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	145736	A. BUILDING _____ B. WING _____	C 12/12/2014

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ALDEN TOWN MANOR REHAB & HCC	6120 WEST OGDEN CICERO, IL 60804

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F 000	INITIAL COMMENTS Complaint investigation Federal Oversight Support Survey A partial extended survey was conducted. 1494762/IL72792 - F167, F225, F226, F281, F333, F312, F441, F456, 300.661	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, facility failed to ensure facilities last annual licensure and certification survey of 5/8/14 was in binder identified as containing facility complaint and survey results. This deficient practice can affect all visitors and residents in the facility. The facility census on 11/18/14 was 183 residents. Findings include: According to the facility's daily census on 11/18/14 the census was 183 residents. On 11/19/14 at 2:00 pm binder identified as containing facility annual licensure and	F 167		

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

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F 167	Continued From page 1 certification results did not contain survey results for facility ' s last annual licensure and certification. On 11/20/14 at 10:00 am E1(Administrator)acknowledged the facilities last annual was not where it should have been.	F 167		
F 225 SS=F	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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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, facility failed to follow their abuse policy and thoroughly investigate and/or immediately report to administrator and/or notify the Illinois Department of Public Health of allegations of abuse for 12 of 16 residents (R2,R3, R1,R10,R11,R12,R13, R14, R15,R17, R19, R20) all reviewed for allegation of abuse.
In addition the facility failed to initiate a reference check from previous employers for all indirect health care employees who started after 5/8/14 for a total of 6 employees(E11, E15, E14, E17, E13 and E10)out of 6 reviewed for pre-employment reference checks and for 24 out of 24(E5,E6, E7,E8, E9, E29, E30, E33, E34,E35, E36, E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47, E48, E49) employees who are direct care workers hired after 5/8/14 reviewed for pre-employment checks.
Facility failed to ensure Illinois Department of Corrections prescreening was performed for 23(E5, E6, E8, E9, E29, E30, E33, E34, E35, E36,E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47, E48, E49) of 26 employees reviewed for screening for sex offenses placing all residents at risk of potential abuse.
These failure has the potential to affect all 183 residents in the facility.
Findings include:

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Facility data sheet on entrance of 11/18/14 documents a census of 183.
1. Requested all reportable incidents and complete investigations since facility ' s last annual licensure and certification of 5/8/14 from E1(administrator) on entrance as documented on facility data sheet of 11/18/14.
On 11/18/14 at 10:30 am R3 stated she had ben inappropriately touched by " Mexican " who lives here yesterday. On 11/18/14 at 4:30pm E3(Social Worker) stated, " Saw(R3) yesterday morning. She said past couple days he ' s touching her in private areas or butt. Reminded staff nowhere near each other. I told (E1, Administrator) yesterday same day. (R3) told me in the morning. I told (E1, Administrator) in afternoon. This is new allegation of abuse. 1 to 3 hours elapsed before I told administrator. I don ' t know if any investigation after that. "
No accident/incident was presented by facility for R3 with date of 11/17/14. On 11/18/14 at 6:30 pm E1(Administrator) stated, " (E3) mentioned yesterday. She(E3, Social Worker) mentioned (R3) said someone touched her. I took it as same allegation from last week. I can ' t remember wording. " There was no investigation of this new allegation of abuse by E1(Administrator).
Facility policy titled, " Abuse prevention Program, " dated 5/8/14 page 6, states under point 4 Identification, " Employees are required to immediately report any occurrences of potential mistreatment they observe, hear about, or suspect to a supervisor or the administrator, " and " Supervisors shall immediately inform the administrator or designee of all reports of potential mistreatment. Upon learning of the report, the administrator or designee shall initiate an incident investigation. Page 7 point 6 labeled

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" Investigation " of this policy requires, " a. Appoint an investigator. Once an allegation has been made, the administrator or designee will investigate the allegation and obtain a copy of any documentation related to the incident. " Page 8 of policy point 7 titled, " Reporting, " mandates, " Initial reporting of allegations shall be completed immediately upon notification of the allegation. The written report shall be sent to the Department of Public Health. " R3 allegation of abuse on 11/17/14 communicated to E3(Social Worker) was not communicated immediately to E1(Administrator). When E1(Administrator) was advised of this new allegation of abuse, she mistakenly thought E3(Social Worker) was talking about a previous allegation of abuse by R3 dated 11/9/14. Consequently this new allegation of abuse between R3 and R4 was not investigated nor reported to the Illinois Department of Public Health.

