STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146013	A. BUILDING ______ B. WING ______	C 02/27/2015

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BERKELEY NURSING & REHAB CENTER	**6909 WEST NORTH AVENUE OAK PARK, IL 60302**

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F 000	INITIAL COMMENTS Complaint Investigation 1591009/IL75259 - No deficiency Incident Report Investigation IRI to Incident of 2/11/15/IL75183 - No deficiency Incident Report Investigation IRI to Incident of 2/15/15/IL75110	F 000		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to assess for pain and offer pain medication to a resident who sustained a burn injury for one of three residents (R1) reviewed for supervision, in the sample of five residents. Findings include: According to the face sheet R1 was admitted to the facility on 2/3/15. Physician's Order Sheet (POS) dated 2/3/15 indicates R1 was admitted with diagnoses that include Subarachnoid Hemorrhage, Hypertension and Diabetes	F 309		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 309	Continued From page 1 Mellitus. POS dated 2/7/15 indicates diagnosis of Vascular Dementia was added on that date. Nurse's Notes dated 2/15/15 at 7:15am indicates that a CNA (Certified Nursing Assistant) reported to R1's nurse that R1 wandered into the pantry and put her hand in the steamer table and that dietary staff removed the residents hand and removed resident from the pantry. 2/20/2015 at 12:30pm, E4 stated that she was at one of the "ends" passing medications when she was told by E6, CNA that R1 had put her hands into the steam table. E4 stated that she immediately assessed both of R1's hands and that R1's right hand was red and that she applied a cold compress to R1's hand. E4 stated that R1's left hand was not initially red and that R1 did not initially complain of pain. E4 further stated that when she was ready to leave her shift (approximately 7:30am) R1 was expressing discomfort with her hands and that she did not ask R1 if she wanted anything for pain as she was leaving for the day and E3 (Nurse on day shift) was taking over. E4 also stated that she was unable to contact R1's physician to notify of R1's injury and E3 (Nurse) was going to continue to try to contact him. On 2/20/15 at 10:30am E3, LPN stated that when he arrived at the nursing station (on 2/15/15 at approximately 7:00am) E4, LPN was on the phone trying to contact R1's physician. At that time E3 stated that he saw R1 standing at the nurses station with one hand swollen, red and blistered - the other hand "Ok." E3 stated that R1 was not crying but focused on going home and holding the injured hand with the uninjured other hand.	F 309		

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F 309	Continued From page 2	F 309		

E3 stated he was not able to contact R1's physician and was finally able to contact the Medical Director who ordered R1 be sent to the hospital for evaluation.
Nurse's Notes dated 2/15/15 at 8:30am indicate that R1's physician was "unable to be reached, (Medical Director) made aware; transfer (R1) to hospital ER (Emergency Room) for medical treatment. Nurse's Notes dated 2/15/15 at 8:40am indicate Ambulance Transport Service was contacted and arrived at 9:10am.

On 12/25/15 at 12:35pm E3 stated E4 did not give any information regarding pain or pain medication for R1 before she left her shift. E3 stated E4 should have taken care of R1's pain or reported it to him (E4) . E3 did stated he observed R1 holding her injured hand with her uninjured hand and that could be a sign that R1 was having pain due to the burn on her injured hand.

Physician's Order Sheet (POS) dated 2/3/15 indicates R1 was ordered Acetaminophen (analgesic) 650mg (milligrams) to be given every four hours as needed for pain.

Medication Administration Sheet dated 2/3/15 to 2/28/15 indicated R1 did not receive any Acetaminophen on 2/15/15.

An incident report dated 2/15/15 indicated a hot water burn to R1's hand occurred at approximately 6:20am. Nurses Notes dated 2/15/15 at 9:10am indicate at this time, an ambulance transport arrived to transfer R1 to the hospital for evaluation. No documentation of pain assessment or offer of pain medication was found or presented from 6:20am to 9:10am while R1

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F 309	Continued From page 3 waited for transport for evaluation of hot water burn. Hospital discharge records dated 2/15/15 indicate R1 was discharged with primary diagnosis of "First degree burn of multiple sites of wrist and hand." Discharge instructions included: Expect blistering and peeling. Instructions also indicate a burn is classified as a second degree burn when blistering occurs and that over-the counter pain medications may be taken for pain. On 2/20/15 at 10:45am E3, nurse stated that when R1 returned from the hospital she had bandages on both hands and orders for topical antibiotic cream for affected areas. On 2/26/15 at 10:00am E1, Administrator stated her expectation is that one or both of the nurses (E3, E4) should have assessed and offered R1 something for pain after she was burned "especially if she was showing signs of discomfort." Facility Policy Management of Pain (undated) indicates: Aggressive assessing of pain in non-verbal and cognitively impaired residents. Preventing and minimizing anticipated pain when possible. Nursing Involvement/Pain Screening/Assessment 1. Upon change of condition or when new pain or an exacerbation of pain is suspected, the comprehensive Pain Assessment will be completed. Assessment will cover the following areas: intensity, location, onset, type, frequency, description, change, treatment effect and what makes it better or worse.	F 309		

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to follow their policy regarding supervision of residents, provide appropriate supervision for a cognitively impaired resident and prevent access to a hot steam table for one of three residents (R1) reviewed for supervision, in the sample of five residents. As a result, R1 a cognitively impaired resident, placed her hand into hot water on a steam table and obtained a first degree burn. Findings include: According to a face sheet. R1 was admitted to the facility on 2/3/15. Physician's Order Sheet (POS) dated 2/3/15 indicated R1 was admitted with diagnoses that include Subarachnoid Hemorrhage, Hypertension and Diabetes Mellitus. POS dated 2/7/15 indicated diagnosis of Vascular Dementia was added on that date. Nurse's Notes dated 2/15/15 at 7:15am indicates that a CNA (Certified Nursing Assistant) reported to R1's nurse that R1 wandered into the pantry	F 323		

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and put her hand in the steamer table and that dietary staff removed the residents hand and removed resident from the pantry.

