STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146082	A. BUILDING ______ B. WING ______	12/17/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKFORT HEALTHCARE & REHAB CENTER	2500 EAST ST. LOUIS STREET WEST FRANKFORT, IL 62896

(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. Complaint 1556410/IL81685 No Deficiencies Cited .	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

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

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

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F 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to ensure the physician was notified of dietary recommendations for 1 of 10 residents (R4) reviewed for physician notification in the sample of 10. Findings include: 1. On 11/19/15 E3 (Dietitian) noted that R4 has a 10.1 % weight loss over the past six months and a stage four pressure ulcer. E3 recommended Arginaid be increased to twice a day and that a high calorie drink be increased from 90 cc three times a day to 120 cc three times a day . A Fax Confirmation listing R4's weight history, pressure ulcer status and dietary recommendations note, E2 (Director of Nursing) sent this request to Z1 (Physician), four days later on 11/23/15. During an interview on 12/16/15 at 4:15 PM, E2 said that she did not get a response from Z1, after sending the 11/23/15 dietary recommendations, so she sent the Fax Confirmation again to Z1 on 12/07/15. The Physician Order Sheet dated 12/08/15 notes that Z1 agreed to increase the Arginaid to twice a day, and the high calorie drink to 120cc three times a day. The Medication Administration Record for December 2015 notes that R4 began receiving Arginaid twice a day and 120 cc of the calorie drink three times a day on 12/09/15. Twenty days elapsed between the initial recommendation from E3 on 11/19/15 until R4 began receiving the nutritional supplements on 12/09/15.	F 157		
F 315	483.25(d) NO CATHETER, PREVENT UTI,	F 315		

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F 315 SS=D	Continued From page 2 RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and interview, the facility failed to keep the catheter tubing off of the floor for 1 of 1 residents (R2) reviewed for catheter care in the sample of 10. Findings Include: On 12/14/15 at 11:25 AM, R2 is sitting in the dining room with his catheter tubing on the floor. On 12/14/15 at 1:30 PM, R2 is sitting in his wheelchair in his room with his catheter tubing on the floor. On 12/15/15 at 11:25 AM, R2 was sitting at the dining room table with his catheter tubing on the floor. At 12:00 PM, E8 (Registered Nurse) pushed R2 into his room for an accucheck. R2's catheter tubing was dragging on the floor. R2's catheter tubing continued to drag on the floor as E8 pushed him back to the dining room. The Infection Control Log documents R2's Urinary Tract Infection on 11/17/15, 7/6/15,	F 315		

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F 315	Continued From page 3 5/13/15, 3/17/15, and 1/20/15. On 12/17/15 at 9:50 AM, E2 (Director of Nurses) stated that the catheter tubing should not be touching the floor.	F 315		
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 interview, observation, and record review, the facility failed to supervise residents in the beauty shop and to minimize the risks for falls for 3 of 3 residents, (R17, R21, and R40), reviewed for safety and supervision in the supplemental sample. Findings include: 1. On 12/16/15 at 1:49 PM, R40 called out for help from the beauty shop room, located just next to the living room (located approximately 55-60 feet from the nurse's station). IDPH surveyors were present in the living room and heard the call for help. Two surveyors went directly to the nurse's station to alert staff, while two other surveyors went directly into the beauty shop. Upon entry into the beauty shop, R40 and R17 (both sitting in wheelchairs) were both holding an	F 323		

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F 323	Continued From page 4 overhead hair dryer in their hands. The overhead dryer was detached from the pole. R40 stated, "She (R17) took it off her head." IDPH surveyor took the hair dryer from R40 and R17 to hold until staff arrived. R17 then noticed a hair curler on the floor & bent over in her wheelchair to pick it up. While standing in front of R17, IDPH surveyor verbally encouraged R17 not to pick the curler up, however she continued leaning forward and reaching for the curler. Staff arrived as R17 sat back up in her wheelchair. When E13 (Beautician) entered the beauty shop, she stated, "Oh she does this all the time." R21 was also observed in the beauty shop, in a wheelchair under a blow dryer. R21's physician order sheet dated 12/1/15 - 12/31/15 documents a diagnosis of dementia. There was no staff supervision provided in the beauty shop at the time of these observations. R17's Minimum Data Set (MDS) dated 10/25/15 documents that the Brief Interview for Mental Status (BIMS) is 2 of 15. This indicates that the resident's cognitive status is severely impaired. The MDS Section G (Functional Status) documents that R17 requires assist of one person for all Activities of Daily Living. R17's Care Plan documents falls occurred on 10/24/15, 11/7/15, 11/24/15, 12/9/15, and 12/13/15. The Care Plan dated 10/26/15 documents that R17 is high risk for falls related to the dementia diagnosis and frequent attempts to stand up. R17's Care Plan dated 10/26/15 also documents that when resident is up in the wheelchair, R17 must be in supervised area.	F 323		
F 368 SS=C	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		

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F 368	Continued From page 5	F 368		

Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.

