STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145685	A. BUILDING _____ B. WING _____	11/19/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNT VERNON COUNTRYSIDE MANOR	606 EAST IL HWY 15 MOUNT VERNON, IL 62864

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Annual Licensure and Certification Survey After Hours Survey.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164		

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

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F 164	Continued From page 1 Based on observation, and record review, the facility failed to ensure visual privacy for 3 of 16 residents (R1, R2, R3) reviewed for privacy in the sample of 16 and 1 resident (R24) in the supplemental sample. Findings include: 1. At 1:15 PM, on 11/16/15 E7 (Licensed Practical Nurse) was in R2's room. E7 did not close the door to the hall, the window curtain or the privacy curtain around R2's bed before she lifted R2's shirt and exposed R2's abdomen while she disconnected the gastric tube. R2's abdomen was visible from the hallway at this time. Two visitors were present in R2's room at the time. Another visitor was also present in the hall way at this time. The facility's Medication Administration and Flushes of Gastric Tube policy dated 02/07/05 , number six under procedure notes to screen the resident for privacy before discontinuing the gastric feeding. 2. R24's room door was open and a privacy curtain partially pulled around R24 seated on a bed-side commode on 11/17/15 at 10:00am. R24's right thigh was visible at the time of the observation. Certified Nurse Aides (CNA) E5 and E11 were in the room with R24 at that time and R24 was heard to say to the CNA's in the room, "I'm not done yet." 3. On 11/16/15 at 3:45PM, E16 (Registered Nurse) was performing a blood glucose test on R3 in her room. E16 did not pull the privacy curtain between R3 and R22's beds. R3's roommate, R22, was in her bed with a visitor at the bedside. 4. On 11/17/15 at 1:30 PM, E13 CNA (Certified	F 164		

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F 164	Continued From page 2 Nurse Aide) walked into R1's room to do his ROM (Range of Motion) exercises. While E13 was doing R1's ROM she did not ensure the door was closed or the privacy curtain was pulled between R1 and the roommate. R1's roommate was in bed at the time of the observation.	F 164		
F 225 SS=C	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 or licensing authorities. 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). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225		

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F 225	Continued From page 3 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to check with the licensing authority prior to hire for one of three licensed nurses (E22) reviewed for pre-employment screening. These failures have the potential to affect all 80-residents of the facility. Findings include: 1. E2 (Director of Nursing) stated on 11/16/15 at 2:40 PM , that E22(Registered Nurse) was currently employed at another facility and presented her with an active nursing license so she did not check E22's licence status with the Department of Professional Regulation. E22's pre-employment file included a Health Care Worker back ground check dated 09/08/15 and a current Nursing Licence that expired 05/31/16 . The file did not contain information regarding E22's licensure status from the Department of Professional Regulation. 2. The Facility's Resident Census and Conditions of Residents form dated 11/15/15 , documented the facility had a census of 80 residents.	F 225		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315		

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F 315	Continued From page 4 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 provide catheter care for indwelling urinary catheters per the facility policy and procedures and the residents Plan of Care for 2 of 2 residents (R1, R6) reviewed for catheter care in the sample of 16. Findings Include: 1. On 11/15/15 at 9:30 AM, R1 had a large bowel movement in his adult brief that ended up on both of residents legs (front, back and inner), abdomen, entire perineal area both front and back. E8 CNA (Certified Nurse Aide) and E9 CNA placed R1 on the toilet to provide incontinence care and R1 was noted to have an indwelling urinary catheter. Halfway through the incontinence care, E9 went out into the hallway and got dry washcloths. E9 only placed water on the wash cloths and no soap or other cleaning products were applied. E9 then proceeded to finish R1's catheter and incontinence care. E9 also cleaned the Indwelling urinary catheter with just the wet washcloth. There were also feces on the stool and R1's catheter tubing touched the feces on multiple occasions and at the end was only washed with the water wash cloth and no	F 315		

