

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 06/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145454	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER CARLINVILLE REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 751 NORTH OAK STREET CARLINVILLE, IL 62626		
(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 Certification Survey	F 000			
F 309 SS=D	Complaint #1643020/IL85947 - No deficiencies cited. 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 observation, interview, and record review, the facility failed to identify, treat and monitor wounds for 2 of 4 residents (R1, R6) reviewed for wounds in the sample of 15. Findings include: 1. The Minimum Data Set (MDS), dated 5/17/16, identifies R1 to have cognitive impairment and requires extensive to total assistance on staff for bed mobility and transfers. The Care Plan, dated 5/20/16, documents R1 to be at risk for pressure ulcers due to immobility with the goal to have intact skin, free of redness blisters and discoloration. Interventions include: assess skin with all cares, report anything identified, and weekly skin assessments. The Weekly Skin Assessment, dated 6/2/16, documents no new skin issues and none present at the time.	F 309			
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.

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F 309	<p>Continued From page 1</p> <p>On 6/7/16 at 9:18 AM, R1 was sitting in his wheelchair in the hallway outside his room. The chair had no pedals to support his feet. R1's right shin had two large areas of black scabbing present on the shin bone with the surrounding area of at least 2 inches red and edematous looking. R1 wore regular socks with no shoes. At 10:05 AM, E4 and E5, Certified Nurse Aides (CNA), transferred R1 to his bed from the wheelchair via a mechanical lift. R1 had a line of small black scabs present on the outside of his left ankle and a baseball size bruise which was brown/yellowish and purple on his left hip. None of these wounds appeared new as all had thick black scabs on them. R1 also had an elbow protector on his left arm which had slid down and was crumpled up in the anticubital area. Neither of the CNAs pulled the protective sleeve up and neither knew how R1 could have gotten the scraped legs or bruise since he was a mechanical lift. R1 was observed to lay in bed from 10:05 AM until he got up for lunch shortly before noon to lay in the same position as when he was initially positioned. R1's low bed had a foot board and 1/2 rails.</p> <p>On 6/8/16 at 9:07 AM, E3, Assistant Director of Nurses (ADON), observed the scabbed areas on R1's right shin and left ankle and stated R1 sometimes bumps them on his wheelchair pedals, but doesn't have the pedals on his chair anymore. E3 stated R1 likes to move around in bed and will hit his leg on the bed as well. R1 had a large skin tear on the back of his left arm which was bleeding on the bedpad. E3 stated he had the skin tear but didn't know where he got it from. E3 also was unaware of the hip bruise and didn't know where he would have gotten that from</p>	F 309			

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F 309	<p>Continued From page 2 either.</p> <p>On 6/9/16 at 12:45 PM, E2, Director of Nurses (DON), provided the Wound Weekly Evaluation - non pressure for R1's a anticubital area. The 6/8/16 Evaluation documented the left arm skin tear measured 2 cm long by 3 cm wide with edges approximated and steri stripped. The right shin measured 2.4 centimeter (cm) x 1 cm, right lower leg 1 x 0.5 cm scabbed area and the left lower outer ankle had 2 scabbed areas measuring 0.3 cm x 0.2 cm and 0.2 cm x 0.2 cm.</p> <p>On 6/9/16 at 12:45 PM, E2 stated no investigation has been done because they know the wounds are from R1 moving about in his wheelchair and bed and that he is difficult to position in bed and chair. E2 acknowledged that R1's Care Plan does not include him moving about in bed sustaining injuries. E2 also was unable to state any preventative measures that have been taken to ensure R1 receive no further injuries.</p> <p>2. The MDS, dated 5/10/16, identified R6 as being cognitively intact requiring extensive assist of one to two staff for all activities of daily living. The MDS also documents R6 is always incontinent of bowel and bladder. The June 2016 Physician Order Sheets (POS) documents an order for Calmoseptine to coccyx and buttocks every shift (5/24/16.) The Care Plan, dated 5/12/16, documents R6 to be at risk for pressure ulcers with a goal to have skin intact, free of redness, blisters or discoloration by/through next review. Interventions include treatment as ordered, weekly skin checks, turn/reposition every two hours and more often if needed, and pressure relieving devices to wheelchair and bed.</p>	F 309			

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F 309	Continued From page 3 On 6/8/16 at 1:19 PM, R6 was transferred to bed via a mechanical lift by E5 and E7, CNA. R6 stated she had been in the chair since her shower at 7:00 AM. E5 stated she had toileted R6 at 11:30, but R6 did not recall that. E5 and E7 rolled R6 to her right side and removed her pants which were wet throughout the buttocks upper thigh area. R6 had severe deep red/purplish excoriation throughout her peri area, inner thighs, bilateral buttocks and inner buttocks that appears edematous. E7 provided care with wash cloths and foam cleanser. R6 grimaced and moaned as he cleansed between her buttocks and inner thighs. E5 stated the facility had identified these areas earlier and documented it. No ointment and/or cream was applied at the time. The Progress Notes and/or assessment section of R6's record failed to have any evidence the facility identified this concern until 6/8/16. On 6/8/16, E2 provided the Wound Weekly Evaluation, dated 6/8/16, which identifies R6's coccyx ulcer, but does not include measurements. The description of periwound has "none" checked with no infection or inflammation present. The comment section documents "red area to coccyx and peri area and posterior thighs" continuing on to document that R6 is being treated with an antibiotic and has had an increase urinary output as she receives Lasix daily.	F 309			
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities	F 311			

