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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 000	INITIAL COMMENTS	F 000		
F 167 SS=C	Annual Certification and Licensure Survey 483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to have two complaint investigations and the plan of correction for the complaint surveys readily accessible in the Survey Book. This deficient practice has the potential to affect all 57 residents in the building. Findings include: On 5/4/15, the facility submitted a Resident Census and Condition Sheet that documented a census of 57 residents. On 5/5/15 at 11:20 AM, during the Environmental Tour with E9 (Maintenance Director), it was noted that the results of the Complaint Investigations from 12/18/14 and 2/27/15 were not included in the Survey Book. The Plan of Correction for the two complaint surveys were not in the Survey	F 167		

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

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F 167	Continued From page 1 Book. On 5/5/15 at 11:23 AM, E1 (Administrator) stated, "I thought it only had to be the last survey. That's on me. I didn't know that the complaint surveys had to be in there too."	F 167		
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to properly implement its Abuse Prevention Program and failed to perform background checks on a timely basis for eight of 25 employees reviewed (E15, E16, E17, E18, E19, E20, E26, E27). This failure has the potential to affect all 57 residents in the facility. Findings include: The facility procedure as delineated in its Abuse Prevention Program dated 03/02/13, states "Prior to a new employee starting a working schedule: Initiate a reference check from previous employer(s) in accordance with facility policy; Obtain a copy of the state license of any individual being hired for a position requiring a professional license; Check the Illinois Nurse Aide Registry for all new employees; and File an Illinois State Police healthcare worker	F 226		

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F 226	Continued From page 2 background check application on all new hires." A review of 20 out of 24 certified nurse aides (CNA) employed by the facility found that five had delayed background checks: E15's (CNA) date of hire was listed as 1/19/15. E15's personnel file had a CNA certificate indicating she was trained and certified in the State of Florida under a different name. No evidence of inclusion on the Illinois Health Care Worker Registry or of application for deemed status was found in E15's personnel file under either of her two last names. Sex offender and other criminal background checks were initiated on 2/19/15, a month after E15 began work, but were invalid. It was noted that two different spellings of E15's last name were used on the criminal background searches and neither spelling matched E15's name as documented on her social security card and passport. E16's (CNA) date of hire was listed as 2/28/15, but health care worker registry and criminal background checks were not initiated until 3/19/15. E17's (CNA) date of hire was listed as 3/7/15, but health care worker registry and criminal background checks were not initiated until 3/19/15. E26's (CNA) date of hire was listed as 11/19/14, but health care worker registry and criminal background checks were not initiated until 11/30/14. E27's (CNA) date of hire was listed as 11/14/14, but health care worker registry and criminal	F 226		

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F 226	Continued From page 3 background checks were not initiated until 11/30/14. In addition, background checks for three of five other recently hired employees were not checked prior to hire or on a timely basis: E18's (Licensed Practical Nurse) date of hire was listed as 3/26/15, but E18's license verification on the Illinois Department of Financial and Professional Regulation site to confirm her status and other background checks were not initiated until 4/4/15. E19's (Activity Aide) date of hire was listed as 2/3/15, but criminal background checks were not initiated until 2/19/15 and a healthcare worker registry check was not done until 5/6/15. E20's (Registered Nurse) date of hire was listed as 2/2/15, but E20's license verification on the Illinois Department of Financial and Professional Regulation site to confirm her status and other background checks were not initiated until 2/19/15. On 5/7/15 at 1:10 PM, E1 (Administrator) stated that the facility previously received support for Human Resources including employee background checks, from an affiliated company that still processes their payroll. As of mid-summer 2014, the employee screening duties were transitioned to E1 along with website links, but the details of new hire screenings were not fully understood by E1.	F 226		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING	F 309		

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F 309	Continued From page 4 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 observation, interview and record review, the facility failed to track bowel movements for one resident (R6) out of seven residents reviewed for incontinence care in a sample of fifteen residents. R6 had emergency room visits with a diagnosis of constipation and abdominal pain on 4/2/15 and 5/5/15. Findings include: A review of R6's MAR (Medication Administration Record) dated 4/1/15 lists bowel protocol ordered 12/01/14: "If NO BM [bowel movement] after 3 days, give: Milk of Magnesia 30 ml [milliliters] by mouth at bedtime X 1 dose as needed for constipation, if no positive result with Milk of Magnesia, follow with Dulcolax suppository X 1 dose rectally at bedtime, if no positive results after Dulcolax, give enema X 1 rectally at bedtime." None of the above medication was charted as given on 4/1/15-4/2/15, 4/8/15-4/30/15 or 5/1/15-5/5/15. Review of Nurses notes dated 4/2/15 at 11:10 AM by E13 (Licensed Practical Nurse) denotes R6 complained of abdominal pain and vomiting. On 4/2/15 at 11:20 AM, Z3 (Attending Physician) was made aware and ordered transfer of R6 to local community hospital's emergency room for medical evaluation. Discharge records from hospital dated 4/8/15 at	F 309		

