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	14E247	A. BUILDING _____ B. WING _____	05/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JOLIET TERRACE NURSING CENTER	2230 MCDONOUGH JOLIET, IL 60436

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F 000	INITIAL COMMENTS Annual Licensure and Certification Survey Licensure survey for Subpart S - SMI.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225		

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

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F 225	Continued From page 1	F 225		

certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on personnel file review and interview the facility failed to ensure background checks were done within 10 days of hire for 2 of 10 CNA's (certified nurses aides) identified during personnel file review for background checks. (E9 and E10)

The findings include:

On 4/25/13 at 2:00 p.m. during the Healthcare Worker Background Check with E15 (Human Resource Director) E9's and E10's (CNA's) personnel files were checked to ensure the background checks were done within 10 days of hire. Personnel file review showed E9 was hired at the facility on 10/1/09. E9's background check was not done until 2/11/13 (3 years 4 months after date of hire). Personnel file review for E10 showed E10 was hired at the facility on 2/25/05. E10's background check was not done until 4/25/05 (2 months after date of hire).

E15 on 4/25/13 at 2:30 p.m. said, "Background checks should be done within 10 days of hire. E9's background check was not done until 2/13/11 because E9 did not even have a personnel file until I made one for her on 2/11/13. I don't know why E10 didn't have a background check done within 10 days of hire, but our policy is to have the background check done within 10

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F 225	Continued From page 2 days of hire."	F 225		
F 242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to consider resident choices regarding early get- up times. This is for 2 residents in the sample of 23 (R17 and R6) and 6 residents in the supplemental sample (R 32, 33, 34, 35, 36 and R37) reviewed for early get up times. Findings include: R17 stated on 4/23/13 at 10:20am staff get her up every morning at 5:00am, then she sits and waits for breakfast for 2 ½ hours. When asked if she (R17) has told staff that she would like to sleep longer, R17 replied " It's of no concern of theirs I want to sleep longer. " E2 (director of nursing) provided a list of 8 residents who are on the get up early list which stated the residents are gotten up at 6:30am. However, E7 (nurse's aide) stated on 4/23/13 at 9:30am residents are gotten up by the night shift starting at 5:00am. The Get-Up list provided by facility shows R32, R34, R17, R37, R33, R35, R36 and R6 are gotten up early. E5, PRSC, (psychiatric rehabilitative services coordinator) stated on 4/26/13 that he (E5) was, " sure these	F 242		

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F 242	Continued From page 3 residents were not asked about their preference to get up early. "	F 242		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to develop care plans in the areas of falls, smoking, and 1:1 interactions/therapies that were legible, had revised approaches, and had realistic and measurable goals and interventions. This is for 6 residents in the sample of 23. (R25, R26, R4, R2, R17, and R13)	F 280		

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The findings include:

1. Review of the facility's incident reports showed R25 had 7 incidents of falls from 1/3/13 to 2/21/13. R25's MDS's (minimum data sets) dated 12/2/12 and 2/28/13 showed R25's cognition was severely impaired. R25's CAA (care area assessment) for falls dated 3/7/13 showed R25 also had periods of confusion.

Review of R25's plan of care for falls showed the plan of care was 3 pages long with sections of the care plan being illegible. Sections of the plan of care had scratched off areas and/or written over areas. Documentation for approaches were written in the margins of the care plan. Some of the goals/approaches/interventions were unrealistic for R25.

As noted above, R25's cognitive level was severely impaired and R25 had periods of confusion. Unrealistic goals and interventions addressed on the fall plan of care showed, "Will request help. Will ask for assistance." Further review of the plan of care showed R25's diagnoses of hearing loss and bilateral cataracts were not identified as possible contributing factors to the causes of R25's falls.

2. Review of the facility's incident tracking showed R26 had 6 falls from 2/5/13 to 2/15/13. All of the falls occurred in R26's room. Three of these falls occurred between 2/6 and 2/9/13 on the day shift between 10:25 a.m and 11:00 a.m. Two of the falls occurred on the evening shift and one fall occurred on the night shift.