Nursing progress note of 8/19/14 describes a resident to resident altercation involving R1 in which R1 hit another resident. No accident/incident report was forwarded by facility regarding this allegation of abuse. Facility Abuse prevention program page 2 states, " Physical abuse includes hitting, slapping, pinching, kicking ... " R1 ' s altercation with another resident would require an investigation and reporting as per facility abuse policy and procedure. On 11/20/14 at 8:26 am E1(Administrator) stated, " We don't have an incident report. Not reported based on fact he has dementia. "

E1(Administrator) continued explaining a staff witness described R1 ' s behavior as not intentional. Facility failed to provide documentation an investigation was completed and did not complete an accident/incident report.

On 7/18/14 R10 ' s family member complained

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E4(Certified Nursing Assistant) was " discourteous " and did not assist R10 to the bathroom. Abuse policy page 2 defines abuse as including, " ...deprivation by an individual, including a caretaker, of goods or services that are necessary to attain and/or maintain physical, mental and psychological well-being. " Facility investigation report quotes R10 as saying she felt " ignored. " Facility initial report to Illinois Department of Public Health was on 7/21/14; 3 days after complaint was made by resident family member. Abuse policy under reporting requires initial reporting of allegations " immediately " to Illinois Department of Public Health(I.D.P.H). Date stamp on fax confirmation slip is " 7/25/14 " 3 days after initial report of abuse allegation.
On 11/10/14 final I.D.P.H report for R11 describes incident in which an a " C.N.A(Certified Nursing Assistant)was discourteous while providing care. " Name of the C.N.A involved in this incident could not be determined based on facility documentation. Unidentified C.N.A was placed on administrative leave. Facility concludes in this final report that " based on investigation which included resident interviews, staff interviews and record review, it was determined that care was rendered appropriately. " No actual staff interviews were presented as part of the investigation. Rather a summary indicating " staff interviews, (R11) noted to refuse care. "
Facility abuse policy page 7, point 6 c, under " Investigation, " heading states the final investigation report shall include facts determined during the process of investigation, review of medical records, personnel files and interview of witnesses. "
Facility sent an initial and final report for an allegation of " poor customer service " to I.D.P.H involving R2. The final report notes R2

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complained about the night C.N.A on August 8, 2014. Facility investigation does not include actual witness statements. Instead the facility makes a summary statement indicating during staff interviews R2 " noted to be hard to understand when trying to communicate. "
There is no documentation in the investigation presented which identifies the C.N.A involved in this incident by name. Facility abuse policy requires " facts determined during the process of investigation " and interview of witnesses shall be part of the final investigation report as explained on page 7, point 6 c under " investigation, " heading.
Facility notes visitor filed a complaint on 7/21/14 involving " rough " handling during repositioning for R12. Report was made to the I.D.P.H. This incident resulted in C.N.A being placed on administrative leave. Neither the initial or final report identified who the C.N.A was that was involved in this incident.. Investigation did not include actual C.N.A interviews. As a result unable to identify C.N.A involved in rough handling allegation. Facility abuse policy dated 5/8/14 requires facts determined during investigation and witness interviews shall be part of the final investigation report.
On 8/1/14 C.N.A was accused of discourteous and rough handling toward R13. C.N.A was placed on administrative leave. No actual witness statements were included in the investigation. As a result of documentation unable to determine the name of the C.N.A involved in this incident. Unidentified C.N.A was placed on administrative leave according to documentation. Facility did not follow it ' s abuse policy and procedure which requires investigation which includes facts determined and witness interviews be a part of final investigation report.