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F 309	Continued From page 5	F 309		

11:16 AM denotes in part that one of the diagnoses was abdominal pain. Sodium phosphate enema was given rectally on 4/7/15 at 2148 (9:48 PM). Discharge medications included Colace 100 mg (milligram) capsule to take by mouth two times daily along with Lactulose 20 gm (grams) by mouth two times daily which was transcribed on facility MAR upon return to facility. On 4/13/15 at facility, Lactulose was changed to 20 grams by mouth every 8 hours as needed for constipation. Review of nursing notes indicates no charting of bowel movements upon return from hospital through 5/4/15.

On 5/5/15 at 10:10 AM, R6 complained of stomach pain, nausea and vomiting to surveyor. R6 stated it started last evening and he was not able to eat breakfast or drink any water due to pain and nausea. R6 stated, "I told E13 (Licensed Practical Nurse) in the morning about the nausea/vomiting and pain and he would notify the doctor. I think my last bowel movement was either Saturday 5/2/15 or Sunday 5/3/15." E13 entered R6's room and stated, "I paged the attending physician and I am waiting for a call back."

On 5/5/15 at 12:20 PM, E13 stated, "I checked R6 rectally and felt stool. I received an order for Milk of Magnesia 30 milliliters oral every four hours for constipation and if there is still no bowel movement, then the doctor said to transfer R6 to Emergency room for medical evaluation."

On 5/5/15 at 11:32 AM, E2 (Director of Nursing) stated, "There should be a bowel tracking form but it is not being used. The certified nursing assistants should be the ones asking the residents when they had their last bowel movement. But they do not chart it anywhere. It is only charted in the nursing progress notes, if there is a change of condition and/or abdominal

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F 309	Continued From page 6 pain." On 5/5/15 at 4:00 PM, R6 stated, "I still have not had a bowel movement yet and I still have pain in my stomach. I still feel nauseous." E25's (Licensed Practical Nurse) nursing progress note dated 5/6/15 at 00:15 reads: "Resident alert and verbal in bed this shift, complaints of nausea and vomiting. Resident states last bowel movement was 5/3/15 but feels like he needs to have a bowel movement. MD notified. Received new order for Lactulose 30 milliliters oral now at 4 PM, no results noted at 8 PM, digital rectal exam performed. Soft brown stool noted in anus. Medical doctor made aware of findings. New order received to send resident to hospital for evaluation and treatment." Discharge Instructions from hospital dated 5/6/15 denotes abdominal pain and constipation as the diagnoses for R6. Prescription for Magnesium citrate Oral solution 300 milliliters bottle once was written by emergency room doctor. On 5/6/15 at 8:48 AM, R6 stated, "I just got back from hospital and I don't feel nauseated like yesterday. My stomach feels better after I had a bowel movement this morning." R6 was asked by surveyor if staff asks him how often he has bowel movements and R6 stated, "Sometimes, but I really just let them know when I need to be changed." On 5/7/15 at 8:18 AM, during telephone interview, Z3 (Attending physician) stated "R6's bowel movements should be monitored." Surveyor asked if R6's visit to the emergency room for constipation/pain could be avoided if bowel monitoring and tracking was in place and Z3 stated "Yes."	F 309		
F 328 SS=E	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

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F 328	Continued From page 7 The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed 1) to provide proper care for one of one resident (R7) with an implanted port in the sample of 15; 2) failed to properly assess one of one resident (R16) in the supplemental sample observed during nebulizer treatments; and 3) failed to properly store nebulizer masks when not in use for one resident (R6) in the sample and three residents (R16, R17, R29) in the supplemental sample out of four nebulizers observed. Findings include: 1) R7's Face Sheet documents an admission date of 9/17/14. A Physician Order Sheet (POS) dated 9/17/14 documents that R7 has an implanted port in the right upper chest. R7's POS documents: Right upper chest (implanted port) site dressing change once a week. The POS also documents: When not in use, flush with 5 ml (milliliters) normal saline followed by 5 ml Heparin Lock flush.	F 328		

