STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146070	A. BUILDING _____ B. WING _____	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN WILLOWS NURSING CENTER	1600 NORTH BROADWAY, PO BOX 370 SALEM, IL 62881

(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 221 SS=D	Annual Licensure and Certification Survey 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, record review and interview, the facility failed to assess and care plan for the use of a lap cusioning device to ensure that a restraint is not used for discipline or convenience for 1 of 4 residents (R1) reviewed for restraint use in the sample of 11. The findings are: R1 is a 74 year old resident with diagnoses that include Alzheimer's Dementia as noted on R1's March, 2016 Physician Order Sheet (POS). R1 was observed on 3-17-16 at 12:30 pm in the dining room. R1 was seated at a table in a glider/rocker chair, was being assisted to eat but was noted to have a lap cushioning device, used to prevent rising, in place. R1 is ambulatory throughout the facility with the use of a specialized ambulation device. R1 does not have an assessment or a plan of care for the use of the lap cushioning device. E2, Director of Nurses (DON) verified on 3-18-2016 at 8:35 am that R1 does not have an assessment or plan of care for the use of this device. E2 stated that R1 likes to "pop up" suddenly while being assisted with	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 04/22/2016

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F 221	Continued From page 1 eating and agreed the cushion was not care planned for use by R1.	F 221		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure Minimum Data Set assessments	F 278		

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F 278	Continued From page 2 accurately reflect residents' status for one of eleven residents (R7) reviewed for accurate assessments in the sample of eleven. Findings include: 1. R7's Decubiti Report, dated 11/10/15, documents a Stage II pressure ulcer is present to R7's left heel. R7's Decubiti Report, dated 1/31/16, documents "Hospitalized". R7's Hospital Report, dated 2/2/16, documents "debrided tissue from left heel ulcer". R7's Decubiti Report, dated 2/4/16, documents that R7's left heel is "no longer considered pressure ulcer, now surgical site". R7's Decubiti Report, dated 2/22/16, documents "left heel open, wound clinic notified, some pink and black tissue". R7's Minimum Data Set (MDS), dated 2/28/2016, section M0210, enters code 0 which indicates no unhealed pressure ulcer(s). E3, MDS Coordinator stated on 3/16/16 at 2:40 p.m., that section M0210 of the MDS was determined by directive from E2, Director of Nursing (DON) that once a pressure ulcer is debrided, it is then considered a surgical wound. The Center for Medicare and Medicaid Services (CMS) Resident Assessment Instrument Version 3.0 Manual, dated 2015, states on page M-4 that for MDS assessment, initial numerical staging of pressure ulcers and the initial numerical stage of ulcers after debridment should be coded in terms of what is assessed in the look back period. This same manual also states on page M-5 that a pressure ulcer is considered a surgical wound if the pressure wound is surgically closed with a flap or graft.	F 278		

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F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to review and revise care plans to address oxygen use, reclined geriatric chairs, skilled therapy, insomnia, falls and assistive devices for 6 of 11 (R2, R3, R5, R6, R7, R8) residents reviewed for care plans in the sample of 11. The findings are: 1. R3 is an 89 year old resident with diagnoses that include Dyspnea, Chronic Obstructive Pulmonary Disease and Alzheimer's Dementia as	F 280		

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F 280	Continued From page 4	F 280		

noted on the March, 2016 Physician Order Sheet (POS). Observations were made of R3 on 3-16-2016 at 11:30 am in the dining room. R3 was noted to be receiving oxygen by use of a nasal cannula and the oxygen was set at a rate of 2 & 1/2 liters. R3 was also observed on the same day from 2:00 pm to 3:30 pm in his room receiving oxygen with the rate set at 3 liters. R3 does not have a plan of care for the use of the oxygen.

2. On 3/15/16 at 12:30PM, R7 was noted to be laying in bed receiving oxygen per face mask. At this same time, Z2, family member of R7, stated that R7 was on Hospice care and receives oxygen per face mask at all times.

R7's care plan, dated 3/4/16, does not include the use of oxygen.

E3, Minimum Data Set Coordinator states on 3/18/16 at 9:35 a.m. that oxygen was ordered for R7 on 2/28/16 and that order continues. E3 went on to say that R7 is on Hospice Care.

3. R5's care plan, dated 1/19/16, does not include any therapy services. An increase in the need for Activities of Daily Living ability is noted on R5's Minimum Data Set (MDS) dated 10/16/15 when compared to R5's MDS of 1/11/16 after R5 sustained a fall with a fracture that occurred on 10/6/15.

