| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 000 | INITIAL COMMENTS | F 000 | | |
| F 241 SS=E | Annual Licensure and Certification Survey<br>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY<br><br>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review, the facility failed to protect the residents dignity by failing to provide functioning privacy curtains and by not following the facility's privacy policy.<br>This failure affected three out of 10 residents (R7, R11, R12) reviewed for dignity in the sample of 10 and one supplemental resident (R14).<br><br>Findings Include:<br><br>The facility's Resident Rights for all Nursing Procedures Policy dated 3/9/15 documents, "To provide general guidelines for resident rights while caring for the resident...For any procedure that involves direct resident care, follow these steps:....4) if visitors are present, ask them to wait outside unless the resident requests that they remain in the room. 5) close room entrance door and if a semi-private room, pull {privacy} curtain between beds."<br><br>The facility's Daily Census dated 4/10/16 documents R7, R11, R12 and R14 all reside in the second bed of a semi-private room and have | F 241 | | 4/29/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 05/02/2016

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 241 | Continued From page 1<br>roommate's.<br><br>On 4/12/16 at 2:20 pm, R11 stated, "I'm having problems with this catheter, it is hurting me." E5 CNA attempted to pull the privacy curtain {between the two beds} but the curtain would only go to the foot of the bed. E5 stated, "we have a lot of curtains that are like this, we can't provide privacy {to the resident's in the second bed} because the curtain will only come this far, and not all around the second bed." There was a piece of metal, which looked like a screw, in the track preventing the curtain from being able to be pulled further. R11 and R10 (R11's roommate) were lying in their beds. R10 had 3 visitors, one on the side/head of R10's bed, another at the side/foot of R10's bed, both facing R11's direction, and one at the foot of R10's bed. R11's bed is the second bed in the room, furthest away from the door. E7 LPN (Licensed Practical Nurse) asked R11 if E7 could check R11's catheter to make sure it was ok. E7 continued to pull down R11's pants, exposing R11's penis to check the catheter placement. During this time, the visitor remained at the foot of R10's bed, and could see R11. E7 never asked R10's visitors to step out of the room to provide privacy and dignity during cares.<br><br>On 4/11/16 at 11:40 am, E6 CNA (Certified Nursing Assistant) attempted to pull the privacy curtain between the two resident beds in the room to provide cares to R12. The privacy curtain would only extend to the foot of the bed, not around the bed. E6 stated, "this curtain doesn't provide much privacy since it won't pull all the way around the bed and there isn't another curtain on the other side for us to pull, that "clip" is stopping it {pointing up to the ceiling}." A "clip" | F 241 | | |

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|---|---|---|---|
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|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 241 | Continued From page 2<br>was noted to be screwed onto the track of the curtain.<br><br>On 4/12/16 at 3:00 pm, R7 and R14's privacy curtains would not extend past the foot of the bed. There was a piece of metal, which looked like a screw, in the track preventing the curtain from being able to be pulled further.<br><br>On 4/12/16 at 12:30 pm, E1 Administrator confirmed that semi-private rooms should have two curtains, both half "U" shaped. The first bed's curtain provides privacy for first bed and wraps around the foot of the bed. The second bed's curtain {between the two beds} provides privacy for the second bed and wraps around the foot of the bed. E1 stated, "the privacy curtain should be pulled during cares and if the resident's roommate is in the room and has visitors, the staff could and should ask the visitor's to step out while cares are being provided." After showing the "clip" to E1, E1 stated, "I don't know why that's there."<br><br>On 4/12/16 at 12:40 pm, E15 Maintenance Director unscrewed the "clip" and stated, "the track is missing a piece, that is why that {clip} was there. Without it, the curtain would fall out of the track. I'm not sure how that clip got there." | F 241 | | |
| F 280 SS=D | 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP<br><br>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. | F 280 | | 4/29/16 |

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|---|---|---|---|
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|---|---|
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|---|---|---|---|---|
| F 280 | Continued From page 3<br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to add fall related interventions to the care plan for one of seven residents (R5) reviewed for falls in the sample of 10.<br><br>Findings include:<br><br>The facility's Fall Prevention policy dated 1/14/15 documents, "...Fall reports will be reviewed at stand-up meeting (department head meeting) and any new interventions will be written on the careplan."<br><br>On 4/11/16 at 12:00 PM, E3 Assistant Director of Nursing stated, "When somebody falls the nurses fill out the fall report. The nurses will add the interventions to the care plan at the time of the fall."<br><br>R5's Fall Report dated 6/10/15 documents, "(R5) on floor under dining room table lying on back." | F 280 | | |

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|---|---|---|---|
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|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 280 | Continued From page 4<br>This report documents the fall intervention as, "closer monitoring, ambulate (with) assist."<br><br>R5's careplan does not include the intervention of "closer monitoring, ambulate (with) assist" related to R5's 6/10/15 fall.<br><br>On 4/11/16 at 12:00 PM, E3 confirmed no interventions were added to R5's careplan in regards to R5's 6/10/15 fall.<br><br>R5's Fall Report dated 7/10/15 documents, "Found resident sitting on floor between bed and his desk." This report documents the fall intervention as, "Reinforcement (and) reminders to use call light."<br><br>R5's careplan does not include the intervention of "Reinforcement (and) reminders to use call light" related to R5's 7/10/15 fall.<br><br>On 4/11/16 at 12:00 PM, E3 confirmed no interventions were added to R5's careplan in regards to R5's 7/10/15 fall. | F 280 | | |
| F 314 SS=D | 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES<br><br>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores 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. | F 314 | | 4/29/16 |