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F 328	Continued From page 8 On 5/5/15 at 2:15 PM, R7 stated, "I still have my port. The last time the dressing was changed was when I was admitted on September 17, 2014. It was changed at (the hospital) before I came here. That was last time it was flushed too." R7 lifted up her shirt. The implanted port was noted in her right upper chest. A dressing was not in place over the site. The implanted port was accessed with a short tube hanging from it. R7 continued, "They took it off yesterday and never put it back on. The nurse said it had to breathe. They never change the dressing or flush it. That dressing was on there since September 17, 2014." On 5/6/15 at 11:10 AM, when asked about R7's implanted port, E2 (DON-Director of Nursing) stated, "It's accessed? There's a cord there? Well, then it's accessed. In that case, it should be flushed weekly and the dressing should be changed weekly." On 5/6/15 at 11:15 AM, E12 (LPN-Licensed Practical Nurse) stated, "Every month, it should be flushed and the dressing changed. The last DON said that we should do the flushing/changing monthly. I'm not sure if she got an order from the doctor to do it monthly." On 5/6/15 at 11:18 AM, R7 lifted her shirt and there still was no dressing over her right upper chest implanted port. The short tubing was still in place. On 5/6/15 at 11:45 AM, Z2 (Physician) stated, "If the policy (for flushing and dressing changes) is weekly, that sounds reasonable. I'm not actually managing her (implanted port). I would expect that if the access remains that facility cares for it	F 328		

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accordingly. I haven't given any orders to the facility regarding her (implanted port) because I am not managing it. I did not tell them to do the flushing or dressing changes monthly. I just gave an order to the facility to discontinue the access if we're not using it."

R7's Medication Record dated 3/1/15 through 3/31/15 has a handwritten section that reads: Flush port monthly on right side of chest on the 1st of the month. The POS also reads: Change dressing monthly on port on 1st of the month. R7's POS from 1/1/15 through 3/31/15 were reviewed. There was no physician order that indicated that the implanted port should be flushed monthly and dressing changes done monthly. The last order was obtained on 9/17/14 indicating that the implanted port was to be flushed weekly and the dressing changed weekly.

R7's Care Plan documents: INTERVENTIONS: Change (implanted port) site dressing change once a week. Date initiated: 9/25/2014

The Treatment Records for R7's dressing changes to her implanted port site indicate the following:
February, 2015: R7's dressing was not changed.
March, 2015: R7's dressing was changed once.
April, 2015: R7's dressing was changed once.

On 5/6/15 at 2:00 PM, E2 (DON-Director of Nursing) was asked to provide a copy of R7's Treatment Records for September, 2014 through January, 2015. E2 was asked at 3:00 PM and again at 4:00 PM to provide R7's Treatment Records. At 4:45 PM, E2 still had not provided the requested documents. Copies of R7's Treatment Record for September 2014 and December 2014

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were provided late afternoon on 5/7/15. No imported port site dressing changes were charted as done for those months.

A facility policy with a revision date of June 2012 and titled, "Dressing Change, Implanted Venous Port" documents: KNOWLEDGE BASE The implanted venous port access site is a potential entry site for bacteria that may cause a catheter related infection. PROCESS: Dressing changes are only necessary when the implanted venous port will remain accessed for infusion therapy. Dressing changes using transparent dressings are performed: 1. Upon admission 2. Every seven (7) days thereafter (with routine access needle change).

A facility policy with a revision date of June 2012 and titled, "Flushing an Implanted Venous Port" documents: Flushing is performed to ensure and maintain catheter patency and to prevent mixing of incompatible medications/solutions.

2) On 5/4/15 at 9:42 AM, during the Initial Tour with E10 (Restorative Nurse), R17's nebulizer mask was not in use and and not stored properly. The nebulizer mask was laying on a bedside table.

On 5/4/15 at 9:45 AM, it was noted that R16's nebulizer mask was not in use and not stored properly. R16's nebulizer mask was connected to the machine and laying on a bedside table.

On 5/4/15 at 10:14 AM, during initial tour, R29's nebulizer apparatus which includes the chamber,

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mask and tubing were laying in a wicker basket uncovered and not dated.
On 5/4/15 at 10:20 AM, R6's nebulizer apparatus was laying on top of television uncovered and not dated.
At 2:05 PM, E13 (Licensed Practical Nurse) picked up R16's uncovered and undated nebulizer mask from the bedside table. E13 stated, "The night shift people change the mask and tubing and put a date on it. I think it is changed every 15 days, but I am not sure. No special bag is used to store mask and it can be put in a drawer."
3) E13 did not do a respiratory assessment on R16 before or after administering nebulizer treatment. R16's physician order sheet denotes in part the following: "Ipratropium/Albuteral: Use 1 vial by way of nebulizer four times daily (9 AM ,1 PM, 5 PM, 9 PM). R16 has Chronic Obstructive Pulmonary Disorder. Check lung sounds and record before and after treatment: 1. Clear/Within Normal Limits 2. Wheezes 3. Rales 4. Rhonchi 5. Diminished."
On 5/6/15 at 10:12 AM, E12 (Licensed Practical Nurse) administered nebulizer treatment to R16 without assessing and recording lung sounds before or after nebulizer treatment.
On 5/5/15 at 1:30 PM, E2 (Director of Nursing) stated, "The nurse has to follow physician orders, you must assess lung sounds before and after nebulizer treatment to find the baseline."
On 5/7/15 at 2:55 PM, E1 (Administrator) stated "Nebulizer masks and tubing should be dated and changed weekly by the third shift nurses on Sunday nights. The masks absolutely need to be covered in a plastic bag when stored."
Facility's policy titled Infection Control, Oxygen and Nebulization Therapy denotes in part: 3. Disposable equipment and supplies as mentioned