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On Oct. 19, 2014 R14 alleged according to resident interview that, " At bedtime C.N.A was being rude to me. She put in bed and told me to stop bothering. Then I put my call light so she could lower my bed, when she came in she seemed upset and told me again to stop bothering. When she changed my brief she pulled on me by hips. I told her not to do this to me and she said, " what are they going to do? " Neither the initial or final report indicates the name of the C.N.A involved in this incident. There are no actual witness statements such as the C.N.A involved in this incident included with the investigation material. Unidentifiable C.N.A was placed on administrative leave. Facility concluded " that the CNA was impolite. " Facility abuse policy and procedure requires under in its investigation procedures that the final report include facts determined during the process of investigation, review of personnel files and interview of witnesses. Investigation presented by facility was incomplete.

R15 alleges staff member was rough with her on October 16, 2014. No actual witness statements were included with facility investigation and staff involved in this incident were also not identified by name on the I.D.P.H(Illinois Department of Public Health) report of investigation. As a result unable to determine which C.N.A was alleged to have been involved in rough handling. Facility did place this C.N.A on administrative leave. Facility did not follow it ' s abuse policy and procedure investigation procedures by not including witness statements.

R17 alleged R16 was attempting to put his hand inside her shirt on 8/23/14. No actual staff interviews were included in this investigation. Instead facility will state in the final investigation report, " During staff interviews ... " As a result

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unable to identify which staff witnessed this incident and timeline for sequence of events. Facility did not follow it ' s abuse policy and procedure which requires interview of witnesses in its investigation procedures.
R19 alleged R18 placed his hands inside her pants on 5/18/14. Staff names and interviews were not included in this investigation. Facility abuse investigation policy and procedure states staff interviews should be included as part of abuse investigation.
On 10/27/14 R20 was alleged to hit another resident. Actual staff interviews were not included as part of the investigation into alleged abuse. Facility policy and procedure requires inclusion of witness interviews.
On 12/9/14 E1(Administrator) was compiling statements from above incidents. E1 stated she did not know the actual statements or quotes with staff identified by name had to be included in the reports. E1 was asked where her investigation statements were. To which E1 responded I could talk to the staff to verify. E1 was advised I could not identify what staff were involved in these situations. When asked E1 was also not clear on what was considered a reportable abuse allegation for some of the cases.
2. At time of review between 11/18/14 to 11/20/14 E16(Director of Human Resources) had not obtained pre-employment reference checks on 6 indirect care employees(E11, E15, E14, E17, E13 and E10)out of 6 reviewed for pre-employment reference checks and for 24 out of 24(E5,E6, E7,E8, E9, E29, E30, E33, E34, E35,E36, E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47, E48, E49) employees who are direct care workers hired after 5/8/14 reviewed for pre-employment checks.
On 11/19/14 at 3:10 pm E16(Human resource

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director) stated, " No reference checks on anyone since I started. " Facility provided list for indirect healthcare workers dated 11/20/14 which identifies E14, E15, E17, E10, E13 and E11 as active employees and file review determined date of hire of 8/28/14 for E11, 5/15/14 for E15, 6/8/14 for E14, 7/14/14 for E17, 11/3/14 for E13 and 10/15/14 for E10. In addition facility presented a list with a fax stamp of 12/4/14 of staff hired since their last annual licensure and certification which included E5, E6, E7, E8, E9, E29 through E49. E6 through E9 and E29 through E34 are all Licensed Practical Nurses and E35 through E49 are all Certified Nursing Assistants. Facility abuse prevention policy and procedure dated 5/8/14 states under heading 1. Pre-employment Screening of Potential Employees: " Prior to a new employee starting a working schedule: a. Initiate a reference check from previous employer(s), in accordance with the facility policy. "

3. On 11/20/14 at 1:00 pm E16(Director of Human Resources) presented files stating Department of Corrections prescreening was done. The department of corrections screening which was presented was not the DOC sex offender search engine which is required. Fingerprint based Criminal History Records Check policy and procedure dated 8/11 under point 3 of procedure, " The facility will conduct Internet searches on certain web sit, including without limitation the Illinois Sex Offender Registry, the Department of Corrections ' Sex Offender Search Engine. On additional review it was determined only 3 employees (E7, E15, E14) had department of corrections prescreening for sex offenses. This left E5, E6, E8, E9, E29, E30, E33, E34, E35, E36, E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47, E48 and E49

