

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

PRINTED: 10/26/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145614	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2010
NAME OF PROVIDER OR SUPPLIER CHATEAU NRSG & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET WILLOWBROOK, IL 60521		
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F 000	INITIAL COMMENTS	F 000			
F 166 SS=E	<p>Annual Licensure and Certification An Extended Survey was conducted. Complaint Investigations : 1073340/IL49165 - F225 1073347/IL49172 - F225</p> <p>PIGGYBACK 1073576/IL49479-F469 (9/8/10) 483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to resolve grievances made by residents regarding late meal services, staff not answering the call lights in a timely manner; and not addressing the concerns for the lack of help to care for the residents with their Activities of Daily living. Residents voiced concerns in wanting hot toast for breakfast; having enough washcloths or towels to do their daily care. Residents want more activities for residents who use wheel chairs. The residents want the Van fixed for more shopping trips. The activity calendar print was too small for them to read. Portable telephone to use for private calls.</p> <p>Examples include: During the interview conducted with a group of</p>	F 166			
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 166	Continued From page 1 residents on 8/11/2010, the group was very vocal and expressive. They started out asking was there any thing we could do about the administration getting back to them when they submitted written or vocal concerns. The group, family and outside resources stated, "It does no good to tell the staff any of your concerns, they don' t do any thing about them. If you tell the administrator, he never gets back to you. For months, the same concerns are being addressed with no outcomes. The facility staff acts as if they do not like working with the elderly." A review of the facility's Concern Forms from January 2010 to August 2010 note there are the same concerns about staff treatment of residents, and inadequate care of residents. Residents are not getting pain medication when they ask. The facility does not have enough staff to meet the needs of the residents. During an interview with E1 (administrator) on 8/12/10 about the concerns of the residents, he indicated that the systems were not in place to effectively ensure that a resolution was presented to the residents.	F 166			
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to identify medical	F 221			

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F 221	Continued From page 2 symptoms for the use of restraints. This is for one of one resident (R16) restrained in the sample. Findings include: On 8/10/10 during the initial tour of the facility and on 8/12/10 at 12:05 pm R16 was observed seated in his wheel chair and stationed near 2A Nurses station. R16 was restrained with a lap belt and he could not release the belt. The Nurse on the unit stated she does not know why R16 has the lap belt, she also stated she usually does not work on the unit. R16 has no physician order for the use of a lap belt restraint. There was no assessment to indicate what medical symptoms were being treated with the restraint. There is no plan of care or reduction plan for the use of the restraint. On 8/12/10 at 4:30 pm the facility administration staff was made aware of the concern. On 8/13/10 at 10:30 am the facility Nurse Consultant stated R16 should not have been restrained and the restraint was discontinued.	F 221			
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry	F 225			

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F 225	<p>Continued From page 3 or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff and resident interview the facility failed to follow the facility policy and procedures for promptly reporting allegations of mistreatment and possible abuse to the administrator, ensuring staff is removed to protect residents during investigations, conducting a thorough investigation, and reporting to the State the outcome of the</p>	F 225			

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F 225	<p>Continued From page 4 investigations.</p> <p>This is for 27 residents, R19, R14, R27, R38, R73, R26, R20, R21, R29, R34, R35, R36, R37, R6, R25, R102, R30, R156, R151, R48, R155, R107, R17, R121, R66, R128 and R1 who had complaints of mistreatment and had injuries of unknown origin.</p> <p>Findings include: During the tour conducted on 8/10/10 at 11:00a.m. and throughout the survey, multiple residents reported that they were unhappy with the staff and the way staff spoke to them. Residents and family stated that staff are rude and do not treat them with respect. A group meeting was held with residents on 8/11/10 at 10:30a.m. In the meeting, residents were very vocal about the care and services not being provided in a timely manner to meet their needs and the treatment that they receive from staff. The group stated these concerns were voiced to the staff and administration and nothing was done.</p> <p>A review of the facility's Concern Forms from January 2010 to August 2010 and in resident and family interviews, the following resident concerns were noted:</p> <p>1) 1/31/2010 R19 was transferred to the toilet on 7-3 shift the staff are rough and R19 hit her hip on the toilet. When resident told aide that she hit her hip, the aide did not respond. The aide was also rude.</p> <p>2/11/2010 R19 reported a CNA is not friendly to her. Resident states E15 acts as if it is a chore to help her with her activities of daily living. R19 is afraid to state the Certified Nursing Aide's name</p>	F 225			

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F 225	<p>Continued From page 5</p> <p>for fear of retaliation from staff or that staff will not help her anymore.</p> <p>2/19/2010 R19 reported a staff member on the day shift Tuesday or Wednesday was rough with her and threw her arm over when resident was reaching back to point to an area which was causing her pain during incontinence care.</p> <p>On 6/2/10, R19's family voiced concern that R19 was left on the toilet for an extended period. R19 was calling out due to pain and no one responded to his calls or call light.</p> <p>A 5/10/10 concern from R19's daughter states the call light response during the 11-7 shift is very slow. And the staff attitudes are poor when the staff answers the light. The 3-11 shift often put evening supplies in the resident's room without stating when they will be back to help them.</p> <p>R19 voiced a concern on 8/1/10 at 11:20a.m. She was still in the bed. R19 was crying and upset. Indicating she had her call light on and was in a soiled diaper on for over one hour.</p> <p>2) 2/17/2010 R14 reported to the facility on a Concern Form that during the 11-7 shift on the 16th or 17th, aide E16 answered the resident's call light. After waiting an extended period of time, the aide told the resident "I am the only one here and my back hurts." The aide then turned off the light and left the room.</p> <p>During the tour conducted on 8/10/2010 at 11:00a.m... R14 asked the surveyor if the Department could do any thing about the call lights not being answered timely. R14 states she often wets in the bed. Because she will put the</p>	F 225			

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F 225	<p>Continued From page 6</p> <p>call light on and sometimes the staff will come and turn it off without taking care of her concerns. R14 states she has very poor eyesight and can only see white objects. R14 says when she asks the staff what is their name she seldom gets an answer. R14 is on hospice and stated she wanted water. No fresh water was observed on the bedside table.</p> <p>3) R14's roommate, R27 spoke up and said that everything R14 was saying was true. She wanted water also and she also had to urinate in her pants because the staff on all shifts did not answer the call light. R27 said, "We only put the light on when we really need some thing. It will take over an hour sometimes to get help, if they come at all."</p> <p>While in the room surveyor placed the call light on for staff to get water for these residents. The light was placed on at 11:05a.m. Both residents said "You're going to be waiting a long time." At 11:35 a.m. the consultant nurse came by and answered the call light.</p> <p>4) 2/19/2010 R38 concern from family about the poor response to call light and poor treatment from staff in the way the staff speaks to residents.</p> <p>3/2/10 family of R38 reported as she was leaving the facility a CNA was swearing in the hallway complaining about the work and co-workers. Staff used the words M---F---- twice.</p> <p>5) On 2/4/2010, R73 was left hanging in the mechanical lift alone until the CNA went to get a new battery. Interview with E3 assistant director of nursing on 8/12/10 indicated that two staff are required to use a mechanical lift.</p>	F 225			

