STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 Federal Oversight Support Survey SubPart U Validation Survey The Parkway Manor is in substantial compliance with Subpart U, 77 Illinois Administrative Code 300.7000.	F 000		
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 privacy for one resident (R111) in the supplemental sample during the medication pass. Findings Include: On 1/27/16 at 5:10 PM, R111 was sitting in the Dining Room area of 200 hall way with other residents and visitors present. E38 LPN (Licensed Practical Nurse) took out a Rivastigmine medication patch 4.6mg (milligram) from the medication cart and took it to R111 at the Dining Room table. E38 LPN then pulled down the back of R111's shirt, exposing the skin on her upper right back and removed the used patch. E38 then exposed R111's left upper back and applied the new patch to R111's upper left back. On 1/27/16 at 5:10 PM, E38 stated she did not	F 241		2/10/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/26/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 241	Continued From page 1 know if R111 had a signed consent in her chart stating if it was ok for nurses to apply R111's medication patch in the dining room area. On 1/27/16 at 5:15 PM, when questioned E2 DON (Director of Nursing) if it was ok to apply R111's medication patch while she was in the dining room area, E2 stated that putting R111's medication patch on in the dining room is similar to doing a blood glucose monitoring or giving an injection and should be done in the residents room. E2 stated E38 should not have applied R111's medication patch while she was in the dining room area unless they had signed permission from R111's Power of Attorney stating it was ok. E2 stated she did not know if R111 had a signed consent to apply R111's medication patch in the dining area. There was no consent found in R111's medical record, giving the facility consent and permission to apply R111's medicaiton patch in the dining room area.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure that a vision impaired resident received adequate assistance	F 246		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 246	Continued From page 2 at meal time for 1 of 1 visually impaired residents (R9) observed at meals in the sample of 22. The findings are: 1. R9 is a 97 year old resident identified on the current care plan (review date of 11/5/15) of being visually impaired, legally blind and having a right prosthetic eye. On 1/27/2016 at 12:15 pm, R9 was asked how her lunch was. R9 stated "Well it would be better if I knew what I was eating" and then stated that she was legally blind. Prior to this conversation at 12:05 pm, E45-Certified Nurse Aide, was observed to deliver R9's plate of food to R9 and tell her that she had "chicken, broccoli, dressing and cake." E45 did not identify for R9 where each food item was in relation to location on her plate. R9 is on a Pureed consistency diet as ordered and noted on the January 2016 Physician Order sheet. The menu board in the dining room identified the main entree as pork. E45 was asked about the identification of "chicken" and looked at the menu board and stated well I guess it was pork. E45 did not return to R9 and correctly identify the meat item.	F 246		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 279	Continued From page 3	F 279		

assessment.

The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review, the facility failed to develop a comprehensive care plan to address identified problem areas for 6 of 22 residents (R3, R9, R11, R14, R16, R18) reviewed for care plans in the sample of 22 and 2 residents (R79, R91) in the supplemental sample.

The findings are:

1. R9 is a 97 year old resident who was admitted on 7/29/2015 as noted on the Admission Sheet. R9 is identified on the current care plan (review date of 11/5/15) in the category's of Activities and Fall risk, as being visually impaired, legally blind and having a right prosthetic eye. Care plan approaches list "assistance for eating, set up and assist as needed. The Care Plan does not further address any individualized approaches for R9's visual limitations.

On 1/27/2016 at 12:15 PM, R9 was asked how her lunch was. R9 stated "Well it would be better

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 279	Continued From page 4	F 279		

if I knew what I was eating" and then stated that she was legally blind. Prior to this conversation at 12:05 PM. E45-Certified Nurse Aide, was observed to deliver R9's plate of food to R9 and tell her that she had "chicken, broccoli, dressing and cake." E45 did not identify for R9 where each food item was in relation to location on her plate. R9 is on a Pureed consistency diet as ordered and noted on the January 2016 Physician Order sheet. The menu board in the dining room identified the main entree as pork. E45 was asked about the identification of "chicken" and looked at the menu board and stated well I guess it was pork. E45 did not return to R9 and correctly identify the meat item.

2. R11 is a 67 year old resident admitted on January 25, 2016 at 4:35 PM with diagnosis of Bronchitis, Chronic Airway Obstruction; Shortness of Breath; Tachycardia; Gastritis without hemorrhage; Acute Pain; Muscle Weakness; Anxiety; Depressive Disorder; and Vitamin D Deficiency according to R11's face sheet.

R11's nursing note dated January 26, 2016 at 8:20 AM, states: "Res (resident) c (with) c\o (complaints of) loose stools et (and) stomach cramps last NOC (night). Abd (abdomen) soft et (and) non tender. Occasional c/o stomach cramping. Bowel sounds active x (times) 4 quad. (quadrants) (Z5's, R11's personal care physician) office notified. Awaiting call back from Z5's nurse for further orders."

R11's Care Plan list a "Problem Start Date of 01/27/2016, at least 24 hours after DX of c-diff." with approaches stated as "Encourage resident to wash hands after defecation. Encourage resident to wash hands before meals; Follow principles of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 279	Continued From page 5	F 279		

infection control and universal/standard precautions for cdiff (Clostridium difficile colitis)" 24 hours after R11 complained of loose stools.

On January 28, 2016 at 8:30 AM during an interview, R11 stated in a response related to why there was an isolation cabinet in his room states, "They (the facility staff) told me this morning I have cdiff. I have had diarrhea for a while now, before I went into the hospital. I bet I got it at the other place I was at prior to going to the hospital."

R11's nursing note dated January 27, 2016 at 10:43 AM states "resident positive for C-Diff, MD notified." and another note dated January 27, 2016 at 11:02 AM states "(Z5) notified of stool specimen results. Res continues on Flagyl as previously ordered r/t loose stools. Awaiting MD response."

3. R16 is an 87 year old resident admitted into the facility on December 15, 2015. The Physician Order Sheet list R16 with a diagnosis of Enteritis Clostridium Difficile on December 23, 2015.

R16's nursing notes dated December 18, 2015 states "Res has had several episodes of diarrhea x (times) 2. Resident does report she has history of IBS (irritable bowel syndrome), but also reports she took multiple antibiotics while in hospital. Will obtain stool sample to r/o (rule out) CDiff. Z2 notified."

R16's Care Plan lists a Problem as "She has c-diff" with a Problem start date of December 23, 2015 and lists approaches as "Encourage resident to wash hands after defecation. Encourage resident to wash hands before meals" and "Follow principles of infection control and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 279	Continued From page 6	F 279		

universal/standard precautions for diff." 5 days after R16 complained of loose stools and diff was suspected.

4.) R14 ' s nursing note dated 1/10/16 at 12:44 PM by E21 (LPN) shows " Resident complains of having diarrhea at least twice a week. Residents Power of Attorney requesting doctor be notified. Resident denies any pain or discomfort. Resident states " It ' s been going on for a while now. I can ' t remember how long " Doctor notified along with current medication list.
R14 ' s nursing note on 1/12/15 shows a doctors order to check stool for C-Diff.
R14 ' s nursing note on 1/15/16 has resident positive for C-Diff.
R14 ' s Plan of Care shows problem start date of 1/15/16, R14 has diagnosis of C-diff and staff are to follow principals of infection control and universal/standard precautions for C-Diff. This is at least 5 days after first signs and symptoms of C-Diff were noted.
5.) R18 ' s progress notes dated 11/28/15 states resident is incontinent of loose-moucousy stool.
R18 ' s progress note dated 11/29/15 shows labs positive for C-Diff
R18 ' s Care Plan Snapshot with date of 12/2/15, 2/2/16 shows a problem start date of 11/29/15 for diagnosis of C-Diff and the goal is that C-Diff will be resolved with no further complications with goal target date of 12/15/15. This is a day after R18 had the initial signs/symptoms of C-Diff.
6.) R79 ' s progress note from 1/26/16 shows resident with loose, foul smelling stool, doctor was notified, stool specimen was collected for C-Diff
R79 ' s progress note from 1/27/16 shows lab reports resident is positive for C-Diff
R79 ' s Care Plan Snapshot for 11/2/15 to 2/2/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 279	Continued From page 7 shows identified problem of C-Diff on 10/25/15 and the goal is to have no further complications regarding the C-Diff with target goal date of 11/6/15. R79 ' s Care Plan Snapshot of 11/12/15 to 2/2/16 shows problem date for C-Diff as 10/25/15 and resolution with no further complications by 11/15/15. R79 ' s Care Plan Snapshot of 11/26/15 to 2/2/16 shows problem date for C-Diff of 10/25/15 and target goal for resolution and no further complication on 11/27/15. R79 ' s Care Plan Snapshot of 1/21/16 to 2/2/16 shows problem date for C-Diff of 1/6/16 and target goal for resolution and no further complications on 1/22/16. R79 ' s Current Plan of Care with Last Care Conference of 1/25/16 shows problem date for C-Diff of 1/27/16 and target goal for resolution and no further complications is 2/12/16. This is the day after R79 ' s initial signs/symptoms of C-Diff were noted. Review of all the above Care Plan shows no new interventions or changes. 7.) R91 ' s progress note from 1/25/16 shows resident observed with multiple loose stools this shift; stool foul smelling, liquid; will obtain stool specimen to rule out C-Diff; Doctor notified. Sample was obtained and lab notified for pick up R91 ' s progress note from 1/27/16 shows doctor notified of positive C-Diff results. R91 ' s Current Care Plan with Last Conference Date of 2/1/16 shows a problem start date of C-Diff on 1/28/16 and the target goal is R91 will have no further complications by 2/20/16. Under approaches states, to follow principles of infection control and universal standard precautions for C-Diff. This is 3 days after first signs and	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 279	Continued From page 8	F 279		

8.) R3 ' s Quarterly Assessment dated 1/4/16 under section D (Mood) is coded as no mood indicators or issues. Under section E (Behaviors) shows it is not coded for any indicators for psychosis or behavioral symptoms or any associated issues identified with behaviors.
According to same assessment R3 requires extensive assistance of two staff for bed mobility, transfers, dressing, toilet use and personal hygiene
R3 ' s Care Plan with last Care Plan Conference date of 12/7/15 provided as R3 ' s most current plan of care shows R3 has and ADL (Activity of Daily Living deficit related to bed mobility, at times requires extensive assist of two; R3 has and ADl deficit related to transfers and requires extensive assist of two; R3 exhibits the following behaviors: resist care, hits, kicks, bites direct care staff trying to approach her to provide personal care. R3 ' s Point of care history requested from re-admission on 10/27/15 to 1/27/16 with print date of 1/27/16 shows last documented behavior on 11/12/16 at 2:29 AM.
R3 ' s Behavior tracking Form for 12/2015 shows one behavior on 12/20/15 at 8:45 AM and was resistive to care, duration one hour and severity was moderate.
R3 ' s Behavior Tracking Form for 01/2016 shows behavior on 1/1/16 at 2:00 AM and was resistive to care, the duration was 5 minutes and severity is note coded..
According to document dated 2/2/16 signed by Z2 for R3 shows "It is clinically contraindicated to attempted any reduction on this medication since it is effective with resident exhibiting no signs/symptoms of any agitation, aggressive or combative behaviors in January 2016,
No other documentation can be found regarding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 279	Continued From page 9 R3 having behaviors of resisting care of staff before and during time pressure ulcer was acquired in the facility. R3 ' s decrease behavior was not identified in the plan of care and no new non-pharmacological interventions were put on R3 ' s plan of care related to improvement in behaviors.	F 279		
F 281 SS=F	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 CDC (Center for Disease Control) recommendations/guidelines and disinfection product manufactures guidelines for infection control and to prevent the spread of the infectious organism C-Diff(Clostridium Difficile). This failure has the potential to affect all 110 residents. Findings include: At 2/3/16 at 9:10 AM, E2 DON (Director of Nursing) stated that infection control policies are based on CDC (Centers for Disease Control) guidelines, so if something is not in the facility policy, CDC guidelines are used. 1. According to the CDC (Center for Disease Control) information titled " CDC 24/7: Saving Lives. Protecting People-Frequently Asked Questions about Clostridium difficile for Healthcare Providers " shows any surface, device, or material (e.g., commodes, bathing	F 281		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 10	F 281		

tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the C-Diff spores. C-Diff spores are transferred to patients mainly via hands of healthcare personal who have touched a contaminated surface or item. How can C-Diff infections be prevented in hospitals and or other healthcare settings: Use Contact Precautions: for patients with known or suspected C-Diff infections- use gloves when entering patients ' rooms and during patient care, perform hand hygiene after removing gloves (because alcohol does not kill C-Diff spores, use of soap and water is more efficacious than alcohol based hand rubs, preventing contamination of the hands via glove use remains the cornerstone for preventing C-Diff transmission via the hands of healthcare workers. Use gowns when entering patients rooms and during patient care. Dedicate or perform cleaning of any shared medical equipment. Continue these precautions until diarrhea ceases (because C-Diff infected patients continue to shed organism for number of days following cessation of diarrhea). Implementation and environmental cleaning and disinfection strategy: Ensure adequate cleaning and disinfection of environmental surfaces and reusable devices, especially items likely to be contaminated with feces and surfaces that are touched frequently. Consider using EPA (Environmental Protection Agency)-registered disinfectant with a sporicidal claim for environmental surface disinfection after cleaning in accordance with label instructions. Follow the manufacturer ' s instructions for disinfections of endoscopes and other devices. Recommended infection control practices in long term care and home health settings are similar to those taken in traditional health care settings. According to the CDC document titled " Infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	**3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959**

