

Findings include:

1. On 6/15/15 at 12:07 PM E5 Licensed Practical Nurse (LPN) dispensed medications for R5 and partially pushed in the lock on the medication cart. E5 proceeded into R5's room and administered the medication, and then went into the bathroom to wash hands. During this time the medication cart in the hallway was not in E5's visual control. E5 returned to the cart and pulled the lock on the medication cart out without using the keys and opened the draw to begin the next medication administration.

On 6/15/15 at 12:18 PM E5 left the cart unlocked by only pushing the lock in partially and left the medication cart out of E5's visual control in the hallway while administering R3's eye drops. When finished, E5 entered the bathroom to wash hands while the medication cart remained out of E5's visual control. E5 returned to the cart and pulled the lock out with E5's fingers, and, without using keys replaced the eye drop bottle in the cart.

On 6/15/15 at 2:02 PM E5 Licensed Practical Nurse (LPN) removed R1's eye drop bottle from the cart and left the medication cart unlocked by pushing the lock in partially. E5 proceeded to R1's room and pushed the door partially closed behind E5 leaving the cart out of visual control. After administering R1's eye drops E5 went into the bathroom to wash hands while the medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 431	Continued From page 13	F 431		

cart remained out of visual control. E5 returned to the medication cart and pulled the lock out with E5's fingers without using keys and returned the eye drop bottle into the cart.

On 6/17/15 the facility provided an undated list of residents who were independent with mobility (R1,R3-R6, R9,R11,R12,R17,R19,R20 R22,R23). These residents could potentially gain access to unlocked medications.

The "Procurement and Storage of Medications" policy dated 10/06 states "All medications, except those requiring refrigeration, shall be kept in the locked medicine room or locked medication cart."

2. On 6/16/15 at 11:35 AM E6 LPN administered Hydrocodone-Acetaminophen 10-325mg (milligram) from the scheduled medications in the medication cart, not the locked compartment. E6 stated, "If a resident has scheduled narcotics we leave them with the scheduled medications and the extras are locked in the lock box in the cart."

On 6/16/15 at 4:38 PM E7 Registered Nurse (RN) opened the medication cart and pulled the medication cards that are narcotics that are not locked in the lock box. There were the following medications: R2 had Oxycontin and R24 had Hydrocodone-Acetaminophen.

On 6/17/15 at 12:30 PM the medication storage room was checked with E6. The unlocked refrigerator had the following narcotics: R1, R10, R15 and R16 all had Morphine.

E6 stated, "the narcotics in the medication cart get counted at the end of each shift but the narcotics in the refrigerator get counted by the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	14E360	A. BUILDING _____ B. WING _____	06/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHELDON HEALTH CARE CENTER	170 WEST CONCORD SHELDON, IL 60966

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F 431	Continued From page 14 Hospice nurses and they aren't here everyday. One Hospice company has a nurse here twice a week and the other company has a nurse here four times a week." On 6/17/15 at 4:00 pm E2 stated, "I actually never thought about the Hospice medications in the refrigerator, we will have to get another lock box." The facility's Controlled Substances policy dated 10/06 documents, "...Schedule II drugs are to be kept under two separate locks requiring two separate keys...." According to the Lexicomp Drug Reference Handbook dated 2014-2015 Oxycontin, Hydrocodone-Acetaminophen, and Morphine are listed as Controlled Substances.	F 431		