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F 225	<p>Continued From page 7</p> <p>On 2/3/10, while transferring R73 with the mechanical lift. R73 lost balance and fell on top of the CNA on the bed. The handset was broken on the lift. The use of a mechanical lift requires two staff.</p> <p>6/7/10, R73 reported the 3-11 shift aide who put her to bed did so alone. R73 is a two-person transfer with a mechanical lift. The CNA would not let R73 keep her shoes on as she requested for stability during transfer. The CNA refused to change R73 a second time when resident urinated in the newly changed diaper. The aide left the room and did not give the resident the call light. R73 said she had to call for help. R73 states she was "humiliated" by the way, the CNA spoke to her when she came into her room later in the p.m. on 6/6/10 telling R73 to "stop crying."</p> <p>6) 2/23/2010 R26 reported some aides were rough when putting him to bed. R26 felt that they were "throwing me around."</p> <p>7) 3/3/10 R20 reported a CNA bounced her around. R20 said to CNA "that hurts" and the staff told R20 to "shut up." This was the first time this CNA took care of R20.</p> <p>6/29/2010, R20 reports she was in pain and could not find her call light, R20 started calling out stating she called out for 20 minutes. When the CNA came, she said, "What are you hollering for"? R20 said she needed a pain pill. The aide left and about 20 minutes later the nurse came in and asked what is wrong.</p> <p>8) 4/6/2010 R21 reported that a staff member</p>	F 225			

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F 225	<p>Continued From page 8</p> <p>CNA or Nurse pulled her off the toilet by the fingers on her left hand. R21 is complaining of pain in left index finger.</p> <p>9) 4/13/2010 family reported a large bruise over the eye and bruise below the chin of R29 family was not aware of an incident.</p> <p>10) 4/26/10 R34 reported that CNA raised her voice and stated to resident "You are yelling at me and not respecting me." R34 had waited for an hour to get up from bed. CNA had a poor attitude.</p> <p>11) 5/3/10 R35 reported she had to be put on the toilet. R35 put her call light on. R35 was told by two different aides to wait. It was during change of shift. R35 was very unhappy by the demeanor of the aide. R35 asked the name of the aide and the aide would not tell her.</p> <p>12) 6/18/2010 R36 reported an aide came in his room to get resident up for a shower. R36 said he had a shower the day before. The aide told R36 you did not have a shower yesterday and the aide stated, "You are lazy. " The aide then told R36 "She was tired and needed sleep." R36 was upset by the staff remark and stated, " I have never been lazy."</p> <p>13) 7/9/10 R37 reported a CNA in the main dining room was very rude and resident was upset by the attitude.</p> <p>14) R6 resides in the facility's secured unit, seldom gets out of bed and is debilitated with pressure sores. R6 in a soft, weak voice asked if she could have water. No water or liquids were available in the room for R6. The CNA on duty</p>	F 225			

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F 225	<p>Continued From page 9</p> <p>was asked if R6 could have some fluids. The CNA stated she gets thickened liquids, and no liquids were provided at this time.</p> <p>15) 4/14/10 R25 voiced a concern that he waited one hour to be suctioned this morning. A CNA answered the call light, then he waited an hour for the nurse. On 4/27/10, the family of R25 wrote concerns of R25 waiting from 11:30-12:00a.m. to be suctioned. That staff acknowledged the call light but did not come for a half hour.</p> <p>On 6/24/10, R25's family voiced concern about the 11-7 shift on 6/20/10 at approximately 6:00a.m. A nurse and CNA came into R25's room to reposition R25. The family was in the room. Staff was heard to say, "Leave it for the next shift." After the staff left, R25's spouse went to the bed to adjust his pillow and found the bed was soaked with urine. A review of the facility's Concern form dated 1/11/2010, noted that R25's family reported that R25 is not being turned every two hours and has a stage II pressure sore.</p> <p>16) 7/27/2010, R102's family during care conference, voiced concerns that R102 is remaining in a wet incontinence product and not being cleaned well enough, which contributed to R102's development of a sore on her buttocks. Family voiced concerns with the turnover of staff in the facility. Family would like a consistent caregiver for their relative. The family voiced concerns that the nursing staff was unaware that R102 has to be fed. And this was just one of the examples of the poor communication the facility has.</p>	F 225			

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F 225	<p>Continued From page 10</p> <p>17) R30 reported on 5/17/10, the CNA got her ready for bed at 6:30p.m. R30 said the CNA never returned to the room for the rest of the night. At 10:00p.m., R30 put her call light on. R30 reported no one answered the light until 12:30a.m. when she was finally put to bed. R30 did not get to sleep until 1:00a.m.</p> <p>18) R156's family on 1/13/10 voiced a concern about the call light response on the 11-7 shift being very slow. On 1/13/10, a nurse started a nebulizer treatment and did not return for over an hour. Staff told resident that she would be back in 10 minutes.</p> <p>19) R151 on 1/14/10 was left in the shower room unattended. A concern was placed by R151's family. R151 said she had to get herself dressed and managed to get out of the shower room by herself. R151 said the CNA told her she had to get someone else ready.</p> <p>20) A 2/22/10 concern was placed by family of R48, who complained that on 2/21/10, R48 was in the dining room with her diaper "soaked." Family also complained that mother does not have on a diaper at times. R48 is on hospice services. Resident and family want her to have on briefs.</p> <p>21) 2/25/10 family reported R155 had to wait over one hour for a bedpan. On 2/25/10 at 7:00a.m., CNA took a long time to answer the call light. The aide came into the room, turned off the light and did not answer any of R155's questions.</p> <p>22) A concern voiced 5/27/10 by R107's family, indicated they came to visit Saturday morning and found mother being fed in bed in her</p>	F 225			

