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	145717	A. BUILDING _____ B. WING _____	10/23/2015

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COLUMBIA REHAB & NURSING CENTER	253 BRADINGTON DRIVE COLUMBIA, IL 62236

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F 000	INITIAL COMMENTS	F 000		
F 309 SS=D	Annual Licensure and Certification Survey 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: A. Based on observation, interview and record review the Facility failed to adequately assess/monitor pain relief for one of 12 residents (R1) reviewed for pain control needs in the sample of 21. Finding includes: On 10/21/2015 at 12:20 PM, R1 was sitting in her room. R1 closed her eyes, grunts and let out a sigh. When asked if something is wrong, R1 stated, "My legs are bothering me and I am in a lot of pain." E2, Director of Nursing, was notified of R1 complaining of pain. On 10/21/2015 at 12:24 PM, E8, Certified Nursing Assistant (CNA), stated "(R1) had an acetaminophen tablet at noon as (R1) receives three doses a day: at 8 AM, 12 PM, and 5 PM." On 10/21/2015 at 1:20 PM, R1 was in her room lying in her bed. R1 moaned softly and stated,	F 309		

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

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"My legs still hurt; the medicine has not helped me."

On 10/22/2015 at 9:48 AM, R1 stated "My legs are hurting me again today and I am really tired."

On 10/21/2015 at 12:35 PM, E7, Therapy Manager, stated "(R1) had a CVA (Cardiovascular Accident) in July of 2015. (R1) was doing well and improving. (R1) went from a two person stand by pivot transfer to a mechanical lift and geriatric chair. (R1) has been complaining of pain and is able to verbalize the pain during therapy and has been declining in the last few weeks. (R1) has been having pain in her lower extremities and right arm. We are also noticing more muscle tone. (R1) has taken two steps back in therapy and I believe it's contributed to her pain."

On 10/21/2015 at 2:20 PM, E21, CNA, stated "(R1) has pain in her legs during care which started some time after her stroke, she has pain a lot in her legs."

On 10/22/2015 at 9:55 AM, E9 stated "(R1) occasionally complains of her legs and arm bothering her."

On 10/22/2015 at 9:10 AM, E3, Licensed Practical Nurse (LPN), stated "(R1) had a blood clot in the left leg and her leg bothers her sometimes."

On 10/22/2015 at 9:20 AM, E4, CNA stated "(R1) sometimes complains of pain in her legs."

R1's Medication Record Pain Assessment from 10/1-10/21/2015 documented R1 had no pain each day and shift during this time period.

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R1's October 2015 Physician's Order Sheet (POS) documents Acetaminophen was prescribed 500 milligrams (mg) three times a day, and 500 mg every six hours as needed for pain. R1's Medication Administration Record (MAR) for October 2015 documents on 10/20/2015, the day of the survey, the only extra dose of acetaminophen being administered for pain.

R1's Daily Skilled Nursing Notes do not document any pain for the month of September of 2015.

R1's Treatment Encounter Notes, dated 10/12/2015, document (R1) demonstrated increased left upper extremity pain and increased tone. R1's Treatment Encounter Notes, dated 10/21/2015, document in part "demonstrates increased left upper extremity pain and increased tone."

On 10/22/2015 at 11:20 AM, Z1, R1's Physician, asked E7, if (R1) is having pain during therapy and E7 states "Yes." Z1 stated "No one had notified me of (R1) having any pain. Therapy should have told the nurses so the nurses could have communicated with me. This is definitely a break down in the system."

B. Based on observation, interview and record review, the facility failed to apply dressing as ordered for one of one residents (R10) reviewed for wounds in the sample of 21.

Findings include:

R10's Minimum Data Set (MDS), dated 8/26/15, documents R10 is cognitively intact.

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F 309	Continued From page 3 On 10/20/15 at 11:23 AM, R10 was lying in bed. R10's right lower extremity was uncovered. There was an open wound area to R10's right lateral ankle with several dark black areas. R10's right ankle had no dressing in place. At 2:02 PM on 10/20/2015, R10's right ankle wound still was still open to air with no dressing in place. R10 stated, "I had a dressing on my leg yesterday, but I haven't had one on it yet today." At 2:10 PM on 10/20/15, E14, LPN, stated that the dressing is suppose to be done every day. E14 then applied a dressing to R10's right ankle wound. R10's Physician's Order (PO), dated 10/17/15, documents "1. wet to dry dressing to eschars right ankle, 2. Hydrogel to open wound right ankle with dry dressing and discontinue skin prep to right ankle ulcer." R10's PO, dated 10/20/15, documents to cleanse right lateral ankle wound with Normal saline, apply hydrogel with dry dressing daily. On 10/22/15 at 9:51 AM, E2 stated "I would expect them to have it (R10's wound) covered. Even if there was a question of what type of dressing, I would expect it to be covered until the order was clarified."	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the Facility failed to provide assistance with eating, grooming and complete incontinent care for 2 of 21 residents (R12, R14) reviewed for assistance with Activities of Daily Living (ADLs) in the sample of 21.