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F 315	Continued From page 5	F 315		

soap or cleansing product. During the cleansing of R1 ' s penis E9 on multiple occasions wiped feces around the public area in a downward motion from the base of the penis toward the tip of the penis. E9 also did not ensure that all the feces were removed from all other body parts before finishing with the penis. At no time did E9 cleanse R1's penis in a circular motion starting at the tip and going all the way to the base to ensure complete cleansing. E8 went to get a replacement strap for R1's leg bag because the strap and bag had been soiled with feces. The leg bag was only cleansed with a wet wash cloth and no soap or cleaning agent.
On 11/15/15 at 10:00 AM, E9 confirmed she had only put water on the washcloth when she had returned to finish R1's incontinence care.
According to R1's Care Plan with initiation date of 9/23/15 he is at risk for urinary tract infections related to having and indwelling catheter and under interventions states to give good pericare every time resident is incontinent
According to the facility policy titled " Perineal Care and Urinary Incontinence Care " dated 8/10/05 states under equipment to have peri-wash or soap and for male residents states: If resident has had incontinent urine or feces above the perineum, be sure to begin by cleansing above the penis and the inner thighs using clean technique. Cleanse area around the penis from front to back. Grasp the penis gently with one hand and wash the penis with the other hand. Begin at the meatus and wash in a circular motion toward the base of the penis.
According to the facility policy titled " Perineal Care (Catheter Resident) " dated 4/96 states the purpose is to cleanse the perineum and to prevent infection and odor, as well as, guard against urinary tract infections. Stated to have

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F 315	Continued From page 6 warm water and soap and cleanse around the meatus with a washcloth and warm, soapy water. States to use a clean part of the wash cloth and cleanse the catheter tubing to about 3 inches away from the meatus. For the male resident, using a clean washcloth, cleanse the penis in a circular motion from tip to base. 2. On 11/15/15 at 10:40 AM, E5 and E12 both CNA's had gotten R6 up out of bed and placed her in the recliner in her room. After both staff left R6's room, they acknowledged they had completed R6's care at that time. R6's indwelling urinary catheter tubing was noted to be touching the floor on the right side of the chair as well as her catheter bag under the chair's foot. R6's catheter bag also had no protective covering. On 11/16/15 at 12:15 PM, E11 CNA exited R6's room with her meal tray and indicated she had finished with the resident. R6 was in her low bed and her indwelling urinary catheter tubing and bag was lying on the floor on the right side of the bed. R6's catheter bag also had no protective covering. On 11/16/15 at 10:50 AM, Z1 (Family Member) stated that she on more than one occasion noted R6's indwelling catheter is not being taken care of the right way, with the tubing and bag touching the floor and she has even had to go and complain to the nursing staff about it because R6 has issues with recurring urinary tract infections. According to R6 ' s Care Plan with initiation date of 11/4/15 she has an indwelling catheter, has chronic urinary tract infections and receives a long term antibiotic	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

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F 323	Continued From page 7 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to implement identified interventions in the residents Care Plan to help prevent falls for 1 of 7 residents (R1) reviewed for falls in the sample of 16. Findings include: On 11/15/15 at 9:30 AM R1 was noted to be in a room at the end of the hallway, which is visually the farthest room away from the nurses station According to R1's Quarterly Care Plan dated 9/23/15 documents falls on 7/29/15, 8/9/15, 8/16/15, 2 falls on 8/29/15 and 9/21/15. Review of fall documents for R1 also shows a fall on 6/18/15. On 8/17/15 the resident had a fall and the new intervention is that the facility will place anti-roll back devices on R1's wheelchair to prevent chair from moving if resident forgets to lock the chair in place in the future. Documentation from 9/2/15 shows the resident transferred himself from the recliner to the wheelchair and fell. R1, on the same day had an additional fall off the bed later in the day with no noted injuries. Documentation from 9/2/15 states that upon investigation it was found that resident did not have the correct wheelchair with anti-rollbacks on it. Resident transfers himself frequently and does not lock his brakes. On 11/18/15 at 2:45 PM, E14	F 323		