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F 225	Continued From page 10 without DOC sex offenses check in place. E16(Director of Human Resources signed statement indicating the Department of Corrections check was not done on most employees as required. Facility abuse prevention program dated 5/8/14 documents under pre-employment screening of potential employees that prior to a new employee starting under 1.e that " All potential employees must have their name verified against the Illinois Department of Corrections .... "	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement and operationalize their abuse policy and procedure which requires: initiation of reference checks from previous employers for all indirect health care employees who started after 5/8/14 for a total of 6 employees(E11, E15, E14, E17, E13 and E10) out of 6 employees and for direct care workers hired after 5/8/14 for a total of 24 employees(E5, E6, E7, E8, E9, E29, E30, E33, E34,E35, E36, E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47, E48, E49) of 24 employees reviewed for pre-employment reference checks; Initiation fingerprint background check within 10 days of hire or terminate after 30 day of	F 226		

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employment and the fingerprint back ground check not intitated for 1 of 11 employees E11 all reviewed for healthcare worker background checks.
Health care worker registry check should be performed prior to employment for two employees(E13, E15) out of 11 employees checked for pre-employment screening;
Health care worker registry checks were not performed at all for two employees (E11, E12) out of 11 employees reviewed for pre-employment screening;
Health care worker registry check should be performed prior to employment for two employees(E13, E15) out of 11 employees checked for pre-employment screening;
Pre-employment screenings were performed prior to an employee beginning a working schedule for four employees(E8, E11, E15, E13) out of 11 employees reviewed for timeliness of background checks;
Department of Corrections screening for sex offenses was performed for 23 employees(E5, E6, E8, E9, E29, E30, E33, E34, E35, E36, E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47, E48, E49) of 26 employees reviewed for screening of sex offenses.
These deficient practices placed all 183 residents in the facility at risk for potential abuse.
Findings include:
Facility policy and procedure titled, " Abuse prevention, " dated 5/8/14 and or "
Fingerprint-based History Records check, " dated 8/2011 requires:
· that prior to an employee starting a working schedule that a reference check from previous employers be initiated.
· The applicant or employee will go to a livescan vendor assigned by the facility and have

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his or her fingerprints collected electronically and transmitted to the department of State Police within 10 working days after signing the authorization and disclosure form. If the applicant or employee does not go to the livescan vendor and have his or her fingerprints collected electronically within 10 working days, the employee will be suspended from working, until such time as proof is provided that the individual has had his or her fingerprints collected. electronically rom a Livescan vendor. If the employee or applicant has not had his or her fingerprints collected electronically by a Livescan vendor within 30 days after being hired, the employee shall be terminated.

· Registry check done on all licensed and unlicensed workers before start working.

· Pre-employment screening of all potential new employees against the Illinois department of Corrections (Sex Offender Search Engine) website.

On 11/19/14 at 3:10 pm E16(Director of Human Resources) stated, " no reference checks on anyone since I started. " Facility provided list of indirect health care workers dated 11/20/14 which identified E14(dietary aide) with an employment file hire date of of 6/18/14, E11(dietary aide) with an employment file hire date of 8/28/14, E15(dietary aide) with an employment file hire date of 5/15/14, E10(activity aide) with an employment file hire date of 10/15/14, E13(receptionist) with an employment file hire date of 11/3/14, and E17(office manager)with an employment file hire date of 7/14/14. In addition facility presented a list of direct health care workers with employment dates since the facilities last annual licensure and certification which included E29 through E49. E29 through E34 are all Licensed Practical nurses and E35

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through E49 are all Certified Nursing Assistants. Employment files were reviewed with E16 and no pre-employment reference checks were documented as initiated on any of the files presented. E16 signed document with names of Licensed and Unlicensed workers with statement, " None of these files have reference checks unless hired within the last 2 weeks. " Facility did not follow pre-employment reference checks required by their policy.

On 11/26/14 at 10:00 am E16 identified E11 ' s date of hire as 8/28/14. No livescan proof of fingerprinting was presented for E11 was presented for E11 as of 11/26/14 which is almost 3 months after E11 began to work. E11 was not suspended from working within 10 working day timeframe established by finger-print based criminal history check policy and was not terminated until after fingerprint result was found missing during audit. Facility did not follow policy and procedure.