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|---|---|---|---|---|
| F 314 | Continued From page 5<br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review the facility failed to monitor and assess a pressure sore weekly for one of two residents (R10) reviewed for pressure sores in the sample of 10.<br><br>Findings include:<br><br>The facility's Wound Round policy dated 9/17/15 documents, "Wound rounds will be done weekly by designated nurse. Nurse doing rounds will document wound stage, measurement, appearance and if acquired/admitted with wound on tracking form."<br><br>R10's nurse's note dated 3/27/16 at 7:43 PM documents, "Noted to have a 1 cm (centimeter) skin tear/ shearing on (R10's) right buttock."<br><br>R10's physician order sheet documents an order dated 3/31/16 for a hydrocolloid dressing to right buttock, change every three days.<br><br>R10's nurse's note dated 4/10/16 at 3:50 PM documents, "<br>Serosanguinous drainage noted, foul odor noted."<br><br>R10's hospice care summary dated 4/11/16 documents, "Facility nurse reports a change to buttocks wound as being larger, necrotic with foul smell...wound to coccyx 4x4 cm to left side and new area noted, 3x3 areas are red with necrotic tissue noted. Area cleansed and (absorbent polyurethane foam dressing) applied, new orders written for wound care."<br><br>Review of R10's medical record did not document an assessment of R10's wound after it was found | F 314 | | |

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| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 314 | Continued From page 6<br>on 3/27/16 until 4/10/16. Review of R10's medical record did not document measurements of R10's wound after 3/31/16 until 4/11/16.<br><br>On 4/12/16 at 9:50 AM, E2 Director of Nursing stated, "Area on right buttock was a one cm sheared area. The treatment was (barrier) cream then it changed to a hydrocolloid dressing on 3/31/16 because the area had opened up. The area was not reassessed until 4/10/16. The area was not remeasured at that time. The facility wounds are measured on Wednesdays, once (R10's) treatment was switched to the hydrocolloid dressing it should have been measured." | F 314 | | |
| F 315 SS=D | 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER<br><br>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the 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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on record review and interview, the facility failed to provide catheter care to one of two residents (R11) reviewed for catheters in the sample of 10.<br><br>Findings Include: | F 315 | | 4/29/16 |

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|---|---|---|---|---|
| F 315 | Continued From page 7<br><br>R11's Order Summary Report dated April/2016 documents an order for a 18 French Indwelling Catheter and a Diagnoses of Enlarged Prostate with Lower Urinary Tract Symptoms.<br><br>R11's Minimum Data Set dated 3/10/16 documents R11 is alert and oriented and has an Indwelling Catheter.<br><br>R11's Care Plan dated 2/27/16 documents, "uses {an} indwelling Foley catheter for ongoing treatment for urinary retention...Foley cath care every shift and PRN (as needed)."<br><br>On 4/12/16 at 8:40 am, R11 stated "the girls clean it {catheter} every once in a while, maybe every few days. They haven't cleaned it today, or yesterday."<br><br>On 4/12/16 at 8:55 am, E4 CNA (Certified Nursing Assistant) confirmed E4 was assigned to R11. E4 stated, "(R11's) catheter care had not been completed yet today." When surveyor asked to see cares when E4 provided them, E4 stated, "(E4) gets off duty at 11:00 am, if (E4) does catheter care, (E4) will come and get the surveyor." E4 never came to get the surveyor for catheter care observation.<br><br>On 4/12/16 at 2:20 pm, E5 CNA confirmed E5 was now R11's assigned CNA. E5 stated, "(E5) really don't know how often catheter care is done on (R11), (E5) would assume daily." E5 stated that (E5) does catheter care only after (R11) has sat on the toilet to have a bowel movement.<br><br>On 4/12/16 at 3:40 pm, E2 DON (Director of Nursing) stated, "catheter care is part of routine | F 315 | | |

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|---|---|---|---|
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|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 315 | Continued From page 8<br>cares for someone with a catheter. Cares should be provided first thing in the morning when the resident is being gotten up, along with other cares and PRN. It is unfortunate that the CNA's wouldn't just do it as a standard. I guess we will have to add it to the CNA's daily assignment, so that they don't forget to do it." | F 315 | | |
| F 323 SS=E | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>These failures resulted in four deficient practices.<br><br>A. Based on interview and record review the facility failed to provide supervision in the shower room, resulting in a fall for one of seven residents (R13) reviewed for accidents in the sample of 10.<br><br>B. Based on interview and record review the facility failed to implement fall interventions for two of seven residents (R1, R5), and failed to thoroughly re-evaluate and modify post fall interventions for one resident (R5) reviewed for falls in the sample of 10.<br><br>C. Based on interview and record review the facility failed to report a fall with injury to the state agency for one of seven residents (R1) reviewed | F 323 | | 5/4/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 323 | Continued From page 9 | F 323 | | |

for falls in the sample of 10.