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F 323	Continued From page 8 MDS/CPC(Minimum Data Set/Care Plan Coordinator) stated she had been doing the reviews of the falls and updating the falls and doing the root-cause-analysis with the interdisciplinary team since September this year. E14 stated that R1 did not have the correct wheelchair with the two falls on 8/29/15 that had been identified as a concern and contributing factor with those falls. E14 stated that at that time E14's Care Plan stated he should have an anti-rollback chair and he did not on that day. E14 confirmed R1's falls are due to him transferring himself without assistance or supervision.	F 323		
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to provide liquids at the consistency ordered by the physician for 1 of 1 resident (R8) reviewed for thickened liquids in the sample of 16 and 2 residents (R17 and R18) in the supplemental sample. Findings include: On 11/15/15 at 9:35AM, an plastic container containing white granules and labeled with R8's name was sitting on the bedside table in R8's room. At this time, E2 (Director of Nurses) stated this is a food thickener. There was no measuring	F 365		

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F 365	Continued From page 9	F 365		

device noted in the room. On 11/15/15 at 10:25AM, a plastic container containing white granules and labeled with R17's name and directions for nectar thickened liquids was sitting on the bedside table in R17's room. The label stated for nectar consistency to add 1 1/2 tablespoons to 4 ounces of liquid. There was no measuring device noted in the room. On 11/16/15 at 3:00PM, E3 (Food Service Supervisor) stated the thickener is to be labeled with the name of the resident, consistency and measurement needed.

E18 (Certified Nurse Aide-CNA) stated on 11/18/15 at 10:30AM, she follows the label to thicken the liquids and uses a plastic teaspoon to measure. E18 stated to thicken the liquids for nectar consistency she uses 3 teaspoons to equal 1 1/2 tablespoons. On 11/18/15 at 10:55AM, E19 (CNA) stated R18 is on thickened liquids and the container label explains the measurement needed. At this time, the label on R18's container stated for Nectar thickened to add 1 1/2 tablespoons to 4 ounces of fluids. E19 stated she thickens the liquid according to the drink. E19 stated if it is milk she uses 1 1/2 tablespoons, juice 1 tablespoon and if it is water she uses 1/2 tablespoon. E19 added that 1/2 tablespoon is equal to 1 1/2 teaspoons. This surveyor asked why E19 uses different measurements. E19 stated because they thicken differently.

On 11/18/15 at 10:00AM, a pitcher of water at regular consistency was sitting in R17's room on the over the bedside table. On 11/15/15-11/18/15 at various times throughout the day, R17 was propelling herself about the facility in her wheelchair.

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F 431	Continued From page 10	F 431		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, 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:	F 431		

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Based on observation, interview and record review the facility failed to ensure discarded medications were being stored in a secure location, to indicate the date an injectable medication was opened and failed to maintain visual control of medications while administering medication. This has the potential to affect all 80 residents living in the facility

Findings include:

The Facility's Census and Conditions of Residents form dated 11/15/15, documents the facility had a census of 80 residents.

1. At 9:50am on 11/17/15 a key hanging outside the biohazard room opened the door and allowed entry to the unattended room. A red sharps container filled with many (1 to 1 1/2 inches in depth / to numerous to count) unidentified pills, tablets, medication vials, the outer packaging for medication patches and syringes was observed on the counter. The sharps container was further found to have a lid that could be removed from the base to allow access large enough for the products inside to be removed by hand.

