| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145757 | A. BUILDING _____ B. WING _____ | C 04/01/2016 |

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| F 000 | INITIAL COMMENTS<br><br>Complaint Investigation<br><br>1651380/IL84019 - F226<br>1651457/IL84117 - F315<br>1651544/IL84216 - F315, F441<br>1651623/IL84314 - F226 | F 000 | | |
| F 226 SS=D | 483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES<br><br>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to follow their Abuse policy and notify the Administrator of a resident injury for one of three residents (R3) reviewed for abuse in a sample of 7.<br><br>The findings include:<br><br>According to the Minimum Data Sets (MDS) dated September 2, 2015, R3 is totally dependent on staff for transfers, dressing, and hygiene, always incontinent of bowel and bladder, and staff assessment for mental status codes R3 as severely impaired.<br><br>During an interview with E1 (Administrator) on March 17, 2016 at 9:30 AM, E1 states, "I was notified of a resident to resident altercation at 3:00 PM on March 13, 2016. I immediately | F 226 | | |

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

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| F 226 | Continued From page 1<br>notified the family and physicians after the residents were separated. E2 (DON) came into the facility to start an investigation and E7 (Licensed Practical Nurse) is the staff member that called E2. R3 was sent to the hospital, and R2 was placed on one on one's, and sent to the hospital that evening for a psychiatric consult.<br><br>According to the undated "Abuse Prevention Program Facility Procedure, page 3A of 7, under V. Internal Reporting Requirements and Identification of Allegations, Employees are required to report any incident ... "<br>According to the police report dated March 13, 2016 at 3:01 PM, Z5 (local police officer) interviewed R2, E2, E15 (Certified Nurses Aide - CNA) and E16 (CNA) without conclusions as to how R3 had been injured.<br>The local hospital records for E3's admission on March 13, 2016 indicate under Chief Complaint Description, "(R3) was brought in by ambulance ...post trauma. Patient was found normal for 1 hour; in the following hour she was found to have severe ecchymosis and skin tears and hematomas to her right upper extremity as well as hematoma and ecchymosis to her left face and head. Patient was found in bed with these injuries. Patient is bedridden." Under Physical Exam on the same document, "Head/Eyes: /Additional notes "positive ecchymosis and edema to the left side of the head and the temporal and frontal region, to the left forehead, Orbital region, left side pneumatic region. Upper extremities, Diffuse ecchymosis and edema to the right forearm and right humerus with multiple areas of skin tears. Positive mild ecchymosis to palmer portion of right first digit and Impression: Head injury, closed, contusion, arm upper; Nasal fracture. Discharge Diagnosis (1) Facial abrasion, | F 226 | | |

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| F 226 | Continued From page 2<br>and (2) Head injury without concussion or intracranial hemorrhage, (3) Contusion, arm, upper, (4) Head injury, closed."<br>R3's Diagnostic Imaging report dated March 14, 2016 from a local hospital for a computerized tomography (CT) of the sinus Facial Nasal states: "Fracture of the left nasal ala with overlying soft tissue swelling. No other fractures."<br><br>During an interview with E1 on March 29, 2016, E1 states, "none of the staff I interviewed during this investigation admitted to putting (R3) to bed, feeding her, or trying to get her up. We cannot prove it but as the investigation continues, we think someone tried to put her to bed, she fell, and staff did not report it. R2 and R3 were in bed when the staff went in the room. R3 was injuried somehow and the staff is not admitting to it and no one believes it was R2 that hurt her (R3)."<br><br>R2's behavior tracking from January 2016 through March 11, 2016 does not indicate R2 has physical agression toward staff or other residents.<br><br>According to the final report of the facilities investigation of R3's injury, reviewed on March 31, 2016 at 4:00 pm, abuse was unsubstantiated by the roommate and the injuries to R3 was felt to be in line with R3 falling, during an unknown staff member returning R3 to bed or getting R3 out of bed and not reporting the fall or injury. | F 226 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>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 | F 315 | | |

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| F 315 | Continued From page 3 | F 315 | | |

resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate 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, interview, and record review the facility failed to answer call lights in time to prevent incontinence, and use proper infection control practices for one of four residents (R4) reviewed for incontinence in a sample of 7.
The findings include:

1. R4's Minimum Data Sets dated January 13, 2016 evaluates R4 as needing extensive assistance with one person physically assisting with toilet use, and scores the Brief Interview for Mental Status as 15, indicating R4 is cognitively intact.