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F 311	<p>Continued From page 4 specified in paragraph (a)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to encourage and allow residents to feed themselves to maintain or improve their abilities with eating for 2 of 13 residents (R3, R8) reviewed for eating assistance in the sample of 15.</p> <p>Findings include:</p> <p>1. R3's Physician Order Sheet (POS), dated 5/31/16, documents that R3 has a diagnosis of chronic pain, muscle weakness, cerebrovascular disease, cognitive deficits following cerebrovascular disease, and other specified forms of tremors. R3's Care Plan, dated 6/18/13, documents that staff are to allow R3 to feed himself. R3's Care Plan documents that R3 is to be provided a plate guard to promote and aid in self feeding. On 6/7/16 at 8:05 AM, R3 was served breakfast on a plate with a plate guard. R3 was not encouraged to feed himself during the breakfast meal. E20, Social Services Director, fed R3 breakfast. At 12:15 PM on 6/7/16, R3 was served lunch on a plate with a plate guard. E13, Licensed Practical Nurse (LPN), fed R3 his lunch, and did not encourage R3 to feed himself. R3 did not attempt to feed himself during the breakfast or lunch meal on 6/7/16. On 6/10/16 at 11:30 AM, E2, Director of Nursing (DON), stated that she would expect staff to encourage resident to feed themselves.</p> <p>The facility Policy Assistance with Meals, dated February 2014, documents that residents shall</p>	F 311			

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F 311	Continued From page 5 receive assistance with meals in a manner that meets the individual needs of each resident. 2. On 06/07/15 from 8:20 AM to 9:15 AM, R8 was observed during the breakfast meal service. R8 was given a plate of pureed food with a plate guard and a small plastic coated spoon. R8 struggled to get the food on the spoon due to the plate guard being in the incorrect position to enable R8 to effectively get the food onto the spoon. R8 used the fingers of her left hand to push the food onto the spoon multiple times in order to eat it. R8 ate 100% of the food. On 06/07/16 at 11:50 AM, R8 was observed during the lunch meal service. R8 was served her meal on a plate with a plate guard and a small plastic coated spoon. E16, Certified Nurse Aide (CNA), fed R8 with a regular spoon while R8 was attempting to use her own spoon to feed herself. R8 was more agitated and not wanting to eat as much at this meal time. R8 ate only 50% of the food. The MDS, dated 06/03/16, documented R8 is severely cognitively impaired and requires extensive assistance of one staff for eating. The Care Plan, dated 06/06/16, documented staff to encourage R8 to use a small plastic coated spoon at meals. There was no mention of the use of a plate guard or allowing R8 to feed herself to maintain or improve her abilities in eating.	F 311			
F 314 SS=G	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	F 314			

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F 314	<p>Continued From page 6</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, observations and record review, the facility failed to identify, assess, monitor and prevent new pressures sores from developing for 5 of 8 residents (R1, R6, R8, R9 & R10) reviewed for pressure ulcer treatment and prevention in the sample of 15. This failure resulted in a decline of the ulcer for R9 evidenced by an increase in size and 90% slough wound bed in one week.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS), dated 5/16/16, identifies R9 as having severe cognitive impairment who requires extensive to total assist of two staff for all activities of daily living except eating. The MDS documents R9 to be always incontinent of bowel and bladder. The Braden Scale, dated 5/17/16, scores R9 at high risk for pressure ulcers. The Care Plan, dated 5/17/16, identifies R9 to have an in-house acquired sacral pressure ulcer with interventions directing staff to assess skin with all cares and report, air flow mattress and wheelchair cushion, (offloading) boots, float heels in bed and turn/reposition every two hours and more frequently if needed in part. R9's June 2016 Physician's Order Sheet (POS) includes an order to cleanse the sacral ulcer, apply Puracel (cut to size) cover c (with) sacral</p>	F 314			

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F 314	<p>Continued From page 7</p> <p>foam dressing every three days, Sure prep right hip (5/20/16) and cover with Optifoam border, and Sure Prep to blister inner right knee and cover with border gauze every shift until healed. R9's Registered Dietician Evaluation, dated 5/5/16, documents R9's Albumin is low at 3.1 (normal 3.4-5.)</p> <p>On 6/7/16 at 9:15 AM, R9 was transferred to bed by E4, Certified Nurses Aide (CNA), and E6, Registered Nurse (RN). R9 had been incontinent of bowel/bladder and had deep creases across both buttocks, upper thighs and hips. R9 had a folded top sheet in between his knees and protective boots bilateral. R9's dressing (undated) on his coccyx was loose on the bottom edge and had bowel movement inside. The wound base was visible without moving the dressing and the base was pink, very sloughy with irregular edges. R9 had a dressing (dated 6/6/16) on his mid left buttock, and an open blister looking area on inner right knee that did not have the dressing on it as ordered. R9 was provided poor incontinent care and left on his right side. R9's deep creases remained at 9:50 AM. R9 was observed every 15 minutes through 11:57 AM to remain on his right side without repositioning. The soiled loose coccyx dressing had not been changed as of 11:57 AM according to E4 who was in the room getting him up for lunch.</p> <p>The Pressure Ulcer Weekly Wound Evaluation, dated 5/31/16, documents R9's sacral ulcer was acquired on 2/8/16, had light drainage, granulation present (beefy red), stage II 2 cm (centimeter) x 3 cm x 0.1 cm, no tunneling, wound edges attached and flat, no infection suspected, no inflammation and no treatment change. The Weekly Wound evaluation dated</p>	F 314			