Review of R26's fall care plan showed the care

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F 280	Continued From page 5 plan to be 4 pages long with areas of illegible documentation. Review of approaches/interventions included an intervention of "Thirty minute monitoring of resident for 11-7 shift." As noted above; of the 6 falls, only one occurred on the 11-7 shift. R26's diagnoses also included Bilateral Cataracts. There was no mention of R26's bilateral cataracts included in the approaches/interventions addressed as a possible contributing factor to R26's falls. Interviews with E1 (Administrator), E2 (Director of Nurses), and E3 (ADON/Restorative Nurse) on 4/26/13 at 10:30 a.m. noted all to say they did not address and/or analyze all of the possible contributing to residents' falls and include all of the information on the residents' care plans. 3. Review of POS (physician's order sheet) shows R17 is 72 years old with diagnosis including dementia, schizoaffective disorder, Parkinson's and hypertension. Review of fall care plan dated 1/16/13 shows R17 ambulates with the assist of 1 with a rolling walker. Review of fall care plan dated 8/14/12 and updated with goals through 5/12/13 states R17 fell in room on 10/4/12, was observed on knees on 10/28/12, and had 2 unwitnessed falls on 11/3/12/and 11/6/12. The approaches following these falls, in addition to the falls sustained on 11/10/12 and 1/16/13, is to remind R17 to use the call light several times a day, safety mat next to bed and to place R17 in the dining room when	F 280		

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she is confused. The facility approaches were not evaluated to determine their effectiveness and the goals are not measurable.
4. Review of facility incident reports shows that R13 had 5 falls in December: 12/1/12, 12/2/12, 12/20/12, 12/21/12, 12/31/12 and one fall on 2/5/13. Care plan dated 3/10/12 through 12/21/12 documents that some of the falls resulted from R13 standing up from chair and losing balance and falling to floor while walking. The interventions listed are not assessed for their effectiveness nor are they individualized to R13 needs, approaches were not evaluated to determine their effectiveness and the goals were not measurable.
E2 (director of nursing) stated on 4/25/13 at 1:25pm he was not employed at the facility at the time R13 was falling and does not know why other possible factors that may be causing R13 to fall were not included on the fall care plan such as medication (R13 is on antipsychotics), pain (R13 complains of pain to back and abdomen) and incontinence concerns. Urological workup dated 3/7/13 states R13 is severely bothered by frequent urination and urge incontinence and feels wet all the time. R13 stated on 4/25/13 at 12:50 pm when she has to go to the bathroom the urge comes on so fast she feels like she has to run almost to get to the toilet.

5. R4 was wearing a hat, sun glasses and gloves. During observations on 4/24/2013 and 4/25/2013, R4 was in his room or wandering around the day room. R4 was not observed participating in any psychosocial programs. R4

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did not respond to questions or engaged in conversation for a brief period.

The nurse, (E4) who usually worked with R4, was interviewed on 4/24/2013 at 10:15 AM. E4 said that R4 was focused on internal stimuli or internal voices. E4 stated that R4 mainly walks around the facility and is a high risk smoker. E4 said that R4 has been found smoking in his room or none designated smoking area.

R4' s PRSC (E11) was interviewed on 2/24/20/13 at 10:29 AM. E11 stated, " He (R4) is not coming to group. I do 1:1 ' s with him, once a week and per (behavioral) episode. He gets 1:1 ' s for walking around and using other's property. R4 needs group (psychosocial group) like Health and Hygiene. He (R4) needs encouragement to take shower and wear clean clothing. He (R4) needs money management. R4 borrows money ... R4 has not been to money management (group). " E11 stated no other psychosocial therapy has been offered him.

Later on 4/26/2013 at 10:30 AM, E11 and E6 (PRSD) were interviewed. E11 and E6 were unable to present any plan of care with therapeutic goals and staff interventions for conducting R4's 1:1's psychosocial session. E11 and E6 had no evidence of a revised plan of care to address R4 ongoing non compliance with the facility's smoking policy.

Review of R4's Resident Admission Sheet documented R4 was originally admitted to the facility on 5/04/2012. Also, R4 is a 54 year old male with diagnosis including: Schizoaffective and Obsessive Compulsive Disorder.