On 2/24/15 at 10:00am E9, Dietary Aide stated she arrived to the facility at 6:00am (on 2/15/15) and saw R1 sitting in the Dining Room and at that time went downstairs to get the coffee. E9 stated she came back upstairs and noticed R1 walking as she was passing the coffee. E9 then stated that at that time the pantry door was open and she moved the coffee into the pantry where the steam table is kept and then went back downstairs. E9 stated that when she came back upstairs she saw R1 sticking her hands in the steam table water and take them out of the water while R1 was saying "Oh!" and then sticking her hands back in the steam table water. E9 stated she was able to grab R1's wrists before she could stick them in the water for the third time and removed R1 from the pantry. E9 stated that she usually leaves the door open to the pantry after she arrives in the morning and generally turns the steam table on at approximately 6:15am. E9 stated that she would often have to run downstairs for other supplies so it was easier just to leave the pantry door open.

On 2/25/15 at 12:50pm E9 stated there were approximately six other residents in the dining room (on 2/15/15) when she left the pantry door open and went downstairs to get coffee.

On 2/20/15 at 11:30am the surveyor noted a small pantry (kitchenette) adjacent to dining room where steam table is stored and utilized. Also the surveyor observed, to the immediate left of the dining room exit door is the pantry entrance.

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F 323	Continued From page 6 On 2/20/15 at 12:30am E4 (nurse) stated that she was the only nurse on duty on the nightshift of 2/14/15. E4 stated R1 was up all night, in and out of other residents rooms and required constant redirection throughout the night and that "(R1) was into stuff all night." E4 stated she was at one of the "ends" passing medications when she was told by E6, CNA that R1 had put her hands into the steam table. E4 stated that she immediately assessed both of R1's hands and R1's right hand was red and that she applied a cold compress to R1's hand. E4 stated that R1's left hand was not initially red and that R1 did not initially complain of pain. E4 further stated that when she was ready to leave her shift (approximately 7:30am) R1 was expressing discomfort with her hands and that she did not ask R1 if she wanted anything for pain as she was leaving for the day and E3 (day shift) was taking over. E4 also stated that she was unable to contact R1's physician to notify of R1's injury and E3 (nurse) was going to continue to try to contact him. E4 stated that the steam table is usually started approximately 4:30am to 5:00am and the door to the pantry is supposed to be locked at all times. On 2/20/15 at 10:30am E3 also stated R1 was not easily redirected and "can't leave anything on the carts because (R1) would move everything around." The only time R1 would relax was when her family was here visiting. E3 went on to state "I think (R1) needs 1:1 supervision." On 2/20/15 at 10:45am E3 stated that the kitchen (pantry) door is always supposed to be closed unless there is someone in there. On 2/25/15 at 12:35pm E3 stated R1's behavior "Had been like that from the beginning"	F 323		

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F 323		F 323		

Continued From page 7
and that the Director of Nursing was aware of her behaviors."

On 2/24/15 at 12:55pm E5 (CNA) stated she was one of two CNAs on the night shift on 2/14/15 and that usually there are three CNAs at night. E5 stated R1 was "busy all night" and she (E5) escorted R1 back to her room many times, with R1 being resistant to redirection at times. E5 stated she was in a another residents' room providing care when she was told about R1 putting her hands in the steam table water.

On 2/14/15 at 1:05pm E6 (CNA) stated he was the other CNA on duty the night R1 put her hands in the steam table. E6 stated R1 was going in and out of other residents rooms, taking items off carts and going into the nursing station "the whole night" and that "they just couldn't keep track of (R1) as she was literally going throughout the whole building." E6 also stated he was in providing care for a resident when R1 went into the pantry and put her hands in the steam table.

According to the above interviews, both CNAs on duty (during the night shift 2/14/2015)were providing care to other residents and the one nurse on duty was at the far end of the unit passing medications to residents. No staff were supervising R1 when she went into the pantry and placed her hands in the steam table water.

Hospital discharge records dated 2/15/15 indicate R1 was discharged with primary diagnosis of "First degree burn of multiple sites of wrist and hand."

R1's care plan with an initial date of 2/04/2015 and a canceled dated of 2/17/2015 indicate no

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F 323	Continued From page 8 interventions of how staff would monitor R1's behaviors when wandering. On 2/24/15 at 12:30pm E7 (Social Service Director) stated she was not aware of R1's escalating wandering behaviors and that she should have been notified by nursing. On 2/20/15 at 1:50pm E1, Administrator stated she was aware that staff were not locking the door to the pantry stating, "It seemed to work out ok with visitors and staff if it was not locked." E1 went on to state E9 (Dietary Aide) should have closed the door to the pantry before she went downstairs to get more supplies. Facility Policy entitled, Supervision of Resident dated 12/22/14 indicates: Residents with cognitive impairments and or residents who are at risk for falls will be monitored and supervised to reduce the risk of falls or injuries. Residents who are assessed with cognitive impairments will have appropriate care plan put in place. At least one staff person will remain in common areas when residents with cognitive impairments are present.	F 323		