

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

PRINTED: 04/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145939	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/18/2011
NAME OF PROVIDER OR SUPPLIER WATERFRONT TERRACE			STREET ADDRESS, CITY, STATE, ZIP CODE 7750 SOUTH SHORE DRIVE CHICAGO, IL 60649		
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F 000	INITIAL COMMENTS	F 000			
F 167 SS=C	<p>Annual Certification Survey</p> <p>Licensure Survey for SubPart S:SMI</p> <p>Complaint survey 1085030/IL51152-no deficiencies</p> <p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to post a notice indicating where the survey results could be found without having to request them. This deficient practice has the potential to affect all 98 residents residing in the facility.</p> <p>Findings include: On two days of the survey, 3-15-2011 and 3-16-2011, there was no observed signage directing individuals to the facilities survey results and plan of correction. During the environmental tour on the first floor on 3-16-2011 at 12:00pm with tour guide (Corporate Director) Z1, surveyor observed no visible signage to direct individuals</p>	F 167			

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 167	Continued From page 1 to the facilities recent survey results and plan of correction. Corporate director, Z1 was interviewed on 3-16-2011 at 12:00pm regarding survey result signage. Z1 responded, " The survey results and plan of correction is at the first floor nursing station, it was in the front office but we moved it due to remodeling, residents would have to ask the nurse for the results. We will post a visible sign to inform all residents and visitors where to go to have access to the survey results and the plan of correction in the front office, the entrance to the building. "	F 167			
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by o483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation , interview and record review the facility failed to ensure that one resident , R11 in a sample of 20 residents had been assessed for self administration of medication and obtained a physicians order to self administer medication. Findings include: R11was readmitted on 2-25-2011 with a pertinent diagnosis of altered mental status, convulsions, and shortness of breath. On 3-15-2011 during initial tour with tour guide (Director of Nursing, DON) E2, R11 was observed with Albuterol HFA 90 micrograms at her bedside table. Surveyor asked R11, do you self administer albuterol? R11 responded, " oh	F 176			

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F 176	Continued From page 2 yes I use it when I need it , two puffs twice a day , when I need it. " (DON)E2, who was present during the observation was asked if R11 self administers her albuterol. E2 responded, " I will check on it. " On 3-16-2011 (DON) E2 was asked again in the daily status meeting at 4:00pm if R11 self administers Albuterol. E2 responded again " I will check on it. " Review of R11 ' s clinical record, Physician Order Sheet (POS) for February, 2011 and March 2011 documents an order for " Albuterol HFA 90 Micrograms 2 puffs every 12 hours and as needed for shortness of breath. " There was no self administer order for Albuterol documented on February and March POS for 2011. As a result of surveyor inquiry the POS dated 3-16-2011 documents " Albuterol HFA 90 Micrograms resident may keep have at bedside. " Nursing progress note dated 3-16-2011 at 4:30pm documents " Doctor returned page order to have inhaler at bedside. " None of the R11 care plans address self administration of albuterol HFA.	F 176			
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 record review and staff interview, the facility failed to complete a timely investigation of 1 allegation of theft for 1 resident (R5) of 20 sampled residents due to a failure to follow the facility's abuse policy on reporting allegations to a	F 226			

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F 226	Continued From page 3 supervisor. This failure has the potential of affecting all 98 residents in the facility. Findings include: Review of social service notes for R5 reflects a social service note dated 11/1/10 describing an allegation R5 made against staff for stealing money from her. When surveyor requested to see the follow-up investigation on this allegation on 3/17/11 at the daily status meeting, E1(Admin) and E2 (DON) both were not sure if they were aware of the allegation and E1 stated he would check to see if they had an investigation. The following day, 3/18, E2 gave surveyor an investigation dated 3/18. During interview with E2 on 3/18, E2 dated that the person who received the allegation was E17 (social services). E2 stated that she had spoken to E17 that morning, and E17 had told her that she spoke to someone from nursing, but she could not recall who. E2 stated that she is the abuse coordinator and was the one who should have been notified. E2 denied knowing about this allegation until surveyor mentioned it 3/17. E2 stated she began her investigation today, and has already reinserviced E17 on the reporting requirements for allegations of abuse or theft.	F 226			
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest	F 250			