E2, Director of Nurses states on 3/15/16 at 1:40 p.m. that a plan of care regarding therapy should be present on the care plan of a resident with a history of a fall with a fracture.

4. On 3/15/2016 at 8:10 am during the initial tour

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of the facility and throughout the survey, R2 was observed in a semi-reclining position in a reclining chair. R2's current Care Plan does not identify that such a chair is in use or state it's purpose. This was verified by E2, Director of Nursing on 3/18/2016 at 12:15 pm.

5. R8's Personal Device Tracking Log states that a Pelvic Support Belt was initiated on 11/2/2015. The use of the Pelvic Support Belt was not included on R8's current Care Plan. This was verified by E2 on 3/17/2016 at 2:05 pm

6. a) Review of R6's Incident/Accident Reports notes the following falls and interventions for his falls on 12/16/15, 1/21/16, 1/28/16, 2/3/16 and 2/23/16 were not listed on R6's Fall Care Plan:
On 12/16/15 at 11:45pm, R6's report states staff heard R6's alarm sounding and that R6 was found on his back on the floor next to his bed. This report states that R6 said he was trying to go to the bathroom. This same report also states that R6 was confused. This report documents that staff reminded R6 to call for assist and that staff was instructed to toilet R6 every two hours when R6 is awake.
On 1/21/16 at 7:15pm, R6 tipped his wheelchair over backwards in the doorway of his room. This report states that R6 was confused and rear anti-tippers were placed on the wheelchair.
On 1/28/16 at 5:35am, R6 removed the lap top cushion from his wheelchair, lost his balance and sat on the floor. The report states R6 was reminded not to remove the lap top cushion.
On 2/3/16 at 12:00am, R6 removed the lap top cushion from his wheelchair, stood up and leaned against the lobby door. The report documents the door opened up and R6 lost balance and fell. This same Incident/Accident report documented

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F 280	Continued From page 6 R6 declines further restraint. On 2/23/16 at 9:30pm, R6 was found half on the bed and half off of the bed and was confused. The report states that R6 sustained a laceration on his nose and above his left eye and that soft rails were added to the bed rails. The facility's undated Policy for Fall Prevention documented, "after a fall has occurred, the care plan will be updated to reflect any changes for fall prevention." On 3/18/16 at 8:35am, E2 (Director of Nurses) said all of R6's falls and interventions should be documented on R6's Fall Care Plan and she is unsure why they aren't. 6. b) The Fall Care Plan for R6, with the initiated date of 11/30/15 documented R6 is to have a "chair/bed alarm". The care plan did not document the use of a reclining geriatric chair. It is documented in R6's Nurse's Notes on 1/15/16, 2/23/16, 2/24/16 and 2/25/16 that R6 was in a geriatric chair. R6 was up in a reclined geriatric chair without a personal safety alarm on 3/15/16 at 9:00am, 10:15am, 11:35am 12:20pm, and 2:05pm. E2 (Director of Nurses) said at 8:35am on 3/18/16, she (E2) is unsure why the reclining geriatric chair isn't on the care plan and that it should be. On 3/17/16 at 9:50am, E2 said R6 should have a personal alarm on when in the reclining geriatric chair. On 3/15/16 at 12:40pm, E4 (Certified Nurse Aide) said R6 doesn't need a personal alarm on when he is in the reclined geriatric chair.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

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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 observation and interview, the facility failed to ensure that residents who use urinary catheters have a catheter anchoring device in place for 2 of 2 (R3, R5) residents reviewed for catheters in the sample of 11.

The findings include:

1. R3 was observed receiving catheter care on 3-16-2016 at 1:45 pm. R3 did not have an appropriate catheter anchoring device in place at this time. A piece of tape was noted on the catheter tubing but not attached to the resident. E6, Certified Nurse Aide (CNA) stated that they were out of the anchoring devices that are normally used.

2. On 3-15-16 at 9:30am and on 3/16/16 at 1:55pm, R5 was observed with a urinary catheter but without a urinary catheter anchoring device in place. E2, Director of Nursing (DON) stated on 3/15/16 at 1:40 p.m., that all urinary catheters should be anchored and that the facility uses tape or stick on anchor devices.