(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 281	Continued From page 11 Prevention During Blood Glucose Monitoring and Insulin Administration " shows The CDC has become increasingly concerned about the risks for transmitting of hepatitis B virus (HBV) and other infectious disease during assisted blood glucose (blood sugar) monitoring and insulin administration. CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirement: Finger stick devices should never be used for more than one person, whenever possible blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer ' s instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. General: Unused supplies and medication should be maintained in clean areas separate from used supplies and equipment (e.g. glucose meters) does not carry supplies and medications in pockets The facility identified germicidal bleach wipe used to clean the blood glucose monitoring machine documents " a 3 minute contact time is required to kill Clostridium difficile spores and reapply as necessary to ensure that the surface remains wet for the entire contact time. Allow surface to air dry. " This is the directions identified on the container as instructions for use. The facility identified disinfection use by the facility to use when cleaning residents rooms by housekeeping staff for residents identified in isolation for C-Diff, documents guideline for use " when cleaning for C-diff a 8 minute contact time is necessary for cleaning the spore and fecal matter/waste must be thoroughly cleaned from surfaces/objects before disinfection by application with a clean cloth, mop, and/or sponge saturated	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 12 with the disinfectant product. Cleaning is to include vigorous wiping and/or scrubbing, until all visible soil is removed. Special attention is needed for high touch surfaces. Surfaces in patient rooms are to be cleaned in an appropriate manner. Restrooms are to be cleaned last. " This is the directions identified on the container as instructions for use. According to the informational document provided by the facility regarding their bleach solution, documents " kills C-Diff spores in one step in three minutes but, contact time for disinfectant is the amount of time a surface must remain wet with the product to achieve disinfectant. " The Center for Disease Control, CDC, guidelines under 11/1 Environmental Measures " Certain Pathogens (e.g. ....C. difficile) may be resistant to some routinely used hospital disinfectants. Also, since C-Difficile may display increased level of spore production when exposed to non-chlorine based cleaning agents, and spores are more resistant than vegetative cells to commonly used surface disinfectants, some investigators have recommended the use of 1:10 dilution of 5/25%...hypochlorite (household bleach) and water for routine environmental disinfection of rooms and with patients with C. difficile when there is continued transmission. " a. On 1/27/16 at 9:52 am, observation was made of wound care being performed on R7 ' s right heel. E8 (Licensed Practical Nurse) performed the treatment correctly but when the treatment was complete E8 put the scissors that was used during the task into her (E8) right pocket of her uniform shirt without cleaning them first. E8 said she didn ' t ' clean the scissors but she was going to later. E8 said she put the scissors in a pocket by themselves and wouldn ' t put anything else in with them.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 13 b. On 1/27/16 at 7:25 PM, E39 RN (Registered Nurse) entered R11's room to give him his evening medications and was not wearing gloves. R11 had isolation signs posted on his doorway. At that time E2 DON (Director of Nursing) was questioned as to why R11 was on isolation and she stated R11 had been diagnosed with C-Diff and he had just been put on isolation today. R11's nursing note dated January 26, 2016 at 8:20 AM states "Res (resident) c (with) c/o (complaints of) loose stools et (and) stomach cramps last NOC (night). Abd (abdomen) soft et non tender. Occasional c/o stomach cramping. " R11's nursing note on January 27, 2016 at 10:43 AM "...reports resident positive for C-Diff, MD notified" A lab report from a local hospital laboratory dated January 27, 2016 states the lab specimen was collected on January 26, 2016 at 10:31 AM as: "C.Difficile PCR Positive C#, a positive result indicates the detection of toxigenic C.Difficile DNA." The Care Plan for R11 lists a problem start date of January 27, 2016 for "Dx (diagnosis) of C-diff." with approaches on the same date of "Follow principles of infection control and universal/standard precautions for c diff," which was more than 24 hours after R11 first reported symptoms. c. R14 ' s nursing note dated 1/10/16 at 12:44 PM by E21 (LPN) shows "Resident complains of having diarrhea at least twice a week. Residents Power of Attorney requesting doctor be notified.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 14 Resident denies any pain or discomfort. Resident states "It's been going on for a while now. I can ' t remember how long." R14 ' s nursing note on 1/12/15 shows a doctors order to check stool for C-Diff. R14 ' s nursing note on 1/15/16 has resident positive for C-Diff. R14 ' s Plan of Care shows problem start date 1/15/16, R14 has diagnosis of C-diff and staff are to follow principals of infection control and universal/standard precautions for C-Diff. On 1/26/16 at 4:00 PM, E6 LPN (Licensed Practical Nurse) monitored R14 blood glucose. E6 stated " I can ' t take the strip bottle in the room because R14 is on isolation. " E6 performed glucose test but the machine did not register R14's result and E6 placed the used lancet into the trash can. E6 took lancet out of the trash can, wrapped the lancet and monitor strip in a glove, placed the blood glucose meter on the counter top and washed hands. E6 then put on gloves picked up contaminated glove with gloved hand and exited the isolation room. E6 placed wrapped glove in sharps container. E6 then removed gloves and cleaned her hands with alcohol cleanser only. E6 then touched top of medication cart and blood glucose strip container, obtained another strip, applied cleaned gloves and re-entered isolation room. When E6 finished the procedure she took the blood glucose machine out of the isolation room and used germicidal bleach wipe to clean the blood glucose monitoring machine. She wiped over the surface of the blood glucose meter once for less than ten seconds and placed it on top of the germicidal wipe that was on top of the 100 hallway medication cart. E6 then waited three minutes and placed the blood glucose machine inside the top drawer of the 100 hallway medication cart	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 15	F 281		

without any protective covering and on top of another blood glucose monitoring machine. The medication cart contained another blood glucose monitoring machine, eye drops, nasal sprays, insulin pens and oral medications.
On 1/27/16 at 9:00 AM, E6 (LPN) stated she thought R14 went on isolation the first time on 1/16/16 and the second time she thought R14 went on isolation on 1/25/16. E6 stated that R14 was on isolation for C-Diff. E6 stated the way she cleaned blood glucose monitor was to wipe it down and then let it sit for three minutes. E6 did not verbalize knowledge of manufacture guidelines regarding the use of germicidal cleaner used for blood glucose monitoring for Clostridium Difficle.
On 1/27/16 at 9:35 AM, R14 stated staff had been helping her after she went to the bathroom. R14 stated staff had to help her because she was having problems getting herself completely cleaned because she was having diarrhea and loose stools. R14 stated this (staff helping) was before her son had spoken with nursing about his concern about her having so many diarrheas. R14 stated she thought the problem with the diarrhea and loose stool was going on for a week or two before her son had spoken to the nurse about his concerns about her having the diarrhea. R14 stated that after her son spoke to nursing and relayed his concerns to them about her loose stools and diarrhea, nursing then spoke to the physician about these symptoms. R14 stated she had been told just to make sure she washed her hands really good. R14 stated she has been, and continues to go to the main dining room for meals and goes to activities and wheels herself around the facility. R14 stated that she keeps her own journal to write down when she has showers and when she has bowel movements so she can

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 16	F 281		

keep track of her care. R14's journal showed bowel movements noted every day from 1/19/16 to 1/27/16. R14's Brief Mental Assessment was done on 1/5/16 and shows a score of 12 indicating she is able to answer questions appropriately.
On 1/27/16 at 9:45 AM, E2 (DON) stated R14 was on isolation starting on 1/15/16 but came off for a couple days and went back on 1/25/16.
On 1/27/16 at 10:15 AM, E11 CNA (Certified Nursing Assistant) stated she had given R14 a shower last Tuesday (1/20/16). E11 stated R14 was on isolation at that time. E11 stated she gave R14 the shower in the community bathroom on 100 hallways. E11 stated when she was done with R14 ' s shower; she wiped everything in the common bathroom down with the bleach wipes. E11 was not able verbalize how to clean according to the bleach wipe manufactures guideline. E11 did not indicate if or how the shower room was mopped or deep cleaned or if this was done.
On 1/28/16 at 11:10 AM, E20 LPN (Licensed Practical Nurse) entered R14's identified C-Diff isolation room to administer insulin. E20 took R14 ' s insulin pen into the room and injected R14 in the abdomen. E20 placed the insulin pen on the sink, and it was half on a barrier and half on the countertop. E20 washed her hands and applied new gloves and picked up insulin pen and placed it on clean barrier next to the blood glucose monitoring machine. E20 picked up insulin pen and exited room. E20 wiped over R14 ' s insulin pen with the facility designated bleach disinfectant for less than 10 seconds and placed it in top of medication cart drawer with other insulin pens. When questioned E20 stated she should have cleaned the insulin pen longer before she placed it in the medication cart. At no time did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 17	F 281		

E20 re-clean the identified contaminated insulin pen. When E20 was questioned, she stated she was just starting her noon medication pass and would be giving more medications and insulin.
On 1/29/16 at 8:45am, DON stated if resident is symptomatic for C-Diff will go ahead and put in isolation.
On 1/29/16 at 9:45 AM, E22(Housekeeper) stated R14's room was on the 100 hallway. E22 stated she normally cleaned R14's room and even prior to her being put on isolation resident was having "explosive, foul smelling stool" and she was pretty sure it was C-Diff. E22 stated that when she had asked the nursing assistant what was going on with R14, they were aware she was having loose stool and E22 figured the nurses knew too. E22 stated even before R14 was on isolation R14 had a loose stools and R14 had stool all over the bathroom and across her room to her closet. E22 stated that R14 would try to clean up the feces herself but didn't do a very good job. E22 stated R14 trying to clean up after problems with loose stools had occurred more than once. E22 stated she had been sweeping R14 ' s room with a broom and bringing it out and putting it on the housekeeping cart as well as the dustpan. E22 stated she probably should have not done this and used the dust mop. E22 stated she never used a gown when cleaning R14 room. E22 stated when she cleans a room for C-Diff she cleans the bathroom in the middle of the cleaning process, not last. E22 stated she used the same housekeeping cart to clean hallway 100 and 200. E22 stated she was the regular housekeeper on these units and her assignment for each day was to take care of both 100 hallway and 200 hallway.
On 2/2/16 at 3:25 PM, Z3 (Power of Attorney) for R14 stated that he was the one that made the facility nurse aware of R14 having issues with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 18 loose stools. Z3 stated R14 had so much loose stool in her adult brief that it was saturated and coming apart. Z3 stated R14 had told him and the nurse who was a Registered Nurse that she had been having the loose stools for a while and she had been needing help making sure she was getting herself clean. Z3 stated that a while back, around the beginning of 2015, R14 had issues with C-Diff and the facility had treated it totally different. Z3 stated they had been much more strict with the isolation precautions and were cleaning all the time. Z3 stated this is why he was so concerned this time because the facility didn ' t seem to be doing any precautions. Z3 stated the only way he had been made aware of what the " bug " was is because he had family in the medical field and they had explained how serious it could be. Z3 stated the facility did not do any education with him or R14 except put R14 on isolation and tell them to make sure to wash their hands with soap and water because alcohol wouldn ' t work. Z3 stated that approximately 10 days ago he was at the facility visiting R14 and the nurse had done R14 ' s blood glucose monitor and gave R14 her insulin in the common area across from the dining room. Z3 stated the nurse did not have the cart with her but made two trips up the hallway once with the blood glucose machine and once with R14 ' s insulin. On 2/2/16 at 4:05 PM, Z2 (Medical Director/Primary Care Physician) stated he was the Medical Director for the facility and was the Primary Care Physician for R14 and R16. Z2 stated that if a resident was having any signs and symptoms of an infectious disease and specifically C-diff such as loose stool, then he would expect the facility to put them on the appropriate isolation as soon as the symptoms were present. Z2 stated he would expect the	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 19	F 281		