Finding include:

1. On 10/20/15 at 1:09 PM through 1:20 PM, R14 was in the dining room with her tray on the table beside her, but she was not eating and almost all of her lunch was still on her tray. No staff encouraged R14 or assisted her to eat. R14 also had 1/2 -3/4 inch long hairs present on her chin.

On 10/21/2015 at 9:05 AM , R14 was reclined in her geriatric chair in the dining room. R14's breakfast was on the table. R14 had her eyes closed and was not eating her breakfast. R14 had not touched her breakfast. No staff cued R14 to eat or assisted her with eating. At 10/21/2015 at 9:35 AM, E22, Certified Nursing Assistant (CNA) asked R14 if she wanted any more breakfast, R14 did not respond and stared into space. E22, then removed R14 from the dining room. No breakfast was consumed or touched by R14.

On 10/21/15 at 12:16 PM, R14's long chin hairs were still present. R14's tray was delivered to her at 12:29 PM. R14 started eating her cake. At 12:34 PM, R14 was drinking her milk, but no longer eating. From 12:34 PM through 12:50 PM,

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R14 only consumed 1/2 of her cake. No staff encouraged or assisted R14 to eat.

On 10/23/2015 at 10:10 AM, E17, CNA, stated "(R14) can eat by herself and if she is sleeping staff is suppose to wake her up and encourage her to eat. We do not assist (R14) with feeding, but we do tell her to eat. If she does not eat anything, then we are suppose to go and get a nurse."

R14's Minimum Data Set (MDS), dated 08/03/2015, documents R14 requires supervision-oversight, encouraging or cueing for eating and extensive assistance of one person for personal Hygiene.

R14's most current Care Plan, Revision on 11/12/2014, documents R14 needs extensive to total assistance for most ADL's to remain clean, neat and free from body orders. R14's Care Plan also documents "EATING- (R14) requires set up assistance of 1 staff at all meals. She can feed herself, however staff do encourage her to consume adequate amounts daily as needed."

2. On 10/21/15 at 11:02 AM, E15 and E16, CNA's, provided perineal care for R12 for urinary incontinence. E15 cleaned R12's perineal area, but failed to clean his scrotum.

The facility's Perineal Care policy, revised 2015, documents (in part) "Steps in the Procedure: 6. For a male resident: (3) Continue to wash the perineal area including the penis, scrotum and inner thighs."

On 10/22/15 at 9:50 AM, E2, Director of Nursing (DON), stated that she would expect the CNA's to

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F 312	Continued From page 6 do complete hygiene and pericare, including the scrotum for males. On 10/23/15 at 9:58 AM, E1, Administrator, stated "I don't have a policy on ADL's. We use ADL tracking on the computer. Same thing with meals, we use the ADL tracking and meal assessment." Regarding R14, E1 stated "(R14) is a cuer. If a resident is not eating, the staff should encourage and cue her to eat, then notify the nurse."	F 312		
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 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 complete incontinent care to prevent a potential urinary tract infection (UTI) for 1 of 3 residents (R2) reviewed with a history of UTI's in the sample of 21. Findings include: R2's Minimum Data Set (MDS), dated 7/25/15,	F 315		

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F 315	Continued From page 7 documents R2 has severe cognitive impairment, is incontinent of bowel and bladder, and requires extensive assistance for all personal care. R2's Diagnoses Report, dated 10/14/15 documents a history UTI. On 10/20/15 at 1:45 PM, E11, Certified Nurse Aide (CNA), provided perineal care for R2 for urinary incontinence. E11 washed each side of R2's groin, but failed to separate and cleanse between the labia. On 10/22/15 at 9:50 AM E2, Director of Nurses, (DON), stated, "I would expect complete hygiene and pericare including the scrotum for males and between the labia for females. Gloves should be changed and sanitize hands or wash hands when going from dirty to clean areas." The facility's undated Perineal Care policy documents, in part, "5. For female resident: b. (1) Separate labia and wash area downward from front to back."	F 315		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer medications at the ordered time. There were 25 opportunities with 2 errors resulting in a 8% medication error rate. The errors involved one	F 332		

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resident (R23) in the supplemental sample out of 7 residents observed during medication administration.

