STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145743	A. BUILDING _____ B. WING _____	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WEST SUBURBAN HOSPITAL MED CTR	**ERIE AT AUSTIN OAK PARK, IL 60302**

(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	F 000		
F 157 SS=D	Annual Licensure/Certification 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced	F 157		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 by: Based on observation, record review, and interview, the facility failed to notify the family after 2 fall occurrences involving 1 of 10 sampled residents(R 4). Findings Include: On 4-12-11 at 12:10pm, surveyor observed R4 being transferred from the bed to the wheelchair, accompanied by 2 staff members, E 7(Certified Nursing Assistant), and E 8(Physical Therapist), R 4 legs became weak, resulting in the inability to stand. Both E 7 and E 8 proceeded to assist the resident onto the floor. Review of the incident report dated 4-12-11 does not indicate that the family were notified. Review of the nursing note dated 4-13-11 at 4:50 am states that resident was found on the floor. Further review of the nurses note does not indicate that the family were notified. Review of the incident report dated 4-13-11 indicates that there was an attempt to notify the family. Interview with E 12(Registered Nurse), on 4-13-11 at 12:30pm stated that he completed the incident report involving the incident on 4-12-11. When asked, did he attempt to notify the family? E 12 stated that he was not aware of having to notify family after an incident. Review of the facility policy related to incident reports states that "if the resident is alert and oriented and has a fall or other incident, staff are to ask their permission to notify their family, if a patient is cognitively impaired, then we will notify the residents representative." This was not done.	F 157		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS	F 221		

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F 221	Continued From page 2 The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that an assessment for restraint use involving 1 of 10 sampled residents(R 3) was done prior to use. Findings include: 1. 4/12/2011, R 3 was observed sitting in a wheelchair in her room (537) at approximately 10 am. The resident was slumped over in the wheelchair. A chest restraint was around her waist and chest with each end tied to the back of the wheelchair. R3's husband was present at the time in the room. E 3 (DON) was in the room at the time of the observation and interviewed. E 3 started that R 3 is impulsive and will get up at anytime. The device was being used to stop her. 2. R 3 had a restraint order dated 4/12/2011 for a rollbelt and full siderails. 4/12/2011, at approximately 2:30pm, E 3 was interviewed in the 5 th floor nursing station concerning R3's restraints. The rollbelt and siderails are applied to the resident while in bed. There are no orders for a restraint while up in a wheelchair.	F 221		

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F 221	Continued From page 3 3. 4/14/2011, E 1 (Administrator) was asked for a restraint assessment showing that R 3 is in the least restrictive restraint. No assessment was forthcoming.	F 221		
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that psychotropic medication use was appropriate involving 1 of 10 sampled residents (R 3). Findings Include: 1. 4/12/2011, R 3 was observed sitting in a wheelchair in her room (537) at approximately 10 am. The resident was slumped over in the wheelchair. A chest restraint was around her waist and chest with each end tied to the back of the wheelchair. R3's husband was present at the time in the room. E 3 (DON) was in the room at the time of the observation and interviewed. E 3 started that R 3 is impulsive and will get up at anytime. The device was being used to stop her. 2. 4/12/2011, R 3 had an order for 1 mg of Ativan at bedtime. R 3 was admitted to the facility, 4/4/2011 with a diagnosis of left pelvic fracture	F 222		

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F 222	Continued From page 4 and dementia. 4/4/2011, at 9pm, R 3 started having behavior. A rollbelt was applied at 10:30pm, 4/4/2011. 4/5/2011, at 9:45pm an order was written for 0.5 mg of Ativan twice daily. No assessment or behavior modification care plan was a part of R3's immediate care plan. 3. 4/14/2011, Z1 (Pharmacist) was interviewed in the 5th floor conference room. Z1 stated that she reviewed R3's drug regimen, 4/13/2011. Z1 recommended changing the Ativan to Seroquel PRN. Z1 confirmed that the Ativan order (1 mg at bedtime) was a restraint and has a long lasting "hung over " affect.	F 222		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that 1 resident outside the sample of 10 (R 13), was provided privacy while receiving a sub-cutaneous route medication. . Findings include: During the medication pass on 4/13/11 that began at 8:45 AM, E 13 (nurse) was observed to give R 13 a subcutaneous injection of Arixtra 2.5 mg into R13's right abdomen. E 13 was observed to raise R13's blouse to inject the	F 241		