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F 225	<p>Continued From page 11</p> <p>nightgown and shirt, which were soaked. It appeared her mother was not changed.</p> <p>23) On 6/25/10, the family of R17 reported, when they came to visit on 6/24/10 at 3:00p.m. R17 was in bed. The bed was wet with urine as were R17's shirt and pants.</p> <p>24) 7/8/10, R121 family voiced concerns about R121 having dried feces on the outside of clothing and being very wet.</p> <p>25) 8/1/2010, the family of R66 voiced concerns that R66 had to eat her breakfast in bed because no one was available to get her up. R66 placed call light on to use the bathroom and no one came for more than 30 minutes. Family notes this is becoming a pattern. The call light remained on for 20 minutes or more.</p> <p>26) 8/9/10, R128 voiced concerns he had not been changed at 8:05a.m and had waited for 1 and 1/2 hours for care. R128 could not go to breakfast. R128 was waiting in the hallway asking staff for assistance.</p> <p>27) R1 had numerous incidents of bruising and injuries without investigations as follows:</p> <p>07-09-10 at 10:45 AM- has new bruise noted several bruises -left & right hips, abdominal area, thigh & lateral side area</p> <p>08-09-10 at 1:55 PM -Open area to right knee.</p> <p>08-08-10 at 11:15 PM - heard that she was crying & I went to see her. Bumped her right knee on the couch in the hallway.</p> <p>08-05-10 at 10:40 PM - on the floor on the foot part of the bed side lying position with her</p>	F 225			

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F 225	<p>Continued From page 12</p> <p>head on the floor...she claimed she hit her head on the floor. Observed to have pinkish discoloration & appears to be slightly swollen on the left side of the forehead. Left upper arm & left forearm with small area of purplish discoloration; right lower arm with reddish/ purplish discoloration; left upper thigh, lateral aspect with pinkish discoloration approximately measures 8.0 cm X 2.0 cm.</p> <p>08-03-10 at 7:30 PM - the C.N.A said she was trying to toilet the resident. She (C.N.A) said she (R1) was agitated & fighting. The C.N.A stated she (C.N.A) accidentally scratched the top of her (R1's) left hand. Small skin tears to the top of her left hand with small amount of bleeding.</p> <p>08-02-10 at 11:25 AM - on the floor in her bedroom ...laying on her right side of the floor right next to bed ... Resident complaint of pain on her head.</p> <p>08-01-10 at 5:30 PM, the C.N.A said the resident (R1) became angry & threw her chair alarm across the table & hit another residents plate...the nurse noted 2 purple color bruises to the right forearm. The resident (R1) taken to her room by the nurse.</p> <p>07-28-10 at 7:15 PM- the C.N.A said he saw another resident pushing the resident's (R1) wheelchair in the hallway and (R1) bumped her knee against the wall. Noted a small abrasion to the right knee with small amount of bleeding.</p> <p>07-17-10 at 10:53 AM-While C.N.A was dressing resident (R1) for breakfast noted an old bruise to the back of the right knee ...dark purplish in color.</p> <p>07-03-10 at 9:57 AM - bruising noted to shoulders.</p> <p>07-02-10 at 8:46 AM - observed during shower to have an old bruise to right buttocks, left shoulder has light bluish bruising, & right</p>	F 225			

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F 225	Continued From page 13 upper shoulder with purple bruising. 07-01-10 at 8:50 PM - observed lying on the floor on the bathroom. The resident was yelling out saying she was trying to go to the bathroom. Noted a small amount of bleeding from the right side of her head. 07-01-10 at 6:10 PM - was observed lying on the floor in her room in front of her wheelchair. The resident said she fell. All of these incidents were not thoroughly investigated. Interview with the Assistant Director of Nursing on several days of the survey confirmed there were no thorough investigations conducted. The Assistant Director of Nursing E3 stated "It's because she got behavior problem." On 8/11/2010, (E1) the facility's abuse coordinator and administrator, was interviewed. E1 was asked if any of concern allegations were investigated by the abuse committee. E1 stated he was "sorry" that the allegations reported in the concern forms did not have a formal investigation. E1 said no allegations of abuse or mistreatment had been reported to the State all year.	F 225			
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, record review and	F 244			

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F 244	Continued From page 14 interview the facility failed to listen to the residents and family group recommendations and grievances about resident care and life in the facility and failed to communicate its decision to the resident and /or family. Examples include: During the survey conducted 8/10/2010, a group meeting was conducted with residents. The residents were very vocal and voiced to surveyor that they wanted to discontinue the resident council meeting. The group said that the concerns they voice to the administration mean nothing. Nothing is done to address resident concerns. Therefore, they see no reason to keep the meeting. A review of six months of resident council minutes, identify that month after month residents and families have repeated concerns about staff not answering the call lights in a timely manner, missing clothing and items are not recovered and no explanation from the facility is given. Residents complained staff are leaving residents on the toilet and having them wait for long periods. Food is served often late and cold. Coffee and tea often served cold. Residents want condiments with foods that require them like hot dogs. Interview with (E1, administrator) confirmed that the facility did not have a system in place that responded to resident council concerns or that gives residents a response about resolutions to their concerns.	F 244			
F 246 SS=E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES	F 246			

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F 246	<p>Continued From page 15</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to:</p> <ol style="list-style-type: none"> 1) Meet resident needs and answer Nurse Call lights in a timely manner. This is for R14 in the sample of 24, and R63 from the supplemental sample. 2) Accommodate R17's request for coffee on 08-11-10 in a timely manner. <p>Findings include:</p> <ol style="list-style-type: none"> 1. On 8/10/10 at 10:48 am R63 had her Nurse Call light on. No one responded to the Nurse Call light until 11:10 am. At this time a surveyor approached a Certified Nurse Aide (CNA) who stated she is from Hospice, but willing to help R63. When approached R63 stated she had her call light on for a long time. R63 wanted someone to turn off her television, because her television was too loud and it was disturbing to her sleep. 2. On 8/10/10 at 3:48 pm R14 received a long distance phone call at the Nurses Station. The staff went to inform R14 about the phone call. R14 told the staff that she needs help to get up and to inform the caller that she will call them back. R14 turned on the Nurse Call light at 3:52 p.m. No one responded to the call light until 4:16 pm (24 minutes later). When R14 got help to get 	F 246			

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F 246	Continued From page 16 her up she called the caller saying she could not get up to answer his call and apologized to him. R14 later said the caller was her brother who is sick wanted to talk with her. R14 has blindness in her both eyes and needs staff assistance to get her up from the bed to the wheelchair. 3. On 08-11-10 at 11:30 a.m., R17 was observed in the second floor dining room during an activity. During lunch time 12:15 p.m., R17 was asking for coffee. There were four CNAs in the dining room feeding residents. R17 continued to state "I want coffee." None of the staff in the dining room responded to R17's request. At 12:55 p.m., one resident shouted "Shut up"! The resident then stated "He's very annoying, can't even eat peacefully around here! Why don't they just give him what he wants"? At 12:55 p.m., the C.N.A stated "His liquids needs to be thickened, I'll call the kitchen." At 1:05 p.m. (after 50 minutes) R17 was given a thickened cup of coffee.	F 246			
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure Nurses administer medications to the residents as ordered by the physician, and failed to maintain professional standards of practice by not keeping prescribed medications secured. This is for one resident in the sample of 24 (R18)	F 281			