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F 314	<p>Continued From page 8</p> <p>6/7/16 documents decline - measuring 3.8 cm x 2.6 cm x <0.2 cm slough tissue present (90% slough covered), serosanguinous purulent moderate drainage with macerated reddened periwound tissue, no infection/inflammation present. The physician was notified and treatment orders were changed. Under the comments section of the evaluation, it documents "area to sacrum has worsened. MD (medical doctor) is aware staff was educated on turning/repositioning, Resident is last up, first to go down." R9's Care Plan was not revised according to the evaluation.</p> <p>The Weekly Wound Evaluation for R9's knee, dated 6/10/16, documented the knee ulcer acquired in house 5/9/16 as a blistered area, dry, closed measuring 1 cm x 1 cm.</p> <p>On 6/8/16 at 9:07 AM, R9 was in bed on his right side. R9 remained on his right side throughout the morning until after 12:00 PM based on every 15 minutes observations. R9 remained in bed for lunch on his right side.</p> <p>The facility's policy/procedure entitled "Pressure Ulcers/Skin Breakdown - Clinical Protocol," dated 2/2014, documents that staff will attempt to identify cause contributing to skin breakdown and implement appropriate preventative measures. The Policy documents the physician will document pertinent orders to be carried out for pressure ulcers.</p> <p>2. The MDS, dated 5/17/16, identifies R1 has cognitive impairment and requires extensive to total assistance of staff for bed mobility, transfers and bathing/hygiene. The MDS documents R1 is always incontinent of urine and occasionally</p>	F 314			

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F 314	<p>Continued From page 9</p> <p>incontinent of bowel. The Care Plan, dated 5/20/16, documents R1 is at risk for pressure ulcers due to immobility with the goal to have intact skin, free of redness blisters and discoloration. Interventions include: assess skin with all cares, weekly skin assessments, cushion to chair, incontinent care as needed, turn and reposition every 2 hours and more often if needed. The Weekly Skin Assessment, dated 6/2/16, documents no new skin issues and no pressure ulcers.</p> <p>On 6/7/16 at 7:55 AM, R1 was in the wheelchair in the dining room for breakfast. R1 was under constant observation throughout breakfast and at 9:18 AM, E3 Assistant Director of Nurses (ADON) propelled R1 to the hallway outside his room. At 9:50 AM, R1 was taken to the shower room to be repositioned by E4 and E5, Certified Nurse Aides (CNA), who just grabbed the straps of the lift pad and pulled him up in the chair. No off loading was done. R1 was then taken to his room. R1 had regular socks on with no shoes. At 10:05 AM, R1 was lifted to bed via a mechanical lift. R1 had deep creases throughout his hips, buttocks and upper thighs. R1 had a deep red area inner left buttock and a broken blister at the base on his fifth toe which was the size of a dime. R1 grimaced when the foot was moved. There was no dressing on the toe. E4 and E5 positioned R1 on his right side with no padding or protection on his feet and nothing between his knees which were held together.</p> <p>The Progress Notes, dated 6/7/16 at 10:33 AM, documents R1 to have a "new area noted to left pinky toe - appears to be a blister that has popped et (and) res stated his toe rubbed on his shoes, new order received for Hydrogel et dry</p>	F 314			

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F 314	<p>Continued From page 10</p> <p>dressing daily." No changes were made to the Care Plan to include preventative measures on his feet.</p> <p>On 6/8/16 at 9:07 AM, R1 was in bed on his right side. He had regular socks on his feet and no treatment/dressing on the blistered area on the base of his small toe as ordered the previous day. R1 grimaced when E3 removed his sock. E3 looked in his sock and in his bed and was not able to locate the dressing. R1 laid on his right side with the head of the bed elevated throughout the entire morning with observations done every 15-20 minutes until 11:30 AM when he go up for lunch. R1 was taken to lunch without wearing shoes.</p> <p>On 6/9/16 at 12:30 PM, E2, Director of Nurses (DON), provided the wound weekly evaluation that identifies R1's toe wound as a "non-pressure" sore even though E1 identified it from rubbing on his shoe. The eval was dated 6/7/16 and documents the area as acquired during stay, moist, popped blister, no drainage, measuring 1 cm (centimeter) x 1 cm. The facility has not implemented any prevention measures for his feet or regarding shoes in an effort to prevent further breakdown.</p> <p>3. The MDS, dated 5/10/16, identified R6 as being cognitively intact requiring extensive assist of one to two staff for all activities of daily living. The MDS documents R6 is always incontinent of bowel and bladder. R6's June 2016 Physician Order Sheets (POS) document an order for Calmoseptine to coccyx and buttocks every shift (5/24/16.) The Care Plan, dated 5/12/16, documents R6 is at risk for pressure ulcers with a</p>	F 314			