Findings include:

On 10/21/15 at 1:04 PM, E10, Registered Nurse (RN), administered Levemir insulin 20 units and Novolog insulin 15 units subcutaneously to R23's left lower quadrant abdomen. E10 stated at that time, "I waited to see how her appetite was before giving. She (R23) already ate, ate well."

R23's Admission Physician Order Sheet (POS), dated 10/20/15, documents the orders "Levemir 20 units subcutaneous BID (twice daily)" at 9:00 AM and 8:00 PM, and "Novolog 15 units subcutaneous TID (three times daily) AC (before meal)" at 7:00 AM, 11:00 AM, and 5:00 PM.

On 10/22/15 at 8:08 AM, E10 stated, "I gave the Levemir late after lunch at her (R23) request because that was they way it was given in the hospital. I talked to (Z2, R23's Physician) and told him that I gave it late and he said that was ok. I will get her back on schedule today. No, I didn't write an order or a note about it."

On 10/22/15 at 1:28 PM, E2, Director of Nursing (DON), stated "I would expect the nurse to notify the MD (Medical Doctor) if the insulin was not going to be given in the time frame of within one hour before and within one hour after it was ordered and get orders for later administration."

On 10/22/15 at 3:00 PM, Z3, Consultant Pharmacist, stated that it is not optimal for either the Novolog or the Levemir to be given late as it was for R23. Z3 stated it is better to give the

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F 332	Continued From page 9 Novolog right before the food. Z3 also stated that he wouldn't want this late administration to be repeated. The facility's Six 'Rights' for Administration of Medications policy, updated 6/19/12, documents (in part) "5. The right time: administer drugs as instructed on the MAR (Medication Administration Record) and within the time frame established by your facility." The facility's Tips for Safe Medication Administration policy, updated 6/9/12, documents (in part) "3. Accurately dispense medications to residents. Allow one (1) hour before to one (1) hour after schedule time of medication to administer medication."	F 332		
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	F 441		

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determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the Facility failed to follow isolation precautions and complete handwashing to prevent the spread of infection for 10 of 21 residents (R1-R5, R7, R11, R12, R14, R15) in the sample of 21 and 33 residents (R23, R24-R36, R38, R39, R41-R58) in the supplemental sample.

Findings include:

1. On 10/21/2015 at 10:05 AM, E5, Certified Nursing Assistant (CNA), was in R11's room on the 200 Hall wearing Personal Protective Equipment, including a gown and gloves. There was a sign for Contact Precautions on the R11's door. E5 stood in the door way and handed E6, CNA, four red bags with a biohazard label on them. E6 was not wearing any gloves at the time

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and proceeded to the eye station where she donned one glove and walked all the way to the 300 Hall. E6, knocked on the Soiled Utility Holding Room door and waited. E6, then placed the four red bags on the floor and knocked again until the door was answered. E6, then proceeding back to the 200 Hall, moved a yellow "caution wet floor" cone and then proceeded to wash her hands.

2. On 10/21/15 at 12:55 PM, E10, Registered Nurse (RN), stated R23 was on contact isolation for a MDRO (multi drug resistant organism) in her urine. There was a sign for Contact Precautions on R23's door. E10 donned an isolation gown and gloves, took a stethoscope, pulse oximeter, and R23's insulin pens into the room. After administering the insulin to R23, E10 stepped out of the doorway to her medication cart and placed the insulin pens directly on top of the medication cart. E10 continued to wear the same gloves as she reached around the isolation gown and into her pocket to get her keys, unlocked the medication cart, and then placed the keys back into her pocket. E10 picked up papers on her medication cart with the same soiled gloves. E10 picked up her cell phone with the same soiled gloves and replaced it on the top of the medication cart. E10 removed the soiled gloves, washed her hands, removed the isolation gown, and sanitized her hands. E10 donned gloves and used bleach wipes to wipe off the insulin pens and the area of the medication cart where they were laying. E10 continued to wear the same gloves as she opened the medication cart drawer to put away a box of nebulizer solution. E10 removed the gloves, but did not sanitize or wash her hands. E10 picked up the paper that she had touched earlier with her soiled gloves and used

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her pen to write on the paper. E10 picked up her cell phone that she had touched earlier with her soiled glove and placed it into a glove. E10 stated she was going to let R23 use her phone. E10 had left the stethoscope and pulse oximeter on first bed in the isolation room. E10 donned gloves and stepped into the room to retrieve the equipment. E10 used a bleach wipe to clean the stethoscope and pulse oximeter and placed them onto the medication cart. E10 used the same gloved hands to lock the medication cart. E10 opened the isolation cart and stated that they did have dedicated equipment for R23, but she did not use it. E10 then removed her gloves.

