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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Licensure Survey for Subpart S: SMI Complaint #1546164/IL81391: No deficiencies	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		

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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representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review the facility staff failed to report an allegation of abuse immediately to the Administrator delaying the initial investigation of potential abuse for 3 months for 1 of 7 residents (R11) reviewed for abuse allegations in the sample 15.

Findings Include:

On 11/17/15, at 9:00 AM, during the Group Interview Meeting R11 stated "I was sleeping by the piano three months ago, and (E8, Certified Nursing Assistant,CNA) pinched me on the shoulder to wake me up. I told (E3, Licensed Practical Nurse LPN) that (E8) pinched me on the shoulder. (E3) checked my shoulder out, and told me (R11) that she (E3) didn't see any spots on my shoulder. (E8) came back and asked me why did I scream and was I trying to get her in trouble."

On 11/18/15 at 1:00 PM E3 stated "(R11) told me about three months ago that (E8) scared her when she woke her up. (R11) did not tell me that (E8) woke her by pinching her. (R11) told (E4, Registered Nurse,RN) that (E8) pinched her. (E4) reported it (the pinching allegation) to me.

R11's Medical Record did not document any

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F 225	Continued From page 2 information about this allegation of abuse. The facility had no documentation that an investigation had been completed regarding this allegation. On 08/17/15, at 3:45 PM, E1 Administrator stated "I am not aware of this allegation, but I will investigate it now." R11's Minimum Data Set (MDS), dated 8/25/2015 documents R11 is cognitively intact.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility staff failed to operationalize its abuse policy by not reporting a allegation of abuse immediately to the administrator delaying the initial investigation of abuse for one of seven residents (R11) reviewed for abuse allegations in the sample of 15. Findings Include: 1. The undated Facility Policy entitled Abuse Prevention Program Facility Procedures documents, in part, "Employees are required to report any incident, allegation or suspicion of potential abuse, neglect, mistreatment, or misappropriation of resident property they	F 226		

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F 226	Continued From page 3 observe, hear about, or suspect to the administrator immediately. The supervisors shall immediately inform the administrator or person designated to act as administrator in the administrators absence of all reports of incidents, allegations, or suspicion of potential abuse, neglect, mistreatment, or misappropriation of resident property. the nursing staff is additionally responsible for reporting on a facility incident report the appearance of suspicious bruises, lacerations, or other abnormalities as they occur. The nursing supervisor is responsible for reporting to the administrator. 2. On 11/17/15, at 9:00 AM, during the Group Interview Meeting, R11 stated "I was sleeping by the piano three months ago, and (E8, Certified Nursing Assistant,CNA) pinched me on the shoulder to wake me up. I told (E3, Licensed Practical Nurse, LPN) that (E8) pinched me on the shoulder. (E3) checked my shoulder out and told me (R11) that she (E3) didn't see any spots on my shoulder. (E8) came back and asked me why did I scream, and was I trying to get her in trouble." R11's Medical Record did not document any information about this allegation of abuse. The facility had no documentation an investigation was completed regarding this allegation. On 08/17/15, at 3:45 PM E1, Administrator stated "I am not aware of this allegation, but I will investigate it now."	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must	F 309		

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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 interview and record review, the Facility failed to coordinate services between the facility and Hospice for 1 of 1 resident (R3) reviewed for hospice services in the sample of 15.

Findings include:

R3's Physician Order dated 8/6/2015 documents, "Admit to Hospice diagnosis Congestive Heart Failure. " R3's Physician's Order (PO) dated 10/14/2015 documents, "Discharge from Hospice." R3's PO dated 10/16/2015 documents, "Readmitted to Hospice."

On 11/17/2015 at 9:15 AM, R3's hospice medical record was reviewed. No Care Plan was found and the last documented nurse's note was dated 9/29/2015.

On 11/17/2015 at 9:20 AM, E2, Interim Director of Nurses (DON), stated, "I have only been here a week and a half. I am not sure were the records are. I will find out."

On 11/17/2015 at 10:00 AM, Z4, Hospice Registered Nurse (RN), stated, "I have the nurses notes with me today. I just hadn't had time to print them out and put them in the chart. (R3) is visited

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by hospice nursing once a week and hospice CNA's (Certified Nurse's Aides) twice a week." When questioned about the Care Plan, Z4, states, "Surely it is in the chart." Z4 confirmed it was not in the chart. When questioned about how care is coordinated with the nurses and CNAs, Z4 states, "There is a CNA Care Plan in the chart for coordination." When asked where the CNA care plan was in the chart, Z4, states, "Well its not here either. I will have to print both care plans out."

On 11/17/2015 at 10:35 AM, E1, Administrator, stated, "The Director of Nurses is the one that oversees the coordination of care with hospice but, right now we have a interim DON so she won't know anything about this. "

On 11/17/2015 at 10:40 AM, E23 Corporate Consultant, stated, "Yes, the notes and Care Plans should be in the chart for coordination of care."

The "Hospice Services Agreement" dated 9/1/2013 documents, in part, "(Hospice Company) shall provide the creation and maintenance of a clinical record for each resident hospice patient. Included in the clinical record shall be (Hospice Company's) initial assessment and certification for services and any recertifications, the Plan of Care and all modifications thereto, a record of all medications prescribed and delivered to the resident hospice patient, all clinical notes written by the resident hospice, patient's attending physician, (Hospice Company's) Medical Director, and all other professionals and volunteers of (Hospice Company's) and nursing facility relating to care of the resident hospice patient."