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F 314	<p>Continued From page 11</p> <p>goal to have skin intact, free of redness, blisters or discoloration by/through next review. Interventions include treatment as ordered, weekly skin checks, turn/reposition every two hours and more often if needed, and pressure relieving devices to wheelchair and bed.</p> <p>On 6/8/16 at 1:19 PM, R6 was transferred to bed via a mechanical lift by E5 and E7, CNA. R6 stated she had been in the chair since her shower at 7:00 AM. E5 stated she had toileted R6 at 11:30 AM, but R6 did not recall that. E5 and E7 rolled R6 to her right side. The back of her pants were wet throughout the buttocks area and upper thighs. Her incontinent brief was saturated with urine and was soiled with bowel movement. R6's coccyx had a small pea size open area directly on the coccyx that was covered with cream. E5 stated the facility had identified that earlier and documented it.</p> <p>On 6/8/16, E2 provided the Wound Weekly Evaluation, dated 6/8/16, which identifies R6's coccyx ulcer, but does not include measurements. The description of periwound has "none" checked with no infection or inflammation present. The comment section documents "red area to coccyx and peri area and posterior thighs" continuing on to document that R6 is being treated with an antibiotic and has had an increase urinary output as she receives Lasix daily. The evaluation failed to include staging on the small open area noted on her coccyx.</p> <p>4. On 06/07/16 from 6:45 AM to 10:15 AM, under constant observation, R8 was observed sitting up in a high back wheelchair in a tilted back position. At 9:37 AM, E14, CNA was observed telling E15, Licensed Practical Nurse (LPN), that R8's</p>	F 314			

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F 314	<p>Continued From page 12</p> <p>wheelchair had been stuck in the same position and could not be repositioned. R8 was taken down to the dining room via wheelchair to an activity without being toileted or checked for incontinence.</p> <p>On 06/08/16 at 9:45 AM, E5 and E18, CNAs, were observed during transfer for R8. A skin check was done. R8's buttocks were reddened and deeply creased with a new, unidentified open area near the coccyx/sacral region, measuring approximately 1.0 cm x 1.0 cm. The area was partially denuded with some redness in the center. E3 used skin prep around the open area and placed a hydrocolloid foam dressing on the open area. No wound cleanser was used and no perineal care was performed at this time. E5 and E18 stated that they work with R8 often and had not noticed any skin breakdown until now. E3 stated R8 has an order to apply a barrier cream to the buttocks on every shift or as needed.</p> <p>The POS, dated 06/01-30/16, documented R8 had the following diagnoses, in part as, Alzheimer's Disease, Mental Disorders due to known physiological condition. The MDS, dated 06/03/16, documented R8 is severely cognitively impaired with short and long term memory deficits. It documented R8 requires total assistance of at least two staff for transfers, dressing and toilet use. It also documented R8 requires total assistance of at least one staff for locomotion, hygiene and bathing. The MDS also documented R8 had no pressure ulcers as of this date.</p> <p>The Care Plan, dated 06/06/16, documented R8 was identified as potential for developing a pressure ulcer, incontinent of bowel and bladder</p>	F 314			

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F 314	<p>Continued From page 13</p> <p>and immobility. The interventions were listed, in part as, assess, record and monitor wound healing and turn and reposition every two hours and more often as needed.</p> <p>The Braden Scale for predicting pressure ulcer development, dated 03/08/16, documented R8 was at high risk for developing a pressure ulcer. The Weekly Pressure Ulcer Report, dated 05/30/16, did not have R8 listed as having a pressure ulcer. The Weekly Pressure Ulcer Report, dated 06/09/16, listed R8 as having a facility acquired Stage II pressure ulcer of the coccyx/sacral region measuring 1.0 cm x 1.0 cm x 0.1 cm. The Weekly Skin Check, dated 06/08/16, documented R8 had no new areas of skin impairment or no new changes this week.</p> <p>5. R10's Care Plan Initiated 06/17/2016 documents R10 is at risk for pressure ulcers and needs turned and repositioned every 2 hours and as necessary.</p> <p>On 6/7/2016, R10 was sitting in a geriatric chair with bilateral feet slightly edematous and dangling without support starting at 6:45 AM in dining room. At 9:20 AM, E13, Registered Nurse (RN), pushed R10 over to television area where she remained until removed by E4, CNA, at 12:07 PM. At 12:07 PM, E4 and E5, CNA, took R10 to her room. E5 stated that they were going to reposition R10. R10 was pushed into her room with E4 and E5 grabbing the straps on the mechanical lift pad under R10 and pulled upwards only and E3 was present during this time.</p> <p>On 6/9/2015 at 10:20 AM, E3 was asked if just lifting up on mechanical lift pad under a resident</p>	F 314			

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F 314	Continued From page 14 is considered repositioning? E3 stated she didn't agree with repositioning a resident with just using the mechanical lift pad straps being lifted up by staff and resident being put back down. The Nursing Services Policy and Procedure Manual (Revised April 2013) documents Intervention/Care Strategies "#4. Residents who are in a chair should be on an every hour (q 1 hour) repositioning schedule." Preparation documents "#1. Review the residents care plan to evaluate for any special needs of the resident."	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 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 interview, observation and record review, the facility failed to provide thorough incontinent care, timely checking/changing and catheter care for 2 of 3 residents (R6, R10) reviewed for urinary tract infections (UTI) and catheters in a sample of 15. Findings include:	F 315			