facility to notify the primary care physician for further direction with regard to culture or care of the issue. Z2 stated C-Diff is a spore and therefore was not cleaned in the same manner as some other organisms. Z2 stated he would expect the facility to clean according to what the direction or guidelines of the product said, or according to the facility policies. Z2 stated all staff should be communicating to nursing if they are seeing signs of C-Diff such as the loose stool.
d. During an observation on January 29, 2016 at 8:10 AM, E18, (Housekeeper), and E19 (Housekeeper trainee) entered R16's room to spray R16's bed with sanitizing solution containing bleach. According to a lab result dated December 23, 2016, R16's stool was positive for cdiff infection. E19 was holding a spray bottle of disinfectant containing bleach in one hand and a cleaning rag in another. E19 sprayed the mattress then immediately wiped the mattress with the cloth in the other hand. After E19 finished wiping R16's mattress, E19 handed the disinfectant bottle containing bleach to E18. E18 took the bottle and without changing gloves, took keys out of her uniform pocket, opened the housekeeping locked storage area, placed the bottle into the housekeeping cart on top of the other bottles of cleaning solutions including window cleaner and a bottle labeled "Oxyfest" without cleaning the bottles. E18 and E19 were wearing gloves during the spraying and wiping of R16's bed and mattress but neither were wearing gowns or any other personal protection equipment (PPE) to protect E18's or E19's clothing from becoming contaminated. E18 and E19 removed their gloves, went into R16's bathroom, washed their hands and exited the room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 20 On January 29, 2016 at 9:20 AM, E18 and E19 returned to R16's room to perform mopping, cleaning and disinfection assignments to the furniture, bathroom, sink shower, floor, trash and linen containers, etc. E18 and E19 went to the PPE container inside the entrance door to the room, obtained gowns, and took the gowns into R16's bathroom and both put on the gowns and gloves in R16's bathroom. E19 went to the housekeeping cart located outside R16's doorway, unlocked the storage area on top of the housekeeping cart, retrieved the sanitizing solution and began spraying the over the bed table, bedside table, floor, chest of drawers, heater/air conditioner, bathroom floor, shower, sink top, toilet, walker, and toilet riser. E19 then retrieved a broom from the housekeeping cart and started sweeping the wet floor under R16's bed, around the above mentioned furniture, and in front of the doorway. E19 went to the housekeeping cart and obtained the dust pan from the housekeeping cart and swept the dirt from the floor into the dust pan and placed the dirt into the trash can in R16's room, then placed the broom and dust pan back on the housekeeping cart without disinfecting the broom or dust pan. E18 was in R16's bathroom wiping down the shower, and stated "I need some gloves" came out of R16's bathroom removed the gloves she was wearing, and protective gown covering her clothes, leaving R16's room without washing her hands. E18 verified per interview on January 29, 2016 at 9:30 AM she went to the janitor's closet to obtain the box of gloves, and placed the gloves on the housekeeping cart. Upon re- entering R16's room E18 put a protective gown over her uniform and went back into R16's bathroom and started wiping down the walker, toilet riser, sink surface, sink faucets, wall and towel bars. E18	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 21	F 281		

left the bathroom and walked to the housekeeping cart, and without changing gloves retrieved more cleaning cloths from a plastic bag half full of cloths on the housekeeping cart, contaminating the clean cloths. E19 was mopping the floor and stopped mopping to pick up a piece of trash off the floor, placed it in the trash can in R16's room, then continued mopping, contaminating the mop handle. E19 mopped the flooring under R16's bed, then proceeded to R16's bathroom, then returned to the rest of the bedroom floor, mopping the bathroom floor prior to mopping the floor entering R16 bedroom. E18 and E19 removed the PPE, placed it in the trash can in R16's room, went into R16's bathroom, washed their hands and left R16's room. E18 and E19 entered R19's room to perform mopping, cleaning and disinfection assignments to the furniture, bathroom, sink shower, floor, trash and linen containers, etc. According to the initial MDS, R19 does not have a diagnosis of cdiff. However, according to R19's care plan dated December 29, 2015 shows a reduced immunity, due to receiving radiation for lung cancer. E19 used the same contaminated broom, dust pan and mop handle, that was used in R19's room to clean R16's room.

R16's face sheet states she was admitted on December 15, 2015 at 12:43 PM, and according to the Admission Minimum Data Sets (MDS) dated December 22, 2015 has a diagnosis of Diabetes Mellitus type II; Ulcerative Colitis; Hip Fracture; Pressure Ulcer; Pain; Weakness; and Diarrhea.

R16's nursing note dated December 18, 2015 at 8:30 PM, states, "Res (resident) has had several episodes of diarrhea x (times) 2 days. Res does report she has hx (history) of IBS (irritable bowel

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 22	F 281		

syndrome) but also reports she took multiple antibiotics while in hospital. Will obtain stool sample to r\o (rule out) cdiff. (R16's) physician notified, and on December 18, 2015 R16's Physician Order Sheet (POS) lists an order for "stool for cdiff."

R16's nursing note dated December 21, 2015 at 10:50 AM states "No BM (bowel movement) x 3 days. Res reports that she had a BM yesterday." Another nursing note dated December 23, 2015 at 2:21 AM states "Stool sample x 1 obtained at this time, lab notified for p\u (pick up)."

R16's laboratory report for the stool for cdiff from a local hospital laboratory dated December 23, 2015 states "collected December 23, 2015 at 4:00 PM; received 5:23 AM; and verified 10:53 AM, cdiff positive, a positive result indicates the detection of toxigenic c. difficile DNA."

R16's care plan has a problem start date of December 23, 2015 and states "She has c-diff" with approaches initiated on the same date of as: "encourage resident to wash hands after defecation. Encourage resident to wash hands before meals. Follow principles of infection control and universal/standard precautions for c diff." This care plan was initiated 5 days after symptoms of diarrhea had begun.

e. According to the facilities Infection Control log for 01/2016, R18: had diagnosis and treatment for C-Diff on 11/29/15, 12/18 &/or 19/15, and 1/6/16. All of R18 diagnoses of C-Diff are designated as nosocomial infections.
f. R19's Care Plan with last conference date of 1/25/16 shows an admit date of 12/2/15 and diagnosis of Carcinoma in situ of unspecified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 23	F 281		

bronchus and lung, and identified problem is R19 requires radiation, Lung cancer. R19's goal is she will not exhibit signs of complication reduced immunity secondary to radiation use. Approach by the facility is to monitor/observe/assess resident for signs/symptoms of complications related to radiation therapy including reduced immunity.
g. R79's progress note from 1/26/16 shows resident with loose, foul smelling stool, doctor was notified, stool specimen was collected for C-Diff
R79's progress note from 1/27/16 shows lab reports resident is positive for C-Diff
Infection Control Log for November 2015, December, 2015 and January 2016 shows R79 with nosocomial C-Diff infections with onset dates of 11/6/15, 11/11/15, 12/30/15 and 1/27/16. This has the C-Diff infection with onset date of 11/11/15 as resolved on 11/30/15.
According to the facilities current Infection Control Log for January 2016, R79 was identified as having and/or being treated for signs and symptoms of C-Diff on 1/27/16.
R79's Care Plan Snapshot of 1/21/16 to 2/2/16 shows problem date for C-Diff of 1/6/16 and target goal for resolution and no further complications on 1/22/16.
R79's Current Plan of Care with Last Care Conference of 1/25/16 shows problem date for C-Diff of 1/27/16 and target goal for resolution and no further complications is 2/12/16. This is the day after signs and symptoms of C-Diff were noted by facility. Under approaches states to follow principles of infection control and universal standards of precautions for C-Diff.
h. R91's progress note from 1/25/16 shows resident observed with multiple loose stools this shift; stool foul smelling, liquid; will obtain stool