2. At 12:20pm on 11/16/15 E7 (Licensed Practical Nurse) put medication for R1 on the dining room table while R1 was eating. E7 poured the pills on the bare table top. E7 was observed to walk away from R1 to the other side of the dining room and did not observe R1 taking the medication. R1 was observed to roll the pills to the edge of the table to better grip each one before putting the pill in his mouth. E7 was questioned about placing R1's pills on the table top and E7 replied that is how R1 likes them. The facility's Medication Administration policy dated

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F 431	Continued From page 12 11/96 page 2 j. states in part..."The nurse administering the medication shall remain with the resident until the medication is swallowed." 3. On 11/17/15 at 10:45 AM in the facility medication room in the refrigerator the following was noted: *In the freezer area there were large amounts of ice filling up over half of the area. *On the underneath side of the freezer into the refrigerated area there was clear liquid dripping. These drops were noted to be dripping onto medications on the top self. *There was also a pool of clear liquid the size of a quarter in the middle of the top shelf. *The box to R1's Compazine was noted to be wet and coming apart. *Where the dripping liquid was noted there were 17 loose stock Bisacodyl Suppositories and 30 loose Acetaminophen 650 mg (milligram) suppositories. *There was an open bottle of Tubersol Solution with a lot # of C4583AA that did not have a date when it was open When questioned E7 LPN at that time stated it was supposed to be dated when it was opened because it is only good for so long and she thought it was only a week or two. According to the undated facility document titled " Storage and Maintenance of Medication " it stated all drugs are to be stored under proper temperature controls. The refrigerator must maintain a proper temperature and be kept clean and organized.	F 431		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an	F 441		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 13 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 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, record review and	F 441		

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	145685	A. BUILDING _____ B. WING _____	11/19/2015

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interview, the facility failed to adequately disinfect blood glucose monitors after resident use, failed to maintain aseptic technique during care of residents and failed to prevent cross contamination during storage of resident care equipment. These failures have the potential to affect all 80 residents living in the facility.

Findings include:

The facility's Resident Census and Conditions of Residents form dated 11/15/15 documented the facility had a census of 80 residents.

1. E10 (Licensed Practical Nurse) came out of resident room 108 on 11/17/15 at 9:55am carrying a obviously wet washcloth by the corner with bare hands. E10 was continually observed from that time to place the washcloth in a barrel, walk to the nurses station, enter the medication room, touch the medication cart and medication cart computer, leave the medication room, tidy a medication cart by the nurses station and take a liquid supplement and cooling container to another room. There was no hand washing or hand sanitizing observed during the entire observation.

2. E21 (Certified Nurse Aide, CNA) removed a purse from a locked cart on the 100 hall on 11/17/15 at 10:05am. E21 stated at that time that the locked cart stored CNA supplies for the residents Activities of Daily Living (ADL) for example; incontinent briefs and water for oxygen concentrators. The cart also held CNA's personal belongings including: bottled soda, a disposable coffee cup and the purse removed by E21 intermingled with the resident supplies. A second locked CNA cart on the 200 hall was observed at

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F 441	Continued From page 15 10:22am with personal belongings (plastic containers of food and an unsealed sports drink) stored with the residents ADL care supplies. 3. On 11/17/15 at 10:22am the rinse hose was submerged in the hopper on the 300 hall in the soiled utility room. 4. On 11/17/15 at 9:50am in the biohazard room a clear bag of soiled linen with obvious brown material on the items in the bag were sitting on the top of a biohazard barrel. 5. On 11/15/15 at 9:30 AM, in the bathroom that is shared by R1 and R27 on the bathroom sink there were three uncovered, used disposable razors with no names. On 11/15/15 at 10:15 AM, E9 (Certified Nurse Aide, CNA) stated both R1 and R27 used disposable razors and they should be labeled and they should not be left out on the sink. E9 further stated these items should not be shared by residents and should not be left out and unlabeled in the bathroom 6.On 11/15/15 at 9:30 AM, R1 had an incontinent episode and the gel cushion in his wheelchair was soiled. E8 (CNA) and E9 did not clean the cushion and then placed the resident back on the soiled cushion after the incontinence care. When questioned at that time E9 stated she should have cleaned the cushion with some kind of disinfectant cleaner. 7.On 11/17/15 at 11:45 AM, E7 LPN (Licensed Practical Nurse) went in an office across from the beauty shop to do a blood glucose test for R17. When E7 went into the office she placed the blood glucose monitor on top of the desk without any barrier. 8.On 11/17/15 at 12:00 PM, E7 went into the Physical Therapy room to perform a blood	F 441		

