STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145597	A. BUILDING _____ B. WING _____	07/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEKIN MANOR	**1520 EL CAMINO DRIVE PEKIN, IL 61554**

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F 000	INITIAL COMMENTS Annual Licensure and Certification. Complaint 1121989/IL53518- No Deficiency Complaint 1122173/IL53731- No Deficiency	F 000		
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, interview and record review, the facility failed to provide medical justification for the use of restraints for three of three residents (R3, R13, R15) reviewed for restraints in the sample of 18. Findings include: 1. R3's Care Plan dated 7/18/11 documented diagnoses of Dementia and History of Falls. On 7/18/11 at 1:30 p.m. R3 was in the hallway walking herself in her enclosed framed wheeled walker. On 7/19/11 at 9:05 a.m. R3 was walking in her enclosed framed wheeled walker with E5 (Physical Therapy Assistant). E5 asked R3 to raise the bar on the walker. R3 became very confused and combative and could not raise it. E5 stated that R3 uses the walker because she has had several falls.	F 221		8/5/11

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

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F 221	Continued From page 1 On 7/19/11 at 10:25 a.m. Z1 (Family Member) stated that R3 has had the enclosed framed wheeled walker for approximately a week. Z1 stated that the reason she was given the walker was because R3 was always sliding out of her chair. Z1 asked R3 to release the bar on the walker, but R3 could not do it. Z1 stated "she can't raise the bar." 2. R13's Physicians Order Sheet dated 6/1/11-6/30/11 documented a diagnosis of Abnormal Posture. On 7/20/11 at 8:00 a.m. R13 was sitting upright at the dining room table waiting for breakfast with Lap Belt on. On 7/20/11 at 11:30 a.m. E17 asked R13 to remove her Lap Belt. R13 was very confused and unable to remove the lap belt. 3. On 7/20/11 at 10:00 AM, R15 was sitting in his wheel chair alone in his room. R15 had a self releasing seat belt across his upper legs. At 11:00 AM on 7/20/11, E23 (Certified Nurse Assistant) and E23 (Certified Nurse Assistant) were in the room with R15. They asked R15 to remove the lap restraint three times. R15 just sat in the wheelchair looking at them with no verbal or physical response. On 7/20/11 at 12:00 PM, R15 was sitting in the day area in the wheelchair with lap belt in place at a bedside table by the nursing station eating lunch. At 2:00 PM R15 was still seated near the nurse's station with lap belt still in place. The care plan dated 6/16/11 documents an approach to release seat belt during meals and increase to short periods after meals under the problem "Resident requires self releasing belt	F 221		

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F 221	Continued From page 2 alarm when up in wheel chair. Documented in this same care plan under problem "increased risk for falls related to history of falls, history of fractured left hip, impaired daily decision making and impaired sense of safety awareness." is an approach with start date of 3/15/10 "Self releasing seat belt alarm on when up in wheelchair. Release every two hours for repositioning/comfort and during meals and activities while under direct supervision." The Minimum Data Set dated 12/14/10 and 3/15/11 Section P Restraints is marked "0" Not used. The Care Area Assessment Summary Physical restraint care area did not trigger for restraints. On 7/20/11 at 3:00PM Z8(wife) stated that R15 spends most of the time in his room alone. Z8 stated that the facility put the seat belt on R15 to keep him in the wheelchair. Z8 stated that the staff are really busy and don't have time to watch him. Z8 stated that R15 has fallen several times, one time sustaining a hip fracture. Z8 stated, "I wonder if it would be all right for me to release the seat belt while I am with him at the supper meal?" Z8 stated that she comes to visit every afternoon and assists him with the evening meal.	F 221		
F 315 SS=D	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	F 315		8/5/11

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F 315	Continued From page 3 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, record review, and interview, the facility failed to have a diagnosis justifying the use of a catheter for two of four residents with catheters (R2, R14) in the sample of 18. Findings include: 1. R14's admission record dated 12/16/11 shows R14 is a 55 year old male with diagnoses that include: Dementia, Penile Cachexia (wasting away/withering of the physical structure of the penis) and a history of urinary retention. A patient transfer form dated 12/16/11, from a local hospital, documents R14 also had a catheter upon admission to this facility. E2, Director of Nursing, on 07/20/11 at 12:30 p.m., stated that R14 has had the catheter since admission and there has never been any attempt to discontinue the catheter and no other type of catheters have been used such as an external, condom type, catheter that R14 could remove and replace himself. E2 stated that R14's physician wants to keep the catheter in place because of R14's history of frequent urinary infections. E2 stated that R14 continues to have frequent urinary tract infections even with the catheter in place and also because R14 continues to masturbate, causing redness and placing him at higher risk for urinary tract infections. E2 stated she has asked R14's	F 315		

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F 315	Continued From page 4	F 315		

physician about discontinuing R14's catheter because R14 continues to have infections and because of the risk of serious injury to R14's penis related to sexual behaviors and catheter.

R14 stated on 07/21/11 at 9:05 a.m., that he does not know why he has to wear a catheter and "Hates it." R14 stated that he had asked his physician if he could have the catheter removed and the physician told him "No." R14 stated the physician did not explain why R14 needs a catheter. R14's catheter was observed in place at this time.

E21 (Certified Nursing Aide) stated on 07/21/11 at 9:10 a.m., that R14 frequently is found with his hands down his pants and that R14 has a catheter.