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F 281	<p>Continued From page 17 and nine supplemental residents.(R69, R89, R29, R107, R105, R115, R28, R26 and R84).</p> <p>Findings include:</p> <p>On 8/10/10 E10 (Nurse) administered medications scheduled for 4:00 pm on second floor (2B). At 5:30 pm there were 10 residents did not receive their 4:00 pm medications: R69 has medication (Levodopa) to be administered on time for her Parkinson's. R89 has medications (Glucophage) for her Diabetes to receive at 4:00 pm. This medication was yet to be given at 6:30 pm. R29 had to wait to receive his Insulin before meals. The meal time was 5:00 pm, his blood sugar testing was not done or Insulin received until 5:35 pm. R18 was to receive her medications (Reglan and Omeprazole) before meals, he ate his supper at 5:00 pm and did not receive these medications until 6:15 pm.</p> <p>During the reconciliation of the medication observation, it was noticed that 8/10/10 morning medications were not signed out as given. The details are:</p> <p>R107 11:00 am Sucralfate 1 gram and Tylenol 500 mg Noon dose was not signed off as given.</p> <p>R105 Ultram 50 mg Noon dose was not signed off as given.</p> <p>R115 Sucralfate 1 gram 11:00 am dose was not signed off as given.</p> <p>R28 Incentive Spirometry treatment, and Robitussin-DM were not signed off as given for</p>	F 281			

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F 281	Continued From page 18 Noon. R18 Methylin - Schedule II tablet 10 mg, Artificial tears and Multivitamin at Noon were not signed off as given. R26 Azopt eye drops at 2:00 pm; Multivitamin, Potassium Chloride 10 mEq, Folic Acid 1 mg, Plavix 75 mg, Zinc Sulfate 220 mg, Tylenol 500 mg, Artificial tears, Vitamin C 500 mg, Coreg 6.25 mg, Vitamin E 400 units, Lasix 20 mg, Nystatin at 8:00 am; and Antivert 25 mg for 8:00 am and Noon were not signed out as given. R84 Azopt eye drops at 2:00 pm; Multivitamin, Potassium Chloride 10 mEq, Folic Acid 1 mg, Plavix 75 mg, Zinc Sulfate 220 mg, Tylenol 500 mg, Artificial tears, Vitamin C 500 mg, Coreg 6.25 mg, Vitamin E 400 mg, Lasix 20 mg, Nystatin, for 8:00 am and Antivert 25 mg for 8:00 am and Noon were not signed off as given.	F 281			
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to evaluate two of 24 sampled residents (R10 and R24) need for assistive devices to promote comfort and maintain good body posture. Findings include: (1) On 08-10-10 at 12:30 p.m., R10 was in the dining room sitting on her wheelchair leaning on	F 311			

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F 311	Continued From page 19 her left side. On 08-11-10 at 10:50 a.m., R 10 was observed in the dining room during activities, leaning on the left side of the wheelchair. There was no positioning device noted on these 2 days. R10's position (while sitting on the wheelchair) was shown to the Restorative Nurse (E4) at 1:00 p.m. E4 stated "I didn't notice her leaning before. I have a positioning board in my office, we could try that!" (2) On 08-11-10 at 11:50 a.m., R24 was observed in the dining room sliding down in his wheelchair. This observation was shared with the Restorative Nurse (E4). There was no positioning device noted to prevent R24 from sliding down nor were staff observed to reposition R24. E4 claimed no matter what type of wheelchair he will use he still will slide he just needs to be constantly be pulled up. E4 was told that based on observation R24 had not been repositioned for more than 2 hours.	F 311			
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES 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. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview the facility failed to: - prevent 1 resident (R11) who was admitted into	F 314			

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F 314	<p>Continued From page 20</p> <p>the facility with skin intact from developing pressure sores while at the facility. - follow the physician's order for the treatment and care of the pressure sore.</p> <p>This failure resulted in 1 of 4 residents within the sample with pressure sores (R11) developing a, stage III pressure sores to the left ischium that progressed to a stage IV and increased in size and depth.</p> <p>Findings include;</p> <p>R11 is 79 years old. R11's diagnoses include Cardiovascular Accident, Chronic Obstructive Pulmonary Disease, Osteoarthritis and Bipolar disorder. Documentation denotes that upon admission into the facility, R11's skin was intact.</p> <p>Review of the Braden scale review done by the facility on 4/26/10 notes that R11 is at mild risk for the development of pressure sores.</p> <p>Review of R11's RAP summary report dated 3/12/10 notes that R11 is confused, disorientated, with impaired cognitive skills. Further documentation denotes that R11 requires extensive assistance with bathing, bed mobility, transfer, dressing, and grooming. Documentation states that R11 is incontinent of both bowel and bladder.</p> <p>Review of R11's clinical notes dated 7/6/10 notes, open area noted to the left ischium, 0.5cm in size. Further documentation denotes that the physician was notified and treatments were ordered.</p> <p>No documentation or observations were noted in</p>	F 314			

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F 314	<p>Continued From page 21</p> <p>the record by staff regarding the progress, lack of progress or disposition of R11's pressure sore after the initial development on 7/6/10.</p> <p>Review of the physicians order sheet (POS) list treatment orders for the pressure sore dated 7/6/10. Review of the treatment administration record (TAR) denotes that treatment was not initiated until 7/9/10, three days after the orders were received.</p> <p>The clinical record notes no further documentation or assessment of the condition of R11's pressure sore until 7/14/10. Nurses notes indicate that R11 {went to see wound care consultant....sent to the hospital from the wound care clinic...}.</p> <p>Review of the emergency room admission report by the emergency room physician, indicates: On examination today by Z1(wound care physician) R11's ulcer was noted to be quite deep with extension close to the bone. Further documentation denotes that upon arrival to the hospital R11's pressure sore was measured at 4cm, with significant exposure of subcutaneous tissue.</p> <p>Documentation notes that R11 was admitted to the hospital on 7/14/10, with a diagnosis of infected stage IV pressure sores to the left Ischium. After debridement and antibiotic therapy, R11 was discharged back to the facility on 7/19/10.</p> <p>Documents produced by the facility on 8/11/10 includes observations of R11's wound on 7/19, 7/24 and 7/31/2010, which were all after R11 was readmitted back into the facility after</p>	F 314			