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 24 specimen to rule out C-Diff; Doctor notified. Sample was obtained and lab notified for pick up R91's progress note from 1/26/16 shows doctor noted resident ' s loose stool, approved request for stool sample check for C-Diff. R91's progress note from 1/27/16 shows doctor notified of positive C-Diff results. R91's Current Care Plan with Last Conference Date of 2/1/16 shows a problem start date of C-Diff on 1/28/16 and the target goal is R91 will have no further complications by 2/20/16. Under approaches states, to follow principles of infection control and universal standard precautions for C-Diff. This is three days after signs and symptoms of C-Diff are identified. According to the facilities Infection Control Log for December 2015 and January 2016 R91's onset date was 1/27/16 and is identified as a nosocomial infection i. According to document provided by facility on 1/29/16 the following residents share blood glucose monitoring machines according to the specified hallways: 100 hallway: R26, R31, R34, R47, R19 (C-Diff identified resident) 200 hallways: R57, R1, R3, R54, R57, R110 300 hallways: R62, R66, R67, R108, R70 400 hallways: R78, R80, R81, R83, R85, R86 600 hallway: R89, R99, R104, R90, R92, R109, R105, R102, R16 (C-Diff identified resident) j. On 1/26/16 at 4:25 PM, E9 RN (Registered Nurse) performed blood glucose monitoring for R66 in her room. E9 took the machine out of the top drawer of the medication cart with her bare hand and placed it on top of the cart. E9 put on gloves and picked up the monitor and went into R66 ' s room. E9 used the monitor by holding it in her hand during the check and exited the room and used a germicidal wipe to clean the machine	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 25 for over three minutes but then immediately placed it in the top drawer of the medication cart hallway and blood glucose monitor was not dry at that time and not placed in any type of protector. In the top of the drawer was another blood glucose monitoring machine as well as insulin pens, oral medications, eye drops, nasal sprays and inhalant medications. On 1/27/16 at 9:05 AM, E2 DON(Director of Nursing) stated to clean a blood glucose monitor after use in an isolation room or for someone on C-Diff isolation, the staff is suppose to wipe it for one minute then let it air dry for three minutes. E2 stated each hallway has a designated medication cart and each cart has at least two blood glucose monitoring machines and the machines are shared between residents and they are cleaned with the germicidal bleach cleaners for infection control. On 1/27/16 at 10:50 AM, E15 LPN (Licensed Practical Nurse) stated she normally works on the 200 unit and as far as she knew, to clean the blood glucose monitoring machine was to wipe of the machine for one minute and then let it dry for three minutes. E15 did not indicate any difference with cleaning in isolation or a regular room. E15 was not aware of contact time of the manufacture guidelines for the germicidal bleach wipes. On 1/27/16 at 11:00 AM, E14 RN (Registered Nurse) stated her normal assignment is the 400 hallway and the way she cleaned a blood glucose monitoring machine was to wipe the machine for one minute and then let dry for three minutes. E15 stated she was not aware of any difference if it was an isolation room or not. E15 stated she was not aware of contact time of the manufacturer guidelines for the germicidal bleach wipes.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 26 On 1/28/16 at 10:00 AM, E16 (Housekeeper/laundry Aid) stated she didn't work as a housekeeper very often but was training E17 (Housekeeper). E16 stated she had been trained to use a bleach based disinfectant but they had started using a different cleaner and she was not sure of how to use it, but E17 had been trained by another housekeeper on how to use that disinfectant product. E16 stated she used a pre-mixed solution from the maintenance room to mop the floor of all the rooms, E16 indicated she used these for the isolation rooms as well. E16 stated if someone was on isolation it was on a board in the maintenance room and the reason they were on isolation. E16 then proceeded to the maintenance room between 400 and 600 hallways and showed a bleach based product in awhite bottle she used to clean isolation rooms. On 1/28/16 at 10:45 AM E4 (Housekeeping Supervisor) was in the maintenance room. The board that is used to identify residents on isolation precautions and the corresponding reason/organism did not show R11 listed. E4 stated the staff is to use the corporate identified disinfectant which is a bleach product to clean surfaces and floors. E4 stated the pre-mixed solution in the maintenance room is not to be used when cleaning for C-Diff. E4 stated E16 should not be using the white bleach product she had showed earlier in the maintenance room off the 400 hallway. E4 stated corporate had given the facility a new product to use to disinfect for C-Diff. E4 stated all staff should know and have been trained how to use this product correctly with any type of isolation but especially C-Diff infections. E4 stated she expected housekeeping staff to clean an identified C-Diff isolation room with the corporate provided product and that included to mop the floors.	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 27 On 1/28/15 at 11:00 AM, E5 (Housekeeper) stated if someone was on isolation it should be on the board in the maintenance room. E5 was unable to verbalize why R11 was on isolation precautions. E5 stated when she cleaned an identified isolation room for C-Diff she sprayed with the disinfectant the facility had told her to use. E5 stated she sprayed all the surfaces then went back and wiped it off with a paper towel. E5 stated she would take the broom and dust pan into isolation room and dust mop the floor. E5 stated she then would spray the bottom of the broom bristle with the identified disinfectant and the dust pan and place them back on her housekeeping cart. E5 stated she mopped the room with the pre-mix solution from the maintenance room and stated it was a yellow product and already on her cart and the mop heads were soaked in it. E5, Housekeeping, stated on 1/29/16 at 9:45 AM when cleaning the room of a resident who is on contact isolation for C-Diff, E5 does not routinely wear personal protective equipment such as gowns, masks, or shoe covers. E5 stated that if there was visible soiling such as urine or bowel on the floor then E5 would put on shoe covers. E4, Housekeeping Supervisor, stated on 1/29/16 at 9:50 AM that the same broom and dustpan are used to clean multiple rooms on same halls, including isolation rooms of residents on contact isolation for C-Diff. E4 stated she never even thought about the sweeping brooms and dustpans going in and out of residents rooms from an isolation room, and those needing to be cleaned, and how or when, and then putting them back on the housekeeping carts after use in an isolation room. On 2/03/2016 at 9:10 am, E1-Administrator and E2 Director of Nurses, were asked about the	F 281		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 281	Continued From page 28 Infection Control Log and to explain how the column "Nosocomial YES/NO" was used. E2 stated that nosocomial meant that the infection was acquired in any health care setting. E1 stated at that time that for the purpose of their infection log, nosocomial would mean that the infection was aquired in house at their facility. E2 then stated, "I did not realize that". E2 further stated at this time that if someone has signs and symptoms of Clostridium Difficle infection, "we would put them on isolation at first suspicion even before a positive culture." According to the Resident Census and Conditons of Resident report dated 1-26-16, the facility had 110 residents in the facility.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure interventions identified on the plan of care were followed for 1 (R4) of 22 residents reviewed for care plans in the sample of 22. Findings include: R4's Care Plan with admit date of 10/30/15 and last care conference on 1/25/16 shows R4 is at risk for falls related to reduced independent mobility, diagnosis of glaucoma, hypertension, weakness, vitamin D Deficiency, fall resulting in left hip nonsurgical fracture on 1/1/16 20lb TTWB	F 282		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 282	Continued From page 29 (toe touch weight bearing) to LLE (left lower extremity) Transfer X1 staff member and the goal is R4 will have decreased risk for falls this quarter. Under approaches shows to transfer method: gait belt; level of assistance; extensive of assist of 1. TTWB LLE. On 1/26/15 at 1:50 AM, E29 (Garden Court Coordinator) and E27 CNA (Certified Nursing Assistant) transferred R4 from her wheelchair to the toilet. E27 CNA grabbed R4 underneath her left arm during the transfer instead of using just the gait belt. R4 was taking shuffle steps and bearing full weight on both lower extremities. On 2/2/15 at 12:45 PM, E26 CNA transferred R4 off of the toilet into her wheelchair. E26 was standing behind R4 during the transfer. R4 let go of the grab bar in the bathroom in order to pull up her own pants up and put full weight on both lower extremities. When questioned, E26 was unable to answer if R4 had any weight bearing restrictions with her transfers. On 2/2/15 at 1:00 PM, E28 CNA stated she is one of the regular staff that helps take care of R4. E28 was questioned if R4 had any weight bearing restrictions for transfers. E28 stated she did not know of any. On 2/2/16 at 12:40 PM, Z4 (Physical Therapist) stated when staff are transferring a resident they should use a gait belt for the transfer. Z4 stated the person/s transferring should be using the belt to physically assist the resident. Z4 stated staff should not have a hold of the resident under the arm because of patient safety. Z4 stated if someone is shuffling their feet and putting weight on the extremity then a 20 lb. TTWB LLE restrict transfer is not being done correctly and resident is bearing more weight than they are supposed to. Z4 stated this would be full weight bearing if the resident is making a shuffling gait. Z4 stated	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 282	Continued From page 30 an orthopedist will recommend restricted weight bearing to promote healing especially if the resident is not able to have a surgery done for some reason. Z4 stated a 20lb TTWB could be done with one person but staff would have to be positioned in front of the resident and the resident would have to have ahold of the person assisting with the transfers. Z4 stated the resident would need to have ahold of the staff members forearms and the resident's foot or extremity with the weight bearing restriction would need to be barely touching the floor or have in the air during the entire transfer. Z4 stated if the resident let go of the grab bar and stood on both feet and pulled up her own pant then a 20lb weight bearing restriction could not have been done correctly.	F 282		
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 ensure safe transfers for 1 (R4) of 6 residents reviewed for falls and transfers in the sample of 22. Findings include: R4's progress note on 12/14/15 states resident returned to facility from appointment with orthopedic doctor, to continue 20 lb. (pound)	F 323		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 323	Continued From page 31 TTWB (Toe Touch Weight Bearing) LLE (Left Lower Extremity). On 1/26/15 at 1:50 AM, E29 (Garden Court Coordinator) and E27 CNA (Certified Nursing Assistant) transferred R4 from her wheelchair to the toilet. E27 CNA grabbed R4 underneath her left arm during the transfer instead of using just the gait belt. R4 was taking shuffle steps and bearing full weight on both lower extremities. On 2/2/15 at 12:45 PM, E26 CNA transferred R4 off of the toilet into her wheelchair. E26 was standing behind R4 during the transfer. R4 let go of the grab bar in the bathroom in order to pull up her own pants and put full weight on both lower extremities. E26 was unable to answer if R4 had any weight bearing restrictions with her transfers when she was questioned at that time. On 2/2/15 at 1:00 PM, E28 CNA, stated she is one of the regular staff that helps take care of R4. E28 was questioned if R4 had any weight bearing restrictions for transfers. E28 stated she did not know of any. On 2/2/16 at 12:40 PM, Z4 (Physical Therapist) stated when staff are transferring a resident they should use a gait belt for the transfer. Z4 stated the person/s transferring should be using the belt to physically assist the resident. Z4 stated staff should not have a hold of the resident under the arm because of patient safety. Z4 stated if someone is shuffling their feet and putting weight on the extremity then a 20 lb. TTWB LLE restrict transfer is not being done correctly and resident is bearing more weight than they are supposed to. Z4 stated this would be full weight bearing if the resident is making a shuffling gait. Z4 stated an orthopedist will recommend restricted weight bearing to promote healing especially if the resident is not able to have a surgery done for some reason. Z4 stated a 20lb TTWB could be	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 323	Continued From page 32 done with one person but staff would have to be positioned in front of the resident and the resident would have to have ahold of the person assisting with the transfers. Z4 stated the resident would need to have ahold of the staff members forearms and the resident's foot or extremity with the weight bearing restriction would need to be barely touching the floor or have it in the air during the entire transfer. Z4 stated if the resident let go of the grab bar and stood on both feet and pulled up her own pants then a 20lb weight bearing restriction could not have been done correctly. R4's Care Plan with admit date of 10/30/15 and last care conference on 1/25/16 shows R4 is at risk for falls related to reduced independent mobility, diagnosis of glaucoma, hypertension, weakness, vitamin D Deficiency, fall resulting in left hip nonsurgical fracture on 1/1/16 20lb TTWB to LLE Transfer X1 staff member and the goal is R4 will have decreased risk for falls this quarter. Under approaches shows to transfer method: gait belt; level of assistance; extensive of assist of 1. TTWB LLE.	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.	F 328		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 328	Continued From page 33	F 328		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview and record review the facility failed to follow their policy and procedures for Peripherally Inserted Central Catheter's (PICC) for 1 (R12) of 4 residents reviewed for special care needs in the sample of 22 residents.
Findings include:
On 1/27/16 at 8:00 AM, E9 RN (Registered Nurse) was administering medication for R12 through her PICC line inserted in her upper left forearm. E9 did not have on gloves when she took the tubing for the PICC out of the packaging. E9 touched the clean tubing against R12's trash can and the floor beside the bed. E9 continued to use the contaminated tubing and connected it to the needleless connector in R12 ' s right arm and into the medication and mixture solution. E9 spiked the administration set into the solution and did not have on gloves. E9 wiped the needleless connector with alcohol and immediately inserted the flush syringe into the needleless connector, no air dry was allowed for. E9 removed the syringe from the needleless connector, cleansed the needleless connector with alcohol and immediately inserted the administration set into the needleless connector, no air dry time was allowed for.
On 1/27/16 at 8:40 AM, E9 (RN) entered R12 ' s room without any gloves. E9 picked up a syringe of 0.09% Sodium Chloride that was lying on R12's bedside table. E9 cleansed the needleless connector with alcohol and immediately flushed the needless connector with the Sodium Chloride flush and no time was allowed for air dry.
On 1/27/16 at 9:00 AM, when questioned E2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 328	Continued From page 34 DON (Director of Nursing) if nursing staff were to wear gloves during the medication administration of a PICC and/or the ordered flushes, E2 stated "Yes, she should have had on gloves." R12 ' s MAR (Medication Administration Record) for 1/1/16-1/28/16 shows R12 was to receive Cubicin (Antibiotic) recon solution; 500 mg (milligrams) intravenous every morning and flush PICC with 10 ml (milliliters) NS (Normal Saline) before and after medication administration for osteomyelitis. The facility policy titled " Administration of an Intermittent Infusion " with revision date on 8/15/12 shows staff should wash hands and don gloves. Using aseptic technique, remove administration set from packaging and assess integrity, ensuring protective covering are on both ends. Using aseptic technique, remove protective cover from administration set spike and insert spike into solution containing access port. Vigorously cleanse needleless connector with alcohol. Allow to air dry. Maintaining aseptic technique, attach flush syringe to needleless connector. Verify venous access patency. Flush with prescribed flushing agent. Remove syringe. Vigorously cleanse needleless connector with alcohol. Allow to air dry. Attach administration set to needleless connector. When infusion is completed: wash hands and don gloves; vigorously cleanse needleless connector with alcohol. Allow to air dry. Flush venous access device with prescribed flushing agent to maintain patency between intermittent infusions."	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	F 371		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 371	Continued From page 35 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, interview, and record review the facility failed to maintain a final rinse temperature of 180 degrees in the high temperature sanitizing dishwasher. This has the potential to affect all 110 residents in the facility. Findings include: During an observation on January 26, 2016 at 9:20 AM, after being requested to check the high temperature dishwasher for appropriate temperature, E36, Dietary aide, placed a temperature test strip with a blue line on the end of the strip, on a cup and ran the cup through the high temperature dishwashing machine. Upon completion of the wash cycle, the blue strip at the end of test strip turned lighter but remained blue. E36 states "I don't know why the strip is not turning, I always thought it was when the bar turned orange the temperature on the booster heater shows 180 degrees." E36 initialed and dated the temperature test strip and placed it into the bag that contained the test strips and the High Temperature Dish Machine Temperature Log for January 2016. During an interview on January 27, 2016 at 11:10 AM, E37, Dietary Aide while washing dishes with	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 371	Continued From page 36 the high temperature dish washing machine, when asked how often he checks the sanitizing of the dishes with the test strips stated, "Daily." During an observation at the same date and time, this surveyor requested E37 to check the dishwasher with the test strips, and E37 looked at this surveyor, looked back at the dish washer, booster heater, spray nozzle, and finally at E23, Dietary Manager. E23 stated "It's in the baggy" and pointed to the bag containing the test strips. E37 retrieved the test strips, pulled one out of the bag, and placed it between the table and the dishwasher door, then closed the door to the dishwasher on the test strip and ran the dishwasher through a wash cycle. When the wash cycle was complete E37 removed the strip and looked at the end of the test strip, the color of the test strip was bright orange. According to the manufacturers directions on the test strips, bright orange indicates the dishwasher is maintaining the proper temperature. E37 then initialed and dated the strip and placed it into the bag that contained the test strips and the High Temperature Dish Machine Temperature Log for January 2016. On January 27, 2016 at 11:45 AM, E37 in regard to a question on what was the procedure when the temperature of the dish machine was below 180 degrees on the final rinse, stated "I scrape the dishes, rinse them, put them on the rack and run them through" pointing to the dishwasher, and did not mention washing the dishes in the three compartment sink. The directions on the dishwasher temperature single use test strips state "1. Attach the test strip to a utensil or rack by wrapping around and slipping the color bar through the slit under the Taylor name. Wash the item. 2. If the color bar	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 371	Continued From page 37	F 371		

has turned bright orange, the dishwasher is maintaining the proper temperature. Important: Be sure to secure the test strip before washing."

During an interview with E23 on January 27, 2016 at 11:45 AM when questioned about how frequently the dietary staff are to check the dish washing machine with the strips to make sure the temperature is high enough stated "I expect the dishwashers to check the sanitizing rinse weekly with the test strips. They are to date and initial the strip and attach them to the temperature log. I don't know why E37 told you daily."

The High Temperature Dish Machine Temperature Log dated January 1, 2016 through January 26, 2016 specifies: Two mornings where the final rinse temperature is 180 degrees for breakfast. The rest of the breakfast temperatures run as low as 168 degrees; two mid day times where the final rinse temperature is 180 degrees for dinner. The rest of the dinner temperatures run as low as 169 degrees and; two evenings where the final rinse temperature is 180 degrees for supper. The rest of the supper temperatures run as low as 155 degrees with 12 days the temperature was not documented on the log form. There were only two test strips in the bag with the temperature log, the test strip dated January 26, 2016 and January 27, 2016 and no test strips in the bag for the weeks beginning January 3, 10, or 17, 2016.