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F 280	Continued From page 8 Review of R4's Social Service Notes, dated 4/19/2013, documented R4 was observed by staff smoking in a non designated area. Review of R4 's care plan did not address his Obsessive Compulsives Disorder. His (R4 's) care plan was not revised with goals and interventions for therapeutic or psychosocial sessions. The approaches to manage/supervised R4 noncompliance with the smoking policy was also not revised as needed. 6. Review of R2's Information Sheet document R2 is a 59 year old male, residing at the facility since 12/14/2013 and has diagnosis including: Bipolar Disorder, Schizoaffective, Anemia and Neuropathy. Review of R2's fall risk assessment documented that R2 is at risk for falls. Review of the facility Incident Reports and Log documented that R2 had the multiple falls (approximately 9 falls) on the following dates: 2/05/2013, 2/21/2013, 2/22/2013, 2/25/2013, 3/01/2013, 3/02/2013, 4/22/2013, 4/14/2013, 4/17/2013 and 4/18/2013. Review of R2's care plan documented R2 was at risk for falls. However, R2's care plan was not specific in documenting the risk factors staff identified after each of R2's fall occurrence. Also, R2's care plan was general and lack documentation of staff interventions changing/revising after each fall occurrence.	F 280		
F 309	483.25 PROVIDE CARE/SERVICES FOR	F 309		

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F 309 SS=D	Continued From page 9 HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview and observation the facility failed to comprehensively assess, develop and implement individual pain management plans for 2 (R13 and R17) of 6 residents reviewed for pain in the sample of 23. 1. Review of POS (physician order sheet) for April 2013 shows R13 is 63 years old with diagnosis including chronic obstructive pulmonary disease, neurogenic bladder, schizoaffective disorder, congestive heart failure and cardiomyopathy. Review of Minimum Data Set dated 4/3/13 shows R13 is alert and oriented with no cognitive deficits. R13 was observed on 4/26/13 at 10:40am to be standing in the dining room and appeared to be grimacing. R13 stated she has pain in her legs and back most of the time. R13 said the pain medication does not help much especially when her arthritic pain starts up. Review of a Pain Evaluation form dated 2/5/13 shows R13 was sent to the hospital for pain in her back and abdomen. A Comprehensive Pain Assessment dated 3/15/13 upon readmission, is totally blank except for a " NO " checked to answer the question " does the resident have	F 309		

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any diagnosis which would give you reason to believe she/he would be in pain. " There was no pain care pain in R13's medical record.
E2 (director of nursing) stated on 4/24/13 at 2:30 pm there was no further information/assessment of R13's pain. E2 stated R13 receives prn Motrin when she asks. R13 confirmed there was no care plan addressing R13's pain.

2. R17 was lying on her bed on 4/23/13 at 9:30am. E7 (nurse's aide) entered the room and stated she (E7) was going to assist R17 to the bathroom. R17 was observed to be very stiff as she was sitting up in bed and then moving to a standing position. R17 was also observed to be grimacing as she was moving. R17 confirmed that she has pain upon movement, rating it at a 7 on a scale of 1 - 10, with 10 being the worst. While R17 was in the bathroom, E7 stated that R17 prefers to lie in bed rather than get up. E7 said that R17 does complain of pain at times and assumes R17 gets pain medication from the nurse when she needs it.
Review of POS shows that R17 is 72 years old with diagnosis including dementia, schizoaffective disorder, Parkinson's and hypertension. This POS also shows R17 's only pain medication as M PAP (acetaminophen) 325 mg, 2 tabs, every 4 hours as needed.
E2 (director of nursing) stated on 4/25/13 that R17 does not have a comprehensive pain assessment but has had her pain assessed following several incidents completed after each fall. Review of these assessments (10/24/12, 10/28/12, 11/3/12, 11/6/12, 11/10/12 and 1/16/12) are specific to any pain resulting from the specific incident and do not constitute a comprehensive pain assessment. E2 also confirmed that R17

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F 309	Continued From page 11 does not have a care plan addressing R17's pain. E1 (administrator) and E2 were asked to provide the facility's policy and procedure of their pain management program. None was produced by end of survey on 4/26/13. E3 (assistant director of nursing) stated on 4/26/13 at 1:20pm that the facility's policy for pain management was to send those residents to the pain clinic.	F 309		
F 323 SS=E	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 record review and interview the facility failed to analyze risk factors and perform analysis of root causes for residents sustaining incidents or accidents. The facility also failed to monitor effectiveness of the interventions and change/modify the interventions as necessary to prevent recurrence of incidents. This is for 6 residents in the sample of 23 (R17, R13, R25, R26, R2, and R9). Findings include: Review of POS (physician's order sheet) shows R17 is 72 years old with diagnosis including dementia, schizoaffective disorder, Parkinson's and hypertension. Review of fall care plan dated	F 323		