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F 323	Continued From page 8	F 323		
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 record review, observation and interview the facility failed to thoroughly assess causative factors for falls and implement appropriate safety measures to prevent recurring falls for 1 of 5 residents (R6) reviewed for falls in the sample of 11. Findings Include: R6 has resided in this facility since 11/19/15, according to the facility admission record with this same date. R6's Accumulative Diagnosis Sheet with dates 11/19/15 through 3/11/16 lists diagnoses to include; Depression, Altered Mental Status, Parkinson's Disease and Alzheimer's Dementia. R6's Fall Risk Assessment, dated 11/19/15, documented R6 is a High Risk for falling. R6's Minimum Data Set (MDS) with the date 2/25/16 documented a 6/15 for Brief Interview for Mental Status indicating R6 has severe impaired cognition. The MDS documented R6 requires extensive assist for transfers, ambulation and toileting. Review of R6's Incident/Accident Reports notes the following falls: 11/25/15 at 12:00 am, R6 was found sitting in the	F 323		

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floor in front of the wheelchair in his room. R6 stated, "I was trying to go to the bathroom". Facility staff documented, "1:1 reinforced to call for assist and call light demonstrated".
On 11/29/15 at 2:40pm, R6's Incident/Accident Report documented R6 was standing in the hallway in front of the wheelchair with the clip alarm in place and sounding. R6 slid down the front of the wheelchair and onto the floor and no injuries were noted. The form documented R6 was confused and there were no new interventions documented on R6's Incident/Accident report, care plan or nurse notes.
On 12/16/15 at 11:45pm, staff heard R6's alarm sounding. R6 was found on his back on the floor next to his bed. R6 stated he was trying to go to the bathroom. The form documented R6 was confused. Staff reminded R6 to call for assist and staff was instructed to toilet R6 every two hours when R6 is awake.
On 1/17/16 at 11:15pm, R6 was found in the floor in another resident room. R6 was confused. R6 had lifted the lap top cushion off of the wheelchair. R6 was reminded to keep the lap top cushion in place.
On 1/28/16 at 5:35pm, R6 removed the lap top cushion from his wheelchair and lost balance and sat in the floor. R6 was reminded not to remove the lap top cushion.
On 2/3/16 at 12:00am,, R6 removed the lap top cushion from his wheelchair, stood up and leaned against the lobby door. The door opened up and R6 lost balance and fell. The Incident/Accident report documented that R6 declines further restraint.
On 2/10/16 at 12:00am, R6 was found lying on the floor next to the door in his room. R6 was confused. No interventions documented on the

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form. It was documented on this report R6 was placed in a reclined chair.
R6's current Fall Care Plan with the initiation date of 11/30/16 documented falls only for 11/25/15, 11/29/15, 1/17/16 and 2/10/16 and there were no interventions listed for each fall. This Fall Care Plan also documents that R6 uses a chair/bed alarm.
The facility's undated Policy for Fall Prevention documented "after a fall has occurred, the care plan will be updated to reflect any changes for fall prevention".
R6's Daily Skilled Nursing Assessment documented on 11/29/16 at "7-3" shift, R6 attempts to stand alone and ambulate. On the same date at 6:00pm, it is documented, R6 self removes personal alarm. On 1/11/16 for 12:00am through 8:00am, it is documented, personal pull alarm in place but takes it off and somehow without sounding the alarm at times.
On 1/15/16 at 1:00am, R6's Nurse's Notes documented, wandering in other residents rooms, R6 takes the personal alarms off so they don't alarm, was assisted to a reclining geriatric chair and placed at the nurse station. R6's Nurse's Notes, on 2/25/16 at 12:00am through 8:00am, documented R6 forgets to get help when needing to get up, attempts to get help when needing to get up, attempts to get self up out of reclined chair eight times this morning.
On 3/15/16 at 12:40pm, R6 was observed in a reclined chair in the hallway without a personal alarm on. On 3/17/16 at 9:50am, R6 was observed in a reclined chair in the hallway without a personal alarm on.
During an interview on 3/18/16 at 8:35am with E2 (Director of Nurses), when asked about R6's recurring falls, E2 said, R6 doesn't ask for assist and often attempts to get up without assist. E2

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F 323	Continued From page 11 went on to say that different interventions have been attempted and she (E2) wasn't sure why all the falls and interventions are not listed on R6's care plans. E2 said R6 is placed in a wheelchair with a lap top cushion or a reclined chair as fall interventions, depending on his (R6) wakefulness. On 3/17/16 at 9:50am, E2 said R6 should have a personal alarm on at this time and she was unsure why he didn't. At 12:40pm on 3/15/16, this surveyor asked E4 (Certified Nurse Aide) if R6 should have a personal alarm on at this time when in a reclined chair and E4 replied, no, not when he is in the chair.	F 323		
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 on observation, interview and record review, the facility failed to ensure that dietary staff prepare resident fluids at mealtime in a sanitary manner. This has the potential to affect all 41 residents of the facility. The findings are:	F 371		