D. Based on observation, interview and record review the facility failed to utilize a gait belt during resident transfers for two residents (R4, R6) of seven residents reviewed for falls in the sample of 10.

Findings include:

A. The facility's Fall Prevention policy dated 1/14/15 documents, "....Fall assessments are completed by nurse on day of admission, quarterly, and with change of condition, and reviewed after each fall.... A color coded star is placed on the name plaque by the resident's room....Yellow indicates moderate risk for falls..."

R13's Physician's Order Sheet (POS) dated April 1, 2016 documents the diagnoses of Early Onset Cerebellar Ataxia, Syncope and Collapse, Constipation, Major Depression Disorder and Muscle Weakness. R13's Minimum Data Set (MDS) dated 1/1/15 documents transfer assistance as extensive assistance of two plus persons. This same MDS documents R1's toilet use assistance as extensive assistance of two plus persons.

R13's Fall Assessment dated 10/1/15 documents R1 as being at moderate risk for falling. R13's Care Plan documents, "..needs assist with ADLs (Activities of Daily Living) r/t (related to) weakness....Bathing: Extensive assist from two staff date initiated 6/29/15...Toileting: needs extensive assist from two staff date initiated 1/27/15...."

R13's "Resident Fall Report" dated 12/29/15 at

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 323 | Continued From page 10 | F 323 | | |

7:10AM documents, "...(R13) was in the shower chair and states (R13) was trying to go to the bathroom and fell out of the chair forward hitting her head." This same document asks the question, "Was there anyone with you when you fell?" The answer checked is "No."

R13's Nurses Notes dated 12/29/15 at 7:10 AM documents, "(R13) was in the shower chair in the shower room and states she was trying to go to the bathroom and fell out of the chair forward hitting her head on the floor. (R13) alert and oriented, large hematoma noted on right side of forehead and small amount of bleeding noted from mouth area. (R13) c/o (complained of) some back pain. 911 called...."

R13's Nurses Notes dated 12/30/15 at 11:51 AM documents, "(R13) returned from (the hospital) via (transport company) accompanied by daughter. Skin assessment completed. Noted to have small bruise to right shoulder. Large hematoma to right side of forehead and bruising to bilateral face and lips. Edema noted in face and lips as well. States pain is a 6/10 in head. Received two (Hydrocodone/Acetaminaphen) prior to leaving hospitl per phone report...."

R13's Hospital History of Present Illness dated 12/29/15 documents, "...per ER (Emergency Report) patient did have loss of consciousness for multiple seconds resulting in fall from seated position with trauma to the right side of her face.....Assessment/Plan....Encephalopathy likely secondary to Syncopal episode, possibly post concussive syndrome...."

On 4/12/16 at 1:17PM R13 stated, "I fell in the shower and broke my front teeth, I had to have

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
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| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 323 | Continued From page 11 | F 323 | | |

new ones." At this time R1 began to tear up and became emotional.

R13's Progress Note by Z2, R13's Dentist, dated 1/7/16 documents, "Extracted two anterior teeth...."

On 4/13/16 at 11:05AM E2 Director of Nursing (DON) stated on 12/29/15 the shower aide was finishing up R13's shower and went to R13's room to get some clothing that she had forgotten and left R13 alone in the shower room.

On 4/13/16 at 10:50AM R13 stated she had never been left alone in the shower room before the fall on 12/29/15.

On 4/13/16 at 11:19AM, E2 DON and E3 Assistant Director of Nursing stated they brought E13 Certified Nursing Assistant (CNA) into their office after the fall and counseled E13 not to leave residents alone in the shower room. E3 stated that she didn't write E13 up she just talked to her about not leaving residents alone in the shower room.
At this same time E3 stated that the facility does not have a shower policy.
B. The facility's Fall Prevention policy dated 1/14/15 documents, "fall reports will be reviewed at stand-up (department head) meeting and any new interventions will be written on the careplan."
The facility's Fall Protocol dated 1/14/16 documents, "The staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling. If the individual continues to fall, the staff and physician will re-evaluate the sitiuation and consider other possible reasons for the resident's falling besides

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|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

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|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 323 | Continued From page 12 | F 323 | | |

those that have already been identified and will re-evaluate the continued relevance of current interventions."

1. R5's Minimum Data Set (MDS) dated 10/20/15 documents R5 as requiring extensive assistance with transfers and limitation in range of motion of both upper and lower extremities.

R5's Fall Report dated 6/10/15 documents, "(R5) on floor under dining room table lying on back." This report documents the fall intervention as, "closer monitoring, ambulate (with) assist."

R5's Fall Report dated 7/10/15 documents, "Found resident sitting on floor between bed (and) his desk." This report documents the fall intervention as, "Reinforcement (and) reminders to use call light."

R5's Fall Report dated 10/3/15 documents, "(R5) observed lying on floor in bathroom next to toilet." This report documents the fall intervention as, "Remind (R5) to call for help before going to bathroom."

R5's Fall Report dated 10/18/15 documents, "(R5) trying to put (self) to bed (and) got feet caught and tangled in blankets." This report documents the fall intervention as, "pressure pad alarm." This report documents the result of the fall as, "(L) elbow fracture."