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F 315	<p>Continued From page 15</p> <p>1. The Minimum Data Set (MDS) dated 5/10/16 identified R6 as being cognitively intact requiring extensive assist of one to two staff for all activities of daily living. The MDS documents R6 is always incontinent of bowel and bladder. The June 2016 Physician Order Sheet (POS) documents R6 is receiving Keflex 500 milligram (mg) Twice daily (6/2/16) for a urinary tract infection along with a diuretic Lasix 40 mg (5/3/15) every day. The Care Plan, dated 5/12/16, does not identify incontinence or UTI's as a concern for R6, but does include interventions under skin to provide care as needed.</p> <p>On 6/8/16 at 1:19 PM, R6 was transferred to bed via a mechanical lift by E5 and E7, Certified Nurse Aides (CNA.) R6 stated she had been in the chair since her shower at 7:00 AM. E5 stated she had toileted R6 at 11:30 AM, but R6 did not recall that. E5 and E7 rolled R6 to her right side and removed her pants which were wet throughout the buttocks upper thigh area. R6 incontinent brief was saturated and soiled with soft bowel movement on the inner buttocks and peri area. R7 washed R6's inner thighs and down each side of inner groin, then the inner buttocks with a wash cloth and foam cleanser, but failed to cleanse inner labial and the peri area even though she had soft bowel movement on the inner buttocks.</p> <p>On 6/8/16, E2, Director of Nurses (DON), provided the Wound Weekly Evaluation, dated 6/8/16, that includes a comment section which documents "red area to coccyx and peri area and posterior thighs" continuing on to document that R6 is being treated with an antibiotic and has had an increase urinary output as she receives Lasix daily. There is no evidence the facility took</p>	F 315			

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F 315	Continued From page 16 measures to check/change R6 more frequently or to provide proper peri care. On 6/9/16 at 3:00 PM, E2 stated R6 was treated for a UTI identified in February 2016 and most recently had been exhibiting increase confusion so the physician opted to treat a UTI since these are the symptoms she exhibits when she has one. E2 stated R6 has shown much improvement on the antibiotic. 2. On 6/7/2016 at 1:00 PM, E5, Certified Nurse Aide (CNA), and E6, CNA, attached mechanical lift to the straps of the lift pad under R10. E6 removed the urinary drainage bag from R10's geriatric chair and placed the urinary drainage bag on top of R10's abdomen during the mechanical lift transfer to bed. E6 lowered the mechanical lift and took R10's urinary drainage bag off abdomen and threw the urinary drainage bag to the foot of bed. R10's Care Plan, Revision on 09/04/2014, documents "CATHETER: (R10) has a supra pubic catheter. Position catheter bag and tubing below the level of the bladder." The undated Catheter Care,Urinary policy and procedure under General Guidelines, Maintaining Unconstructive Urine Flow documents "#3 The urinary drainage bag must be held or positioned lower than the bladder at all times to prevent the urine in the tubing and drainage bag from flowing back into the urinary bladder."	F 315			
F 318 SS=G	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a	F 318			

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F 318	<p>Continued From page 17</p> <p>resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to ensure that appropriate treatments and services including correct Passive Range of Motion (PROM) and splints are provided as needed for 3 of 7 residents (R1, R8, R10) reviewed for range of motion and positioning in a sample of 15. This failure resulted in R1 developing further contracture and skin breakdown.</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS), dated 5/17/16, identifies R1 to have cognitive impairment and requires extensive to total assistance of staff for bed mobility/transfers and has limitations upper/lower on one side. The MDS documents R1 gets PROM (Passive Range of Motion) 5 days a week. The Care Plan, dated 5/20/16, identifies R1 to have contractures on the left side since a Cerebral Vascular Accident (CVA) with an intervention for staff to do PROM to left side 5-10 repetitions to each joint BID (twice daily.)</p> <p>On 6/7/16 at 7:45 AM, R1 was in the dining room in his wheelchair. There were no pedals on his wheelchair and his legs were dangling off the seat of the chair with no support to his feet. R1's left arm was contracted up against his chest and his</p>	F 318			

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F 318	<p>Continued From page 18</p> <p>hand was contracted into a ball. He had no protector in his hand. R1 had a elbow protector on his left arm which had slid down into the anticubital area. R1 was poorly positioned and repeatedly leaned over to his right side with his head off the wheelchair. At 10:05 AM, E4 and E5, Certified Nurses Aides (CNA), transferred R1 to bed via a mechanical lift. R1 appeared to have foot drop. E4 stated R1's left hand does not open, but E5 stated he can open it and assisted R1 in stretching out his fingers. R1's fingernails were very long. R1 moaned when his fingers were opened. R1 laid on his right side throughout the rest of the morning with his left arm drawn up to his chest.</p> <p>On 6/8/16 at 9:15 AM, R1 was in bed and had a palm protector in place on his left hand. R1 wore it throughout the day.</p> <p>On 6/9/16 at 10:00 AM, R1 again had his palm protector on. At 2:20 PM, E8, CNA, removed the protector and stated she only does PROM on R1's left side. E8 attempted PROM on R1's hand with no range done on his fingers and no opposition of the thumb was done. E8 failed to do abduction/adduction on the left hand fingers, no range was done for the toes at all and no internal/extension or abduction/adduction of the hip was done. E8 stated she has worked with R1 for about 7 months and has seen some improvement.</p> <p>A progress note, dated 6/8/16, documents "PT (Physical Therapy) is to evaluate and treat left AC (anticubital) Fossa laceration and flexion contractor after CVA to open the area, increase range of motion and more air."</p>	F 318			