The October 2015 Infection Control Report documents R23 is on contact isolation for MDRO Escherichia coli urinary tract infection.

On 10/23/2015 at 11:30 AM, the Facility provided a list of residents residing on the 200 Hall (R4, R11, R14, R15, R24-R34), 300 Hall, (R1, R5, R7, R35, R36, R38, R39, R41, R42-R53) and part of the 400 Hall that (R3, R54-R58) who would be affected by the Infection Control Breach. The facility identified the residents on 200 Hall and part of 400 Hall as those that would have medications administered from E10's Medication Cart.

3. On 10/20/15 at 1:45 PM, R2 was incontinent of urine. E11, CNA, took a damp cloth and washed each side of R2's groin with separate areas of the cloth, then dried the area using the same soiled gloves. E11 changed gloves without washing or sanitizing her hands. R2 was rolled to the right side and E12, CNA, used a wet cloth to wipe R2's right gluteal area and back. E12 then dried the area using the same soiled gloves. E11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145717	A. BUILDING _____ B. WING _____	10/23/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLUMBIA REHAB & NURSING CENTER	253 BRADINGTON DRIVE COLUMBIA, IL 62236

(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
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left the room without washing hands, and returned with clean linen for E12 to cleanse R2's left gluteal area and upper back. E12 took off the soiled gloves and sanitized her hands. E12 threw the gloves across R2's bed toward the trash can. The soiled gloves missed the trash can, landing on the floor. E11 donned new gloves and tied up the bag of dirty linen before removing the soiled gloves. E11 donned the right glove, picked up all bags, carried them to the bathroom and put on them on the floor. E11 washed her hands and applied a glove to the right hand. E11 picked up bags containing soiled linens and opened the door with an ungloved left hand.

On 10/22/15 at 9:50 AM, E2, Director of Nurses, (DON), stated, "Gloves should be changed and sanitize hands or wash hands when going from dirty to clean areas."

On 10/22/15 at 10:00 AM, E2 stated, "Once entering the room, don't come out without degowning and degloving, sanitizing or wash hands before touching equipment outside of the room. We usually have dedicated equipment for isolation rooms."

4. On 10/21/15 at 11:02 AM, E15 and E16, CNA's, provided perineal care for incontinence for R12. E15 washed R12's perineal area. E12 used the same gloves to dry R12. E15 continued using the same soiled gloves to wash R12 rectal area and then dry him.

On 10/21/15 at 11:11 AM, E20, Licensed Practical Nurse (LPN), washed her hands, donned clean gloves, closed R12's privacy curtain

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contaminating the gloved hands, then proceeded administering medications via R12's gastrostomy feeding tube.

On 10/23/15 at 1:36 PM, when asked if a person touches the privacy curtain with gloved hands before administering medications through a tube feeding what would be expected, E2, Director of Nursing, stated, "I would expect a person to have clean gloves on when they proceeded with delivering a tube feeding."

The Facility's undated Infection Control Policy/Procedure Hand washing/Hand Hygiene documents, in part, "When to use alcohol based rub: If hands are not visibly soiled, use an alcohol based rub for all the following situations. 6. Before moving from contaminated body site to a clean body site during resident care. 9. After contact with inanimate objects, (for example), medical equipment in the immediate vicinity of resident; and/or 10. After removing gloves. When to wash hands: 3. After excretions (feces, urine, or material soiled with them) or secretion (from wounds, skin infections, etcetera.) before touching any resident again. 4. After caring for an infected or contaminated resident. 10. Before and after use of gloves, gowns, and masks."

The Facility's undated Isolation Policy/Procedures documents, in part, "Remove the gown before exiting the room, Remove gloves before leaving the room and wash hands immediately with an anti-microbial agent. If unable to wash hands immediately after removal of gloves, an approved alcohol based hand rub can be used until hands can be washed. After removing your gloves and washing your hands, do not touch potentially contaminated environmental surfaces or items in

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F 441	Continued From page 15 the resident's room."	F 441		