R5's plan of care does not include interventions dated for the 6/10/15 or the 7/10/15 fall.

On 4/11/16 at 12:00 PM, E3 Assistant Director of Nursing confirmed that R5's interventions for R5's falls on 6/10/15 and 7/10/15 were not

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 323 | Continued From page 13 | F 323 | | |

documented on R5's care plan.

On 4/11/16 at 12:00 PM, E3 stated, "When somebody falls the nurses fill out the fall report. The nurses will add the interventions to the care plan at the time of the fall. The report then comes to the office and then I make sure interventions were added to the care plan. The CNAs (Certified Nurse's Assistants) can see the interventions on the point of care on the kardex. The interventions on the kardex carry over from the care plan. The interventions (R5's) for 6/10/15 and 7/10/15 were not on (R5's) care plan so would not be on (R5's) kardex. I look back at the care plans to see the past interventions. I would have done something different (for the intervention for the 10/3/16 fall) if the intervention for the falls on 6/10/15 and 7/10/15 were added to (R5's) care plan. May have put alarms on sooner..Alarms work for the most part. (Alarms) alert the staff."

On 4/11/16 at 1:58 PM, Z1 (R5's physician) stated after a fall, " I would see what steps to take to prevent future falls. I would expect them (the facility) to do a new intervention. Alarms are useful to make people aware to prevent falls."

2. The facility's undated Fall Log documents R1 had a fall on 2/28/16 at 8:45pm.

R1's Resident Fall Report dated 2/28/16 documents R1's fall in the dining room occurred when R1 was attempting to stand unassisted and slid out of chair. The alarm was attached and did not unattach from shirt. This report documents the root cause as R1 got up unassisted. This report also documents the pull tab alarm was tested at that time and works now. The

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 323 | Continued From page 14 | F 323 | | |

intervention placed in response to this fall is documented as "Pull tab on chair" which was already in place during this fall. No new intervention was identified.
R1's Progress Notes dated 2/28/16 at 8:45pm documents, "... Noted resident laying on the floor in front of (R1's) w/c (wheelchair). Alarm attached and did not come unattached from w/c (wheelchair)... "
On 4/12/16 at 9:25am, E3, Assistant Director of Nursing (ADON) stated that on 2/28/16 at 8:45pm, R1 was trying to walk. E3 stated the root cause of R1's fall on 2/28/16 at 8:45pm was R1 stood up unassisted but did not know why R1 was trying to walk. E3 stated, "The progress note says the alarm was not attached and did not come unattached." E3 stated E3 was unaware that R1 had a pull tab alarm in place. E3 also stated if the initial intervention placed by the nurses is inappropriate that E3 updates the intervention with an appropriate one in response to the root cause of each fall. E3 stated, "(E3) would expect to keep asking why for falls until (E3) couldn't ask anymore." E3 stated that R1 standing up unassisted was not the root cause of R1's fall on 2/28/16 at 8:45pm.

On 4/12/16 at 10:05am, E2, Director of Nursing (DON) stated, "... You have to ask why (in regards to the root cause of each fall) until you can't ask anymore. (E2) agree we (facility) need to really dig deeper (for the root cause of each fall)."

C. R1's Order Summary Report dated 4/11/16 documents R1's diagnoses including Dementia with Behaviors and Orthostatic Hypotension.

R1's "Morse Fall Scale" dated 12/2/15 documents

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 323 | Continued From page 15<br>R1 as a high risk for falling.<br><br>The facility's undated Fall Log documents R1 had a fall on 2/19/16 at 6:15pm.<br><br>R1's Resident Fall Report dated 2/19/16 at 6:15pm documents R1 was rushing and lost balance and fell in the hallway while ambulating back to R1's room. This report also documents R1 was unresponsive, sustained a laceration from the fall and that R1 was sent to the emergency room where he received staples. This report documents, "... (State Agency) notified? No"<br><br>R1's Physician Discharge Orders dated 2/19/16 documents, "Laceration, Minor Head Injury."<br><br>R1's CT (Computed Tomography) exam report dated 2/19/16 documents, "... A right parietal scalp soft tissue injury with skin staples..."<br><br>On 4/12/16 at 9:25am, E3, Assistant Director of Nursing (ADON) stated when R1 was sent to the emergency room after the fall on 2/19/16, the ER ordered a head CT test with showed no intracranial abnormalities. E3 stated, "I was under the impression we (the facility) only notified the (state agency) for broken bones. (E1, Director of Nursing and E2, Administrator) do the reporting to the (state agency)... (E1 and E2) were aware of the fall and laceration with staples."<br><br>On 4/12/16 at 10:05am, E2, DON stated, "We (the facility) normally report (an incident) if the resident is admitted to the hospital with an injury... (E2) was curious about this one. (E2) personally thought about reporting (R1's fall on 2/19/16 with injury)..." | F 323 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 323 | Continued From page 16 | F 323 | | |

D. The facility's Ambulation/Gait Belts policy dated 5/17/07 documents, "(The facility) recommends that each CNA (Certified Nursing Assistant) use an ambulation/gait belt when transferring or ambulating a resident.... "

1. R4's Minimum Data Set (MDS) dated 1/6/16 documents diagnoses of Arthritis, Other Intervertebral Disc Degeneration Lumbosacral Region, Polyneuropathy, and Spinal Stenosis Lumbar Region. This MDS also documents R4 requires Extensive Assistance of one person for Transfers.