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F 314	Continued From page 22 hospitalization. The 7/24 and 7/31 documents were noted to have been just completed on 8/10/10. E7 (treatment nurse) was observed to provide wound care to R11 on 8/11/10. The wound was noted to be located at the base of the left lower buttock/ischial area. Per interview on 8/11/10 E7 (treatment nurse) stated that R11 did acquire the pressure sore while at the facility. E7 further stated that it was initially thought that R11's wound was a result of an abscess and not a pressure sore. E7 did not know why the treatments were not initiated on 7/6/10 when the order was received.	F 314			
F 315 SS=G	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to complete an accurate and thorough assessment of factors for R1's urinary incontinence, identify whether the causes of R1's incontinence were reversible or irreversible, develop and implement a program	F 315			

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NAME OF PROVIDER OR SUPPLIER CHATEAU NRSG & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET WILLOWBROOK, IL 60521		
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F 315	<p>Continued From page 23</p> <p>based on individual resident assessment, and create a specific and individualized bowel and bladder plan of care.</p> <p>These failures resulted in R1's decline in bowel and bladder function. R1 was occasionally incontinent (2 or more times a week) and declined to frequently incontinent (incontinent daily). A fall on 07-01-10 occurred while resident was trying to go to the bathroom unassisted. R1 sustained a small amount of bleeding from the right side of her head. This is for 1 of 24 sampled residents.</p> <p>Findings include: On 08-12-10 at 1:30 PM, R1 was observed in the hallway sitting in a wheelchair and was noted with a very strong urine odor. R1 was asked if able to stand up, stated "Yes", grabbed the hallway handrail and stood up without assistance. R1 said "My panty is wet, I need to get changed." The CNA (E17) was informed of R1's request and the surveyor's observation.</p> <p>At 1:40 p.m., R 1 was taken to the bathroom; transferred self from wheelchair to the toilet without physical assistance from the staff and was able to clean herself after urinating. E17 stated "Sometimes she can tell if she needs to go to the bathroom. She can do a lot for herself, she can stand up. She just needs cuing." R1's Minimum Data Set dated 11-04-09 showed a score of 2 & 2 - occasionally incontinent (2 or more times a week) on bowel and bladder function then on 07-14-10 Minimum Data Set shows R1 with a decline and scored as frequently incontinent (incontinent daily). There was no evaluation on how & why R1 declined in her bowel and bladder functioning.</p>	F 315			

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F 315	Continued From page 24 Review of R1's plan of care showed that there was no plan of care developed to address the incontinence problem of R1. Review of the incident reports on 08-02-10 at 6:00 PM- awake most of the night, got out of bed twice, observed walking to the toilet unassisted. 07-01-10 at 8:50 PM - observed lying on the floor on the bathroom. The resident was yelling out saying she was trying to go to the bathroom. Noted a small amount of bleeding from the right side of her head. The facility has not obtained R1's voiding pattern to provide an individualized toileting plan or evaluate the type of incontinence and how the facility will assist R1 to maintain or improve her current bowel and bladder functions.	F 315			
F 332 SS=E	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, record review and interview the facility failed to administer medications to the residents with an error rate no greater than 5%. The medication error rate was 15%. This is for two residents (R14 and R18) in the sample and three residents (R25, R26 and R27) from the supplemental sample. Findings include: On 8/10/10 evening two surveyors observed four nurses administering medications on the second	F 332			

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F 332	<p>Continued From page 25</p> <p>floor. A total of 40 opportunities were observed and six errors occurred. The following are the details of errors:</p> <p>(1) E10 at 4:05 pm administered R26 his medications scheduled for 4:00 pm. R26 has physician order to administer Colace 100 mg at 4:00 pm. This medication was not available for R26. E10 stated the facility uses floor stock of Colace which she did not have.</p> <p>(2) At 4:40 pm E10 administered R14's medications scheduled for 4:00 pm after she ate her dinner. E10 crushed all her six scheduled medications including Reglan 5mg, Carafate 1 GM and Ferrous Sulfate 325 mg. R14 has physician order 7/2/10 to administer Reglan before meals.</p> <p>(3) At 4:45 pm E10 administered R27 her 4:00 pm scheduled medications. At this time E10 did not find Oscal 500/125 mg to administer for R27. E10 stated the facility use Oscal floor stock which she could not find to administer. R27 has physician order 4/6/10 to give at 8:00 am and 4:00 pm.</p> <p>(4) At 6:15 pm E10 administered R18 his Reglan 5 mg scheduled for 4:00 pm. R18's physician order 9/6/06 noted to give this medication at 8:00 am and 4:00 pm before meals. R18 ate his dinner at 5:00 pm and the medication was given at 6:15 pm. R18 also has physician order 11/26/06 to give Omeprazole 20 mg at 4:00 pm before meals. E10 missed giving this medication.</p> <p>(5) At 4:15 pm E13 administered R25 his Fluticasone Salmeterol Inhaler one puff that is scheduled for 4:00 pm. E13 did not shake the inhaler at least for one full minute to ensure the efficacy of the medication absorption.</p> <p>On 8/12/10 the facility administration staff were made aware of the concerns related to</p>	F 332			

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F 332	Continued From page 26	F 332			
F 333 SS=D	<p>medication administration errors.</p> <p>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</p> <p>The facility must ensure that residents are free of any significant medication errors.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to provide antibiotic therapy (Zosyn) as prescribed by the physician. These failures resulted in a significant medication error for the treatment of R13's recurrent urinary tract infection. R13 had not been given her prescribed antibiotic therapy for the additional 10 days/40 doses. The facility was not aware of this significant medication error until 08-12-10. This applies to 1 of 24 sampled residents</p> <p>Findings include: On 08-10-10 at 11:40 a.m., R13 was observed in bed with PICC line on the right upper arm. The Nurse (E18) stated "She has not used that (PICC line) for a while. " Interview with the Director of Nursing (E2) on several days of the survey, E2 claimed that the PICC line was used to administer R13's antibiotic for her pressure ulcers. Review of R13's transfer sheet dated 07-06-10; R13 was transferred to the hospital for re-insertion of the PICC line. The transfer sheet from the nursing home reads: observed catheter approximately 12 cm out, sending her to the hospital for PICC line placement evaluation. The hospital consultation report dated 07-07-10 reads: She (R13) is here because of her PICC malfunction and there appears to be another</p>	F 333			