An interview with E23 on January 28, 2016 at 3:00 PM stated when asked what the dietary staff are to do when the temperature of the dish machine falls below the 180 degrees for the final rinse "They are suppose to hand wash the dishes in the 3 compartment sink if the booster goes out

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 371	Continued From page 38 or the temperature is below 180 degrees in the final rinse." When asked if the dietary staff washed the dishes by hand on the days the temperature log indicated the temperature was below the 180 degrees E23 stated "No they didn't, I have got a call into the people that service the booster heater to get it checked out." According to the Resident Census and Conditons of Resident report dated 1-26-16, the facility had 110 residents in the facility.	F 371		
F 431 SS=E	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	F 431		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 431	Continued From page 39 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: Based on observation, interview and record review the facility failed to label Blood Glucose Monitoring strips to ensure accuracy of Blood Glucose results according to the facility policy and procedure and the manufactures guidelines. This failure had the potential to affect 5 residents (R62, R66, R67, R70, R108) in the supplemental sample reviewed for labeling and storage of drugs and biological's. Findings Include: On 1/26/16 at 4:25 PM, E9 RN (Registered Nurse) performed Blood Glucose Monitoring for R66. E9 took the Blood Glucose Monitoring Strips out of the top drawer of the Medications Cart for the 300 hallway. There was only one bottle of Blood Glucose Monitoring Strips. E9 confirmed when questioned, that the one bottle of Blood Glucose Monitoring Strips was shared with residents on the 300 hallway but, that she used a new strip on each resident. The Blood Glucose Monitoring Strip Container E9 took the strip from to do R66's Blood Glucose Monitoring did not have an open date on it. On 1/27/16 at 8:00 AM, E9 RN (Registered	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 431	Continued From page 40	F 431		

Nurse) was doing morning medication administration on 300 hallway. In the top of the 300 hallway cart was a container labeled Blood Glucose Monitoring Strips. When questioned E9 confirmed there is only one bottle in the 300 hallway cart. E9 also stated that "no" the strip container was "not dated and didn't need to be because they used the expiration date on the bottle". E9 also confirmed the same container of strips were "used for everyone on" the "300 hallway that" received and "has" orders for "Blood glucose checks" monitoring.

On 1/2716 at 8:00 AM, E2 DON (Director of Nursing) was with E9 RN at the 300 hallway medication cart and stated "We use the expiration date on the bottle of the strips (blood glucose), we don't have to date them when they're open because we go by the expiration on the bottle."

According to the facility document titled "Blood Glucose monitoring and/or Insulin" with a date of 1/29/16 signed by E2 shows the following residents receive blood glucose monitoring on the 300 hallway and would have potentially used the Blood Glucose strips that were not dated when opened to monitor their Blood Glucose: R62, R66, R67, R70, R108.

According to the Blood Glucose Test Strips User Guide with no date shows under storage and handling: When stored properly, unopened test strips are stable until the expiration date on the bottle and to use within 6 months after first opening.

According to the Blood Glucose Test; Operators Manual, provided by the facility with no date shows under Important: Record the "date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 431	Continued From page 41 opened" on the bottle label. Discard the bottle and any remaining test strips after 6 months from date of opening.	F 431		
F 441 SS=L	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 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and	F 441		2/10/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 42 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 standard and contact isolation precautions/protocols when caring for residents with infections, failed to adequately clean and thoroughly disinfect shared medical equipment, and failed to use proper infection control practices for cleaning of isolation rooms to prevent transmission of Clostridium Difficile (C-Diff) between residents. This failure resulted in an Immediate Jeopardy with the potential to affect all 110 residents. While the Immediate Jeopardy was removed on 02/02/16, the facility remained out of compliance at a severity level 2 as the facility continues to educate staff and evaluate the effectiveness of the Infection Control policies and procedures. Findings Include: On 2/3/16 at 9:10 PM, E2 stated that infection control policies are based on CDC (Centers for Disease Control) guidelines so if something is not in the facility policy, CDC guidelines are used. According to the CDC (Center for Disease Control) information titled " CDC 24/7: Saving Lives. Protecting People-Frequently Asked Questions about Clostridium difficile for Healthcare Providers " shows C-Diff (Clostridium Difficile) is a spore forming toxin. Disease resulting from C-Diff infections: PCM (pseudomembranous colitis), toxic mega colon, perforations of the colon, sepsis and death. Clinical symptoms: watery diarrhea, fever, loss of appetite, nausea, abdominal pain. Patients at	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 43 increased risk for C-Diff: antibiotic exposure, gastrointestinal surgery/manipulation, long length of stay in healthcare settings, a serious underlying illness, immunocompromising condition, advanced age. C-Diff infections: patient exhibits clinical symptoms, patient test positive for C-Diff organism/or its toxin. How is C-Diff transmitted: C-Diff is shed in feces. Any surface, device, or material (e.g., commodes, bathing tubs, and electronic rectal thermometers) that becomes contaminated with feces may serve as a reservoir for the C-Diff spores. C-Diff spores are transferred to patients mainly via hands of healthcare personal who have touched a contaminated surface or item. How can C-Diff infections be prevented in hospitals and or other healthcare settings: Use Contact Precautions: for patients with known or suspected C-Diff infections- Place these patients in private rooms, if no private room available, patients can be placed in rooms (cohorted) with other patients with C-Diff infections, use gloves when entering patients ' rooms and during patient care, perform hand hygiene after removing gloves (because alcohol does not kill C-Diff spores, use of soap and water is more efficacious than alcohol based hand rubs, preventing contamination of the hands via glove use remains the cornerstone for preventing C-Diff transmission via the hands of healthcare workers. Use gowns when entering patients rooms and during patient care. Dedicate or perform cleaning of any shared medical equipment. Continue these precautions until diarrhea ceases (because C-Diff infected patients continue to shed organism for number of days following cessation of diarrhea). Implementation and environmental cleaning and disinfection strategy: Ensure adequate cleaning and disinfection of environmental surfaces and	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 44	F 441		

reusable devices, especially items likely to be contaminated with feces and surfaces that are touched frequently. Consider using EPA (Environmental Protection Agency)-registered disinfectant with a sporicidal claim for environmental surface disinfection after cleaning in accordance with label instructions. Follow the manufacturer's instructions for disinfections of endoscopes and other devices. Recommended infection control practices in long term care and home health settings are similar to those taken in traditional health care settings.
According to the CDC document titled " Infection Prevention During Blood Glucose Monitoring and Insulin Administration " shows The CDC has become increasingly concerned about the risks for transmitting of hepatitis B virus (HBV) and other infectious disease during assisted blood glucose (blood sugar) monitoring and insulin administration. CDC is alerting all persons who assist others with blood glucose monitoring and/or insulin administration of the following infection control requirement: Finger stick devices should never be used for more than one person, whenever possible blood glucose meters should not be shared. If they must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. Insulin pens and other medication cartridges and syringes are for single-patient-use only and should never be used for more than one person. Best practices for Assisted Blood Glucose Monitoring and Insulin Administration: If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 45	F 441		

manufacture does not specify how the device should be cleaned and disinfected then it should not be used. If shared, blood glucose meters should be cleaned and disinfected after every use. Insulin vials: if the vials must be used for more than one person it should be stored and prepared in a dedicated medication preparation area outside of the patient care environment and away from potentially contaminated equipment. Blood Glucose Meters: Whenever possible, blood glucose meters should be assigned to an individual person and not shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared. General: Unused supplies and medication should be maintained in clean areas separate from used supplies and equipment (e.g. glucose meters) does not carry supplies and medications in pockets
The facilities policy and procedure titled " Nursing: Categories of Transmission-based Precautions " with revision date 8/09 documents in part " It is the policy of the facility to follow established transmission-based (isolation) precaution. The objective is to prevent the spread of infection in the facility. The staffs responsible are nursing staff, housekeeping staff and any and all staff having direct contact with the resident. Contact precautions must be implemented, in addition to Standard Precautions for resident known to be infected or colonized with organisms that can be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident care items in the resident's environment. Examples of infections requiring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 46 Contact Precautions include, but not limited to: Clostridium Difficile. Gloves and hand hygiene: wear gloves upon entering the room if contact with resident or potentially contaminated surfaces is possible, during the course of caring for resident, change gloves and perform hand hygiene (wash hands if dealing with C-Diff) after having contact with infective material, remove gloves before leaving the room and perform hand hygiene (wash hands if dealing with C-Diff), after glove removal and hand hygiene, ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident ' s rooms. Wear a gown (clean, non-sterile) when entering the room if you anticipate that your clothing will have substantial contact with the resident, environmental surfaces, or items in the resident's room; if the resident is incontinent; or if the resident has diarrhea. Resident care equipment: When possible, dedicate that use of noncritical resident care equipment items such as stethoscope, sphygmomanometer, bedside commode, or electronic rectal thermometer to a single resident to avoid sharing between residents; if use of common items is unavoidable, then adequately clean and disinfect them before use for another resident. " The facilities policy and procedure titled " Housekeeping Isolation Procedure " with revision on 01/03 documents in part " It is the policy of the facility to ensure that contagious disease are not transmitted to other residents and the purpose is to enforce the procedure to keep contagious disease to a minimum. The staff responsible: Administration, Director of Nursing, Food Services Supervisor, Food Service Staff, Nursing Personnel, Housekeeping Supervisor, Housekeeping Staff. The procedure: Housekeeping shall receive written notice from	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 47	F 441		

nursing staff that a resident is in isolation. The notice should include resident's name, room number and date of isolation onset. The same daily cleaning procedures used in other resident rooms should be used to clean rooms and bathrooms of residents in isolation. Cleaning equipment used in rooms of residents requiring isolation should be disinfected before being used in other resident rooms. Dirty water discarded, wiping cloths and mop heads should be laundered and dried and buckets disinfected before re-use. When cleaning a room, use the same precautions as other staff members (gowns, gloves). All horizontal surfaces of furniture, mattresses, etc. should be cleaned with disinfectant solution. All floors, including bathrooms should be mopped with disinfectant solutions. Wash walls with disinfectant solutions, thoroughly scrubbing exposed areas. "
According to the facilities policy and procedure titled " Policy no: 1.11 (IL) Area: Admiration Subject: Infection Control " with revised date 08/09 documents " Infection Control Policy: All residents with known or suspected infectious conditions will be cared for using the most appropriate nursing care determined for the benefit and safety of the resident concerns, the other residents in the facility, and the safety of the employees. Standard Precautions: Standard Precautions are based upon the principle that all blood, body fluids, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions should be applied to the care of all residents regardless of the suspected or confirmed presence of an infectious agent. Standard Precautions include but are not limited to: Hand Hygiene, Safe injection practices, Proper use of PPE (Personal Protective

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 48	F 441		

Equipment) (gloves, gowns, mask, etc.), resident placement within the facility, care of the environment, textiles, and laundry, handling equipment, disposal of waste. Hand washing is the foundation of controlling infectious disease. Personnel must wash their hands when coming on duty; when they are visibly soiled; when they are between residents; after they handle dressings, urinals, bedpans, needles, or syringes; after toilet use; and when they complete duty. Unless hand washing is specifically required, antimicrobial agents such as Alcohol based rubs are appropriate for cleaning hands and can be used for direct resident care. Gowns are worn by all personnel coming in direct contact with residents who require contact (if necessary) precautions. Gloves, disposable in nature, will be worn unless sterile gloves are necessary. Gloves will be changed after direct contact with resident's secretion or excretions, even if care of resident has not been completed. Environmental control will consist of dusting with damp cloth and wet mopping room after all other rooms have been cleaned. Employee traffic to and through the room will be limited to that which is necessary. Terminal cleaning upon termination of isolation includes cleaning and bagging equipment for disinfections or sterilization; washing furniture and mattress covers; washing grossly soiled areas on walls; and wet mopping floors by means of double bucket technique.