R4's Transfer Assessment dated 4/4/16 documents R4 requires assist of one person. R1's Fall Assessment dated 4/5/16 documents a Moderate Risk for Falling.

On 4/11/16 at 10:03AM, E14 Certified Nursing Assistant (CNA) stood next to R4 as R4 locked his wheelchair brakes and pushed himself up then E14 held onto R4's slacks as he pivoted to the high back chair. R4 then proceeded to stand again and E14 pulled on his slacks to assist him up out of the high back chair and held onto R4 as he pivoted back to the wheelchair and sat down. E14 at no point during R4's transfer used a gait belt.

On 4/11/16 at 10:10AM, E14 stated R4 does not require a gait belt because he usually transfers himself.

On 4/12/6 at 3:53PM, E2 Director of Nursing stated, "If (E14) had to hold onto (R4's) pants she should've used a gait belt."

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 323 | Continued From page 17<br><br>2. R6's MDS dated 2/23/16 documents diagnoses of Arthritis, CVA (Cerebrovascular Accident), Muscle Wasting and Atrophy, and Syncope and Collapse. The MDS also documents R5 requires Extensive Assistance of one person for Transfers.<br><br>R6's Transfer Assessment dated 2/22/16 documents Limited Assist from one person with a wheeled walker. R6's Fall Assessment dated 2/22/16 documents High Risk for Falling.<br><br>On 4/11/16 at 10:05AM, E14 put the walker in front of R6 as R6 raised himself in his lift recliner and pushed himself up with both hands. R6 walked to the bed and plopped down on the bed. R6 then tried to get up off the bed and couldn't. E14 assisted R6 up off the bed with her hand under his arm. E14 did not utilize a gait belt at all during this transfer. E14 stated he does not require a gait belt because he walks himself to the dining room.<br><br>On 4/11/16 at 3:53PM E2 stated, "to be safe E14 should have used a gait belt on R6." | F 323 | | |
| F 329 SS=D | 483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS<br><br>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. | F 329 | | 4/29/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 329 | Continued From page 18<br>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to complete accurate psychoactive assessments, failed to adequately monitor identified targeted behaviors and nonpharmacological interventions, failed to develop a comprehensive care plan and failed to document resident's responses for non pharmacological interventions for two of two residents (R1, R7) reviewed for psychotropic medications in the sample of 10.<br><br>Findings include:<br><br>1. R7's Medication Administration Record (MAR) dated 4/1/16 documents R7's diagnoses including Dementia with Behavioral Disturbance and Unspecified Psychosis. This MAR also documents R7 has an order for Seroquel (Antipsychotic) Tablet 25mg (milligrams), give 12.5mg by mouth two times a day. This same MAR also documents to complete a behavior | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 329 | Continued From page 19<br>progress note every shift but does not document what targeted behaviors are to be documented.<br><br>R7's Progress Notes dated 8/11/15 document R7 received an order for Seroquel 12.5mg by mouth daily. R7's Order Summary report dated 4/14/16 documents an order to increase Seroquel to 12.5mg twice daily on 8/21/15. There is no documentation of a comprehensive assessment completed prior to increasing the Seroquel dose. R7's Progress Notes dated 8/11/15-8/21/15 document R7 refused medications on 8/14/15, 8/16/15 and 8/21/15. R7's Progress Notes dated 8/11/15-8/21/15 document behaviors on 8/13/15 at 3:11pm, with redirection helping at times and 8/16/15 at 5:32pm, with no documentation of nonpharmacological interventions attempted. There is no other documentation of R7's targeted behaviors or nonpharmacological interventions attempted warranting the increase in R7's Seroquel dose.<br><br>R7's Order Summary Report dated 4/4/16 documents R7 received an order for a decrease in Seroquel to 12.5mg by mouth daily on 11/30/15. R7's Progress Notes dated 11/30/15 at 1:56pm to 12/6/15 at 10:32am do not document R7 having any targeted behaviors. R7's Progress Notes dated 12/6/15 at 9:48pm document, "Res extremely disruptive and agitated tonight. Yelling at staff... Squeezed a staff members hands and wouldn't let go until (E17, Licensed Practical Nurse) calmed (R7) down. Refusing to go to bed... Will be passing along to next nurse... changed back to BID (twice daily) dose to help (R7) with (R7's) increased agitated behaviors."<br><br>R7's Order Summary dated 4/4/16 documents R7 received an order to increase Seroquel to 12.5mg | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 329 | Continued From page 20 | F 329 | | |

by mouth twice daily on 12/30/15. R7's psychoactive medication monitoring assessment dated 12/9/15 documents R7 as receiving Seroquel 12.5mg by mouth daily. This assessment documents R7's behaviors had remained the same or controlled and that R7's behaviors did not worsen. There were no other psychoactive assessments documented after 12/9/15 prior to the increase of Seroquel on 12/30/15.

R7's Progress Notes dated 8/1/2015 to 4/12/2016 do not consistently document R7's targeted behaviors, nonpharmacological interventions and/or responses to interventions.