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F 333	Continued From page 27 urinary tract infection. The hospital transfer sheet dated 07-07-10 sent to back to the nursing home showed that the old PICC line was removed and a new power PICC was inserted and with an order for 4 more weeks of Zosyn at Nursing Home, a dose of Zosyn IVPB was given at 12:00 noon. Facility prescription order showed the following antibiotic order for R13: Zosyn solution 4g-0.5g/100ml;amt: 2.25 gm/50 ml; intravenous Every 6 hours (12 AM- 6 PM- 12 PM- 6PM) Diagnosis: Infection, slow virus Start Date: 07-07-10 End date: 08-07-10 This order was not followed; review of R13's Medication Administration Record for the month of July 2010 showed that the last dose of Zosyn was given on 07-28-10 not 08-07-10. 10 days, 40 doses of antibiotic were not provided to R13. The Administrative Staff were informed of this significant error for R13 on 08-12-10 during the daily status meeting.	F 333			
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353			

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F 353	<p>Continued From page 28</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview the facility failed to provide adequate staff to ensure:</p> <ol style="list-style-type: none"> 1. Residents are gotten out of bed at times that is their preference. 2. Call lights are answered in a timely manner. 3. Enough staff is available for residents who require assistance with feeding, turning, transferring and toileting 4. Nutrition and all meals are delivered and served in a timely manner. <p>Examples include:</p> <p>On 8/10/2010, at 11:00a.m., surveyors observed residents on the 2B units. Multiple calls light were going off. R14 and R27 were requesting water and R27 was severely itching from a skin rash. Both were requesting assistance. The call light was placed on at 11:05 and was answered by a facility consultant at 11:35a.m.</p> <p>A review of the staffing for 2B, identified as a skilled unit identified that there were 4 CNAs assigned. Two CNA s were assigned lunch at 11:00 a.m. Interview with (E3) ADON and E19,</p>	F 353			

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F 353	<p>Continued From page 29</p> <p>E20 staffing coordinators, indicated that the nurses are responsible to cover the floor during lunch. The nursing staff were observed to be engaged with three physicians at the nursing stations. The panel on the counter of the nurse's desk showed 5 calls were visible.</p> <p>A review of Resident Council Meeting minutes and Concern Forms note multiple complaints of call lights not being answered in a timely manner. Residents voiced concerns of staff coming into resident rooms, turning off the call light and not coming back. Residents state staff often say they are with other residents and could not come back.</p> <p>January 2010, Council meeting minutes report nursing aides are leaving residents on the toilet and having them wait long amounts of time. Resident stated the third shift needs the most improvement for call lights. Residents state there are not enough aides to help all the residents.</p> <p>February 2010, Council meeting minutes report, "The weekends are terrible and seems like there is never enough staff on the floor."</p> <p>A group meeting was conducted with residents on 8/11/2010. During this meeting, residents voiced concerns of having to wait for long periods to get food trays, especially on the weekends. The food trays are delivered late often sometimes over one hour. The staff will call in especially on the weekends, and the units do not have enough staff to feed and serve trays to residents at the same time. Many times the food is cold. In a review of a year of resident council meeting minutes, residents consistently report that staff</p>	F 353			

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F 353	Continued From page 30 taking a long time to answer call lights.	F 353			
F 363 SS=F	<p>A 7/5/2010 concern, voiced by R39's family, notes that R39 remains in bed at 11:00a.m. Nurses reported to family that they were short staffed. R39's family indicated that his wife should not "suffer" because the facility did not have enough help.</p> <p>483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, the facility failed to assure the menu was followed at the breakfast meal on 7/31/10 and 8/1/10, failed to assure juice was at the proper dilution and portion size, and failed to prepare enough spinach to serve all residents on 8/11/10.</p> <p>Findings include:</p> <p>During the group interview on 8/11/10 the residents stated that the juice is watery, the kitchen runs out of food, and they don't get the correct food. Surveyors and E6 food service supervisor tasted the orange, apple, and cranberry juice from the juice dispenser in the kitchen. The facility uses a concentrated system that mixes with water to yield a mixed orange, apple and cranberry juice. The orange juice and</p>	F 363			

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F 363	<p>Continued From page 31</p> <p>apple juice tasted weak (too dilute). E6 said she would call the company about the problem. A service call was made and a technician came at 3:30pm on 8/11/10 to check the calibration in the juice. His report indicates that the orange and apple juice needed to adjusted to increase the strength of the concentrate. It is not known how long the diluted juice was served.</p> <p>Surveyor obtained the nutritional value and ingredients for the orange juice product from the facility and juice company on 8/18/10. The product is not 100% orange juice, but a blend or orange concentrate, apple concentrate filtered water, citric acid, natural flavors, vitamin C. An 8 oz glass contained 100% vitamin C daily value (DV) if diluted properly, however the daily menu plan for each day only plans for 6 oz. Nutritional values of the apple and cranberry juice indicate that 8 oz are required to have 100% DV for Vitamin C., therefore the menu plan at 6 oz per day does not meet this requirement, and since the juice has been served diluted, this decreases the nutritional value even more.</p> <p>A concern form dated 8/1/10 states a resident indicated that he did not have any juice with his meals all day Saturday and Sunday. The action taken states that social service bought juice for lunch and dinner on 8/1/10- contacted service department for juice machine and left message for service. Company is coming out 8/2/10.</p> <p>Interview with E6 on 8/18/10 indicated the juice machine broke on Friday evening 7/30/10, the manager on duty bought juice on 8/1/10 No Juice was available on 7/31/10. The menu plan for Saturday and Sunday breakfast is for 6 oz of vitamin C juice. This was necessary to assure</p>	F 363			

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F 363	Continued From page 32 enough servings from the fruit and vegetable group were served, and provide the RDA for Vitamin C. During the group interview on 8/11/10 residents stated that the kitchen runs out of food, or staff tells them they don't have any more. At the noon meal on 8/11/10 the menu called for baked ham, spinach, bread dressing, pie and cornbread. Surveyor observed the main dining room during the 12:25 pm seating, the kitchen ran out of spinach and substituted California blend vegetables. There was still 1 unit left to serve.	F 363			
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community. There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below. The facility must offer snacks at bedtime daily. When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure that a bedtime snack is offered	F 368			

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F 368	Continued From page 33 daily.	F 368			
F 369 SS=D	<p>Findings include:</p> <p>During individual interview and group interview residents were asked if they get snacks at bedtime daily. Residents responded "No"! The residents stated the only way they get a snack is to beg for one. This information was relayed to E1 (Administrator).</p> <p>483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS</p> <p>The facility must provide special eating equipment and utensils for residents who need them.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to; - assess and provide the appropriate utensils and adaptive equipment for 2 of 24 residents in the sample. (R12 and R10)</p> <p>Findings include:</p> <p>R12 is a 47 year old with diagnose including Huntington's Chorea and dysphagia.</p> <p>During lunch meal observation on 8/10/10 R12 was observed attempting to feed himself using regular feeding utensils. R12 was noted to have severe spastic involuntary tremors of his upper extremities, head and torso. R12 had extreme difficulty scooping food onto the fork, and was observed numerous times attempting to use his</p>	F 369			