The facility identified germicidal bleach wipe (Environmental Protection Agency Register Number: 69687-1-1375349) noted to have a blue label on 1/26/16 at 4:00 PM used to clean the blood glucose monitoring machine includes the following directions " a 3 minute contact time is required to kill Clostridium difficile spores and reapply as necessary to ensure that the surface

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 49	F 441		

remains wet for the entire contact time. Allow surface to air dry. "
According to directions on the disinfection cleaning product used by housekeeping (Environmental Protection Acency Regulation Number: 5741-28) noted to have red label on 1/28/15 at 10:45 AM, shows on the label when cleaning residents rooms for residents identified in isolation for C-Diff, the following instructions are specified on the label " when cleaning for C-diff a 8 minute contact time is necessary for cleaning the spore, and fecal matter/waste must be thoroughly cleaned from surfaces/objects before disinfection by application with a clean cloth, mop, and/or sponge saturated with the disinfectant product. Cleaning is to include vigorous wiping and/or scrubbing, until all visible soil is removed. Special attention is needed for high touch surfaces. Surfaces in patient rooms are to be cleaned in an appropriate manner. Restrooms are to be cleaned last. "
According to directions on the germicidal wipe product noted to have a purple lable on 1/26/16 at 4:00 PM (Environmental Protection Acency Number: 88494-2-37549) shows no indicated use for C-Diff. Product label shows it is an alcohol wipes for and under directions for use: This product is not to be used as a terminal sterilant/high level disinfectant. Under cleaning: use one or more wipes, as necessary, to wet surface sufficiently and to thorougly clean the surface. Disinfectant: Treated surface must remain visibly wet for one minute to achieve complete disinfection of all pathogens listed o this label. Allow surface to air dry. Contact time: Allow surface to remain wet for 1 full minute.
On 1/27/16 at 9:05 AM, E2 DON stated these are used for regular cleaning of items(container with purple container). E2 stated the container with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 50 blue label is and bleach base and for C-Diff and the purple label is an alcohol base and is not effective with C-Diff so staff should not be using if resident is on isolation for C-Diff to clean items on or in the medications carts. E2 stated the one (purple label) can be used to clean the Blood Glucose Monitoring Machine unless the resident has C-Diff because it will kill most orgainisms as long as staff follow the directions. According to the informational document provided by the facility regarding their bleach solution, documents " kills C-Diff spores in one step in three minutes but, contact time for disinfectant is the amount of time a surface must remain wet with the product to achieve disinfectant. " According to the facility policy titled "Glucose Monitoring" with a revision date of 01/15 shows to please follow instructions listed in the designated Blood Glucose Monitoring System User's Guide to performing a test. How to Clean/Disinfect the designated Blood Glucose Monitoring System: The machine should be disinfected between uses, using a validated disinfecting agent. According to the facility designated Blood Glucose Monitoring Operator's Manual with no date shows: Materials Needed: A valid disinfecting wipe. Cleaning and disinfecting the meter and lancing device is very important in the prevention of infectious disease. Cleaning is the removal of dust and dirt from the meter and lancing device surface so no dust or dirt gets inside. Cleaning also allows for subsequent disinfection to ensure germs and disease causing agents are destroyed on the meter and lancing device surface. The following products are validated for disinfecting the Blood Glucose Meter: Disinfectant towels or wipes with - (EPA(Environmental Protection Agency) Number:69687-1; 56292-8;	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 51 59894-10-37549;67619-12). Important: Users need to adhere to standard precautions when handling or using this device. All parts of the glucose monitoring system should be considered potentially infectious and are capable of transmitting Blood-borne pathogen between patients and healthcare professionals. A new pair of clean gloves should be worn by the user before testing each patient. Wipe all external areas of the meter including both front and back until surface visibly clean. Allow the surface of the meter to remain wet at room temperature for the contact time on the wipes's direction for use. Wipe meter dry or allow to air dry. The Center for Disease Control, CDC, guidelines under 11/1 Environmental Measures " Certain Pathogens (e.g. ....C. difficile) may be resistant to some routinely used hospital disinfectants. Also, since C-Difficile may display increased level of spore production when exposed to non-chlorine based cleaning agents, and spores are more resistant than vegetative cells to commonly used surface disinfectants, some investigators have recommended the use of 1:10 dilution of 5/25%...hypochlorite (household bleach) and water for routine environmental disinfection of rooms and with patients with C. difficile when there is continued transmission. " According to the facilities updated Infection Control Log provided on 2/2/16 for November 2015, December 2015 and January 2016 through the morning of 2/2/16, the following is documented for R11: Hallway 400; Admit date-1/25/16; onset date-1/27/16; site-stool; symptom-frequency; culture-yes; organism-C-diff; isolation-yes; nosocomial-yes; resolved-blank On 1/27/16 at 7:25 PM, E39 RN(Regisered Nurse) entered R11's room to give him his	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 52	F 441		

evening medications and was not wearing gloves. R11 had isolation signs posted on his doorway. At that time E2, DON (Director of Nursing) was questioned as to why R11 was on isolation and she stated R11 had been diagnosed with C-Diff and he had just been put on isolation today. According to R11's face sheet, R11 was admitted on January 25, 2016 at 4:33 PM, and according to a progress note from the referring local hospital dated January 22, 2016, R11 has the following impressions: "Increased size of a pleural based, speculated nodular lesion in the left upper lobe; Mild new midiastinal lymphadenopathy; right pleural effusion, suspicious for pneumonia; Similar marked emphysematous disease; and Cholelithiasis." In addition, according to a Esophagogastroduodenoscopy (EGD) report dated January 22, 2016 a post-operative diagnosis of "Hiatal hernia; and Barrett's esophagus."

R11's nursing note dated January 26, 2016 at 8:20 AM states "Res (resident) c (with) c/o (complaints of) loose stools et (and) stomach cramps last NOC (night). Abd (abdomen) soft et non tender. Occasional c/o stomach cramping. Bowel sounds active x (times) 4 quad. (quadrant). Z5 (R11's physician) notified. Awaiting call back from (Z5's) nurse for further orders."

R11's nursing note dated January 26, 2016 at 1:08 PM states "Received a new order from (Z5) to check stool for cdiff et start Flagyl 250 mg (milligram) 1 tab (tablet) PO (orally) TID (three times a day) x 10 days" and the following nursing notes for R11 on January 27, 2016 at 10:43 AM "...reports resident positive for C-Diff, MD notified" January 27, 2016 at 11:02 AM "(Z5) notified of stool specimen results. Res continues on Flagyl

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 53	F 441		

as previously ordered r/t (related to) loose stools. Awaiting MD (medical doctor) response." Another note dated January 27, 2016 at 2:17 PM "Received new order from (Z5) to increase Flagyl to 500 mg 1 tab PO TID x 4 days."

A lab report from a local hospital laboratory dated January 27, 2016 states the lab specimen was collected on January 26, 2016 at 10:31 AM as: "C.Difficile PCR Positive C#, a positive result indicates the detection of toxigenic C.Difficile DNA."

The Care Plan for R11 lists a problem start date of January 27, 2016 for "Dx (diagnosis) of C-diff," with approaches on the same date of "Encourage resident to wash hands after defecation, encourage resident to wash hands before meals" and "Follow principles of infection control and universal/standard precautions for c diff," which was more than 24 hours after R11 first reported symptoms.

According to the facilities updated Infection Control Log provided on 2/2/16 for November 2015, December 2015 and January 2016 through the morning of 2/2/16, the following is documented for R14:
Hallway 100; Admit date-1/10/15; onset date-1/15/16; site-stool; symptoms-odor; culture-yes 1/15/16; organism-C-Diff; isolation-yes; nosocomial-yes; resolved 1/22/16
Hallway 100; Admit date-1/10/15; onset date 1/25/16; site-stool; symptoms-foul odor; culture-no; organism-C-Diff; isolation-yes; nosocomial-yes; resolved-blank
R14's nursing note dated 1/10/16 at 12:44 PM by E21 LPN shows " Resident complains of having diarrhea at least twice a week. Residents Power

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 54	F 441		

of Attorney requesting doctor be notified.
Resident denies any pain or discomfort. Resident states " It ' s been going on for a while now. I can't remember how long " Doctor notified along with current medication list.
R14's nursing note on 1/12/15 shows a doctors order to check stool for C-Diff.
R14's nursing note on 1/15/16 has resident positive for C-Diff.
R14's Plan of Care shows problem start date of 1/15/16, R14 has diagnosis of C-diff and staff are to follow principals of infection control and universal/standard precautions for C-Diff.
R14's Nursing note dated 1/25/16 at 5:05 PM shows new orders received to discontinue stool for C-Diff, Give Vancomycin for a total of 21 days.
R14's nursing note dated 1/26/16 at 1:14 AM shows resident continues on Vancomcin related to C-Diff. No adverse reactions noted. Isolation precautions continue.
R14's nursing note dated 1/26/16 at 9:27 AM, shows Vancomycin treatment continues related to C-Diff.
On 1/26/15 during initial tour at 9:45 AM, R14's room was observed and had no signs posted in room or on door to indicate she was on isolation precautions.
On 1/26/15 at 9:55 AM, E24 LPN (Licensed Practical Nurse) stated R14 was on isolaiton and R14's room should be identified as a resident on isolation. E24 stated R14 "just now" went on isolation. E24 stated he was setting up the isolation "now."
On 1/26/16 at 4:00 PM, E6 LPN (Licensed Practical Nurse) monitored R14 blood glucose. E6 stated " I can't take the strip bottle in the room because R14 is on isolation. " E6 performed glucose test but the machine did not register R14's result and E6 placed the used lancet into

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 55	F 441		

the trash can. E6 took lancet out of the trash can, wrapped the lancet and monitor strip in a glove, placed the blood glucose meter on the counter top and washed hands. E6 then put gloves on, picked up contaminated glove with gloved hand and exited the isolation room. E6 placed wrapped glove in sharps container. E6 then removed gloves and cleaned her hands with alcohol cleanser only. E6 then touched top of medication cart and blood glucose strip container, obtained another strip, applied cleaned gloves and re-entered isolation room. When E6 finished the procedure she took the blood glucose machine out of the isolation room and used germicidal bleach wipe to clean the blood glucose monitoring machine. She wiped over the surface of the blood glucose meter once for less than ten seconds and placed it on top of the germicidal wipe that was on top of the 100 hallway medication cart. E6 then waited three minutes and placed the blood glucose machine inside the top drawer of the 100 hallway medication cart without any protective covering and on top of another blood glucose monitoring machine. The medication cart contained another blood glucose monitoring machine, eye drops, nasal sprays, insulin pens and oral medications.

On 1/27/16 at 9:00 AM, E6 LPN stated R14 had been on isolation for a while and R14 was originally put on isolation on 1/15/16 after a positive stool for C-Diff and then came back off after she was on Vancomycin for 7 days. E6 stated that R14 had more loose stool and the doctor had originally ordered to get another stool to check for C- diff but then just gave an order not to get the stool culture and put R14 on liquid Vancomycin for three more weeks. E6 stated she thought R14 went back on isolation on 1/25/16 but wasn't positive. E6 stated the way she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 56	F 441		

cleaned blood glucose monitor was to wipe it down and then let it sit for three minutes. E6 did not verbalize knowledge of manufacturer's guidelines regarding use of germicidal cleaner used for blood glucose monitoring for Clostridium Difficile.

On 1/27/16 at 9:35 AM, R14 stated staff had been helping her after she went to the bathroom. R14 stated staff had to help her because she was having problems getting herself completely cleaned because she was having diarrhea and loose stools. R14 stated this (staff helping) was before her son had spoken with nursing about his concern about her having so many stools. R14 stated she thought the problem with the diarrhea and loose stools was going on for a week or two before her son had spoken to the nurse about his concerns about her having the diarrhea. R14 stated that after her son spoke to nursing and relayed his concerns to them about her loose stools and diarrhea, nursing then spoke to the physician about these symptoms. R14 stated she had been told just to make sure she washed her hands really good. R14 stated she has been and continues to go to the main dining room for meals and goes to activities and wheels herself around the facility. R14 stated that she keeps her own journal to write down when she has showers and when she has bowel movements so she can keep track of her care. R14's journal showed bowel movements noted every day from 1/19/16 to 1/27/16. R14's Brief Mental Assessment was done on 1/5/16 and shows a score of 12, indicating she is able to answer questions appropriately.

On 1/27/16 at 9:45 AM, E2 DON stated R14 was on isolation starting on 1/15/16 but came off for a couple days and went back on 1/25/16.

On 1/27/16 at 10:15 AM, E11 CNA (Certified

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 57	F 441		

Nursing Assistant) stated she had given R14 a shower last Tuesday (1/20/16). E11 stated R14 was on isolation at that time. E11 stated she gave R14 the shower in the community bathroom on 100 hallways. E11 stated when she was done with R14's shower; she wiped everything in the common bathroom down with the bleach wipes. E11 was not able verbalize how to clean according to the bleach wipe manufactures guideline. E11 did not indicate if or how the shower room was mopped or deep cleaned or if this was done.

On 1/28/16 at 11:10 AM, E20 LPN (Licensed Practical Nurse) entered R14's identified C-Diff isolation room to administer insulin. E20 took R14's insulin pen into the room and injected R14 in the abdomen. E20 placed the insulin pen on the sink and was half on a barrier and half on the countertop. E20 washed her hands and applied new gloves and picked up insulin pen and placed it on clean barrier next to the blood glucose monitoring machine. E20 picked up insulin pen and exited room. E20 wiped over R14's insulin pen with the facility designated bleach disinfectant for less than 10 seconds and placed it in top of medication cart drawer with other insulin pens. When questioned E20 stated she should have cleaned the insulin pen longer before she placed it in the medication cart. At no time did E20 re-clean the identified contaminated insulin pen. When E20 was questioned, she stated she was just starting her noon medication pass and would be giving more medications and insulin.

On 1/29/16 at 8:45, the DON stated if resident is symptomatic for C-Diff will go ahead and put in isolation.