The facility's Antipsychotic Drug Tracking document dated September 2015 and October 2015 document R7 as having increased hallucinations and hitting staff. These same tracking sheets document R7's order for Seroquel 12.5mg twice daily. There is no documentation of nonpharmacological interventions or the resident's responses to nonpharmacological interventions. The Antipsychotic Drug Tracking document dated November 2015 does not document behaviors and documents a reduction of Seroquel to 12.5mg five times a week. The facility's Antipsychotic Drug Tracking document dated December 2015, January 2016, February 2016, March 2016 documents increased agitation, yelling at roommate, throwing food at meal time but does not document nonpharmacological interventions or the resident's response to any nonpharmacological interventions. These documents dated monthly December 2015-March 2016 also document R7's order for Seroquel was increased on 12/30/15 to 12.5mg twice daily and R7 continued with the

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 329 | Continued From page 21<br>same behaviors.<br><br>R7's Care Plans for Antipsychotic medications and behaviors dated 1/31/16 do not document R7's identified targeted behaviors of pinching and agitation. These care plans also do not document R7's identified nonpharmacological interventions of redirection, pain control, toileting or reassurance.<br><br>On 4/12/16 at 10:50am, E8, Registered Nurse (RN) stated, "(E8) do quarterly reviews (of Antipsychotic medications)... and also (do a review) if there is a change in medication (Antipsychotic medication), not generally for a reduction, but definitely for an increase and on initial admission... Quarterly assessments are all (E8) have ever done here (at this facility)... (E8) agree there are no assessments prior to the increases in Seroquel on 8/21/15 and 12/30/15 for R7."<br><br>On 4/13/16 at 10:05am, E8, RN stated R7's targeted behaviors include verbal aggression, swearing, yelling, physical aggression and striking out at staff. E8 stated R7's nonpharmacological interventions for R7's behaviors include allow time for feelings, offer choices, 1 to 1 visits, pain control, toileting and reassurance. E8 stated only a couple of R7's nonpharmacological interventions are in R7's care plan, but not all of them. When asked how the nurses know what targeted behaviors and nonpharmacological interventions are being monitored for each resident, E8 stated, "I can't say, unless they look at the assessment or other things they tried." E8 also stated the nurses should be documenting the effectiveness of nonpharmacological interventions. E8 stated, "I only do quarterly | F 329 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 329 | Continued From page 22 | F 329 | | |

assessments. I don't have documentation of an assessment when R7's Seroquel was increased. (E8) wasn't aware that if we (facility) wanted to increase it (an Antipsychotic medication)- (we) had to do an assessment." E8 also stated the staff should be documenting the resident's targeted behaviors, nonpharmacological interventions and the responses to the nonpharmacological interventions in the nurses notes. E8 stated, "Nonpharmacological interventions and behaviors should be documented where the nurses can access them in the care plan or (E8) could add them to the Medication Administration Record (MAR)." E8 also stated there is no documentation that R7's gradual dose reductions were ineffective.

2. R1's Order Summary Report dated 4/11/16 documents R7's diagnoses including Dementia with Behavioral Disturbance. This report documents an order dated 9/9/15 for an increase in Risperdal to 1mg by mouth in the evening.

R1's psychoactive medication monitoring assessments dated 12/2/15 and 3/1/16 document R1 is receiving Risperdal 0.5mg by mouth every evening.

On 4/12/16 at 10:50am, E8, Registered Nurse (RN) stated R1's psychoactive medication monitoring assessments on 12/2/15 and 3/1/16 were inaccurate do to assessing R1's Risperdal dose as 0.5mg daily instead of the 1mg dose R1 was receiving.

On 4/13/16 at 10:05am, E8, RN stated R7's targeted behaviors include verbal aggression, swearing, yelling, physical aggression and striking out at staff. E8 stated R7's nonpharmacological

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 329 | Continued From page 23<br>interventions for R7's behaviors include allow time for feelings, offer choices, 1 to 1 visits, pain control, toileting and reassurance. E8 stated only a couple of R7's nonpharmacological interventions are in R7's care plan, but not all of them. When asked how the nurses know what targeted behaviors and nonpharmacological interventions are being monitored for each resident, E8 stated, "I can't say, unless they look at the assessment or other things they tried." E8 also stated the nurses should be documenting the effectiveness of nonpharmacological interventions. E8 stated, "I only do quarterly assessments. I don't have documentation of an assessment when R7's Seroquel was increased. (E8) wasn't aware that if we (facility) wanted to increase it (an Antipsychotic medication)- (we) had to do an assessment." E8 also stated the staff should be documenting the resident's targeted behaviors, nonpharmacological interventions and the responses to the nonpharmacological interventions in the nurses notes. E8 stated, "Nonpharmacological interventions and behaviors should be documented where the nurses can access them in the care plan or (E8) could add them to the Medication Administration Record (MAR)." E8 also stated there is no documentation that R7's gradual dose reductions were ineffective.<br><br>The facility's Psychotropic Drug Policy and Procedure dated January 15, 2015 documents, "... Behavior monitoring will document specific behavior that indicates the need for administration of the medication... Progress notes will be documented in the the resident's record concerning response..." | F 329 | | |
| F 363 | 483.35(c) MENUS MEET RES NEEDS/PREP IN | F 363 | | 4/27/16 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