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glucose test for R23. When E7 went into the room she placed her blood glucose monitor on top of a bedside table and did not place a barrier on top of the table. E7 then placed the contaminated machine in R23's hands so she could do self teaching with R23. When E7 was finished she exited the room and R23 was assisted out by another staff. E7 then proceeded to give R23 her oral medication E7 did not wash her own hands or R23's hands. E7 then placed R23 ' s medications in R23's hand. When questioned why she had put the medication in R23's hand, E7 stated at that time that was R23's preference. When asked E7 why she would not make sure R23 ' s hands were clean, E7 was unable to answer the question.

9.On 11/15/15 at 10:30 AM, E10 (LPN) was doing R1's ordered treatment/dressing to his buttock. When E10 removed R1's soiled dressing. E10 did not wash her hand or put on clean gloves before she applied R1's clean treatment/dressing. When questioned E10 stated she should always change her gloves between clean and dirty and wash her hands in between taking off the old dressing and putting on the new one even if it is with alcohol gel.

10.On 11/17/15 at 1:30 PM, E13(CNA) was doing ROM (Range of Motion) exercises for R1. When she was finished doing his left foot, she took off her gloves and placed them on R1's mattress and did not clean her hands. R1 then put the gloves from the bed back on to do ROM to his right foot.

11.During the facility tour on 11/15/15 at 9:40AM, a bed pan was resting on the grab bar in a bathroom shared by rooms 308 and 309. Also, observed was a graduated container sitting on the floor. Neither of these items were labeled with a resident's name or in a plastic bag. At 10:15AM, 2 fracture style bedpans were resting on the grab

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bar and one bedpan was observed sitting on the floor in a bathroom shared by rooms 304 and 305. Neither of these items were labeled with a resident's name or in a plastic bag. E1 (Administrator) stated on 11/19/15 at 10:45AM, the bedpans are to be placed in a plastic bag and put inside the resident's bedside table.

12. On 11/15/15 at 10:00AM, E6 (Registered Nurse-RN) was administering oral medications to R20. E6 left the medication cart to go to a refrigerator by the nurses's station to get orange juice and returned to the cart. E6 opened the medication cart and proceeded to mix Miralax into the orange juice. E6 then entered R20's room to administer the medications. E6 left the room and returned to the medication cart, poured oral medications for R21 and went into her room and administered the medications. E6 was not observed to wash her hands during this observation of this procedure.

13. On 11/15/15 at 2:28PM, E6 was getting into the medication cart and obtained a 10 cubic centimeter (cc) 0.9% Normal Saline (NS) syringe. E6 entered R21's room, discontinued an intravenous (IV) infusion and proceeded to flush the IV with the NS. E6 then left the room and disposed of the IV supplies. E6 did not wash her hands during the observation of this procedure.

14.On 11/16/15 at 11:15AM, E15 (RN) was performing a blood glucose test on R17. After performing the test, E15 returned to the medication cart and wiped the meter with a Super SaniCloth. E15 wiped across the meter for approximately 10 seconds and sat it on a dried SaniCloth that was on top of the cart. At 11:50AM, E15 administered oral medications to R23 and

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proceeded to R3 to do a blood glucose test. E15 was not observed to wash her hands between the two residents. E15 used the same meter that was used on R17. After the test, E15 wiped the meter with a Super Sanicloth for approximately 10 seconds and folded the cloth loosely over the meter.