On 1/29/16 at 9:45 AM, E22 (Housekeeper) stated R14's room was on the 100 hallway. E22 stated she normally cleaned R14's room, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 58	F 441		

even prior to her being placed on isolation resident was having " explosive, foul smelling stool " and she was pretty sure it was C-Diff. E22 stated that when she had asked a nursing assistant what was going on with R14, they were aware she was having loose stool and E22 figured the nurses knew too. E22 stated even before R14 was on isolation R14 had loose stools and R14 had stool all over the bathroom and across her room to her closet. E22 stated that R14 would try to clean up the feces herself but didn't do a very good job. E22 stated R14 trying to clean up after problems with loose stools had occurred more than once. E22 stated she had been sweeping R14's room with a broom and bringing it out and putting it on the housekeeping cart as well as the dustpan. E22 stated she probably should have not done this and used the dust mop. E22 stated she never used a gown when cleaning R14's room. E22 stated when she cleans a room for C-Diff she cleans the bathroom in the middle of the cleaning process, not last. E22 stated she used the same housekeeping cart to clean hallway 100 and 200. E22 stated she was the regular housekeeper on these units and her assignment for each day was to take care of both 100 hallway and 200 hallway.

On 2/2/16 at 3:25 PM, Z3 (Power of Attorney) for R14 stated that he was the one that made the facility nurse aware of R14 having issues with loose stools. Z3 stated R14 had so much loose stool in her adult brief that it was saturated and coming apart. Z3 stated R14 had told him and the nurse, who was a Registered Nurse, that she had been having the loose stools for a while and she had been needing help making sure she was getting herself clean. Z3 stated R14 had been keeping a journal of her bowel movements and showers since her admission and the staff was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 59	F 441		

aware of it as far as he knew. Z3 stated that a while back, around the beginning of 2015, R14 had issues with C-Diff and the facility had treated it totally different. Z3 stated they had been much more strict with the isolation precautions and were cleaning all the time. Z3 stated this is why he was so concerned this time because the facility didn't seem to be doing any precautions. Z3 stated the only way he had been made aware of what the " bug " was is because he had family in the medical field and they had explained how serious it could be. Z3 stated the facility did not do any education with him or R14 except put R14 on isolation and tell them to make sure to wash their hands with soap and water because alcohol wouldn't work. Z3 stated that approximately 10 days ago he was at the facility visiting R14 and the nurse had done R14's blood glucose monitor and gave R14 her insulin in the common area across from the dining room. Z3 stated the nurse did not have the cart with her but made two trips up the hallway once with the blood glucose machine and once with R14's insulin.

On 2/2/16 at 4:05 PM, Z2 (Medical Director/Primary Care Physician) stated he was the Medical Director for the facility and was the Primary Care Physician for R14 and R16. Z2 stated that if a resident was having any signs and symptoms of an infectious disease and specifically C-diff such as loose stool, then he would expect the facility to put them on the appropriate isolation as soon as the symptoms were present. Z2 stated he would expect the facility to notify the primary care physician for further direction with regard to culture or care of the issue. Z2 stated the resident and resident ' s Power of Attorney need to be made aware as necessary. Z2 stated C-Diff is a spore and therefore was not cleaned in the same manner as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 60	F 441		

some other organisms. Z2 stated he would expect the facility to clean according to what the direction or guidelines of the product said, or according to the facility policies. Z2 stated all staff should be communicating to nursing if they are seeing signs of C-Diff such as the loose stool. Z2 indicated if a housekeeper or certified nursing assistant is aware of someone having loose stools or any signs of infections they should be communicating this to the nursing staff.
According to the facilities updated Infection Control Log provided on 2/2/16 for November 2015, December 2015 and January 2016 through the morning of 2/2/16, the following is documented for R16:
Hallway 600; Admit date -12/15/15; onset date-1/4/16; site-stool; symptoms-diarrhea; culture-C-Diff PCR (Per Culture Result) 1/3/15; organism-C-Diff; isolation-yes; nosocomial-yes; resolve date-blank
Hallway 600; Admit date-12/15/15; onset date-12/23/15; site-stool; symptoms-diarrhea; culture-C-Diff PCR; organism-C-Diff, isolation-yes; nosocomial-no; resolve date 1/1
On 2/3/16 at 11:28, E1 Administrator stated that she thought the " PCR " abbreviations under the culture area on the Infection Control Log stood for "PerCulture Report."
During an observation on January 29, 2016 at 8:10 AM, E18, Housekeeper, and E19 Housekeeper trainee entered R16's room to spray R16's bed with sanitizing solution containing bleach. According to a lab result dated December 23, 2016, R16's stool was positive for cdiff infection. E19 was holding a spray bottle of disinfectant containing bleach in one hand and a cleaning rag in another. E19 sprayed the mattress then immediately wiped the mattress with the cloth in the other hand. After E19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 61 finished wiping R16's mattress, E19 handed the disinfectant bottle containing bleach to E18. E18 took the bottle and without changing gloves, took keys out of her uniform pocket, opened the housekeeping locked storage area, placed the bottle into the housekeeping cart on top of the other bottles of cleaning solutions including window cleaner and a bottle labeled "Oxyfest" without cleaning the bottles. E 18 and E19 were wearing gloves during the spraying and wiping of R16's bed and mattress but neither were wearing gowns or any other personal protection equipment (PPE) to protect E18's or E19's clothing from becoming contaminated. E18 and E19 removed their gloves, went into R16's bathroom, washed their hands and exited the room. On January 29, 2016 at 9:20 AM, E18 and E19 returned to R16's room to perform mopping, cleaning and disinfection assignments to the furniture, bathroom, sink shower, floor, trash and linen containers, etc. E18 and E19 went to the PPE container inside the entrance door to the room, obtained gowns, and took the gowns into R16's bathroom and both put on the gowns and gloves in R16's bathroom. E19 went to the housekeeping cart located outside R16's doorway, unlocked the storage area on top of the housekeeping cart, retrieved the sanitizing solution and began spraying the over the bed table, bedside table, floor, chest of drawers, heater/air conditioner, bathroom floor, shower, sink top, toilet, walker, and toilet riser. E19 then retrieved a broom from the housekeeping cart and started sweeping the wet floor under R16's bed, around the above mentioned furniture, and in front of the doorway. E19 went to the housekeeping cart and obtained the dust pan	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 62	F 441		

from the housekeeping cart and swept the dirt from the floor into the dust pan and placed the dirt into the trash can in R16's room, then placed the broom and dust pan back on the housekeeping cart without disinfecting the broom or dust pan. E18 was in R16's bathroom wiping down the shower, and stated "I need some gloves" came out of R16's bathroom removed the gloves she was wearing, and protective gown covering her clothes, leaving R16's room without washing her hands. E18 verified per interview on January 29, 2016 at 9:30 AM she went to the janitor's closet to obtain the box of gloves, and placed the gloves on the housekeeping cart. Upon re entering R16's room E18 put a protective gown over her uniform and went back into R16's bathroom and started wiping down the walker, toilet riser, sink surface, sink faucets, wall and towel bars. E18 left the bathroom and walked to the housekeeping cart, and without changing gloves retrieved more cleaning cloths from a plastic bag half full of cloths on the housekeeping cart, contaminating the clean cloths. E19 was mopping the floor and stopped mopping to pick up a piece of trash off the floor, placed it in the trash can in R16's room, then continued mopping, contaminating the mop handle. E19 mopped the flooring under R16's bed, then proceeded to R16's bathroom, then returned to the rest of the bedroom floor, mopping the bathroom floor prior to mopping the floor entering R16 bedroom. E18 and E19 removed the PPE, placed it in the trash can in R16's room, went into R16's bathroom, washed their hands and left R16's room. E18 and E19 entered R19's room to perform mopping, cleaning, and disinfection assignments to the furniture, bathroom, sink shower, floor, trash and linen containers, etc. According to R19's initial MDS, R19 does not have a diagnosis of C-diff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 63	F 441		

However, R19's care plan dated December 29, 2015 shows a reduced immunity due to receiving radiation for lung cancer. E19 used the same contaminated broom, dust pan, and mop handle that was used in R19's room to clean R16's room.

R19's Care Plan with last conference date of 1/25/16 shows an admit date of 12/2/15 and diagnosis of Carcinoma in situ of unspecified bronchus and lung, and identified problem is R19 requires radiation, Lung cancer. R19's goal is she will not exhibit signs of complication reduced immunity secondary to radiation use. Approach by the facility is to monitor/observe/assess resident for signs/symptoms of complications related to radiation therapy including reduced immunity.
R16's face sheet states she was admitted on December 15, 2015 at 12:43 PM, and according to the Admission Minimum Data Sets (MDS) dated December 22, 2015 has a diagnosis of Diabetes Mellitus type II; Ulcerative Colitis; Hip Fracture; Pressure Ulcer; Pain; Weakness; and Diarrhea.

R16's nursing note dated December 18, 2015 at 8:30 PM, states, "Res (resident) has had several episodes of diarrhea x (times) 2 days. Res does report she has hx (history) of IBS (irritable bowel syndrome) but also reports she took multiple antibiotics while in hospital. Will obtain stool sample to r\o (rule out) cdiff. (R16's) physician notified, and on December 18, 2015 R16's Physician Order Sheet (POS) lists an order for "stool for cdiff."

R16's nursing note dated December 21, 2015 at 10:50 AM states "No BM (bowel movement) x 3 days. Res reports that she had a BM yesterday."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 64	F 441		

Another nursing note dated December 23, 2015 at 2:21 AM states "Stool sample x 1 obtained at this time, lab notified for p\u (pick up)."

R16's laboratory report for the stool for cdiff from a local hospital laboratory dated December 23, 2015 states "collected December 23, 2015 at 4:00 PM; received 5:23 AM; and verified 10:53 AM, cdiff positive, a positive result indicates the detection of toxigenic c. difficile DNA."

R16's care plan has a problem start date of December 23, 2015 and states "She has c-diff" with approaches initiated on the same date of as: "encourage resident to wash hands after defecation. Encourage resident to wash hands before meals. Follow principles of infection control and universal/standard precautions for c diff." This care plan was initiated 5 days after symptoms of diarrhea had begun.

According to the facilities updated Infection Control Log provided on 2/2/16 for November 2015, December 2015 and January 2016 through the morning of 2/2/16, the following is documented for R18:
Hallway 600; Admit-11/21/15; onset date-11/29/15; site-stool; symptoms-diarrhea; culture-C-Diff PCR 11/20; organism-C-Diff; isolation-yes; nosocomial-no; resolved 12/14
Hallway 600; Admit date 11/21/15; onset date-12/18/15; site-stool; symptoms-diarrhea; Culture-C-Diff PCR; organism-C-Diff; Isolation-yes; nosocomial-no; resolved-event 12/20
Hallway 600; Admit date 11/21/15; onset date 12/19/15; site-stool; symptoms-diarrhea; culture-C-Diff PCR; organism-C-Diff; isolation-yes; nosocomial-no; resolve date-1/1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 65 Hallway 600; Admit date 1/6/16; onset date-1/6/16; site-stool; symptoms-loose stools; culture-yes; organism-C-Diff; isolation-yes; nosocomial-yes; resolve date-blank On 2/3/16 at 11:28, E1 Administrator stated that she thought the " PCR " abbreviations under the culture area on the Infection Control Log stood for "Per Culture Report." R18's progress notes dated 11/28/15 show resident is incontinent of loose-moucousy stool. R18's progress note dated 11/29/15 shows labs positive for C-Diff. On 1/28/16 R18 had isolation signs on doorway and isolation equipment in her room. R18's Care Plan with last care conference on 2/1/16 shows a problem start date of 12/18/15 for diagnosis of C-Diff and the goal is that C-Diff will be resolved with no further complications with target date of 3/5/16. Care plan approaches show "Encourage resident to wash hands after defecation, encourage resident to wash hands before meals" and "Follow principles of infection control and universal/standard precautions for c diff," R18's Care Plan Snapshot with date of 12/2/15, 2/2/16 shows a problem start date of 11/29/15 for diagnosis of C-Diff and the goal is that C-Diff will be resolved with no further complications with goal target date of 12/15/15. Care plan approaches show "Encourage resident to wash hands after defecation, encourage resident to wash hands before meals" and "Follow principles of infection control and universal/standard precautions for c diff," According to the facilities Infection Control log for 01/2016, R18: had diagnosis and treatment for C-Diff on 11/29/15, 12/18 &/or 19/15, and 1/6/16. All of R18's diagnoses of C-Diff are designated as nosocomial infections.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 66 According to the facilities updated Infection Control Log provided on 2/2/16 for November 2015, December 2015 and January 2016 through the morning of 2/2/16, the following is documented for R79: Hallway-600; Admit date 11/6/15; onset date-11/6/15; site-stool; symptom-admit with; culture-no; organism-C-Diff; isolation-yes; nosocomial-no; date resolved-new event. Hallway-600; Admit date-11/6/15; onset date-11/11/15; site-stool; symptom-diarrhea; culture-C-Diff PCR; organism-C-Diff; isolation-yes; nosocomial-no; date resolved-11/30/15 Hallway 400; Admit date-11/6/15; onset date-12/30/15; site-stool; symptom-diarrhea; culture- C-Diff; organism-C-Diff; isolation-yes; nosocomial-no; resolve date- blank Hallway 300; Admit date-10/19/15; onset date-1/27/16; site-stools; symptoms-foul odor; culture-yes; organism-C-Diff; isolation-yes; nosocomial-yes; resolved-blank On 2/3/16 at 11:28, E1 Administrator stated that she thought the " PCR " abbreviations under the culture area on the Infection Control Log stood for "Per Culture Report." R79's progress note dated 11/6/15 shows resident is to be re-admitted on this day and is still on contact isolation for C-Diff R79's progress note from 11/11/15 shows doctor gave orders to discontinue Flagyl and start Vancomycin 125mg orally 4 times a day for 14 days. Also states resident is positive for C-Diff R79's progress note from 11/25/15 shows resident completed Vancomycin related to C-Diff today and resident remains on isolation precautions related to C-Diff. R79's progress note from 11/29/15 shows stool specimen obtained	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 67 R79's progress note from 12/1/15 shows doctor notified of negative C-Diff results R79's progress note from 12/30/15 shows lab notified nurse of positive for C-Diff. Also shows R79 to receive Vancomycin for a total of 21 days, then re-check 72 hours after last dose R79's progress note from 1/26/16 shows resident with loose, foul smelling stool, doctor was notified, stool specimen was collected for C-Diff R79's progress note from 1/27/16 shows lab reports resident is positive for C-Diff Infection Control Log for November 2015, December, 2015 and January 2016 shows R79 with nosocomial C-Diff infections with onset dates of 11/6/15, 11/11/15, 12/30/15 and 1/27/16. This document shows the C-Diff infection with onset date of 11/11/15 as resolved on 11/30/15. According to the facilities current Infection Control Log for January 2016, R79 was identified as having and/or being treated for signs and symptoms of C-Diff on 1/27/16. R79's Care Plan Snapshot for 11/2/15 to 2/2/16 shows identified problem of C-Diff on 10/25/15 and the goal is to have no further complications regarding the C-Diff with target goal date of 11/6/15. R79's Care Plan Snapshot of 11/12/15 to 2/2/16 shows problem date for C-Diff as 10/25/15 and resolution with no further complications by 11/15/15. R79's Care Plan Snapshot of 11/26/15 to 2/2/16 shows problem date for C-Diff of 10/25/15 and target goal for resolution and no further complication on 11/27/15. R79's Care Plan Snapshot of 1/21/16 to 2/2/16 shows problem date for C-Diff of 1/6/16 and target goal for resolution and no further complications on 1/22/16. R79's Current Plan of Care with Last Care	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 68	F 441		