| (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 |
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| F 363 SS=D | Continued From page 24<br>ADVANCE/FOLLOWED<br><br>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to serve the required amount of protein for the lunch time meal for three residents (R15, R16, R17) reviewed for meals on the supplemental sample.<br><br>Findings include:<br><br>The facility's dietary spreadsheet for 4/10/16 documents the portion size of baked trout as four ounces.<br><br>On 4/10/16 from 11:30 PM to 1:00 PM, R15, R16, and R17 were served baked trout on their lunch trays.<br><br>On 4/10/16 at 1:00 PM, E9 Assistant Food Service Director weighed the serving size of the baked trout. The baked trout weighed two ounces instead of four ounces.<br><br>On 4/10/16 at 1:20 PM, E9 stated, "The trout and the prime rib was the protein containing meats at lunch. The trout weighed two ounces, it was suppose to weigh four ounces. The trout weighs eight ounces when whole {unbaked}. We cut the trout in half after it was baked. We didn't realize | F 363 | | |

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|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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|---|---|---|---|---|
| F 363 | Continued From page 25<br>the trout weighed less after baking it." At that time, E9 confirmed R15, R16, and R17 received two ounces of baked trout on their lunch tray. | F 363 | | |
| F 371 SS=F | 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY<br><br>The facility must -<br>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and<br>(2) Store, prepare, distribute and serve food under sanitary conditions<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review the facility failed to store frozen vegetables and prepared food in a sanitary manner. This failure had the potential affect all 64 residents that reside in the facility.<br><br>Findings include:<br><br>On 4/10/16 at 9:00 AM, the walk in cooler contained four (steam table) metal pans of mixed vegetables and one (steam table) metal pan of green beans. These pans were uncovered. One pan of mixed vegetables sat on top of another pan of mixed vegetables which resulted in the bottom of the pan coming into contact with the mixed vegetables.<br><br>On 4/10/16 at 9:00 AM, E11 Food Service Director confirmed that the mixed vegetables and | F 371 | | 4/27/16 |

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|---|---|---|---|---|
| F 371 | Continued From page 26<br>the green beans were not covered. E11 stated, "The vegetables are going to be used for lunch, they should have covered them."<br><br>On 4/10/16 at 11:30 AM, the prepared lunch meal was stored in a cold food station and a steam table station prior in the dining room. At that time, the frame of the cold food station had accumulated dried food material. This frame was positioned above the food which was being served for the lunch meal. The frame of the steam table station had accumulated dried food material and corrosion. This frame was positioned above the food which was being served for the lunch meal.<br><br>On 4/13/16 at 9:00 AM, E9 Assistant Food Service Director confirmed the cold food station and the steam table station had accumulated dried food material and the steam table station had some corrosion. E9 stated, "They do need to be thoroughly cleaned."<br><br>The Resident Census and Conditions of Resident dated 4/10/16 documents 64 residents reside in the facility. | F 371 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS<br><br>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. | F 431 | | 4/29/16 |

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|---|---|---|---|
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|---|---|---|---|---|
| F 431 | Continued From page 27<br>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.<br><br>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 have access to the keys.<br><br>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.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review and interview, the facility failed to dispose of expired insulin medication, accurately label insulin medication and document date of expiration or opening of two medication inhalers. This failure has the potential to affect one resident (R11) on the sample of 10 and two residents (R18, R19) on the supplemental sample.<br><br>Findings include:<br><br>1. R19's Order Summary Report dated 4/12/16 | F 431 | | |

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|---|---|---|---|
| | 145400 | A. BUILDING _____ B. WING _____ | 04/14/2016 |

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|---|---|---|---|---|
| F 431 | Continued From page 28 | F 431 | | |

documents an order for Lantus (insulin) solution, inject 15 units subcutaneously at bedtime related to Diabetes Mellitus. This Report also documents an order for Advair Diskus (inhaler) 250-50mcg (micrograms)/dose; inhale 1 puff orally two times a day related to Chronic Obstructive Pulmonary Disease.

On 4/10/16 at 430pm, the medication cart for the skilled unit contained a bottle of Lantus solution labeled with R19's name. This bottle also contained a handwritten opened date of 3/4/16. There was no other Lantus insulin medication for R19 in the cart.

On 3/4/16 at 4:30pm, E10, Licensed Practical Nurse (LPN) stated the name as R19 and the date opened as 3/4/16 on R19's Lantus insulin bottle. E10 confirmed there was no other bottle of Lantus insulin for R19 in the cart. E10 stated, "I think it was reordered. It (lantus insulin) is expired." E10 then disposed of the expired Lantus insulin bottle.

On 4/11/16 at 4:30pm, the skilled unit medication cart contained an open, undated Advair Diskus inhaler labeled with the handwritten name of R19.

On 4/11/16 at 4:35pm, E12, LPN stated E12 could not find the date that R19's Advair Diskus inhaler was opened and that it should have the date when it was opened.