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F 250	<p>Continued From page 4</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to provide medically-related social services by failing to initiate behavior management interventions for 1 (R12) of 20 sampled residents who had 2 episodes of suspected alcohol abuse in the facility. This failure has the potential of affecting all 26 residents in the facility with behavioral symptoms.</p> <p>Findings include:</p> <p>R12 was admitted to the facility on 8/12/10 with multiple diagnoses including hypertension and gluteal abscess. Social Service notes reflect that on 12/17, staff were informed that R12 had alcohol in the facility. At that time, R12 denied this and R12 was informed about the facility policy on alcohol. R12 was informed that he would have to follow the facility's policies.</p> <p>Nursing notes from 1/11/11 indicate that alcohol was found in R12's room, and neither resident in the room admitted to owning it.</p> <p>Again on 2/18, social service notes reflect that staff addressed an incidence of R12 being under the influence of alcohol in the facility. R12 was encouraged to remain alcohol free. Following this are several social service notes (2/21, 2/28, 3/2, 3/4) and 3/7) which describe encouraging R12 to attend psycho-social groups, which R12 refused.</p>	F 250			

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F 250	Continued From page 5 Nursing notes from 3/8/11 indicate that R12 was found lying on the floor in his room, exhibiting slurred speech and an unsteady gait, displaying evidence of ETOH use. R12 sustained a small chin laceration at that time. On 3/8, Social Service note from 3/8 again reflects that staff met with R12 to address R12 being under the influence of alcohol, as well as finding alcohol in his room. The alcohol policy was again reviewed with R12, and attendance at a substance abuse program was encouraged. During interview with E14 (Social Service Director) on 3/17 at 11:35 am, E14 stated that R12 does have pass privileges and that his pass privileges have never been revoked or suspended as a result of his alcohol use in the facility. E14 also denied having R12 enter into any type of behavioral contract with the facility. There were no behavioral modification interventions attempted other than talking to the resident. The facility interventions specific to the alcohol use included doing random room search for alcohol and reviewing the facility policy on alcohol use with R12-both of these interventions are undated.	F 250			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: 2nd floor medication room:	F 252			

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F 252	<p>Continued From page 6</p> <p>On 3/15/10 at 2:20 PM, the 2nd floor medication room was observed to contain three employee's coats, a purse, a pair of sneakers and a bag of bibbs. E16 (Nurse) stated that the articles did not belong in there and removed them. Based on observation and staff interview the facility failed to provide a safe and orderly environment for 2 of 20 samples residents (R6 and R12) as well as 1 resident out side the sample. The facility also failed to maintain 2 of 3 medication rooms in a clean and orderly environment with only medications and medication -related equipment stored there. These failures have the potential to affect all 98 residents who reside in the facility.</p> <p>Findings Include:</p> <p>During the intial tour of the first floor on 3/15/2011 at 9:45 AM accompanied by E 4 (minimum data set coordinator) the following was observed.:</p> <p>1) In room 101 there was an oxygen concentrator that had a large amt of dirty white substance on the front of the concentrator as well on the lid of the humidifier bottle was the same flaky white substance. Nebulizer mask was lying on the night stand not covered or in a container. A carton of milk was sitting in the window sill felt warm to touch. there were also 2 empty used urinals on the floor beside the bed.</p> <p>2) In room 103 where R6 and R12 both reside in the bathroom there was mouth wash, shea butter skin lotion and shaving cream stored on top of the paper towel dispenser unlabeled.</p> <p>3) In room 108 there was a urinal with yellow</p>	F 252			

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F 252	<p>Continued From page 7</p> <p>liquid urine like substance sitting on the floor beside the bed on the floor.</p> <p>4) On top the night stand next to R 21' s' bed was a bundle of disposable razors with 8 razors in the package.</p> <p>5) In the bathroom of room 115 were 2 residents reside there was a bar of green soap sitting on the sink not labled, as well as a roll on deodorant on the paper towel dispenser not labled.</p> <p>Interview with E 8 on 3/15/2011 at 10:00AM during the intial tour she stated that no resident was to have disposable razors in there room and removed them.</p> <p>Interview with E1 during the daily status meeting on 3/15/2011 at 3:45 PM stated the residents personal items are to be labled with there name.</p> <p>On 3/16/2011 at 9:20AM during the first floor medication room check with E 3, assistant director of nursing, the following was observed:</p> <p>1)There were boots stored on the counter top behind the medication room door on top of a stack of forms.</p> <p>2) There was a can of benaprotien open in the cabinet with no date.</p> <p>3) On the top shelf in the cabinet next to the sink there were 2 ash trays with a grey ash like substance inside of it. There were also to stained dirty coffee cups on with cigarette burns on the bottom of the cup and on with a brown stain on the outside of the cup as well as the inside of the cup. These were stored next to the gastrostomy</p>	F 252			