Conference of 1/25/16 shows problem date for C-Diff of 1/27/16 and target goal for resolution and no further complications is 2/12/16.
Approaches in all of the above care plans for R79 show care plan approaches of "Encourage resident to wash hands after defecation, encourage resident to wash hands before meals" and "Follow principles of infection control and universal/standard precautions for c diff." Review of all the above Care Plan shows no new interventions or changes.
According to the facilities updated Infection Control Log provided on 2/2/16 for November 2015, December 2015 and January 2016 through the morning of 2/2/16, the following is documented for R91:
Hallway 300; Admit date 12/31/15; onset date-1/27/16; site-stool; symptoms-frequency; culture-yes; organism-C-Diff; isolation-yes; nosocomial-yes; resolved-blank
R91's progress note from 1/25/16 shows resident observed with multiple loose stools this shift; stool foul smelling, liquid; will obtain stool specimen to rule out C-Diff; Doctor notified. Sample was obtained and lab notified for pick up
R91's progress note from 1/26/16 shows doctor noted resident's loose stool, approved request for stool sample check for C-Diff.
R91's progress note from 1/27/16 shows doctor notified of positive C-Diff results.
R91's Current Care Plan with Last Conference Date of 2/1/16 shows a problem start date of C-Diff on 1/28/16 and the target goal is R91 will have no further complications by 2/20/16. Under approaches states, to follow principles of infection control and universal standard precautions for C-Diff.
According to the facilities Infection Control Log for December 2015 and January 2016 R91's onset

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 69 date was 1/27/16 and is identified as a nosocomial infection According to document provided by facility on 1/29/16 the following residents share blood glucose monitoring machines according to the specified hallways: 100 hallway: R26, R31, R34, R47, R19 (C-Diff identified resident) 200 hallways: R57, R1, R3, R54, R57, R110 300 hallways: R62, R66, R67, R108, R70 400 hallways: R78, R80, R81, R83, R85, R86 600 hallway: R89, R99, R104, R90, R92, R109, R105, R102, R16 (C-Diff identified resident) On 1/27/16 at 9:52am, observation was made of wound care being performed on R7's right heel. E8 (Licensed Practical Nurse) performed the treatment correctly but when the treatment was complete E8 put the scissors that were used during the task into her (E8) right pocket of her uniform shirt without cleaning them first. E8 said she didn't clean the scissors but she was going to later. E8 said she put the scissors in a pocket by themselves and wouldn't put anything else in with them. On 1/26/16 at 4:25 PM, E9 RN (Registered Nurse) performed blood glucose monitoring for R66 in her room. E9 took the machine out of the top drawer of the medication cart with her bare hand and placed it on top of the cart. E9 put on gloves and picked up the monitor and went into R66's room. E9 used the monitor by holding it in her hand during the check and exited the room and used a germicidal wipe to clean the machine for over three minutes but then immediately placed in the top drawer of the medication cart hallway and blood glucose monitor was not dry at that time and not placed in any type of protector. In the top of the drawer was another blood glucose monitoring machine as well as insulin	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 70	F 441		

pens, oral meds, eye drops, nasal sprays and inhalant medications.
On 1/27/16 at 9:05 AM, E2 DON (Director of Nursing) stated to clean a blood glucose monitor after use in an isolation room or for someone on C-Diff isolation, the staff is suppose to wipe it for one minute then let it air dry for three minutes.
E2 stated each hallway has a designated medication cart and each cart has at least two blood glucose monitoring machines and the machines are shared between residents and they are cleaned with the germicidal bleach cleaners for infection control.
On 1/27/16 at 10:50 AM, E15 LPN (Licensed Practical Nurse) stated she normally works on the 200 unit and as far as she knew, to clean the blood glucose monitoring machine was to wipe off the machine for one minute and then let it dry for three minutes. E15 did not indicate any difference with cleaning the blood glucose monitoring machine in isolation or a regular room. E15 was not aware of contact time of the manufacturer guidelines for the germicidal bleach wipes.
On 1/27/16 at 11:00 AM, E14 RN (Registered Nurse) stated her normal assignment is the 400 hallway and the way she cleaned a blood glucose monitoring machine was to wipe the machine for one minute and then let dry for three minutes. E15 stated she was not aware of any difference if it was an isolation room or not. E15 stated she was not aware of contact time of the manufacturer guidelines for the germicidal bleach wipes.
On 1/28/16 at 10:00 AM, E16 (Housekeeper/laundry Aid) stated she didn't work as a housekeeper very often but was training E17 (Housekeeper). E16 stated she had been trained to use a bleach based disinfectant but they had started using a different cleaner and she was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 71	F 441		

sure of how to use it, but E17 had been trained by another housekeeper on how to use that disinfectant product. E16 stated she used a pre-mixed solution from the maintenance room to mop the floor of all the rooms, E16 indicated she used these for the isolation rooms as well. E16 stated if someone was on isolation it was on a board in the maintenance room and the reason they were on isolation. E16 then proceeded to the maintenance room between 400 and 600 hallways and showed a bleach based product in white bottle she used to clean isolation rooms.
On 1/28/16 at 10:45 AM, E4 (Housekeeping Supervisor) was in the maintenance room. The board that is used to identify residents that are on isolation precautions and the corresponding reason/organism did not show R11 listed. E4 stated the staff is to use the corporate identified disinfectant which is a bleach product to clean surfaces and floors. E4 stated the pre-mixed solution in the maintenance room is not to be used when cleaning for C-Diff. E4 stated E16 should not be using the white bleach product she had showed earlier in the maintenance room off the 400 hallway. E4 stated corporate had given the facility a new product to use to disinfect for C-Diff. E4 stated all staff should know and have been trained how to use this product correctly with any type of isolation but especially C-Diff infections. E4 stated she expected housekeeping staff to clean an identified C-Diff isolation room with the corporate provided product and that included to mop the floors.
On 1/28/16 at 11:00 AM, E5 (Housekeeper) stated if someone was on isolation it should be on the board in the maintenance room. E5 was unable to verbalize why R11 was on isolation precautions. E5 stated when she cleaned an identified isolation room for C-Diff she sprayed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 72	F 441		

with the disinfectant the facility had told her to use. E5 stated she sprayed all the surfaces then went back and wiped it off with a paper towel. E5 stated she would take the broom and dust pan into isolation room and dust mop the floor. E5 stated she then would spray the bottom of the broom bristle with the identified disinfectant and the dust pan and place them back on her housekeeping cart. E5 stated she mopped the room with the pre-mix solution from the maintenance room and stated it was a yellow product and already on her cart and the mop heads were soaked in it.

E5, Housekeeping, stated on 1/29/16 at 9:45 AM when cleaning the room of a resident who is on contact isolation for C-Diff, E5 does not routinely wear personal protective equipment such as gowns, masks, or shoe covers. E5 stated that if there was visible soiling such as urine or bowel on the floor then E5 would put on shoe covers.

E4, Housekeeping Supervisor, stated on 1/29/16 at 9:50 AM that the same broom and dustpan are used to clean multiple rooms on same halls, including isolation rooms of residents on contact isolation for C-Diff. E4 stated she never even thought about the sweeping brooms and dustpans going in and out of residents rooms from an isolation room, and those needing to be cleaned, and how or when, and then putting them back on the housekeeping carts after use in an isolation room.

On 2/03/2016 at 9:10 am, E1-Administrator and E2 Director of Nurses, were asked about the Infection Control Log and to explain how the column "Nosocomial YES/NO" was used. E2 stated that nosocomial meant that the infection was aquired in any health care setting. E1 stated at that time that for the purpose of their infection log, nosocomial would mean that the infection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 73 was aquired in house at their facility. E2 then stated, "I did not realize that". E2 further stated at this time that if someone has signs and symptoms of Clostridium Difficle infection, "we would put them on isolation at first suspicion even before a positive culture. The Immediate Jeopardy situation was identified on 2-2-2016 and determined to have begun on 1/26/16 after observations and interviews failed to show that the facility had an effective and ongoing program in place for infection control. E1- Administrator and E3- Assistant Administrator, were notified of the Immediate Jeopardy on 2-2-2016 at 1:45 pm. Based on observation, interview and record review, the facility took the following actions to remove the Immediate Jeopardy: 1. All nursing staff were inserviced on proper cleaning and storage of blood glucometer devices used for patients with clostridium difficle by the Director of Nursing on February 2, 2016. This included the use of "Microkill with Bleach", allowing a three minute wet kill time as per manufacturer's recommendations. 2. All necessary staff which included all staff in contact with any Clostridium Difficle isolation room including all nursing, housekeeping, activities, and any other staff thought to benefit from this training at this time were inseviced regarding requirements of Clostridium Difficle isolation and infection control on February 2, 2016 by the Assistant Administrator and Director of Nursing. Additional follow up inservicing with staff was conducted and completed 2-2-2016 to ensure compliance with expectations. 3. All necessary housekeeping in services were completed on February 2, 2016. All cited rooms were properly cleaaned with appropriate	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145841	A. BUILDING _____ B. WING _____	02/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PARKWAY MANOR	3116 WILLIAMSON COUNTY PARKWAY MARION, IL 62959

(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 74 saturation on February 2, 2016. All resident rooms were cleaned per C. Diff isolation procedures on February 2, 2016. Housekeeping supervisor and Assistant Administrator completed this training. We have clarified that no dry cleaning or dry items will be used for the duration of the infection including brooms. Dusters will not be used in such a way as to transmit infection and will not be used in rooms requiring isolation for C. Diff at all. Other organisms of infection will be reviewed on a case by case basis. Details of this training included return staff demonstrations utilizing a cleaning and disinfecting process with the product "Diffense" using the recommended 8 minute kill time on all hard surfaces. 4. The Infection Control Policy and the Transmission Based Policy which specifically addresses Clostridium Difficle has been reviewed and all staff retrained by the facility Assistant Administrator February 2, 2016. 5. All current residents were reviewed for signs and symptoms of C. Diff with no further instances of issue February 2, 2016. 6. E2 and E3 stated that as of Feb 2nd (the date we informed the facility that immediacy was removed), on coming staff were not allowed to work the floor until they received the required training/inservice.	F 441		