On 4/12/16 at 10:25am, E2, Director of Nursing stated, "When insulins ae opened, they (insulins) need to be dated and they (insulins) expire in 30 days... inhalers need to be dated... The nurses should be checking the dates on the medications. (E2) would expect the nurses to look at the date

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 431 | Continued From page 29<br>of expiration before administering the medications (including insulin)..."<br><br>2. R11's Order Summary Report dated 4/12/16 does not document an order for Humalog (insulin).<br><br>On 4/10/16 at 4:30pm, the medication cart for the skilled unit contained a Humalog Kwikpen labeled with a handwritten last name of R11. This insulin pen also contained a handwritten opened date of 2/11/16.<br><br>On 4/10/16 at 4:30pm, E3, LPN stated the Humalog Kwikpen was R11's and was expired. E3 also stated, "Everyone (all nurses) should be checking for expiration dates" when preparing medications for administration. E3 stated insulin expires 30 days after the insulin is opened.<br><br>On 4/12/16 at 10:25am, E2, Director of Nursing stated, "When insulins are opened, they (insulins) need to be dated and they (insulins) expire in 30 days... Usually the name on the label comes from pharmacy; if not they (nurses) write the (correct) residents name on the medication. (R11) has not had an order for Humalog insulin (while a resident in the facility). The nurses should be checking the dates on the medications. (E2) would expect the nurses to look at the date of expiration before administering the medications (including insulin)..."<br><br>3. R18's Order Summary Report dated 4/12/16 documents an order for Advair Diskus (inhaler) 250-50mcg (micrograms)/dose; inhale 1 puff orally two times a day related to Bronchitis.<br><br>On 4/11/16 at 4:30pm, the skilled unit medication | F 431 | | |

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|---|---|---|---|
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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 431 | Continued From page 30 | F 431 | | |

cart contained an open, undated Advair Diskus inhaler labeled with the handwritten name of R18.

On 4/11/16 at 4:35pm, E12, LPN stated E12 could not find the date that R18's Advair Diskus inhaler was opened and that it should have the date when it was opened.

On 4/12/16 at 10:25am, E2, Director of Nursing stated, "... inhalers need to be dated... The nurses should be checking the dates on the medications. (E2) would expect the nurses to look at the date of expiration before administering the medications..."

The manufacturer's Instructions for use for Lantus insulin dated July, 2015 documents, "Do not use Lantus after the expiration date... 28 days after you first use it."

The Prescribing Information for the Humalog Kwikpen from the manufacturer dated November 16, 2015 documents, "... Storage and Handling Do not use after the expiration date... Humalog Kwikpen... must be used within 28 days (of opening) or be discarded..."

The undated Advair Diskus instructions for use documents, "... Safely throw away Advair Diskus in the trash 1 month after you open the foil pouch..."

The facility's Storage and Expiration of Medications, Biologicals, Syringes and Needles policy dated 1/1/13 documents, "... 4. Facility should ensure that medications... 4.2 Have not been retained longer than recommended by manufacturer or supplier guidelines... 5. Once any medication... is opened, Facility should follow

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|---|---|---|---|
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|---|---|
| WESTMINSTER VILLAGE | 2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701 |

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|---|---|---|---|---|
| F 431 | Continued From page 31<br>manufacturer/supplier guidelines with respect to expiration dates for opened medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened..." | F 431 | | |
| F 441 SS=D | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.<br>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. | F 441 | | 4/29/16 |

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|---|---|---|---|---|
| F 441 | Continued From page 32<br>(c) Linens<br>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview and record review the facility failed to implement hand hygiene after providing incontinent care for one of 10 residents (R12) reviewed for hand hygiene in the sample of 10.<br><br>Findings Include:<br><br>R12's Care Plan dated 2/24/16 documents R12 as being incontinent of bowel and bladder.<br><br>On 4/12/16 at 1:55 pm, R12 was lying in bed and had been incontinent of bowel. E5 CNA (Certified Nursing Assistant) cleaned the stool off of R12, using R12's right gloved hand, while E6 CNA held R12 over on R12's left side. Upon completion of incontinent care, E5 did not remove or change gloves and proceeded to take a skin protectant cream off of R12's nightstand and applied it to R12's buttocks, using the same gloved right hand. Once all personal cares were completed, E5 proceeded to touch the bed remote, call light, blanket, night stand drawer, bathroom door knob, and R12's hand with E5's contaminated gloved hand.<br><br>On 4/12/16 at 2:15 pm, E5 confirmed that E5 did not change gloves after providing incontinent care to R12 and before applying the skin protectant | F 441 | | |

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|---|---|---|---|---|
| F 441 | Continued From page 33<br>and touching items in the room.<br><br>On 4/12/16 at 3:40 pm, E2 Director of Nursing stated, "gloves need to be removed immediately after incontinent care is completed and before anything else is touched so you aren't contaminating everything you touch."<br><br>The facility's Infection Control Policy dated 9/17/15 documents, "The purpose of following Standard Precautions is to provide a safe, sanitary and comfortable environment and to help prevent the transmission of disease and infection....these precautions must be used for ALL residents, regardless of diagnosis or presumed infections status, when contact is anticipated with blood, all body fluids, secretions.....Hands shall be washed with soap and water whenever visibly soiled with dirt, blood or body fluids or after direct or indirect contact with such...removed gloves promptly after use, before touching non-contaminated items and environmental surfaces..." | F 441 | | |