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F 323	Continued From page 12	F 323		

1/16/13 shows R17 ambulates with the assistance of one, with a rolling walker.
Review of fall care plan dated 8/14/12 and updated with goals through 5/12/13 states R17 fell in room on 10/4/12, was observed on knees on 10/28/12, and had 2 unwitnessed falls on 11/3/12/and 11/6/12. The approaches following these falls, in addition to the falls sustained on 11/10/12 and 1/16/13, is to remind R17 to use the call light several times a day. A safety mat is to be placed next to the bed and R17 is to be located in the dining room when she is confused. The fall on 1/16/13 resulted in R17 sustaining a hematoma to the left forehead and was sent to the ER, per review of the Investigative report dated 1/16/13. This report also stated R17 was " confused and fell. " Review of these accompanying incident and investigation reports do not analyze the circumstances surrounding R17's falls. They do not analyze factors such as the effects of R17's medication, pain complaints or incontinence issues.
E7 (nurse's aide) stated on 4/23/13 at 9:35am R17 does appear to have pain when she (E7) gets R17 up. R17 stated at this time she has pain at a 7 (1-10) when she gets out of bed. E7 also stated R17 is supposed to call for help when she gets up now because she seems to be getting weaker. E7 said R17 knows when she has to go to the bathroom and tries really hard to stay dry so staff try to get to her as soon as possible so she doesn't attempt to get up on her own.
Review of Minimum Data Set dated 4/3/13 shows R13 is 63 years old, is alert and oriented with no cognitive deficits. This Minimum Data Set also incorrectly states R13 has no problems with falls.
Review of facility incident reports shows R13 had 5 falls in December: 12/1/12, 12/2/12, 12/20/12,

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12/21/12, 12/31/12 and one fall on 2/5/13. The care plan dated 3/10/12 through 12/21/12 documents some of the falls resulted from R13 standing up from chair and losing balance and falling to floor while walking.
E2 (director of nursing) stated on 4/25/13 at 1:25pm he was not employed at the facility at the time R13 was falling and does not know why other possible factors that maybe causing R13 to fall were not investigated such as medication (R13 is on antipsychotics), pain (R13 complains of pain to back and abdomen) and incontinence concerns. Urological workup dated 3/7/13 states R13 is severely bothered by frequent urination and urge incontinence and feels wet all the time. R13 stated on 4/25/13 at 12:50pm when she has to go to the bathroom the urge comes on so fast that she feels like she has to run almost to get to the toilet.
E2 stated on 4/24/13 at 1:10pm the facility reviews all falls every day and the care plans and investigation of the falls would contain all the fall review recommendations. E2 also stated the facility has not performed analysis of the root causes possibly leading to recurrent falls for R13 and R17.

3. Review of R25's closed record admission face sheet showed R25 was admitted to the facility on 11/20/12 with diagnoses including Paranoid Schizophrenia, Hearing Loss and Bilateral Cataracts. Admission MDS (Minimum Data Set) documentation dated 12/2/12 and Significant Change MDS dated 2/28/13 showed R25's cognitive level was severely impaired.

Review of the facility's incident reports showed

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R25 had 8 incidents from 1/3/13 to 2/21/13. Of the 8 incidents, 7 were fall incidents where R25 was noted on the floor. Of the 7 fall incidents; 6 occurred on the 3-11 shift between the hours of 2:00 p.m. and 8:30 p.m. Two of the 7 incidents also showed R25 was incontinent of urine and having to go to the bathroom.

Review of the incident documentation and interviews with E1 (Administrator) and E3 (ADON/Restorative Nurse) showed there was no analysis of R25's falls identifying/analyzing why R25 was having most of his fall occurrences on the 3-11 shift. There was no thorough assessment of R25's falls and no documentation showing the IDT (inter disciplinary team) involvement in an attempt to minimize or alleviate R25's falls. There was no documentation showing R25's diagnoses of hearing loss and/or bilateral cataracts were addressed in determining if either of these diagnoses could possibly be a contributing factor to R25's falls.

Interviews with E1 (Administrator), E2 (Director of Nurses), and E3 (ADON/Restorative Nurse) on 4/26/13 at 10:30 a.m. noted all to say they had not analyzed or assessed resident's falls to determine why residents were having falls.