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F 328	Continued From page 12 above should be changed at least every week or as needed, when the equipment is in use. 5. Anytime the equipment is not used, all disposable supplies should be disposed and equipment should be clean and stored accordingly.	F 328		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to administer medications as ordered. There were 30 opportunities with three errors resulting in a 10% error rate. This applies to three of nine residents (R7, R16, R19) observed in the medication pass. Findings include: On 5/4/15 at 2:00 PM during medication pass observation, E13 (Licensed Practical Nurse) administered one vial of Ipratropium Bromide/Albuteral 0.5 mg/3 mg per 5 milliliters through a nebulizer treatment to R16. At 2:15 PM, E13 stated that he was finished administering R16's nebulizer treatment. Upon inspection of medication chamber, there was still medication left over. R16 did not get the entire medication. At 2:24 PM E13 stated "I know there is medication still in there but the maximum time for the treatment is 15 minutes." On 5/5/15 at 9:08 AM, E12 (Licensed Practical Nurse) did not administer R7's Trolamine 10% cream to lower extremities. R7's physicians order sheet denotes in part the following order:	F 332		

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F 332	Continued From page 13 "Trolamine 10% cream: apply topically to legs four times a daily: 9 AM, 1 PM, 5 PM, 9PM." E12 stated, " (R7) keeps the cream in her room and applies it herself. "R7's MAR (Medication Administration Record) indicates that E12 signed off on the Trolamine without watching R7 apply it. At 9:10 AM, surveyor brought R7 to her room. R7 was asked to show surveyor where the Trolamine cream was located. R7 replied "What cream? I haven't had that cream in a while. We're in May and I haven't had that cream since January. I don't put it on myself; it's always in the nurses' station." On 5/6/15 at 10:30 AM, during facility presentation, E2 (Director of Nursing) stated, "The Trolamine cream was delivered this morning by pharmacy and (R7) received it." E1 (Administrator) stated, "(R7) is not assessed to self-administer medications in her room. The medication should be in the medication cart and given by the nurses." R19's physician order sheet denotes in part: "Liquitears solution: instill one drop in both eyes three times daily: 8 AM, 2 PM, and 8 PM." On 5/5/15 at 2:00 PM, E13 (Licensed Practical Nurse) administered one drop of the Liquitears solution in left eye correctly. When administering the Liquitears in the right eye, it was observed the Liquitears did not go inside the conjunctival sac. The Liquitears solution dropped on R19's right cheek. No further eye drop to the right eye was attempted by E13 at that medication encounter. Facility's policy titled 6.5: Eye Drops Administration Procedure denotes in part: "Procedure: 7. Place hand against resident's forehead to steady and instill one drop inside lower eyelid close to outer corner of eye (conjunctival sac.) Instruct resident to look up."	F 332		
F 364	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR,	F 364		

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F 364 SS=E	Continued From page 14	F 364		

PALATABLE/PREFER TEMP

Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to follow the standardized recipes while preparing pureed food items for two residents (R1, R8) in the sample of 15 and four residents (R25, R26, R27, R28) in the supplemental sample. In addition, the facility failed to serve the main entrée food items according to the standardized menu, affecting 11 residents (R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13) in the sample of 15 and 35 residents (R16, R17, R18, R19, R22, R23, R24, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R46, R47, R48, R49, R50, R51, R52, R53, R54, R55, R56) in the supplemental sample.

Findings include:

The facility's resident diet list dated 5/7/15 indicates that there are six residents that have current diet orders with pureed consistency (R1, R8, R25, R26, R27, R28), and 50 residents that have current diet orders without pureed consistency (R2, R3, R4, R5, R6, R7, R9, R10, R11, R12, R13, R16, R17, R18, R19, R22, R23, R24, R29, R30, R31, R32, R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R46, R47, R48, R49, R50, R51, R52, R53, R54,