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F 252	Continued From page 8 feeding supplies. 4) In the bottom cabinet next to the laboratory specimen refrigerator there was a coat folded up on the shelf. 5) In the bottom cabinet next to the sink there was a blanket folded and stored on a broken shelf.	F 252			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain a sanitary, orderly and comfortable interior for 3 out of 3 oxygen storage rooms, 1 out of 3 soiled utility rooms and the third floor common area. This deficient practice has the potential to affect all residents who require oxygen therapy, and all 28 residents on the third floor. Findings include: During environmental tour on 3-16-2011 which began at 10:50AM, with (Director of environmental services) E6, 3 out of 3 oxygen storage rooms (floor 1, 2 and 3) were observed to have heavy debris and dust build-up on the floor. The west end of third floor, common area had torn drapes hanging in the window. The third floor soiled utility room had a clean wash basin with new toiletry supplies in it. Environmental service director, E6 was interviewed during the discovery of the items. E6	F 253			

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F 253	Continued From page 9 responded, " I will have all the oxygen storage rooms cleaned, and will have the torn curtains on the 3rd floor common area replaced. " E6 threw the clean wash basin with new toiletry items in the trash can, upon discovery.	F 253			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under o483.25; and any services that would otherwise be required under o483.25 but are not provided due to the resident's exercise of rights under o483.10, including the right to refuse treatment under o483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment, for 1 of 20 sampled residents (R9)	F 279			

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F 279	Continued From page 10 with an identified weight issue, and 1 out of 20 residents (R2) with an identified weight issue and a diagnoses of dysphasia and constipation. This deficient practice has potential to affect all 98 residents of the facility. R2 is a 56 year old male with an identified weight issue and a diagnosis that includes constipation and dysphasia. R2 is on a pureed diet. Based on record review on 3/15/11, R2 ' s care plan did not include measurable objectives related to dysphasia, constipation, and identified weight issues. R9 is a 57 year old female with an identified weight issue. Based on record review on 3/15/11, R9 ' s care plan did not include measurable objectives related to identified weight issues. E5 (Care Plan Coordinator) was informed on 3/16/11 of the absence of the above stated objectives in R2 and R9 ' s care plans. On 3/16/11, an updated care plan for R9 was presented to the surveyor. This care plan included objectives for weight gain, with a start date of 3/16/11. On 3/16/11, an updated care plan for R2 was presented to the surveyor. This care plan included objectives for weight gain and constipation, with start dates of 3/16/11. There were no objectives included for R2's need for a pureed diet related to dysphasia. Facility action taken only after prompting and questioning of care plan objectives	F 279			
F 285 SS=D	483.20(m), 483.20(e) PASRR REQUIREMENTS FOR MI & MR A facility must coordinate assessments with the pre-admission screening and resident review program under Medicaid in part 483, subpart C to	F 285			

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F 285	<p>Continued From page 11</p> <p>the maximum extent practicable to avoid duplicative testing and effort.</p> <p>A nursing facility must not admit, on or after January 1, 1989, any new residents with:</p> <p>(i) Mental illness as defined in paragraph (m)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission;</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>(ii) Mental retardation, as defined in paragraph (m)(2)(ii) of this section, unless the State mental retardation or developmental disability authority has determined prior to admission--</p> <p>(A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and</p> <p>(B) If the individual requires such level of services, whether the individual requires specialized services for mental retardation.</p> <p>For purposes of this section:</p> <p>(i) An individual is considered to have "mental illness" if the individual has a serious mental illness defined at o483.102(b)(1).</p> <p>(ii) An individual is considered to be "mentally retarded" if the individual is mentally retarded as defined in o483.102(b)(3) or is a person with a related condition as described in 42 CFR 1009.</p>	F 285			