Nursing notes reviewed for the months of 03/11, 04/11, 05/11, 06/11 and 07/11 show that R14 has been receiving antibiotics for urinary tract infections. A lab report dated 03/12/11 documents that R14's urine sample received from the catheter bag was contaminated with semen.

On R14's 07/12/11 nursing notes indicate that there was profuse amounts of frank blood in R14's catheter tubing/bag and R14 was complaining of lower back pain and sent out to the hospital. Nursing notes dated 03/27/11 and 06/12/11 document staff continue to witness R14 masturbating and that R14 has to have frequent reminders not to masturbate as it pulls at the catheter tubing.

R14's care plan dated 05/11/11 does not show assessing or provide approaches related to R14's sexual behaviors related to the catheter. R14's

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F 315	Continued From page 5 care plan does not address attempts to reduce catheter use or his sexual behavior (masturbating). 2. R2's Physician Order Report dated 6/1/11-6/30/11 documented use of a indwelling catheter related to a diagnoses of Urinary Tract Infection and Osteomyelitis of the Ankle/Foot. On 7/21/11 at 10:00 a.m. E2, Director of Nurses stated that R2 has an indwelling catheter due to Osteomyelitis of the left heel.	F 315		
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 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	F 441		8/5/11

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F 441	Continued From page 6 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: A. Based on observation, record review, and interview the facility failed to obtain manufacturer's recommendations for cleaning the glucose monitoring machine used for multiple residents and failed to clean the glucose monitoring machine between residents for two of two residents (R2,R5) with blood glucose monitoring in the sample of 18 and 12 residents in the supplemental sample (R26, R30-40). Findings include: 1. On 7/19/11 at 11:00 a.m. during Medication pass E16 LPN (Licensed Practical Nurse)obtained a Blood Glucose Monitoring machine from the top drawer of her medication cart and entered R26's room to perform a blood glucose check without cleaning the machine. E16 laid the glucose monitoring machine on R26's bed and proceeded to prepare R26's finger for the monitoring. The blood glucose monitoring was performed. E16 laid the Glucose Monitoring	F 441		

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F 441	Continued From page 7	F 441		

Machine on top of her medication cart and proceeded with her medication pass. E16 then obtained her Blood Glucose Monitoring machine from the top of her medication cart and entered R37's room to perform a Blood Glucose check without cleaning the machine between R26 and R37.

On 7/21/11 at 9:00 a.m. E19 RN (Registered Nurse) stated that between residents the Blood Glucose Monitoring machine is cleaned with an alcohol pad for two minutes before proceeding to the next resident.

The facility's policy provided at time of the survey did not address the cleaning of Glucose Monitoring Machines with multiple resident use. E2 stated on 07/21/11 at 9:30 a.m. that the manufacturer of the Glucose Monitoring Device the facility used was not contacted regarding the cleaning procedure for multiple resident use.

Information provided by the facility documents that R2, R5, R30-R36, and R38-R40 as well as R26 and R37 receive blood glucose monitoring on a regular basis.

B. Based on observation and interview the facility failed to maintain a clean field and wash hands during treatments and care for two of two residents (R3, R10) reviewed for infection control in the sample of 18.

Findings include:

1. On 7/20/11 at 10:00 a.m.E17 and E18 CNA's (Certified Nursing Assistant) entered R3's room to provide incontinence care. After E17 and E18

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F 441	Continued From page 8 entered the room they proceeded to gather belongings with ungloved hands for incontinence care from dresser drawers within the room. E17 and E18's hands were not washed prior to donning gloves. E18 laid towels and supplies on R3's bed without establishing a clean field to work from. E18 then proceeded to pull the privacy curtains with gloved hands. E17 placed a gait belt around R3 and assisted her to bed with same gloves donned. E17 and E18 positioned R3 and began removing clothes and soiled brief. R3 was cleaned of bowel and urine. E17 and E18 removed soiled towels and incontinence pad and placed a clean incontinence pad under R3 with original gloves on. E17 then applied a barrier creme to R3's buttocks without changing gloves. R3's cares were completed, E17 removed gloves in R3's room and failed to wash his hands prior to leaving the room. E17 and E18 acknowledged immediately after exiting R3's room forgetting to wash their hands, changing gloves and establishing a clean field before cares. 2. R10 was admitted with two pressure ulcers with orders to treat daily. On 7/19/11 at 9:30 AM, E16(Licensed Practical Nurse) gathered the treatment supplies and entered R10's room. E20 (Certified Nurse Assistant) was in the room giving pericare to R10. Soiled linen and soiled incontinence pad were laying on the floor beside the bed. E16 picked up the soiled incontinence pad and placed it in the waste basket. E16 did not wash her hands. E16 placed the medication, cleaning solution and bandages directly on R10's bed linen without establishing a clean field. E16 donned two pairs of gloves and began removing the bandages from R10's two stage III pressure ulcers on the right gluteal and buttock. After cleaning the two wounds, E16 removed one pair	F 441		

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F 441	Continued From page 9 of gloves, touching the second pair of gloves with the soiled gloves and applied the ordered medication and clean bandages. E16 then applied skin prep to scabbed pressure areas on both heels without changing gloves and washing hands. On 7/19/11 at 11:30 AM, E16 stated that she realized that she should have washed her hands after picking up the soiled incontinence pad before donning gloves. E16 stated that she put R10's treatment supplies back in the treatment cart with other resident's treatment medications.	F 441		