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F 364	Continued From page 15 R55, R56). On 5/5/15 at 2:24 PM, E3 stated during interview that the lunch menu for 5/5/15 changed because of the Mexican holiday. Week Three - Thursday's dinner menu food items were served on 5/5/15 for lunch. On 5/5/15 at 10:47 AM, E21 (Cook) stated in part that the facility has seven residents with pureed diet orders and that she was preparing the pureed food items. At 10:49 AM, E21 put on gloves and then put an unspecified amount of Spanish rice in the blender, then poured eight ounces of water in the blender, and mixed the rice and water. When asked, E21 could not state how many servings of pureed rice that she was preparing. At 10:51 AM, E21 added an additional, unspecified amount of rice and an additional eight ounces of water to the blender, and mixed the rice and water again. The Pureed Spanish rice recipe documents in part that the ingredients for each serving of pureed Spanish rice are: one ½ cup of Spanish rice and one ounce of beef broth. On 5/5/15 at 10:59 AM, E21 put on gloves and then put an unspecified amount of beef taco meat in the blender and mixed the meat in the blender. When asked, E21 could not state how many servings of pureed beef taco meat that she was preparing. At 10:59 AM, E21 stated in part that the beef taco meat makes its own juice so E21 did not need to add anything to the beef taco meat during the pureed process. The Pureed beef taco filling recipe documents that the ingredients for each serving of pureed beef taco filling are: one #12 scoop (two ounces) of beef taco filling and one ounce of beef broth. On 5/5/15 at 11:04 AM, E21 put on gloves and then put an unspecified amount of soft tortilla	F 364		

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shells in the blender, then poured two 8 ounce cups of whole milk in the blender. E21 then mixed the tortilla shells and milk. When asked, E21 could not state how many servings of pureed tortilla shells that she was preparing.
The Pureed bread recipe documents that the ingredients for 14 servings of pureed bread, are two cups of pureed bread, biscuit and roll mix, 14 ounces of water, and one ¼ cup of vegetable salad oil.
On 5/5/15 at 11:22 AM, E21 stated that when E21 makes pureed food items, E21 follows the recipes in the book.
On 5/5/15 at 2:28 PM, E3 (Dietary Manager) stated that the kitchen staff should follow the recipes when making pureed food items and the staff used the pureed bread recipe for the pureed tortilla shells.
When using unspecified, non-measured amounts of food ingredients, while preparing the pureed food items, there is no process to measure the nutritional content of the pureed food items per serving.
On 5/5/15, during the lunch tray line observation that started at 11:37 AM, E21 used an eight ounce utensil to serve the beef taco meat. After each tortilla shell was filled with beef taco meat, there was some beef taco meat left on the utensil. When asked, E21 could not state exactly how much beef taco meat that E21 put on the residents' tortilla shells.
On 5/5/15, at 11:47 AM, E21 stated that E21 put enough beef taco meat in the tortilla shells to fill them up.
On 5/5/15, during the lunch tray line observation, E21 served the residents lettuce and tomato salad using tongs. When asked, E21 could not state exactly how much salad E21 served the residents.

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F 364	Continued From page 17 On 5/5/15 at 2:28 PM, E3 stated that the staff should serve the food items according to the approved menus. When serving unspecified, non-measured amounts of food items, there is no process to measure the nutritional content of the food items per serving and ensure that the residents receive the appropriate amount of protein per serving. On 5/7/15 at 4:10 PM, E3 stated that the facility does not have any policies regarding the staff following recipes when preparing pureed food items and for serving food items according to the menus. The facility's calorie count sheet dated 5/5/15, lunch, for general diets, documents in part the following: Beef tacos portion - #12 scoop (1/3 cup) = two ounces of protein Lettuce, tomato portion - one cup	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that kitchen staff utilized proper hand hygiene while preparing	F 371		

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pureed food items. This failure has the potential to affect two residents (R1 and R8) in the sample of 15 and four residents (R25, R26, R27, and R28) in the supplemental sample that have current diet orders with pureed consistency.
Findings include:
The facility's resident diet list dated 5/7/15 indicates that six residents (R1, R8, R25, R26, R27, R28) have current diet orders with pureed consistency.
On 5/5/15 at 10:47 AM, while preparing the pureed food items, E21 (Cook) washed her hands for five seconds. On 5/5/15 at 10:55 AM, after preparing the pureed Spanish rice, E21 touched and lifted the garbage can lid with one of her gloved hands, threw some of the Spanish rice in the garbage can, and then washed, rinsed, and sanitized the blender, that E21 used to prepare the pureed Spanish rice, in the three-compartment sink, without removing her gloves and washing her hands. At 10:58 AM, E21 washed her hands for three seconds. At 11:00 AM, after preparing the pureed beef taco meat, E21 washed her hands for five seconds.
On 5/5/15 at 1:33 PM, E3 (Dietary Manager) stated during interview that staff should wash their hands for 30 seconds, when preparing/handling food, and before and after preparing/handling food.
On 5/5/15 at 2:35 PM, E3 stated that staff should change gloves and wash their hands after touching the garbage can or garbage can lid.
The facility's Dietary Department Sanitation & Safety Operation Handwashing policy dated 2010, documents in part the following:
Policy: Dietary employees will practice safe food handling to prevent food-borne illness. Dietary employees will thoroughly wash their hands and exposed areas of their arms with soap and water