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F 371	Continued From page 12 At 11:15 am on 3-16-2016, E7, (Dietary Aide), was observed in the dishwasher area of the kitchen. E7 left the dishwasher area and without washing her hands or applying clean gloves, began to prepare drinking cups. When asked, E7 stated that she was preparing the supplement drinks for the noon meal. E7 was observed to touch the inside rims of the drinking cups as she prepared them. During the preparation, E7 was observed to go to the refrigerator and touch the door handle to obtain a container of milk, touch the door handle of and go into the dry storage area and return with cans of tomato juice, and handle dietary manuals from off of a shelf, then return to fluid preparation and at times, again touch the inside rims of the drinking cups, all without washing her hands. E2, (Director of Nurses) stated on 3-18-2016 at 8:45 am that the handling of the cups in this manner was not a sanitary practice and E7 would need to be retrained on proper sanitary practices. The Resident Census and Conditions of Residents Report dated 3-16-2016 notes the facility census as 41.	F 371		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146070	A. BUILDING _____ B. WING _____	03/18/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TWIN WILLOWS NURSING CENTER	1600 NORTH BROADWAY, PO BOX 370 SALEM, IL 62881

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F 465	Continued From page 13	F 465		

interview, the facility failed to maintain ceiling tile and vents, doors, walls, base boards, plumbing, resident bath and shower rooms and hall heater units. This has the potential to affect all 41 residents in the facility.

The findings are:

A. Upon entrance to the facility at 7:45 am on 3-15-2016, an initial tour of the facility was conducted and the following was observed:

1. In the area of the nurse station, a large ceiling tile was observed bowing down and a near by ceiling speaker was observed with one side of it hanging away from the ceiling.

2. On the 400 hall, a large ceiling vent was observed with a piece of clear tape running across it. The vent was noted to have a build up of dust present. The bottom of the doors to the laundry room, linen room and maintenance room were all noted to be very scuffed and dirty in appearance. A heater unit in the hall was noted to have a build up of dust on the top of it.

3. On the 300 hall the large ceiling vent and a heater unit was noted to have a build up of dust.

4. On the 200 hall the surface of the heater unit at the end of the hall was noted to be very rusted. The left exit door at the end of this hall was chipped and rusted near the bottom edge of the door.

5. Base boards and the lower area of the walls through out the three halls were noted to be very scuffed and dirty looking with random areas of the base board coming loose from the walls.

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F 465	Continued From page 14	F 465		

6. The South Hall Resident Women's Bathroom was noted to have a signed taped to the wall above the whirlpool tub stating, "Please do not use the whirlpool for storage". Inside the whirlpool tub were 2 pillows, 2 bed positioners, and 1 mechanical lift sling. There was a dirty blue glove and a washcloth on the floor between the toilet and the sink. There were brown splatters on the wall behind the toilet.

B. On 3-17-2016 at 9:15 am, a general tour of the facility was completed and the following was noted:

1. The communal men's bathroom/shower area on the 200 hall was cluttered with an over the bed table, linen cart, 5 wheel chairs and a bed side commode. The plumbing of the toilet in the communal women's bathroom on the 200 hall was noted to have a greenish colored hard water build up. The shower area had a cabinet blocking the shower entrance with a sign that stated "Do not use". E5, Certified Nurse Aide stated that this shower room had not been usable for "a few weeks" and that the men's shower room is not used. In room 210. the wall paper above the bed near the window was loose and pulling away from the wall at the seam in a 2 foot long area. A clear piece of tape was covering part of this area. E8, Maintenance Supervisor stated on 3-17-2016 at 10:00 am that there had been an ongoing problem with a leak in the women's communal shower and it was in need of repair again.

2. The men's communal bathroom/shower area on the 400 hall was cluttered with 2 wheel chairs and the shower stall contained a folded wheelchair as well as the shower chair. The

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F 465	Continued From page 15 plumbing of the toilet was noted to have a green colored hard water build up. In the corner near the toilet, the wall was noted to have cracked and peeling paint from midway of the wall and up towards the ceiling. The Resident Census and Conditions of Residents Report, dated 3-15-2016, notes the facility census as 41.	F 465		