4. Review of R26's closed admission face sheet showed R26 was admitted to the facility on 12/16/11 with diagnoses including Schizoaffective Disorder, History of Polysubstance Abuse and Bilateral Cataracts. Review of the facility's incident reports showed R26 had 6 falls from 2/5/13 to 2/15/13. Incident documentation showed all of the falls occurred in R26's room where he was "found on the floor." Of the 6

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incidents; 3 of the incidents occurred on the day shift between 10:25 a.m. and 11:00 a.m. Incident documentation also notes, "Resident attempts to get out of bed to use bathroom."

Review of incident documentation and interviews with E1 (Administrator), E2 (Director of Nurses), and E3 (ADON/Restorative Nurse) on 4/26/13 at 10:30 a.m. showed no assessment/analysis of R26's falls in an attempt to minimize and/or alleviate R26's falls. Even though all of R26's falls occurred in his room, there was no assessment/analysis as to why R26 was falling in his room and no assessment of the need for closer monitoring of R26.

5. Review of R2's Information Sheet documents R2 is a 59 year old male, residing at the facility since 12/14/2012 with diagnoses including: Bipolar Disorder, Schizoaffective, Anemia and Neuropathy.

Review of R2's fall risk assessment documented R2 is at risk for falls.

Review of the facility Incident Reports and Log documented R2 had the multiple falls (approximately 9 falls) on the following dates and times: 2/05/2013 at 2:20 PM, 2/21/2013, 2/22/2013 at 7:45 PM, 2/25/2013 at 9 PM, 3/01/2013 at 7 PM, 3/02/2013 at 4:45 PM, 4/22/2013 at 7:15 PM, 4/14/2013 at 11 AM, 4/17/2013 at 7 PM and 4/18/2013 at 12:30 PM.

However review of R2's Fall Investigation Report (for the above fall occurrence) did not have

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documentation of a comprehensive assessment or an analysis being done by staff after each fall occurrence for R2. The investigations listed risk factors such as decline in cognition, impaired vision, seizure disorder, weakness, and unsteady gait and balance. But the staff did not analyze how these risk factors played a roll in R2's fall occurrences or what interventions were identified to try to lessen their impact. There was no detailed review of R2's medication that could impact his potential for falling, such as: Dilantin, Trazodone, Valproic Acid, Celexa, Haldol Deconate and Vistral. The investigation only listed that R2 was receiving Psychotropics and did not document R2 was being treated with Antiseizure and other medications. The conclusion for R2's fall investigations just restated what happened. The investigation's conclusion lacked a comprehensive plan to implement safety measures/devices or supervision to prevent R2 from falling.

Review of R2's care plan documented R2 was at risk for falls. However, R2's care plan was not specific in documenting the risk factors and staff interventions to address them. R2's care plan was general and lacked documentation of staff interventions being changed after each fall occurrence.

The director of nursing (E2) was interviewed on 4/26/2013 at 11:06 AM. E2 said he or E4 (nurse) did the fall investigations for R2. E2 described R2 as having a decline in mental and physical condition. Review of R2's Fall Investigation Reports with E2 was done. E2 could not provide evidence of a comprehensive assessment being done of R2's medications and physical

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F 323	Continued From page 17 capabilities after each fall occurrences. E2 stated the restorative nurse and pharmacy did not participate in the assessment of R2's condition after each falls. E4 was interviewed on 4/26/2013 at 11:38 AM. E4 said he could recall one physical therapy assessment being done for R2. But, E4 said pharmacy and restorative nursing did not participate in R2's fall investigations. 6. Review of R9 's Information Sheet documented R9 is a 38 year old female who has resided at the facility since 9/11/2012. R9 has a diagnosis of Lumbar Disk Degeneration, Hypertension and Chronic Pain. Review of R9' POS (Physician Order Sheet) documented an order that R9 is on "Fall Precautions". Review of the facility's Incident Reports and Log documented R9 fell in the facility on the following dates: 2/01/2013, 2/08/20, and 1/03/2013, however; R9' Fall Investigation Reports lacked evidence of a comprehensive assessment being done after each fall occurrence.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza	F 334		

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immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

The facility must develop policies and procedures that ensure that --
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding