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F 371	Continued From page 19 at the following times: 2. Before engaging in food preparation 3. After touching anything unsanitary (garbage, dirty dishes) 9. Between removing gloves or aprons and before putting on new gloves or aprons Procedure: Wash well under running water for 30 seconds	F 371		
F 425 SS=F	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to remove expired medical supplies from one of one medication	F 425		

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F 425	Continued From page 20 rooms in the facility. This has the potential to affect all 57 residents in the facility. Findings include: On 5/4/15 at 3:19 PM, the facility's only medication room on the first floor was inspected with E12 (Licensed Practical Nurse). The following medical supplies were noted to be expired: Two boxes of 30 Normal Saline (10 milliliter) syringes expired 2/2015 One box of 28 Normal Saline (10 milliliter) syringes expired 1/2015 Two boxes of 30 Normal Saline (10 milliliter) syringes expired 3/2015 Four bottles of Liquid therapeutic nutrition (30 fluid ounces) expired 12/03/2014 Six packages of urine culture preservative sets expired 5/2014 Six packages of urine culture preservative sets expired on 7/2014 Two packages of urine culture preservative sets expired on 11/2014 One Urine collection kit expired 4/2010 On 5/6/15 at 10:45 AM, during facility presentation, E1 (Administrator) stated "the nurse working midnight shift on Sunday is responsible for checking medical supplies/medications for expiration. I thought this was being done, obviously not. I also thought there was an audit sheet being filled out. I guess not, so I will be creating one." Facility's policy titled, Expired Medication and Medical Supplies denotes in part the following: "Procedure: Designated nursing staff will audit at the end of each month. Expired medical supplies will be disposed of in the proper receptacle. "	F 425		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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F 431 SS=F	Continued From page 21 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 have access to the keys. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 431		

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review, the facility failed to properly date an open vial of insulin for one resident (R18) in the supplemental sample. In addition, the facility failed to ensure that multi-dose vials for house stock were dated when opened, failed to discard opened multi-dose vials according to facility policy and failed to ensure that the medication room was properly secured and accessible only to licensed nurses. These deficient practices had the potential to affect all 57 residents in the facility.

Findings include:

On 5/4/15, the facility submitted a Resident Census and Condition Sheet that indicated a census of 57 residents.

During the Environmental Tour, on 5/5/15 at 11:40 AM, E9 (Maintenance Director) removed a set of keys from his pocket and accessed the Medication Room. At 11:40 AM, there were no nurses available at the adjacent nurses station or in the medication room. At 11:43 AM, E12 (LPN-Licensed Practical Nurse) saw E9 in the medication room with the State surveyor and promptly left. There were medications in plastic bins that belonged to multiple residents that were easily accessible on an open shelf. The medication refrigerator was unlocked and a vial of Haloperidol was easily accessible.

At 11:50 AM, E5 (LPN) and E12 indicated that the following personnel should have access to the medication room: DON (Director of Nursing), treatment nurse and nurses. E12 stated, "(E9) has a key in case anyone needs anything from that room." When E12 was asked about the multiple medication bins she stated, "Those are

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extra medications for the residents. Each resident has a bin."

At 11:52 AM, E1 (Administrator) instructed E9 to immediately give his Medication Room key to E2 (DON).

On 5/5/15 at 2:35 PM, E2 stated, "The expectation is that only the nurses should have a key to the Medication Room." E2 indicated that the facility does not have a policy.

During the Environmental Tour, on 5/5/15 at 11:40 AM, the following was noted in the Medication Room:

-R18's Lantus multi-dose insulin vial was opened. There was no opened date written on the vial. E2 (DON) stated, "There should be an opened date."
-One Tuberculin Purified Protein Derivative multi-dose vial with an opened date of 2/23/15.
-One opened Tuberculin Purified Protein Derivative multi-dose vial without an opened date written on the vial. Both Tuberculin vials had the words "House Stock" on the plastic bag. E2 indicated that it was used for newly admitted residents.

On 5/5/15 at 12:00 PM, E2 was asked about multi-dose vials and stated, "Usually good for 30 days then it should be discarded."

A facility policy with a revision date of April 2011 and titled, "Utilizing a Multi-Dose Vial" documents: PROCESS: Vials will be labeled, after opening with: 1. Resident's name 2. Date and time 3. Nurse's initials. Multi-dose vials are to be discarded if: 1. Open and undated 4. Within 30