Employee file does not include health care worker registry document for E11, E12, E13 and E15. E13 and E15 did have registry checks which were presented later but the registry check was not done until after they started working. E13 date of hire is 11/3/14 and registry form shows date of 12/3/14. E15 date of hire is 5/15/14 and registry check was printed out on 12/3/14. On 11/26/14 E16 stated the registry check was done but not placed in chart. E11 and E12 never had registry checks presented for review. Facility did not follow pre-employment policy requiring registry checks.

Employment files note hire dates of 8/25/14 for E8, 8/28/14 for E11, 5/15/14 for E15, and 11/3/14 for E13. Preemployment website checks which included sex offender, inmate search, and wanted fugitives were not performed until after dates of

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F 226	Continued From page 14 hire for E8, E11, E15 and E13. E8 ' s website checks were done 8/28/14. E11 website checks were obtained 9/18/14. E15 ' s website checks were completed 5/20/14. E13 ' s website checks were performed 11/5/14. Website checks were not performed pre-employment in accordance with their policy and procedure. On 11/20/14 at 1:00 pm E16(Director of Human Resources) presented files stating Department of Corrections prescreening was done. The Department of Corrections(D.O.C) screening which was presented was not the DOC sex offender search engine which is required. E5, E6, E8, E9, E29, E30 E33, E34, E35, E36, E37, E38, E39, E40, E41, E42, E43, E44, E45, E46, E47, E48 and E49 files did not contain the DOC sex offender website check. E16 signed statement indicating the Department of Corrections sex offender site check was not done on most employees as required.	F 226		
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 interview and record review, facility failed to follow the physician order and policy and procedure to ensure medication was administered as ordered for one resident (R3) out of 3 residents reviewed for medication administration. This failure resulted in R3 missing 26 doses of Xenazine. Findings include: Facility medication policy and procedure states	F 281		

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medications will be administered as ordered.
R3 has an order for Xenazine twice a day for treatment of spastic movements due to diagnosis of Huntington ' s Chorea.
Physician order sheet for May of 2014 includes order for Xenazine tablet 12.5 mg every 12 hours. Xenazine has an order date of 10/13/12 according to entry on M.A.R. On 11/25/14 E2(Director of Nursing) was shown R3 ' s M.A.R entries for Xenazine and agreed that according to eMAR notations and nursing notes from May through October of 2014 R3 did not receive her Xenazine as ordered on:

- 5/14 9pm
- 5/15 9am and 9pm
- 5/16 9am
- 5/31 9am and 9pm
- 6/1 9am and 9pm
- 6/2 9am and 9pm
- 6/3 9am and 9pm
- 6/4 9pm
- 6/5 9am
- 8/3 9pm(8/3 emar(electronic medication record) note xenazine pending pharmacy delivery)
- 8/29 9pm(emar note 8/29, pending MD authorization)
- 8/30 9am and 9pm(8/30 emar note, pending delivery)
- 9/1 9am and 9pm(emar note 9/1, MD must fill out forms. Pending Pharmacy Delivery)
- 9/2 9pm(emar note, medication waiting on insurance approval)
- 9/3 9am and 9pm((emar note, pending pharmacy delivery)
- 10/1 9am and 9pm(emar note, medication is on order, waiting for pharmacy)
- 10/2 9am(emar note, medication to arrive from pharmacy today).

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F 281	Continued From page 16 A total of 26 doses of Xenazine were missed. On 12/3/14 at 2:35pm Z1(Pharmacist) went through all pharmacy delivery dates for Xenazine for R3. Z1(pharmacist) determined facility was receiving Xenazine deliveries as ordered and had staff signatures from facility of receipt of medication. All of these orders for Xenazine went out as overnight delivery. Comparing date ordered with delivery date, Xenazine was delivered next day delivery to facility. Z1(pharmacist) explained Xenazine is used to " help with spasms, helps mentally " and between 5 to 12 hours after missing dose it is completely out of system. Z1(Pharmacist) responded lack of this medication would lead to presence of more spasticity in movements but could not say definitively if increased spasticity would be a result of lack of medications alone or progression of disease.	F 281		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to assist with activities of daily living including hygiene care and repositioning for one (R5) of one residents reviewed for hygiene care. Findings include:	F 312		