On March 17, 2016 at 2:00 PM, R4 stated, "They don't clean me up very good after a bowel movement and I cannot do it myself: I need help with it. I can clean myself ok after I urinate. They shut off the call lights and I have waited an hour before. I put on my call light to go to the bathroom about a month ago, and nobody came so I peed on myself and laid in the bed wet from 1:00 PM to 3:00 PM. I was embarrassed."

On 03/30/16 at 10:50am, E19 (Certified Nursing Assistant) was observed performing perineal care for R4 following an episode of urinary incontinence. E19 cleansed urine from R4's

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| F 315 | Continued From page 4 | F 315 | | |

abdomen and thighs. Without changing gloves, E19 touched a package of perineal wipes with the contaminated gloves. E19 then cleansed the urinary meatus with the same contaminated gloves on.
A Urinalysis for R4 dated 02/10/16 showed the urine was cloudy and contained bacteria, mucous and white blood cells. A Nursing Progress note that same date stated, "Resident has a UTI (urinary tract infection), new order for Cipro 250mg by mouth twice daily for seven days."

During an interview with R4 on March 31, 2016 at 9:50 AM, R4 became tearful reporting an incontinent episode waiting for staff to answer her call light to go to the bathroom.

On March 29, 2016 at 10:30 AM this surveyor went into R4's room, pushed the call light for R4's bed and heard a call light alarm sound down the hallway. The surveyor remained in R4's room and after 10 minutes the sound stopped and no one had entered R4's room. R4's call light was pushed again, another alarm sound was heard and once again the alarm sound stopped. At 10:50 AM, this surveyor went to the call light box in the hall and found the room light and alarm was not lit or sounding for R4's room. At 10:55 AM, E20 (Social Services) went to R4's room while this surveyor remained at the call light box and pushed R4's call light. The appropriate room number lit up, and an alarm started sounding, indicating someone had been putting in the codes to shut off the alarm and light without entering R4's room to respond to the call light. After E20 pushed R4's call light the final time, E14 (Certified Nurses Aide) did come to the call light box, punched in two codes to shut off the alarm, and light prior to going to R4's room.

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| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection. | F 441 | | |

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| F 441 | Continued From page 6<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to provide aseptic perineal care and to maintain adequate infection control standards for a resident on contact isolation for one resident (R7) of three residents reviewed for infection control in the sample of seven.<br><br>Findings include:<br><br>On 03/29/16 at 3pm, E18 (Certified Nursing Assistant - CNA) was observed performing perineal care for R7 following an episode of fecal incontinence. E18 cleansed stool from the perineal area, and, without changing gloves, touched a package of perineal wipes with the contaminated gloves. After care, E18 removed her gloves, did not wash or sanitize her hands, and did not put on clean gloves. With bare hands, E18 then positioned R7 during changing of the dressing to the wound on her coccyx.<br>On 03/29/16 at 3:30pm E18 stated, "I think there were a few times when I should have changed gloves during care just now," and "Since this resident is on contact isolation, you are supposed to wear gloves for anything having to do with her infected wound."<br>An Infection Log dated for March 2016 showed R7 is on contact isolation for Methicillin Resistant Staphylococcus Aureus (MRSA) in a coccyx wound. A Wound Culture Report dated 02/22/16 showed: "Two different gram negative rods, these organisms resemble normal fecal flora, and MRSA, heavy growth." | F 441 | | |