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F 334	Continued From page 19 the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on record review and interview the facility failed to ensure documentation and tracking for the Influenza vaccines and Pneumococcal vaccines was accurate and complete. This is for 1 resident in the sample of 23 (R5). The finding includes: Review of R5's Influenza/Vaccination Form located in R5's medical record showed R5 received a Flu vaccine on 10/02/12 and refused a Pneumococcal vaccine on 12/5/11. Review of the facility's Flu and Pneumo Vaccine Tracking Log for 2013 showed R5 had "refused" the Flu vaccine and the Pneumococcal vaccine. No dates were documented on the tracking log as to when the vaccines were refused.	F 334		

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On 4/25/13 at 1:35 p.m. R5 was observed resting in bed in her room. Interview with R5 at this time noted R5 to admit to having a Flu vaccine in Oct. or Nov. 2012. R5 also stated, "I didn't have a Pneumovax shot. I don't care if I get it. I will take it. No one asked me about that one."

During interview with E3 (LPN/ADON - Assistant Director of Nurses)/ Infection Control Nurse on 4/25/13 at 3:15 p.m., E3 was asked about the discrepancies in the documentation of R5's Flu vaccine on the Vaccination Form in R5's medical record vs. the documentation on the Vaccine Tracking Log. E3 had no explanation regarding the discrepancies, but presented an Influenza and Pneumococcal Vaccination form for R5 which showed "Refused" for the Influenza and Pneumococcal Vaccines. This consent had no date of refusal documented for either the Influenza or Pneumococcal vaccines.

As mentioned above, the Vaccination Form found in R5's medical record showed documentation that R5 had received the Flu vaccination on 10/2/12 and refused the Pneumovax on 12/5/11. Interview with R5 also verified R5 had received the Flu vaccine.

Further interview with E3 regarding re-offering the Pneumovax yearly to residents who refused the Pneumovax noted E3 to say, "I don't offer them again when the residents refuse."

During interview with E3 on 4/26/13 at 3:30 p.m. E3 stated, "I went back and talked to R5 and explained the reason why people should receive the Pneumo vaccine. R5 did want the Pneumovax and it was given to her today."

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F 469 SS=E	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to control insects (ants). This practice affected 2 residents (R20 and R13) of 24 residents in the sample and 3 residents (R29, R30, R31) in the supplemental sample. During the group interview on 4/24/12, ants were observed in the room. The resident's room next door was checked and ants were observed. R20 said. "There's been ants for about a week." E1 said, "We have a pest control company that sprays every month. I called them. They will be here tomorrow (4/25/13)." The pest control report for 4/25/13 found ants in R13, R20, R29, R30 and R31's rooms and the break room.	F 469		
F 496 SS=D	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and	F 496		

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competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.

If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

This REQUIREMENT is not met as evidenced by:
Based on reference check review and interview the facility failed to ascertain reference checks were verified to ensure E8 (CNA - certified nurses aide) had worked as a CNA within the last 24 months prior to being hired at the facility in a CNA position.

This is for 1 of 10 CNA personnel files reviewed for reference check verification. (E8)

The findings include:

On 4/25/13 at 2:00 p.m. during the Healthcare

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Worker Background Check, E8's (CNA) personnel file was reviewed with E15 (Human Resource Director) for reference checks. Review of the facility's employment application showed a section for references to be listed, but no section for dates of employment for the reference listed. Documentation in the margin of E8's employment application showed human resource personnel had contacted the Director of Nurses at the referenced facility on 4/29/11 but had not verified dates of E8's employment.

On 4/25/13 at 2:00 p.m. Z1 (Administrator at referenced facility) was contacted to verify E8's dates of employment as a CNA at the facility. Telephone interview with Z1 verified E8's dates of employment as a CNA was 5/27/06 to 4/02/07. As mentioned above, E8 was hired at the present facility on 5/3/11. E8 had no other references verifying she had worked as a CNA after 4/02/07. E8 was hired at the facility on 5/3/11 and worked as a CNA from 5/3/11 to 4/25/13 without verification of working as a CNA two years prior to being hired. Before being hired at the present facility E8 had last worked as a CNA on 4/02/07 (four years prior to being hired).

Interview with E15 on 4/25/13 at 3:00 p.m. noted E15 to say, "Some of the older employment applications did not have a section on the application to list the dates of employment for references. I don't think the dates of employment were verified."