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F 312	Continued From page 17 R5 face sheet documents a date of birth of 5/22/35 making her 79 years old. Diagnoses listed on face sheet include: Aphasia due to cerebrovascular disease, Dementia, and hemiplegia affecting dominant side due to cerebrovascular disease. On 11/19/14 from 6:45 am until 9:15am during continuous every 15 minute observations of R5, no hygiene care or repositioning was performed. R5 was placed in television room at 6:45am. R5 remained seated in television room without movement or incontinence care for 2 hours and 30 minutes. On 11/19/14 at 9:30 am E20(Certified Nursing Assistant) for R5 described R5 as a full assist with activities of daily living requiring repositioning every 2 hours and incontinence care. E20 acknowledged she had not changed or repositioned R5. After prompting R5 was taken to her room and found with bowel movement . R5 care plan identified as active by facility and initiated on 2/16/12 includes intervention of " check and change (R5) for incontinence every 2 hours or as needed."	F 312		
F 333 SS=E	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and record review, facility failed to administer Xenazine (treatment of uncontrolled muscle movement) for 1 of 3 residents (R3) all reviewd for physician ordered medication. This failure has the potential to result	F 333		

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in an increase in spastic involuntary muscle movement.
Findings include:
R3 face sheet documents diagnosis which includes but is not limited to: Huntington ' s Chorea.

Physician note of 8/19 documents ataxia and 9/14 notes increased spastic movements. Additionally R3 had falls on 7/5 while out on pass, 9/4 near nurses station, 8/18 when shoe slipped off. 10/28/14 physician notes is noting " impulsive with recent falls. " Correlation between increased spasticity and lack of medication could not be made. This medication ' s purpose is to treat spasms but there is also no correlation between any of these events and lack of Xenazine. November 23 approximately 3 hours of video footage of R3 was reviewed in which R3 had extensive spastic movements

Medication administration record(M.A.R) for May of 2014 includes order for Xenazine tablet 12.5 mg every 12 hours. Xenazine has an order date of 10/13/12 according to entry on M.A.R. On 11/25/14 E2(Director of Nursing) was shown R3 ' s M.A.R entries for Xenazine and agreed that according to eMAR notations and nursing notes from May through October of 2014 R3 did not receive her Xenazine as ordered on:

- 5/14 9pm
- 5/15 9am and 9pm
- 5/16 9am
- 5/31 9am and 9pm
- 6/1 9am and 9pm
- 6/2 9am and 9pm
- 6/3 9am and 9pm
- 6/4 9pm
- 6/5 9am

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· 8/3 9pm(8/3 emar(electronic medication record) note xenazine pending pharmacy delivery)
· 8/29 9pm(emar note 8/29, pending MD authorization)
· 8/30 9am and 9pm(8/30 emar note, pending delivery)
· 9/1 9am and 9pm(emar note 9/1, MD must fill out forms. Pending Pharmacy Delivery)
· 9/2 9pm(emar note, medication waiting on insurance approval)
· 9/3 9am and 9pm((emar note, pending pharmacy delivery)
· 10/1 9am and 9pm(emar note, medication is on order, waiting for pharmacy)
· 10/2 9am(emar note, medication to arrive from pharmacy today).

On 12/3/14 at 2:35pm Z1(Pharmacist) went through all pharmacy delivery dates for Xenazine for R3. Z1(pharmacist) determined facility was receiving Xenazine deliveries as ordered and had staff signatures from facility of receipt of medication. All of these orders for Xenazine went out as overnight delivery. Comparing date ordered with delivery date, Xenazine was delivered next day delivery to facility.
Z1(pharmacist) explained Xenazine is used to " help with spasms, helps mentally " and between 5 to 12 hours after missing dose it is completely out of system. Z1(Pharmacist) responded lack of this medication would lead to presence of more spasticity in movements. On 12/9/14 at 12:00 noon Z2(Attending Physician for R3) stated, " Yes, there have been changes in spasticity. Always progresses. Very predictable decline is what is expected. " Advised Z2, R3 had missed approximately 26 doses of xenazine. Z2 continued, " Can ' t answer that question that she ' s more uncomfortable(because of missing