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F 285	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure an accurate pre-admission screening was obtained for 3 seriously mentally ill residents (R9, R6 and R5) out of 3 sampled Sub-Part S residents. This failure has the potential of affecting all 10 Sub-Part S residents in the facility.</p> <p>Finding include:</p> <p>R6 is a 51 year old male admitted to the facility on 6/21/10 with multiple diagnoses. Current diagnoses for R6 include schizophrenia.. Review of R6's MDS (Minimum Data Set) of 6/28/10 reflects that R6 is coded as meeting IDPH Sub Part S criteria due to the diagnosis of schizophrenia. R6's pre-admission screening dated 8/12/07 reflects that there is no reasonable basis to suspect an MI (Mental Illness) diagnosis.</p> <p>R5 is a 72 year old female admitted to the facility 10/8/08 with multiple medical diagnoses which include schizophrenia. Review of R5's 10/4/10 MDS reflects that R5 meets IDPH Sub Part S criteria due to the diagnosis of schizophrenia. R5's pre-admission screening dated 12/4/07 reflects that there is no reasonable basis to suspect a DD or MI diagnosis.</p> <p>R9 is a 57 year old female admitted to the facility on 1/7/09 with multiple diagnoses. Her current diagnoses include Schizo-affective disorder. Review of her 1/7/2011 MDS reflects that R9 meets IDPH criteria for Sub Part S due to her diagnosis of Schizo-affective disorder. Review of R9's pre-admission screening dated 10/25/07</p>	F 285			

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F 285	Continued From page 13 reflects there is no reasonable basis to suspect an MI diagnosis for R9. All three residents are identified by the facility as Sub Part s residents. The pre-admission screening for R6, R5 ad R9 were all incomplete due to this inaccurate information. During daily status meeting on 3/17 with E1 (Admin), E2 (DON) and E3 (ADON), E1 stated that these residents were screened prior to admission to this facility, and that he would have a PAS agent rescreen them.	F 285			
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 observation, interview and record review the facility failed to ensure that one resident R4 and all other residents were free from potential accidental hazards. This deficient practice has the potential to affect all 98 residents. Findings include: R4 was readmitted on 3-3-2011 with pertinent diagnosis ' which includes hypertension, diabetes mellitus, chronic obstructive pulmonary disease, and asthma. R4 is also utilizing	F 323			

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F 323	<p>Continued From page 14</p> <p>anticoagulation therapy.</p> <p>On initial tour, 3-15-2011 at 10:00 am with tour guide (Director of Nursing)E2, R4 was observed sitting in her room in a wheelchair, next to the bed with oxygen infusing 2 liters per nasal cannula, R4 was asked by surveyor if there are any concerns that she has with the facility. R4 responded " my lock on my wheelchair is broken and one of the side rails on my bed is unstable I need these to work I do not want to hurt myself. " R4 then demonstrated for E2 and the surveyor the broken brake on the wheelchair and the unstable side rail on the bed. Again, on 3-16-2011 at 9:00am R4 was sitting in the doorway of her room. R4 stated " They have not fixed my bed or wheelchair yet.</p> <p>Review of R4 ' s clinical record documents a score of 15 on the Fall Assessment Tool dated 3-3-2011. Documented at the top of the fall assessment tool is " A score of 14 or greater means the resident is at risk for falls. " Side rail Assessment dated 1-18-2011 documents the use of two half side rails. The residents care plan dated 1-18-2011 documents " Resident requires use of 2(1/2) side rails while in bed to aid in independent mobility. "</p> <p>(DON) E2 was interviewed on 3-15-2011 while in resident room during the initial tour. E2 responded, " We will get it fixed " As a result of surveyors ' inquiry on 3-17-2011 during daily status meeting at 4:00pm,(DON) E2 stated, " we ordered a new electric bed for R4 and the wheelchair is being repaired today. "</p> <p>Findings include: During the environmental tour on 3-16-2011 at 10:50AM with tour guide Environmental director E7, 5 side rails in the corridors on the 3rd floor were observed to be loose. Listed below are the</p>	F 323			