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F 431	Continued From page 24 days of opening. Findings include: On 5/5/15 at 9:44 AM, E12 (Licensed Practical Nurse) went into the medication room in the facility on the first floor to obtain medications for a resident. At 9:46 AM, E12 left the medication room to get scissors down the hall, leaving the medication room door open. At 9:51 AM, E12 walked past the medication room, glanced toward the open medication room door, but kept walking down the hall. At 9:52 AM, E12 went back to the medication room and closed the door. Between 9:46 AM-9:52 AM, surveyor was standing outside of medication room and did not observe any nurses within visual proximity of the medication room. On 5/5/15 at 1:35 PM, E2 (Director of Nursing) stated "the medication room is always under the supervision of the nurses and should remain closed and locked when they are not present in the room." On 5/6/15 at 10:20 AM, during facility presentation, E1 (Administrator) stated "I am going to have the maintenance director adjust the hinge so that door shuts." Facility's Policy titled Medication Storage in the Facility denotes in part the following: "Procedures: 3. Medication rooms, carts, and medication supplies are locked or attended by person with authorized access: a. Licensed Nurses b. Consultant Pharmacist c. Pharmacist Technician d. Individual lawfully authorized to administer drugs e. Consultant Nurses."	F 431		
F 441 SS=E	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	F 441		

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F 441	Continued From page 25 to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failing to perform proper hand hygiene affecting one of one resident (R8)	F 441		

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observed during incontinence care, and two of two resident (R1, R3) observed for wound care treatments in the sample of 15. In addition, the facility failed to perform proper hand hygiene during the medication pass task for one resident (R7) in the sample and five residents (R16, R18, R22, R23, R24) in the supplemental sample among nine residents observed for medication pass, and failed to use proper procedure when cleaning blood glucose monitoring machines in one of two observations.

Findings include:

On 5/4/15 at 1:20 PM, E11 (CNA-Certified Nurse Assistant) donned gloves and transferred R8 from the wheelchair to her bed. E11 removed R8's shoes. Without changing gloves, E11 removed R8's incontinence brief, placed the soiled brief in the garbage can and tied off the garbage liner. E11 did not change her gloves. E11 began to provide incontinence care for R8. E11 applied skin barrier cream on R8's perineal and buttock areas. E11 then removed her gloves and did not perform hand hygiene. E11 reached into her pocket to retrieve gloves. One glove fell on the floor. E11 stated, "No matter how many gloves you put in your pocket, you never have enough." E11's bare hands came into contact with R8's skin as she applied an incontinence brief without donning gloves. Before leaving the room, E11 washed her hands for six seconds.

R3's Medical Record documents a pressure sore on her left heel. R3's Physician Order Sheet (POS) dated May 1, 2015 through May 31, 2015 documents to cleanse the left heel with Normal Saline and apply Medihoney and cover with a dry

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gauze.

On 5/5/15 at 9:45 AM, E5 (LPN-Licensed Practical Nurse/Wound Care) indicated that she was the treatment nurse. E5 entered R3's room and washed her hands for three seconds. E6 (CNA) assisted E5 with the wound dressing. E6 did not perform hand hygiene before applying gloves. E5 left the room twice to retrieve items from the treatment cart. E5 did not perform hand hygiene after re-entering R3's room. As E5 arranged her wound care supplies, she requested that E6 move the garbage can closer to her. With gloved hands, E6 picked up the garbage can and placed it in front of E5. E6 did not change her gloves. E6 lifted R3's left leg. E5 removed the old dressing from R3's left heel. E5 washed her hands for two seconds. E5 requested that E6 get more gloves. E6 removed her gloves and washed her hands for three seconds. E6 re-entered the room and donned gloves without performing hand hygiene. E5 cleaned R3's left heel with Normal Saline and then washed her hands for three seconds. E5 then applied Medihoney and wrapped R3's left heel in gauze. E5 did not perform hand hygiene before leaving R3's room. E6 washed her hands for five seconds.

On 5/5/15 at 10:16 AM, E5 (Wound Care Nurse/Licensed Practical Nurse) washed her hands for five seconds, put on gloves, and then removed the old dressing from R1's left heel pressure ulcer. At 10:18 AM, E5 removed the gloves and washed her hands for six seconds. At 10:19 AM, E5 put on gloves and cleansed R1's left heel pressure ulcer with normal saline soaked gauze pads. At 10:20 AM, E5 removed the gloves and washed her hands for seven seconds. At 10:21 AM, E5 applied the new wound dressing

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to R1's left heel pressure ulcer. At 10:24 AM, E5 washed her hands for eight seconds. At 10:25 AM, E5 put on gloves and removed the old dressing from R1's sacral pressure ulcer. At 10:26 AM, E5 removed the gloves and washed her hands for five seconds. At 10:27 AM, E5 put on gloves and cleansed R1's sacral pressure ulcer with normal saline soaked gauze pads. At 10:28 AM, E5 removed the gloves and washed her hands for seven seconds. At 10:29 AM, E5 applied the new wound dressing to R1's sacral pressure ulcer. At 10:30 AM, E5 removed the gloves and washed her hands for five seconds. At 10:31 AM, E5 put on gloves and removed the old dressing from R1's right ischial pressure ulcer. At 10:33 AM, E5 removed the gloves and washed her hands for six seconds. E5 then put on gloves and cleansed R1's right ischial pressure ulcer with normal saline soaked gauze pads. At 10:34 AM, E5 removed the gloves and washed her hands for five seconds. At 10:35 AM, E5 applied the new wound dressing to R1's right ischial pressure ulcer.