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F 333	Continued From page 20 Xenazine). It ' s like Parkinsonism the medication stops working. " Both Z2(Attending Physician) and pharmacist reported could not discern if increased spasticity was due to progression of disease or lack of medications as this is a progressive disease. Notations in chart citing increased spasticity do not coincide with lack of Xenazine administration.	F 333		
F 441 SS=D	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 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	F 441		

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F 441	Continued From page 21 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, facility failed to ensure hand washing was performed after gloves were changed during incontinence care for one resident(R5) of one residents reviewed for incontinence care. Findings include: On 11/19/14 at 9:30 am E20(Certified Nursing Assistant) performed hygiene care on R5 after an episode of bowel incontinence. After cleaning R5, E20(C.N.A) removed her gloves without washing her hands and proceeded to put new pair of gloves on to finish providing care to R5. Facility policy and procedure titled, " Hand Washing and hand hygiene, " page 1 and 2 states, " Hand hygiene must be performed after touching blood, body fluids, secretions, excretions and contaminated items, whether or not gloves are worn; immediately after gloves are removed; and when otherwise indicated to avoid transfer of microorganisms to other residents, personnel, equipment and/or the Environment. Specific examples include but are not limited to: 6. After removing gloves. " On 11/19/14 at 9:45am E20(C.N.A) stated, " I didn ' t wash hands after changing gloves. I should have to prevent germs from spreading. "	F 441		

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F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION	F 456		

The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, facility failed to repair side rail for one resident (R8) out of three residents reviewed for equipment maintenance.
Findings include:
On 11/18/14 at 9:20 am and 11/19/14 at 7:00 am R8 was in bed with right hand side rail stretching from socket approximately 6 inches leaving a gap between the mattress and the side rail. R8 did not respond to questions in Spanish regarding his ability to turn on 11/18/14 during the initial tour.
On 11/19/14 between 6:30 am and 8:30 am R8 did not turn himself or make any movements to the side.
E18(Certified Nursing Assistant) on 11/19/14 at 7:20 am stated she told the maintenance director R8 ' s side rail was sticking out a month ago. E18 explained R8 is not able to turn himself.

On 11/19/14 at 8:00am E19(Maintenance Director) reported the first time he heard of side rails was yesterday. He had pushed clips in but looks like it didn ' t work.
Documentation in the record versus observations and staff interview are not consistent in determining whether R8 can turn independently or move to point the gap between the side rail and the mattress is a hazard. Staff interviews and observations note R8 as being unable to

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move into a turned position. He may place hand on side rail after he is turned; due to weakness side rail does not help him to turn; R8 does not get out of bed. He may resist care in that he refuses to get out of bed. The use of 2 assistive devices for bed mobility does not mean R8 can independently turn. R8 requires extensive 2 person physical assist for bed mobility according to Section G of quarterly assessment with date of 11/3/14. A current side rail assessment dated 11/3/14 notes that the resident is able to move or attempt to move in bed. R8 ' s movement is limited to crossing legs and using upper hands to hold glass. Interviews from multiple staff, family and physician note R8 is not able to turn or move to a point creating a hazard due to the side rail. Intervention is to allow resident to complete as much as possible on his own. There is also documentation R8 is requesting side rails for fear of falling out with a goal date of 2/1/15. Care plan intervention is to keep bed rails up while in the bed. Additional care plans state: (Problem) - Self Care deficit AXOX2 able to make his needs known, and able to move side to side in bed but needs staff assistance to come to seated position. Goal date 2-1-15. (Intervention) - The resident is able to move side to side, but may need staff assistance with coming to seated position. This particular care plan has an initiation date of 10/17/11 and again staff interviews and observations do not support R8 independently moving from side to side. Facility has updated care plan to reflect R8 ' s current functional status. Care plan which remained active at the time of this review were not revised to reflect R8 ' s functional abilities.