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F 323	Continued From page 15 locations and number of loose side rails. a. The dining room on the 3rd floor, 2 loose side rails one on the north wall and one on the south wall. b. One loose side rail on the east side wall in front of the nursing station. c. One loose side rail on the side of room 309. d. One loose side rail on the side of room 314. Environmental director, E6 was interviewed during the discovery of all loose side rails, E6 responded " we will fix that today. " On 3-16-2011, at 11:46 AM during environmental tour with (Director of Manitenance),E7 room 303 (third floor) was observed to have a bathroom toilet pipe leak, there was a waste basket underneath the leaky toilet pipe that was 1/2 full of water. Water was observed on the floor in the bathroom. In the same room the air conditioning unit cover was on the floor. E6 responded " I do not know what has been happening in here, but we will fix it . " Resident ' s bathroom on the 3 rd floor was observed to have two pieces of unsecured dry wall right above the entrance to the shower stall . On the first floor right above the entrance to the first floor, two pieces of dry wall was off and exposed wiring was hanging over the doorway. Observed in the basement laundry room displayed shelving that had the top shelve occupied with nursing supplies in boxes touching piping. In the vending room in the basement, the east corner ceiling had a large hole in it with exposed piping. Environmental director, E6 was interviewed after the tour which concluded at 12:20 pm, E6 responded " I will fix all of the items mentioned. "	F 323			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS	F 333			

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F 333	<p>Continued From page 16</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that one resident (R22) outside the sampled residents of 20, is free of significant medication errors. This failure has the potential to affect all 98 residents of the facility.</p> <p>Findings include:</p> <p>During the medication pass observation on 3/15/11, 1:40 PM, with E12, R22 was administered one medication, Motrin 800 mg by mouth every 8 hours. Review of the POS (Physician Order Sheet) indicated that the following medications had been omitted:</p> <p>1.) Atrovent 0.02% Inhalation Solution. Use 1 ampule per nebulizer every 6 hours (6-12-6-12).</p> <p>2.) Albuterol 0.083% Inhalation Solution. Use 1 ampule per nebulizer every 6 hours (6-12-6-12).</p> <p>When E 12 was questioned about the omitted medications, E 12 stated that the medications were kept at R22's bedside and administered by R22. When questioned about a physician order for self administration of medications and storing of medications at the bedside for R22, E 12 stated that there was a doctor's order for that.</p> <p>When reviewed again, the POS did not have a physician order for any medications to be kept at R22's bedside. E3 (Assistant Director of Nursing</p>	F 333			

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F 333	Continued From page 17) was informed of the omitted medications on 3/16/10 and agreed stated that there was no physician order to leave medications at R22's bedside nor for R22 to self medicate. When R22 was interviewed on 3/17/11, 10:00 AM, R12 stated that she had not received a nebulizer treatment in over a month and denied that she ever self administered the nebulizer treatments. This was immediately relayed to E3 who later presented the original order from 12/20/10 for: Albuterol and Atrovent Neb Treatment every 6 hours and PRN. This order was written by R 22's physician. The surveyor reminded E3 that although the nebulizer treatment could be given PRN, there was still an order to give it as scheduled every 6 hours.	F 333			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to	F 431			

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F 431	<p>Continued From page 18 have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: 2nd floor medication room:</p> <p>On 3/15/11, 2:20 PM with E16 (Nurse), the surveyor observed two wash basins containing cards of medications. One basin was unlabeled and the other said, "extra". E16 stated that the unlabeled basin was for residents who had gone to the hospital and the extra one was for medications that were discontinued or not being used by the resident. When asked about their policy on storing extra medications, E 16 stated that she was not sure there was one. Also noted in the refrigerator was a vial of insulin (Novolin R) for R28 which was opened and undated. E1 (Administrator), E2 (Director of Nursing) and E3 (Assistant Director of Nursing) were informed of these concerns on 3/16/11 at the daily status meeting. There was no response to the concerns.</p> <p>Based on observation and interview the facility failed to dispose of or store expired medications properly. This failure has the potential to effect all 34 residents who reside of the first floor.</p>	F 431			