On 5/5/15 at 11:17 AM, E12 (Licensed Practical Nurse) cleaned a glucometer for one minute with a germicidal wipe and then placed the glucometer on top of the medication cart. E12 opened the medication administration record (MAR) book which caused the binder cover to rest on top of the glucometer while it was air drying. Manufacturer's guidelines for germicidal wipes denote that the surface should be wet for three minutes.
On 5/5/15 at 1:40 PM, E2 stated, "The glucometer should be wet for three minutes when using the "plus" germicidal wipes instead of the regular germicidal wipes. "

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F 441	Continued From page 29 On 5/4/15 at 12:50 PM, E24 (Licensed Practical Nurse) administered medications to R22 without washing her hands. After administering medications, E24 washed her hands for less than 20 seconds. On 5/4/15 at 12:54 PM, E24 washed her hands for less than 20 seconds after administering medication to R18. On 5/5/15 at 8:41 AM, E12 (Licensed Practical Nurse) washed her hands for less than 10 seconds after administering medication to R23. On 5/5/15 at 9:00 AM, E12 did not wash her hands before taking R7's blood pressure. After taking R7's blood pressure, E12 washed her hands for less than 20 seconds. On 5/5/15 at 9:08 AM, E12 washed her hands for less than 20 seconds after administering medication to R7. On 5/5/15 at 9:30 AM, E12 washed her hands for less than 20 seconds after administering medication to R24. At 9:46 AM, E12 returned to administer additional medication and washed her hands for less than 20 seconds after administering the medication to R24. At 10:12 AM, E12 did not wash her hands before administering a nebulizer treatment to R16 and washed her hands for less than 20 seconds after administration. The facility's undated policy, "Handwashing" documents in part the following: 2. The facility follows the Centers for Disease Control's Guidelines for Hand washing and Hospital Environmental Control. 1996. 4. Appropriate ten (10) to fifteen (15) second hand washing must be performed under the following conditions: d. Before preparing or handling medications; e. Before handling clean or soiled dressings, gauze, pads, etc.; f. After	F 441		

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F 441	Continued From page 30 handling used dressings, contaminated equipment, etc.; g. After contact with blood, body fluids, secretions, excretions, mucous membranes, or non-intact skin; h. After handling items potentially contaminated with blood, body fluids, secretions, or excretions; j. After removing gloves; l. Whenever in doubt; m. Upon completion of duty. " On 5/6/15 at 10:15 AM, E2 (Director of Nursing) stated in part that when performing wound care the staff should wash their hands for 20 seconds On 5/6/15 at 10:20 AM, E2 (Director of Nursing) stated, "During medication administration, nurses are expected to wash their hands before they prepare medications. Then after giving medications to residents, the nurses should wash their hands." On 5/6/15 , E1 (Administrator) stated, "I am going to say that our current hand washing policy is wrong and that it should be at least 20 seconds. I am going to revise the policy."	F 441		
F 494 SS=F	483.75(e)(2)-(3) NURSE AIDE WORK > 4 MO - TRAINING/COMPETENCY A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services; and that individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151-483.154 of this part; or that individual has been deemed or determined competent as provided in §483.150(a) and (b). A facility must not use on a temporary, per diem,	F 494		

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leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (e)(2)(i) and (ii) of this section.

Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in §488.301 of this chapter.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to assure competency based on Health Care Worker Registry requirements for one employee (E6) working as a certified nurse aide (CNA) for over seven months, out of 20 CNA files reviewed. This has the potential to affect all 57 residents in the facility.

Findings include:

On 5/7/15, a review of personnel files for E6 (Certified Nurse Aide/CNA) found that she was originally hired on 7/24/14, worked as an orientee on 7/24/14, 7/25/14 and 7/26/14, but was then put off work due to a hit on her criminal background check. E6 was granted a waiver on 9/17/14 and was rehired on 9/20/14. However, the Health Care Worker Registry check done on 7/29/14 indicated E6 had failed her first competency examination. As of 5/7/15, no further registry checks had been done that indicated E6 had passed her exam.

On 5/7/15,at 3:30 PM, E1 stated she was not

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F 494	Continued From page 32 aware that E6 had not passed her competency exam, was not familiar with the competency information as shown on the registry, and did not have a system for following-up on registry issues. E1 acknowledged that E6 had continued to work since 9/20/14. A check of the registry on 5/7/15 revealed E6 was still not shown as having passed the required competency examination. On 5/5/15 while observing E6 during the lunch period, E6 stated she works on both wings of the facility since all staff rotate to become familiar with all residents.	F 494		