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F 369	Continued From page 34 free hand to place the food onto the fork with his fingers. The plate was observed to slip and slid with each attempt. Food was observed to fall from the plate onto R12's lap and chest area. R12 was observed to continue to struggle to get the food from the plate onto the fork, then into his mouth. R12 was observed to become very frustrated and place the utensil down without completing his meal. There was no staff intervention observed during the observation. Per interview on 8/11/10 E 4 (Restorative Nurse) stated that R12 had not been assessed or even observed for any adaptive equipment to assist him with eating. R10 was observed at the noon meal on 8/11/10 to have difficulty holding a spoon. R10 had a MDS (minimum data set) dated 7/16/10 which indicates she needs limited assistance with eating, with 1 person physical assist. This assessment indicates he has limitation on one side including arm- including shoulder or elbow, hand including wrist or fingers. E4 said that R10 used to have some kind of a utensil with a Velcro strap, but she did not like it. R10 has not been assessed for a more suitable device according to E4. E4 stated that R10 needs to be fed now.	F 369			
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	F 371			

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NAME OF PROVIDER OR SUPPLIER CHATEAU NRSNG & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 7050 MADISON STREET WILLOWBROOK, IL 60521		
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F 371	Continued From page 35 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to air dry dishes and tableware as observed on 8/13/10. Findings include: During the group interview on 8/11/10 residents stated that their dishes and trays were wet when they received their meals. This was relayed to E1 administrator and Z6 corporate dietary supervisor after the group concerns were discussed. A copy of a service call from the chemical supply company dated 8/12/10 was presented to surveyors. The comments section indicates there is an issue with the trays and ware not drying fast enough as they exit the machine. There was no problem with the rinse additive, but the lower temps just make the drying times much longer, especially on plastic. Higher temperatures with the rinse agent is the best way to dry trays fast. The facility uses a low temperature dish machine with chemical sanitation, and thin plastic plates. Surveyor walked through the main dining room on 8/13/10 at 3:30pm when dietary staff were setting the tables. The dishes that had been placed on the table were noticeably wet. This was shown to E1 administrator and E6 dietary supervisor.	F 371			
F 441 SS=K	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441			

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F 441	<p>Continued From page 36</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 441			

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F 441	<p>Continued From page 37</p> <p>by: Based on observation, record review and interview the facility failed to:</p> <p>(1) Ensure staff follow standard precautions during blood sugar testing. The Nurses did not clean or disinfect the glucometers, before or after using and re-using them, as recommended in manufacturer directions and CDC Guidelines.</p> <p>(2) Have a Policy and Procedure for cleaning and disinfecting the glucometer before and after its use.</p> <p>(3) Analyze data from infection control logs to determine the origin of nosocomial infections, and review the use of antibiotics in the facility.</p> <p>For seven of seven residents blood glucose tested the Nurses did not follow safe, effective standard precautions for cleaning and disinfecting glucometers. One resident (R18) in the sample and six residents (R28 through R33) from supplemental sample.</p> <p>This practice of not cleaning and disinfecting glucometers between every use and re-using glucometer created an Immediate Jeopardy (IJ) to resident health, safety and welfare by exposing residents who require blood sugar testing to the spread of bloodborne infections.</p> <p>This systemic failure has the potential to affect all 36 residents (11 residents from the 1st floor and 25 residents from the second floor) who have a diagnosis of Diabetes and are on routine daily blood glucose testing.</p> <p>On 8/12/10 at 2:28 pm the survey team notified the facility administrator (E1) in the facility meeting room at this time of the Immediate Jeopardy (IJ). The IJ began on 8/10/10 at 3:55</p>	F 441			

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F 441	<p>Continued From page 38</p> <p>pm due to the facility failure to clean and disinfect the glucometers according to manufacturer's directions before and after use when testing blood sugars. The immediacy was removed on 8/13/10 at 10:30 am when the facility submitted a removal plan and evidence that the facility identified the staff skill deficit and began inservicing the nurses. The facility remains out of compliance at a level 2 due to the need for the facility to assure all the nurses are educated and practice thorough cleaning and disinfecting of the glucometers.</p> <p>Findings include:</p> <p>On 8/10/10 evening two surveyors observed four different Nurses measuring blood glucose for the residents on the second floor using glucometer. The following are the details of the blood glucose testing.</p> <p>(1) At 3:35 pm E12 measured blood glucose for R30. E12 wiped the strip port on the glucometer after its use with an alcohol wipe once and returned the glucometer to the cart.</p> <p>(2) At 3:40 pm E12 measured blood glucose for R31. E12 wiped the strip port on the glucometer machine after its use with an alcohol wipe once and returned the machine to the medication cart.</p> <p>(3) At 4:55 pm E11 measured blood glucose for R18. E11 after using the glucometer, wiped it with a germicidal disposable wipe for 12 seconds and placed the machine in the medication cart drawer.</p> <p>(4) At 5:20 pm E10 measured blood glucose for R28. E10 after using the glucometer, wiped the machine for 8 seconds with a germicidal disposable wipe and placed the machine in her lab coat pocket.</p> <p>(5) At 5:35 pm E10 measured blood glucose for</p>	F 441			

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F 441	<p>Continued From page 39</p> <p>R29. To measure the blood glucose E10 took the glucometer out of her pocket and used the same machine that was used for R28. After the test for R29, E10 wiped the glucometer for 14 seconds with a germicidal wipe and placed the machine back in her lab coat pocket.</p> <p>(6) At 3:55 pm E13 measured blood glucose for R32. E13 wiped the glucometer after its use with a germicidal wipe for five seconds and returned the glucometer to the medication drawer.</p> <p>(7) At 4:05 pm E13 measured blood glucose for R33. E13 wiped the glucometer for 8 seconds after its use and returned the blood glucometer the medication cart drawer.</p> <p>This unsafe staff practice of handling, storing, cleaning and disinfecting the glucometer before and after its using and reusing has the potential to cause bloodborne infections.</p> <p>The germicidal disposable wipe that was used to clean the blood glucometer is a bacteriocidal, Tuberculocidal and virucidal agent. In order for the germicidal disposal wipe to be effective the manufacturers directions noted to disinfect the surface by: "Thoroughly wet surface, must remain visibly wet for a full two minutes, use additional wipe(s) if needed to assure continuous two minute wet contact time." The Nurses did not follow these cleaning directions after or before use of the blood glucometers.</p> <p>Centers for Disease Control guidelines for RECOMMENDED INFECTION-CONTROL AND SAFE INJECTIONS PRACTICES TO PREVENT PATIENT-TO-PATIENT TRANSMISSION OF BLOODBORNE PATHOGENS, include:</p> <p>* Environmental surfaces such as glucometers</p>	F 441			