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F 241	Continued From page 5 medication. E 13 was further observed failing to close the privacy curtains or the door to R13's room prior to giving the injection. E 3 (director of nursing) stated when interviewed on 4/13/11 at 2:00 PM, that all residents privacy and dignity are to be respected when medications/injections are being administered.	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow professional standards when administering medications for 1 of 10 sampled residents (R6), and 1 resident outside the sample (R13). Findings Include: 1.Record review documents that R13 is a 76 year old male with diagnoses that include Pneumonia, Chronic Obstructive Pulmonary Disease, Diabetes, and Blindness. The physician order dated 3/25/11 instructed that R13 receive Advair inhaler. During the medication administration observations with E13 (nurse) on 4/13/11 that began at 8:45 AM, E13 was observed to leave R13's medication on the overbed table near the	F 281		

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F 281	Continued From page 6 door to R13's room unattended and return to the nursing station. In addition, E13 was observed to administer the Advair inhaler but failed to instruct R13 to rinse his mouth with water after the treatment. Facility policy titled "Medication Pass" documents that the overbed table will be taken in the patients room and remain under the nurses observation, except in isolation rooms. 2.Record review documents that R6 is a 80 year old female with diagnoses that include Congested Heart Failure, Chronic Obstructive Pulmonary Disease, and Lung Cancer. R6's nursing progress notes documents that R6 has a poor appetite. E13 was observed during the morning medication pass on 4/13/11 at 9:30 AM, to administer Advair inhaler to R6. E13 was observed to fail to instruct R6 to rinse her mouth with water post receiving the inhalant. A review of the facility's medication pass record documents instructions for the nurse to have the residents to rinse their mouth with water after each treatment with Advair inhalant. E3 (director of nursing) stated when interviewed on 4/13/11 at 3:30 PM, that the mouth should be rinsed with water after receiving puffs of Advair inhalant. E13 stated when interviewed at this time that she was aware that medications are not to be left in residents rooms unattended.	F 281		

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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 provide a hazard free resident environment by leaving chemicals in the corridor unsupervised by staff and the facility failed to identify a possible tripping hazard involving 1 of 10 sampled residents(R 5), and 1 resident outside the sample (R 11). Findings include: 1. During the initial tour of the facility on 4/12/11 at 10:00 AM, it was observed that a housekeeping cart standing against the wall in the hallway near room 581. It was observed that a spray container of Bathroom Cleaner and bucket containing a sanitizing solution was on top of the cart. In addition, a large bottle of scanning gel was observed sitting on the bladder scanning machine in the corridor. E5 (nurse) stated that the gel should not be left out in the corridor when not in use by the staff. E14 (housekeeping) stated when interviewed at	F 323		

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F 323	Continued From page 8 that time that she was aware that her cart should not be left in the corridor out of her visional range for the safety of the residents. 2. Facility policy titled "Medication Pass" documents that the overbed table will be taken in the patients room and remain under the nurses observation, except in isolation rooms. During the medication administration observations with E13 (nurse) on 4/13/11 that began at 8:45 AM, E13 was observed to leave R13's medication on the overbed table near the door to R13's room unattended and returned to the nursing station. E3 (director of nursing) stated when interviewed on 4/13/11 at 3:30 PM, that the mouth should be rinsed with water after receiving puffs of Advair inhalant. E13 stated when interviewed at this time that she was aware that medications are not to be left in residents rooms unattended. 3.During the environmental tour on 4-13-14 at 10:00 am, accompanied by E 16(Maintenance Director), and E 17(Maintenance), room 583 was entered. Observed the floor threshold related to the bathroom is above the level of the floor related to the room. The floor threshold is as wide as the bathroom door, and measures 1.5 inches in height. The residents in the room both utilized wheelchairs for mobility. Wheelchairs entering and exiting the bathroom will become unbalanced. Interview with E 16 on 4-13-11 at 4:00pm stated that he was aware of the threshold	F 323		