There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.

The facility must offer snacks at bedtime daily.

When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, the facility failed to offer snacks to all residents at bedtime. This has the potential to affect all 39 residents in the facility.

The findings include:

The facility's Resident Census and Conditions of Residents form, dated, 12/14 /15 documented the facility had a census of 39 residents.

1. During the resident Quality of Life Assessment Group Interview held on 12/16/15 at 10:30 am, the four residents in attendance (R40, R14, R26 and R27) stated that they are not offered a snack each evening before bed. R40 stated that she has had an evening snack in the past, but has not

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F 368	Continued From page 6 been routinely offered an evening snack. 2. E16 (Certified Nurse Aide, CNA), who routinely works the evening shift, stated at 3:00 pm on 12/16/15 that snacks are brought to the nurses' station by the dietary staff before they leave for the evening. E16 was asked if the snacks are passed to the residents' rooms, and E16 indicated that the employees do not take them to the residents, but that the residents come to the nurses station to get a snack. 3. E15 (Dietary), who works the evening shift, stated at 3:10 pm on 12/16/15 that a bowl of snacks and a gallon of a sugar sweetened fruit flavored beverage are prepared and left at the nurses' station prior to the kitchen closing for the evening. E15 indicated that there are no pre-planned snacks. E15 chooses the cookies and crackers to serve. E15 did not indicate that snacks are prepared for all diet plans. 4. Review of the facility's pre-planned menu for week 4 of the menu cycle documents that an evening snack for all diet plans is to include a 1/2 cup of fruit drink and to see the snack list. The plan for the No Concentrated Sweets/Low Concentrated Sweets Diet calls for the service of a diet fruit drink.	F 368		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food	F 371		

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F 371	Continued From page 7 under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, the facility failed to maintain sanitary conditions for food storage and preparation. This has the potential to affect all 39 residents in the facility. The findings include: The facility's Resident Census and Conditions of Residents form, dated, 12/14/15 documented the facility had a census of 39 residents. 1. The following are observations of the food preparation and storage areas on 12/14/15 beginning at 10:25am. * In the food storage room, large plastic bins were noted to store containers of dry packaged foods. The plastic bins (approximately 8) did not have lids and were soiled with food debris, dead bugs, and bits of paper. One of the bins held an unsealed package of corn muffin mix. The dry drink mix container had a golf ball sized area of dry purple/black material stuck in the corner. * The right side air conditioner unit in the window above the three compartment sink was noted to have an accordion style flange to seal the unit into the window. The right hand side of the unit was not sealed to the outside and an approximate	F 371		

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F 371	Continued From page 8 2 inch to 1 inch vertical opening was open to the outside. The three compartment sink beneath the window had dead insects in the third compartment. E9 (Dietary) stated at 10:30 am that there had been a plumbing problem a few weeks ago, and the plumbers used the window to access the kitchen with equipment. E9 further stated that the insects were most likely entering through the opening directly above, around the air conditioning unit. * All of the East wall cabinets above the food preparation and steam table were observed to be deteriorating inside. The cabinets were lined with a plastic shelf liner and under the liner the wood was flaking and food particles were noted. The cabinet on the left closest to the coffee pot was noted to have a container of open sugar with a measuring spoon. The area under this container was covered in loose sugar. The underside of the cabinets above the steam table was touched, and flakes of wood fell onto the top of the steamtable lids. * The top of the bulk sugar container on a shelf under the microwave was noted to have an unprotected scoop touching metal steam table dividers. * The wire shelf on the wall near the exit door was soiled and sticky with food debris. * The floor throughout the food preparation area was heavily soiled and there were thick rubber mats that were soiled and sticky near the dish washing machine.	F 371		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 9 2. E9 was observed to serve chicken tacos during the noon meal service on 12/15/15. E9 was observed at 12:10 pm to hold the soft tortilla shell in a gloved hand and to spread the filling with a scoop. E9 was observed to use the same gloved hands to make a lunch meat sandwich, adding the lunch meat and then cutting the sandwich with a knife. E9 moved from the serving utensils to the food products with the same gloved hands. 3. The menu called for the service of brownies to all diets at the noon meal on 12/15/15. E9 has pureed brownies available on the service line with no method to protect the products temperature at the start of the noon meal at approximately 11:45am. E9 was asked and stated at approximately 11:50 am that the brownies had been pureed with milk. At the end of the meal service at 12:30 pm the pureed brownie measured 74 degrees Fahrenheit.	F 371		
F 441 SS=F	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	F 441		

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actions related to infections.

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

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

This REQUIREMENT is not met as evidenced by:
Based on interview, observation, and record review the facility failed to follow current standards of infection control practice. This has the potential to affect all of the 39 residents living in the facility.