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F 431	Continued From page 19 Findings include: On 3/16/2011 during medication room check with E3 (assistant director of nursing) there was a large brown paper bag stored in the bottom cabinet next to the specimen refrigerator. The paper bag contained medication that expired in 2007. The following medications were in the bag: Unit Dose Punch cards: Phenytoin 100 milligrams (mg)- 21 pills Phenytoin 100 mg -28 pills Ascorbic Acid 500 mg - 1 pill Omeprazole 20 mg -5 pills Cyclobenzaprine 10 mg -21 pills Mirtazepine 15 mg - 27 pills Phoslo 667 mg - 8 pills Metoprolol 25 mg - 30 pills Metoprolol 25 mg - 30 pills Risperdal 0.25 mg- 11 pills Risperdal 0.25 mg - 30 pills Risperdal 0.25 mg - 26 pills Glipizide 10 mg- 1 pill Ascorbic Acid 500 mg - 1 pill Metoclopramide 10 mg - 30 pills Clonidine HCL 0.2 mg - 29 pills Nifedipine ER 60 mg - 2 pills Protonix EC 40 mg - 3 pills Haloperidol 5 mg - 30 pills Kepra 500 mg - 16 pills Ascorbic Acid 500 mg - 21 pills Ascorbic Acid 500 mg - 30 pills 1 vial of Novolin R insulin 1 Vial of Lantus insulin 1 bottle of Teargen drops House stock expired 2007 Aspirin 325 mg - 100 pills	F 431			

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F 431	Continued From page 20 Multivitamin with iron - 937 pills Interview with E3 , assistant director of nursing on 3/16/2011 at 10:00 AM she stated "I have no answer for why these medications were in this brown paper bag in the cabinet from 2007. the facility policy is to send the medication back to the pharmacy when a resident is discharged or expires. The medications are to be placed in the return tub on the counter in the medication room. The nurse working the floor is the only one who has a key to the medication room. The pharmacy will not take back medication that expired in 2007. Two registered nurses will have to destroy the medications by placing them in a biohazard sharps container for waste management to pick up.	F 431			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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	F 441			

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F 441	<p>Continued From page 21</p> <p>prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to establish and maintain an effective infection control program which included policies and procedures to ensure precautions are in place and followed by staff. The facility also failed to follow current standards of infection control practices during and following the provision of care for 1 resident in a sample of 20 (R11), and 1 resident outside the sample (R23). This has potential to affect all 48 residents of the facility.</p> <p>Findings include: R11 has the following pertinent diagnosis ' Neurogenic Bladder and Ileostomy, paraplegia. On 3-16-2011 at 1:30 pm during observation of R11 ' s treatments with (Nurse) E15, R11 ' s urinary drainage bag was observed on the floor. At 2:00pm surveyor asked (Nurse) E15 why was R11 ' s urinary drainage bag on the floor, E15</p>	F 441			

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F 441	<p>Continued From page 22</p> <p>responded, " I will get a bag to keep the urinary drainage bag in. "</p> <p>Review of clinical record Physician order sheet (POS) dated 3-7-2011 documents " change uro-illeostomy bag once a week on Wednesdays. " R11 has a current care plan dated 1-12-2011 " Potential for urinary tract infection " the care plan does not address the placement of the urinary drainage bag. "</p> <p>Findings include: On initial tour 3-15-2011 at 9:30 am with tour guide Director of Nursing (DON) E2 on the 2 nd floor the following rooms were observed with the following isolation signage: 200= contact isolation 201= contact isolation 205= contact isolation/isolation respiratory 206= contact isolation 209=contact isolation/respiratory isolation 211= contact isolation 212= contact isolation 215= contact isolation/respiratory isolation There were no observed signs to direct staff on what type of personal protective equipment to utilize when entering the rooms. There was no information directing staff to the nursing station prior to entering the rooms. During the environmental tour on 3-16-2011 at 11:10 am (Maintenance director) E7 entered room 205(Contact and respiratory isolation) room to do a temperature. E7 was informed by surveyor that 205 was an isolation room, after surveyor informed E7 from outside the door, E7 turned around and exited the room. R23 resident in room 205 current POS dated from 3-1-2011 through 3-31-2011 documents " Droplet precaution Methicillin resistant staphylococcus aureaus. "</p>	F 441			

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F 441	Continued From page 23 During daily status on 3-15-2011 Assistant director of nursing(ADON) E3 was interviewed regarding isolation policies. ADON(E3), responded " I will present a policy on 3-16-2011. " (ADON) E3 presented an isolation policy on 3-16-2011 during administration presentation at 10:00am., the policy did not address , how staff are informed of what personal protective equipement to utilize when entering isolation rooms.	F 441			