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F 318	<p>Continued From page 19</p> <p>On 6/9/16 at 2:49 PM, E2, Director of Nurses (DON,) stated the hand device is not a splint, but a palm protector as a nursing measure and that she ordered it about a month ago. E2 stated R1 should have the palm protector in daily.</p> <p>A Joint Mobility Assessment completed by E9, Occupational Therapist (OT), dated 9/9/15, documents daily Left side PROM's per facility protocol. Measurements document all left side joints as having severe limitations of 1-25% range. On 3/23/16, the joint mobility assessment shows severe for all left side joints except the left knee improved from moderate/severe to minimal. On 6/9/16, an additional occupational plan of care was completed and documents R1 "presents with flexion contracture, as did appear on admission to this facility on 7/8/14. Patient was previously place on left upper extremity PROM and hygiene program with restorative at time of OT dc (discontinued) in August 2014. "Patient not always compliant with restorative" and "patient refusing to allow caregiver staff to provide daily, adequate ROM (Range of Motion) to let elbow to prevent further contracture and skin breakdown. Patient now presents with increased flexion contracture, such that he is developing skin breakdown in the anticubital fossa."</p> <p>The Care Plan fails to show R1's refusals nor does it include a plan to ensure R1 receives the ROM when he does refuse and the palm protector daily. Documentation for PROM from 5/25/16 through 6/9/16 shows R1 did not receive ROM at all 5/31/16 and was documented as done one time per day for 4 of 15 days.</p> <p>The facility's policy/procedure entitled "Range of Motion," dated 10/2010, documents it purpose it</p>	F 318			

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F 318	<p>Continued From page 20</p> <p>to exercise the resident's joints and muscles. The Guidelines document staff are to support the extremity at the joint as it is being exercised, move each joint through its range of motion three times unless otherwise instructed, move each joint gently, smoothly, and slowly through its range of motion, and remember to stop at point of pain. The steps in the procedure documents staff are to position resident in the supine position, if permitted remove the pillow. The steps then go through each joint including the toes and fingers. Documentation should be recorded in the medical record and include if and how the resident participated in the procedure or any changes in the resident's ability to participate, any problems or complaints made by the resident, documents refusals and interventions taken to address refusals.</p> <p>2. On 06/07/16, R8 was observed to have severely contracted hands. On 06/07/16 and 06/08/16, R8 was observed at varying times throughout the day with no preventative measures to help maintain or improve the range of motion in her hands.</p> <p>The June 2016 Physician Order Sheets (POS) documented R8 had joint contractures. The Care Plan, dated 06/06/16, documented R8 was to have Passive Range of Motion exercises and after place either carrots or posey hand rolls in R8's hands while awake and can tolerate. The MDS, dated 06/03/16, documented R8 was severely cognitively impaired and required total assistance with dressing, hygiene, bathing and toilet use. It also documented R8 had limited Range of Motion in both the upper and lower extremities.</p>	F 318			

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F 318	Continued From page 21 On 06/09/16 at 4:20 PM, E2 stated that R8 was to have devices in her hands to prevent further decline of the hand contractures, and that R8 had been known to remove splints after staff had applied them to her hands. 3. Intermittent observation on 6/7/2016 starting at 6:45 AM through 11:25 AM of R10 sitting in geriatric chair with bilateral slightly edematous feet dangling in space. On 6/7/2016 at 11:25 AM, E12, CNA, was asked about R10's feet being unsupported. E12 stated we can elevate feet when we put the reclining back of the chair back. R10's Care Plan, Revision date 09/02/2015, documents the intervention to elevate feet as much as possible.	F 318			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review and observation, the facility failed to ensure adequate supervision and effective interventions to prevent falls and injuries for 2 of 6 residents (R1, R11) reviewed for injuries and falls in a sample of 15.	F 323			