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F 323	Continued From page 9 about a week ago, and considering that no resident on record has fallen, indicated no immediacy to correct.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interview, the facility failed to properly label an Intra Venous Anti Biotic medication bag and tubing involving 1 of 24 sampled residents(R 19) Findings Include: Facility policy :Intravenous/Intra-arterial Access Devices-Guidelines for Care" documents that: 11.4 If an intravenous solution bag is not provided by the pharmacy (i.e. no additives), the nurse labels the solution bag with the following information: Patient name, medical record number, solution, start date and time. During the initial tour of the facility on 4/12/11 at 10:00 AM with E5 (nurse), it was observed that	F 328		

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F 328	Continued From page 10 R14 was receiving an intravenous solution of 0.9 normal saline. It was further observed that the bag of normal saline that was infusing at a rate of 80ml per hour. In addition, the liter bag of normal saline failed to contain a label with the residents name, type of solution, date and time that the solution was hung by the nursing staff. E5 stated when interviewed at time time that all intravenous solutions when hung are to be labeled with the above information by the nurse hanging the solution.	F 328		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to store, prepare and serve food under sanitary conditions . This failure has the potential to affect all residents in the facility. Finding Include:	F 371		

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F 371	Continued From page 11 1. 4/12/2011, during the Initial tour of the kitchen with E 18 (Manager of Food Service), the following observations were made: -Condiments stored in the walk in cooler were not labelled when they were open. -A pipe leading from the condenser in the meat freezer was leaking. Food was observed stored under the pipe. 2. 4/12/2011, at approximately 11:35 am a temperature was taken of the yogurt being served for lunch. The temperature was 42 degrees Fahrenheit. E 18(Food Service Manager) was asked if the yogurt was being served cold? She said, "Yes".	F 371		
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	F 441		

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F 441	Continued From page 12 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 interview, the facility failed to follow generally accepted standards of practice related to respiratory care supplies involving 1 of 10 sampled residents(R 2), and 1 resident outside the sample (R 12) and failed to practice aseptic technique involving wound care for 1 of 10 sampled residents (R 2). Findings Include: During the initial tour on 4-12-11 at 10:45 am, the following were observed : 1. Entered room 540 belonging to R 2. Observed 1 oxygen tubing and attached nasal cannula on the floor. The tubing was connected	F 441		

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F 441	Continued From page 13 to the wall flow meter. 2. Entered room 542 belonging to R 12. Observed 1 oxygen mask attached to the oxygen tubing hanging around the wall flow meter. Observed the inside portion of the oxygen mask in direct contact with the call light cord. Both residents were out of their rooms. On 4-12-11 at 4:00pm, during the daily status meeting, the facility was informed of the observations 3. During an observation of a wound dressing change on 4/13/11 at 11:15 a.m., E 13 (staff nurse) did not wash hands after emptying urinal that was sitting on dirty overbed table. E 13 emptied urinal, then placed a cup of water on resident's dirty overbed table. E 13 informed resident she would return pain medication and supplies for wound dressing change. E 13 returned to room and proceeded to place supplies on dirty overbed table. R 13 cleaned overbed table after prompting from surveyor. E 13 setup dressing change supplies on overbed table without setting up sterile barrier for pressure ulcer would care. During the daily status meeting, R 3 (DON) informed of observations. During interview on 4/14/11 at 12:30 p.m., E 15(Infection Control Coordinator), stated that all direct care providers on the skilled care unit were inserviced on handwashing in November of 2010. E 15 stated that inservices were provided on handwashing and C-Diff based on unusual trends. Record review of facility's infections control standard precautions cites practices of hand washing after touching body fluids and contaminated items whether or not gloves are	F 441		

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WEST SUBURBAN HOSPITAL MED CTR	**ERIE AT AUSTIN OAK PARK, IL 60302**

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F 441	Continued From page 14 worn; decontaminate hands routinely between touching patients or equipment.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to document a physician order for 1 of 10 sampled residents (R 4), who was observed receiving oxygen. Findings Include: During the initial tour on 4-12-11 at 9:30 am, surveyor entered room 547. Observed R 4 receiving 2 liters of oxygen per nasal cannula. Review of the POS(Physician Orders Sheet) dated 4-9-11 thru 4-12-11 did not indicate an order written for the use of oxygen. On 4-12-11 at 4:00pm, during the daily status meeting, the facility was notified. Interview with E 1(Administrator) on 4-13-11 at 10:00 am stated	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145743	A. BUILDING _____ B. WING _____	04/14/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 514	Continued From page 15 that all residents that receive oxygen should have a physician order in the record. This was not done.	F 514		