15.On 11/16/15 at 3:45PM, E16 (RN) was performing a blood glucose test on R3. E16 entered the room and laid the meter on the bed linens prior to the test. After the test, E16 stated the meter is to be wiped for 30 seconds and placed on a barrier. E16 wiped the meter for approximately 15 seconds with a Super SaniCloth and sat it on top of the medication cart on a barrier.

16.On 11/17/15 at 12:15PM, E17 (Licensed Practical Nurse-LPN) was returning to the medication cart after performing a blood glucose test on R3. R3 placed the meter on top of the cart 1/2 on and 1/2 off a piece of paper. E17 wiped the meter for approximately 10 seconds with a SaniCloth and sat it on top of the cart on a barrier.

The manufacturer's label directions for the Super SaniCloth state the contact time is 2 minutes and then air dry. The SaniCloth states the item should be visibly wet for 4 minutes.

The Facility's 10/12 Disinfection of Equipment policy states, "1. Glucometer Disinfection: a. i. Place glucometer on barrier ii. Use Caviwipe to disinfect iii MUST remain visibly wet for three minutes and have dry time of three minutes. To ensure glucometer remains wet, you may wrap meter in a NEW Caviwipe. Remember MUST

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F 441	Continued From page 19 have three minute dry time on barrier." On 11/19/15 at 10:45AM, E2 (Director of Nurses) stated the facility changed from Caviwipes to the SaniClothes. E2 stated the nurses did not follow the facilities policy on disinfecting the meters. E2 also stated the nurses are to wash their hands between residents medication administration and before and after IV care.	F 441		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and record review the facility failed to provide an environment where resident care equipment, furnishings, window coverings, linen carts, nurse aide equipment carts, were clean and well maintained. This has the potential to affect all 80 residents in the facility. The findings include: The facility's Resident Census and Conditions of Residents form, dated 11/15/15, documented the facility had a census of 80 residents. 1. On 11/15/15 at 3:15pm five of the television / living room easy chairs were noted to have torn and tattered fabric on the arms of the chairs.	F 465		

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F 465	Continued From page 20 2. On 11/17/15 at 10:05am resident room 109 had a soiled mat under the bedside commode at the side of bed 1. At the bedside stand for bed 2 in the same room a dry meat salad sandwich was observed. Other food and used food containers were on the stand with the television set and the floor by this stand were unwrapped incontinence pads. 3. On 11/16/15 at 1:32pm R10 was seated in a wheelchair sleeping outside his room. R10's wheelchair was visible soiled with food debris and the wheelchair arms were tattered. R10's black shoes were also visible soiled with food debris. 4. On 11/17/15 from 12:00pm to 1:00pm in the main dining room the following resident wheelchairs, walkers and belongings were observed to be soiled with food debris: *R29's wheelchair was soiled *R4's wheelchair and attached backpack were soiled *R30's wheelchair was very soiled. *R31 and R32 both have wheeled walkers that were very soiled *R33's wheelchair was soiled and the arm rest fabric was cracked. During the facility tour on 11/15/15 between the hours of 9:35AM-10:40AM, the following was observed: -R25's recliner had brown stains on the seat and arms. -R22's wheelchair arms were cracked and torn. -R7's wheelchair arms were torn and tattered and his recliner had brown stains. -R10's wheelchair arms were torn and tattered.	F 465		

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F 465	Continued From page 21 5. On 11/15/15 at 10:30 AM, R2 ' s entire enteral feeding pump and pole was soiled with numerous spots of light brown, beige and off white substance. 6. On 11/17/15 from 10:30 AM to 3:00 PM all three of the medication carts where observed to have large amounts of loose pills in the bottoms of the draws. In the 100 hall medication cart there were over 10 loose pills/tablets/capsules. In the 200 hall cart there were over 15 loose pills/tablets/capsules. In the 300 hall cart there were over 25 loose pills/tablet/capsules.	F 465		