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F 323	<p>Continued From page 22</p> <p>Findings include:</p> <p>1. On 6/7/16 at 9:18 AM, R1 was sitting in his wheelchair in the hallway outside his room. He had no pedals on to support his feet. R1's right shin has two large areas of black scabbing present on the shin bone with the surrounding area of at least 2 inches red and edematous looking. R1 regular socks without shoes. At 10:05 AM, E4 and E5, Certified Nurse Aides (CNA), transferred R1 to his bed from the wheelchair via a mechanical lift. R1 had a line of small black scabs present on the outside of his left ankle and a baseball size bruise left hip which was brown/yellowish and purple. None of these wounds appeared new as all had thick black scabs on them. R1 also had an elbow protector on his left arm which had slid down and was crumpled up in the antecubital area. Neither of the CNAs pulled the protective sleeve up and neither knew how R1 could have gotten the scraped legs or bruise since he was a mechanical lift. No feet or leg protection was afforded R1 when he was left on his right side for a nap.</p> <p>On 6/8/16 at 9:07 AM, E3, Assistant Director of Nurses (ADON), observed the scabbed areas on R1's right shin and left ankle and stated R1 sometimes bumps them on his wheelchair pedals, but doesn't have the pedals on his chair anymore. E3 stated R1 likes to move around in bed and will hit his leg on the bed as well. R1 had a large skin tear on the back of his left arm which was bleeding on the bed pad. R1 also had a skin tear on the back of his left upper arm. E3 also was unaware of the hip bruise and didn't know where R1 would have gotten that from</p>	F 323			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145454	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2016
NAME OF PROVIDER OR SUPPLIER CARLINVILLE REHAB & HCC			STREET ADDRESS, CITY, STATE, ZIP CODE 751 NORTH OAK STREET CARLINVILLE, IL 62626		
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F 323	<p>Continued From page 23</p> <p>either as she could recall no recent falls since February 2016.</p> <p>On 6/9/16 at 12:45 PM, E2, Director of Nurses (DON), provided the Wound Weekly Evaluation - non pressure for R1's antecubital area. The 6/8/16 evaluation documented the area on R1's left antecubital area from the protective glove as a "laceration" measuring 4 cm (centimeter) x 3 cm x .4 cm, moist and noted when the "geri sleeve" was removed from the contracted Left upper extremity antecubital area. The left arm skin tear measured 2 cm long by 3 cm wide with edges approximated and steri stripped. The right shin measured 2.4 cm x 1 cm, right lower leg 1 x .5 scabbed area and the left lower outer ankle had 2 scabbed areas measuring 0.3 cm x 0.2 cm and 0.2 cm x 0.2 cm.</p> <p>On 6/9/16 at 12:45 PM, E2 stated no investigation has been done because they know the wounds are from him moving about in his wheelchair and bed, but was unable to identify any preventative measures that have been taken to ensure R1 receives no further injuries from his moving about in bed and/or the wheelchair. E2 stated R1 is difficult to position in bed and wheelchair and moves around a lot which is where she thinks the hip bruise came from. There are no preventative measures in place or revisions made to R1's Care Plan that would ensure futures injuries did not occur.</p> <p>2. The Admission Record documents R11 was admitted to the facility on 3/4/16 following hospitalization for a fractured hip. The Minimum Data Set (MDS), dated 6/3/16, documents R11 as severely cognitively impaired and requires extensive assist of one staff for bed mobility and</p>	F 323			

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F 323	<p>Continued From page 24</p> <p>transfers. The MDS documents R11's balance as not steady, only able to stabilize with staff assistance. The Care Plan, dated 3/4/16, documents R11 as high fall risk with the goal to be injury free due to falls. Interventions on admission include keep room free from clutter and spills, fall assessment quarterly.</p> <p>The Fall Log documents R11 to have had 4 falls following her admission with the fractured hip. Incident Reports documents falls as follows:</p> <p>1) On 4/12/16 at 3:20 PM, R11 was found on the floor in her room with an alarm sounding after attempting to ambulate without assistance. No recommendations were made following this fall.</p> <p>2) On 4/21/16 at 5:34 AM, R11's bed alarm was sounding and by the time staff could respond, R11 was on the floor between the bed and air conditioner. Interventions added after this fall were to educate the resident on the use of the call light and evaluate for a self release seat belt.</p> <p>3) On 4/26/16 at 12:35 PM, R11 was again found on the floor of her room when staff heard her fall. The report documents R11 sustained a bleeding hematoma on the left side of her head and two skin tears to her left arm. Recommendations were to again educate her in the use of the call light with a statement that documents "resident lacks safety awareness" and another recommendation to evaluate her for a self release seat belt.</p> <p>There is no documentation of an evaluation on R11 for her ability to use the call light given her cognitive impairment. There is no documentation the facility evaluated the times of the falls for sufficient staffing since they were unable to reach R11 on 4/12/16, 4/21/16 and 4/26/16 before she</p>	F 323			

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F 323	Continued From page 25 fell when the alarm sounding and evaluated her for effective interventions to prevent falls. On 5/17/16 at 12:35 PM, an Incident Report documents Physical Therapy walked by R11's room and saw her attempting to ambulate in her room by herself. R11 had removed her alarm and was carrying it with. R11 fell before they could reach her. R11's Care Plan, dated 3/4/16, documents on 5/18/16, R11 had a self release seat belt applied and has had no falls since. There is no documentation as to why the self release wasn't attempted earlier in an attempt to prevent falls. On 6/10/16 at 2:57 PM, E2 stated R11 does not use her call light, but hollers out when she needs something as someone walks by in the hall. E2 stated R11 has had no more falls since the self release belt, but she does continue to remove it, but less frequently attempts to get up unassisted.	F 323			
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on interview, observation and record review, the facility failed to provide sufficient fluids at meals and with care for 2 of 5 residents (R1 and R9) reviewed for hydration in the sample of 15.	F 327			

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F 327	<p>Continued From page 26</p> <p>Findings include:</p> <p>1. The Minimum Data Set (MDS) dated 5/17/16 documents R1 to have cognitive impairment and require extensive assist of one staff for eating. The Care Plan, dated 5/20/16, does not include a goal toward meeting R1's daily fluid requirement but have an intervention under nutrition for staff to encourage fluids and monitor. The Registered Dietician's (RD) evaluation dated 2/22/16 documents R1's minimum daily fluid requirement is 2304 cubic centimeters (cc).</p> <p>On 6/7/16 at 7:55 AM, R1 was at the dining room table with a cup of coffee in front of him. He was leaning heavily to his right side. R1's left arm was contracted and he used his right arm to put a straw in his coffee then attempt to drink it. His wheelchair was not locked and his foot kept brushing the floor pushing him away from the table. E13 MDS Coordinator sat to assist R1 in eating. R1 was served orange juice, milk, and coffee with breakfast. He drank only 1/2 of his coffee.</p> <p>At 9:18 AM on 6/7/16, E3 Assistant Director of Nurses (ADON) propelled R1 to the hallway outside his room. At 9:50 AM, R1 was taken to the shower room to be repositioned by E4 and E5, Certified Nurse Aides (CNAs) and then took him to his room to lay him down. R1 was not wet when they laid him down. His water pitcher was on the overbed table at the end of his bed and out of reach. No fluids were offered by either CNAs' before leaving the room. R1's water pitcher remained out of reach.</p> <p>At 11:55 AM, E4 entered R1's room to get him up for lunch. No fluids were offered with care again.</p>	F 327			