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F 441	<p>Continued From page 40</p> <p>should be decontaminated regularly and anytime contamination with blood or body fluids occurs or is suspected.</p> <ul style="list-style-type: none"> * Glucometers should be assigned to individual patients. If a glucometer that has been used for one patient must be reused for another patient, the device must be cleaned and disinfected. * Maintain supplies and equipment such as fingerstick devices and glucometers within individual patient rooms if possible. * Do not carry supplies and medications in pockets. * Because of possible inadvertent contamination, unused supplies and medications taken to a patient's bedside during fingerstick monitoring or insulin administration should not be used for another patient. <p>E10, on 8/10/10 at 6:30 pm stated she was not aware that she has to use the germicidal wipe so that the surface to be cleaned is visibly wet for full two minutes contact time.</p> <p>On 8/12/10 surveyor reviewed the facility policy and procedure for measuring blood glucose for the residents. This policy and procedure did not include any guidelines for the cleaning and disinfecting the glucometer before and after its use.</p> <p>On 8/10/10 there were a total of 11 residents (six residents on second floor; and five residents on first floor) in contact isolation for various infections including Methicillin Resistant Staph Aureus (MRSA), Clostridium Dif. (C-Dif),</p>	F 441			

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F 441	<p>Continued From page 41</p> <p>Vancomycin Resistant Enterococcal (VRE), Extended Spectrum of Beta Lactimace (ESBL) infections in the urine, stool and wound. Five of 11 residents in contact isolation have acquired infections in the facility.</p> <p>Two of six residents from the second floor; and one of five residents from the first floor in contact isolation have a diagnosis of Diabetes and receive daily blood glucose testing. The facility has a glucometer for each medication cart and the staff use and re-use the same glucometer on multiple residents. There is no dedicated glucometer for the residents in isolation.</p> <p>On 8/13/10 the survey team reviewed facility infection control program. The facility infection control log documented (between 2/1/10 and 8/10/10) a total of 187 infections; of which 146 infections were acquired (nosocomial) in the facility; 98 infections were present upon admission to the facility; and 43 cases of prophylactic antibiotic therapy use. These statistics indicate 78% of the infections were acquired in the facility. These infections include: Urinary Tract, Respiratory Tract, Skin, Gastrointestinal Tract, Eye, Ear and Nose. The infectious organisms included were: MRSA, C-Dif., VRE and ESBL.</p> <p>The original CMS form 672 resident census and conditions of residents given to surveyor on 8/11/10 stated there were 10 residents on antibiotics. Review of the infection control log given to surveyor on 8/11/10 indicated more than 10 residents received antibiotics. The 672 was revised to include 26 residents on antibiotics. The infection control log from 7/1/10 to 7/31/10 had 25 incidents of nosocomial infections. The</p>	F 441			

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F 441	<p>Continued From page 42</p> <p>data from this time frame had not been evaluated as of 8/11/10. Surveyor asked for data from 8/1/10 to 8/11/10. This report indicated that 4 new nosocomial infections developed on skin.</p> <p>During the initial tour on 8/10/10, a family member of R15 expressed concern about how his mother has developed MRSA, and recently has to be in isolation with another resident with MRSA. R15's record indicates she was admitted 6/28/10, and tested positive for MRSA in the right great toe on 8/6/10. R15's roommate R63 developed MRSA of a wound on 6/8/10 according to the infection control log. E2 director of nursing said that this is why R15 and R63 are now roommates.</p> <p>The facility presented the following plan to remove the immediacy.</p> <p>(1) Director of Nurses Designee initiated educational training with licensed staff regarding glucometer cleaning techniques. Nurses re-educated on utilizing facility germicidal disposable wipes (Super Sani-Cloth). The facility revised the policy and procedure for cleaning and disinfecting the glucometer.</p> <p>(2) Director of Nurses (DON) Designee re-educated license and unlicensed personnel on measures to prevent the spread of nosocomial infections. Emphasis placed on proper hand washing technique. Staff will complete competency training on measures to prevent the spread of nosocomial infections as well as return demonstration for hand washing.</p> <p>(3) The facility held an emergency Quality Assurance Committee meeting on 8/12/10 to analyze the data on the infection control log to determine the source of nosocomial infections;</p>	F 441			

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F 441	Continued From page 43	F 441			
F 469 SS=D	<p>determine trends and patterns that warrant investigation from Quality Assurance Infection Control Committee. DON designee will monitor.</p> <p>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to keep the facility pest free by not actively treating a suspected incident of bed bugs in one room on the second floor.</p> <p>Findings include:</p> <p>Surveyors received an allegation via phone call on 8/12/10 that there was a problem with bed bugs in a resident room. When asked about this, E1 administrator said that he was just made aware of the issue today, that the pest control company came out and found a dead bed bug in a resident room. The pest control report indicates that a service call was made at 9:40am 8/11/10 Room was checked and a dead bed bug was found on the floor. The chair with bed bugs was removed from the room. E1 said the chair was brought in by the family, and he did not know when it was brought in.</p> <p>Interview with family member on 8/12/10 at 12:40pm in room indicated that the family received a call about a week ago that there was a problem with bed bugs, but there is not a problem</p>	F 469			

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F 469	<p>Continued From page 44 today.</p> <p>Interview with E21 RN on 8/12/10 indicated that about a week or 2 ago, he was working the day shift and the night shift endorsed to him that a bug was found in a resident room. E21 said that E22 the environmental director had the room cleaned. E22 wrote a statement on 8/12/10 that about a week ago, I was informed that a bug was found in a resident room. After the beds were stripped and linen was sent down to laundry, the housekeeper on 2A that day disinfected the room including the beds. The bug was not saved or identified.</p> <p>E22 was interviewed on 8/12/10 at 2:00pm. She said that on 8/11/10 she came in at 5:45am and the night shift must have found the bugs. E22 said a recliner chair was found to have bed bugs and the chair was removed from the building. The room was cleaned and prepared according to instructions from the pest control company. These instructions include information about removing all personal items, linens, curtains, electrical plates from walls closets must be empty.</p> <p>Interview with Z5 from the pest control company in a telephone conversation on 8/17/10 at 1:30pm indicates that if a bug is found, it should be saved and given to the technician for identification. Then they will know how to treat it.</p>	F 469			