Findings Include:

1. The Resident Census and Condition of Residents, dated 12/14/15, documents the facility has a census of 39 residents.

2. On 12/14/15 at 10:30 AM, R2, R4, and R29's blue floor mats, used for residents with fall

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F 441	Continued From page 11 history, are folded and in the residents's chair in the resident's room. On 12/16/15 at 1:00 PM, R2, R4, and R29's blue floor mats are folded and in the resident's chair in the resident's room. On 12/16/15 at 11:10 AM R2, R4, and R29's blue floor mats are folded and in the resident chair in the resident's room. 3. On 12/16/15 at 11:50 AM, a recliner chair in R7's room was noted to have a blue floor mat coiled up in the chair. E8, (Registered Nurse), was present and said that the mat was placed on the floor at night for R7's room mate. 4.Observation of the laundry room on 12/16/15 at 9:35am found that the table for folding laundry in the room held employee belongings including a handbag, lunch cooler, keys and a coat. E11 (Housekeeping) was interviewed at 9:40am outside the laundry room. E11 indicated that is where she puts her belongings when reporting to work. 5.Observation of the laundry room on 12/16/15 at 9:35am found 1 large black plastic bag, 1 small blue plastic bag and 2 clear plastic bags on the floor near the washing machines. The blue and clear bags were sitting in a puddle of clear liquid. E11 identified the bags at 9:40am as the large black bag as garbage to be taken to the dumpster and the smaller bags as mop heads waiting to be washed.	F 441		
F 458 SS=C	483.70(d)(1)(ii) BEDROOMS MEASURE AT LEAST 80 SQ FT/RESIDENT	F 458		

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F 458	Continued From page 12 Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. This REQUIREMENT is not met as evidenced by: Based on observation, and interview the facility failed to provide 80 square feet of floor space per bed for 9 of 10 residents (R1 - R9) reviewed for adequate room size in the sample of 10 and 30 residents (R11 - R40) in the supplemental sample. The findings include: 1. Room measurement for rooms 3 - 6, 10, 11, 15, 18 - 19, 20 - 27 and 29 - 32 provide 69 square feet of floor space per resident bed. Resident rooms 7 - 9, 12 - 14, and 28 provide 72 square feet of floor space per resident bed. 2. The inadequately sized rooms are occupied by residents R1 - R9 and R11 to R40. 3. There were no negative resident interviews regarding room size. The space available was adequate to meet the nursing and resident needs. There were no environmental or infection control issues related to the undersized rooms. 4. On 12/17/15 at 11:05am, E10 (Corporate Nurse) stated that rooms 3 - 19 are Medicaid certified, and rooms 20 - 32 are Medicare and Medicaid certified.	F 458		
F 465 SS=C	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABL	F 465		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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E ENVIRON

The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.

This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview the facility failed to ensure all beds, resident care equipment and door alarms were cleaned and maintained. This has the potential to affect all 39 residents in the facility.

The findings include:

The facility's Resident Census and Conditions of Residents form, dated, 12/14 /15 documented the facility had a census of 39 residents.

1. The specialized mattresses for bed A and B in resident room 18 were observed to be soiled at 11:15 am on 12/16/15. Bed A had a white cotton sheet loosely on top of the mattress, under the sheet the bed had food debris, dried liquid and a small area of unidentified wetness (6 inch circular area). E12 (house keeper)stated on 12/16/15 at approximately 2:00 pm that the beds in room 18 are cleaned while the residents are up and as needed, if a resident has been incontinent. E12 stated that a damp cloth with a cleaner is used to wipe the mattresses.

E12 provided the concentrated container of cleaner used for the beds after the interview. The instructions include to saturate the item with the use of a 10 minute contact time for proper

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146082	A. BUILDING ______ B. WING ______	12/17/2015

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F 465	Continued From page 14 disinfection. 2. The wheelchair for R17 was observed in the beauty shop on 12/16/15 at approximately 2:00 pm. The wheelchair was very soiled with food debris and dried pink liquid. 3. On 12/15/15 at 11:50 AM, the 2 medication cart water pitchers were each noted to have a dry, pink substance present on the handles of each pitcher. The lid of the waste basket in the nursing station was noted to be soiled with a dried, brownish substance, and the base of the blood pressure cuff stand also had a brownish substance present and was in need of cleaning. On 12/16/15 at 12:05 PM, the 2 medication cart water pitchers were again observed to have the same dry, pink substance present on the handles of both pitchers. The lid of the waste basket in the nursing station and the base of the blood pressure cuff stand remained soiled on 12/16/15 at 12:05 PM as well. E8, (Registered Nurse), said on 12/16/15 at 12:30 PM that she thinks the kitchen staff washes the water pitchers at night, but E8 did not know whether the pitchers were placed in the dishwasher. On 12/16/15 at 11:50 AM, R7's wheelchair was unoccupied and noted to be heavily soiled with dried fluids and crumbs on the seat. On 12/16/15 at 11:55 AM, R11's mattress was noted to have a 1 inch length tear in the corner of the mattress. Also, both beds in the same room were noted to be positioned against walls with paint scraped off from bedrails. The old, mismatched floor tiles in the same room were slightly sticky at that time.	F 465		