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F 327	<p>Continued From page 27</p> <p>At the lunch meal, at 12:20 PM, E5 CNAs fed R1 his meal. R1 was only served a glass of tea which he did not drink.</p> <p>On 6/8/16 at 9:30 AM, R1's water pitcher was again sitting out of reach. It was marked and remained unmoved until lunch time.</p> <p>2. The MDS dated 5/16/16 identifies R9 as having severe cognitive impairment who requires extensive to total assist of one staff for eating. The care plan dated 5/17/16 doesn't address R9's hydrational risk but does include an intervention under nutrition for staff to encourage/monitor fluids. The RD evaluation dated 11/23/15 documents R9's minimum daily fluid requirement is 2687 cc/day. R9's BUN on 5/5/16 was elevated at 25 (normal 7-18.)</p> <p>On 6/7/16 at 9:15 AM, R9 was transferred to bed by E4 Certified Nurses Aide (CNAs) and E6 Registered Nurse (RN.) Care was provided for incontinence but no fluids were offered prior to staff leaving the room. At 11:57 AM, R9 was still in bed. Then R9 was fed lunch in the dining room by E5, was served only one glass of red drink which he drank 100% of. No other fluids were offered.</p> <p>On 6/8/16 at 9:07 AM, R9 was in bed. His water pitcher was marked and remained unmoved for the morning. At 12:30 AM, R9 was served only one glass of red drink which he drank 100% of with no refills offered or provided.</p> <p>The facility's policy entitled "Resident Hydration and Prevention of Dehydration" dated 12/2011 documents it is the endeavor of the facility to</p>	F 327			

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F 327	Continued From page 28 provide adequate hydration and to prevent and treat dehydration. Under Prevention of Dehydration, the policy documents "Nurses Aides will provide and encourage intake of bedside, snack and meal fluids, on a daily and routine basis as part of daily care. Intake will be documented in the medical records. Aides will report intake of less than 1200 ml (milliliters)/day to nursing staff. On 6/10/16 at 2:15 PM, E1 Administrator and E2 Director of Nursing stated they would expect the staff to offer and encourage fluids in between meals and with care. E1 stated the facility does not track intake unless the resident is on a fluid restriction.	F 327			
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 This REQUIREMENT is not met as evidenced by: Based observation, interview, and record review the facility failed to maintain the ice machine and check sanitizer in the chemical dish washing machine as needed. This has the potential to affect all 60 residents in the facility.	F 371			

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F 371	<p>Continued From page 29</p> <p>Findings include:</p> <p>1. On 6/7/16 at 3:03 pm the ice machine was full of ice. The machine had leaked across the floor of the room across from the nurses station. E23 Maintenance Man stated the kitchen and entire facility uses this machine and he cleans it monthly. Asked for a date last cleaned, E23 stated he doesn't keep track of the dates but it is in the computer on a monthly task schedule. When asked how he cleaned the machine, E23 explained that he "placed a garbage bag over the ice so the solutions don't drip on the ice" then wiped the top and sides of the machines down with the descaler and sanitizer. E23 then stated he rolls up the garbage bag when removing it from the inside of the machine to ensure that it doesn't drip on the ice inside the bin of the machine. When asked if he emptied the ice out of the bin and cleaned the bin, E23 replied "no."</p> <p>On 6/7/16, E23 was asked for the policy/procedure for cleaning the ice machine and at 3:25pm, E23 provided a sheet dated 6/7/16 from a supplier which was entitled "check filters (if present), clean coils, sanitize interior, delime as necessary." Under Sanitize interior, it documents to "1. Sanitize interior of ice machine per manufacturer's instructions 2. Clean out and sanitize the ice bin." Under the Clean Exterior, it documents staff are to date service tag when service is completed.</p> <p>At 3:25pm, E23 stated he did not have the Manufacturer's Instructions. At 3:37pm, E1 Administrator provided a copy just printed from the internet.</p> <p>The bottle of cleaner, delimer, documents under</p>	F 371			

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F 371	<p>Continued From page 30</p> <p>warnings "causes severe burns", "don't get in eyes", and "Harmful if swallowed." The bottle of Sanitizer documents warnings "If swallowed, call poison control."</p> <p>2. On 6/7/16 at 11:55am, E26 Dietary Aide washed two loads of pots and pans in the chemical dishwasher. E26 was asked if he checked the sanitizer prior to washing the loads and stated it was checked earlier in the day. E26 then pointed to the schedule which had been initialed earlier on 6/7/16. E26 the checked the sanitizer with the strip which did not show any sanitizer present. E25, District Manager then stepped in and stated that the sanitizer was suppose to be checked before every meal dishes are done.</p> <p>3. The Resident Census and Conditions of Residents, CMS 672, dated 6/7/16 documents the facility census as 60 residents.</p>	F 371			