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F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to provide complete passive range of motion (PROM) exercises for the prevention of contractures and treatment of current contractures for 1 of 3 residents (R9) reviewed for PROMs in the sample of 15. Finding includes: R9's Minimum Data Set (MDS) dated 9/26/16 documents multiple diagnoses to include, " Infantile Cerebral Palsy, Paralytic Syndrome, Spastic Quadriplegia, Abnormal Posture and Contracture of Joints Multiple Sites and limitation in ROM on both sides of the upper and lower extremities." R9's most current Occupational Therapy Evaluation dated 7/18/14, documents, "Clinical Impressions: (R9) presents with significant bilateral elbow flexion contractures, right more than left, and has reddened areas in elbow creases during attempts at PROM into extension. Bilateral hands are fisted. High risk of fixed contractures."	F 318		

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R9's Care Plan on Restorative PROM Program dated 9/29/15 documents, "PROM to Right Upper Extremity of 10 repetitions to all joints and planes as tolerated. PROM to Left Upper Extremity and Bilateral Lower Extremity 10 repetitions times 2 sets as tolerated to all joints and planes."

On 11/17/15 at 10:05 AM, R9 was resting in bed on her left side with her right and left elbows flexed, right hand fisted and left hand clutching a hair brush. R9's bilateral hips and knees were flexed in a fetal position.

On 11/18/15 at 10:50 AM, E14, Restorative Aide, provided PROM exercises to R9. E14 did not perform exercises on the following joints and planes: adduction and abduction of all fingers, flexion and extension of the left thumb and fingers, abduction, adduction and opposition of the left and right thumbs, internal and external rotation of both hips, and all planes of both ankle joints and toes.

On 11/18/15 at 2:38 PM, E6, Restorative Nurse, stated she expected all exercises to be done on all joints and planes as tolerated.

On 11/19/15 at 11:47 AM, E22, Certified Occupational Therapist (COTA), stated R9 was not evaluated for contractures after 7/18/14.

The Facility Policy on Restorative/Rehabilitative Nursing Care revised 2015 documents, "4. Rehabilitative nursing care may be performed daily for those residents who require such service including and not limited to: a. Maintaining good body alignment and proper positioning; c. Assisting residents to adjust to their disabilities, e. Assisting residents with their routine range of

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F 318	Continued From page 8 motion exercises."	F 318		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications at the time ordered. There were 25 opportunities with 3 errors resulting in a 12% medication error rate. The errors involved 3 residents (R16, R17, R18) in the supplemental sample out of 16 residents observed during medication administration. Findings include: 1. On 11/17/15 at 11:15 AM, E12, Licensed Practical Nurse (LPN), administered R16 one tablet of Alprazolam 0.5 milligram (mg) by mouth. R16's Physician Order Sheet (POS) dated 11/2015 documents, "Alprazolam 0.5 mg by mouth twice a day (7 AM, 4 PM.)" R16's Medication Administration Record (MAR) dated 11/2015 documents, "Alprazolam 0.5 mg by mouth twice a day (7AM, 4 PM.)" 2. On 11/17/15 at 3:41 PM, E13, LPN, administered R17 her 4:00 PM medications. E13 failed to give R17 her Systane Gel eye drops.	F 332		

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F 332	Continued From page 9 R17's POS dated 11/2015 documents, "Systane Gel Drops 0.4 - 0.3% 1 drop to both eyes twice daily (7 AM, 4 PM.)" R17's MAR dated 11/2015 documents, "Systane Gel Drops 0.4 - 0.3 % 1 drop to both eyes twice daily (7 AM, 4 PM.)" 3. On 11/17/15 at 3:55 PM, E13 administered R18 one tablet of Lyrica 50 mg. R18's POS dated 11/2015 documents, "Lyrica 50 mg capsule by mouth 3 times a day (7 AM, 1 PM, 7 PM.)" R18's MAR dated 11/2015 documents, "Lyrica 50 mg capsule by mouth 3 times a day (7 AM, 1 PM, 7 PM.)" On 11/19/15/at 10:50 AM, E2 (DON) stated she expected the nurses to make sure the right medications are given to the right patient, at the right time, at the right route and the rest of the other rights during medication administration. The Facility Policy on Medication Administration dated 2/6/14, documents, "Procedure: 3. Review the resident's MAR. 4. Read each order entirely. 5. Read each label carefully: when removing from the drawer, when pouring, after pouring. 6. If there is any discrepancy between the MAR and the label, check physician orders before administering medication."	F 332		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441		

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F 441	Continued From page 10 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to adequately develop an ongoing infection	F 441		

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control program that; adequately collects data to calculate and analyze employee infection, and failed to develop an infection control policy to adequately define infection control practice for employees in the facility. This has the potential to affect all 75 residents living in the facility.

Finding includes:

1. On 11/19/15 at 11:45 AM, E2, Director of Nursing, DON, stated that she was not sure who is in charge of tracking and trending employee infections. E2 states that she has been the interim DON for a week and a half and would check to see who was in charge of the employee infection log.

On 11/19/15 at 12:40 PM, E1, Administrator stated that the DON would be in charge of the Employee Infection Control Log but E2, DON is the interim DON and only been here a week and half. E1 further stated the facility fills out employee illness papers but do not compile data anywhere that she (E1) is aware of. E1 stated on the same day at 1:00 PM that the facility discusses infection control in the quarterly Quality Assurance meeting but there is no documentation for tracking and trending employee illness. E1 further stated she could not find any documentation from previous DON on tracking and trending employee infection.

On 11/19/15 at 1:28 PM, E1 stated the Facility does not have an infection control policy for tracking and trending employee illness.

2. The Facility's Resident Census and Conditions of Resident form, dated 11/16/2015, documented the facility had a census of 75

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F 441	Continued From page 12 residents.	F 441		