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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR ESTATES NSG & REHAB	**18300 S. LAVERGNE AVE TINLEY PARK, IL 60477**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 164 SS=D	Annual Licensure and Certification 483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the privacy of	F 164		

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

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F 164	Continued From page 1 one resident (R24) in the supplemental sample reviewed for privacy. Findings Include: On 1/19/16 at 3:30 PM E4 (Licensed Practical Nurse/LPN) provided R24 medication via Gastrostomy Tube (G-Tube) and performed an accucheck. At 3:30 PM E4 approached R24 and introduced herself. E4 explained what she was about to perform. E4 never pulled the privacy curtain nor closed the door. Two residents and staff were noted passing the room and observing the medication pass and accucheck during this time. On 1/19/16 at 4 PM, E4, (Licensed Practical Nurse/LPN) stated, "The curtain should be pulled for privacy." On 1/21/16 E2 (Director of Nursing) provided the policy entitled, "Resident Rights Guidelines" notes "Close the door to the room if appropriate, Screen the resident for privacy. Your medical and personal care are private. Facility staff must respect your privacy when you are being examined or given care."	F 164		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by:	F 221		

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F 221	Continued From page 2 Based on observations, interview and record review, the facility failed to identify and assess full length bilateral side rails as a restraint for three (R3, R9, R14) of 5 residents reviewed for physical restraints in the sample of 19 residents. The findings include: On 1/21/16 at 1:30 PM, R9 was laying in the bed on his backside with bilateral full length side rails up. The bed was 24 inches from the floor and no floor mats present. E12, R9's assigned certified nurse aide was brought into R9's room at 1:32 PM and was asked why R9's bed alarm was laying on the mattresses not attached to anything. E9 showed that the alarm is sensitive and can be pulled easily and stated that is unable to be attached to the bed like other alarms. E12 stated R9 was drowsy sitting in the wheelchair so she laid him down. E12 stated it is normal for R9 to take an afternoon nap. E9 stated the side rails are always pulled up and R9 does not try to get out of bed. E12 was asked if everything was how it should be and she said yes. At 2:20 PM, R9 was on laying on his right side in the bed with full length bilateral side rails up and no floor mats present. R9 was able to reposition himself in the bed. R9's side rail assessments dated 2/20/25, 5/29/15, 7/30/15, 10/23/15 and 10/25/15 documents R9 wants the side rails up, the physician has ordered the side rails, the side rails are to be up at all times when in bed, the side rails can not be released by resident, resident has a history of falls and R9 is not alert and oriented times three and has confusion at times. The 7/30/15, 10/23/15 and 10/25/15 side rail assessments document R9 is able to ambulate.	F 221		

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The assessments do not identify the side rails as restraints.

R9's current (October 2015) care plan documents the use of the bilateral side rails are to enhance functional independence, positioning and turning.

R9's current minimum data set dated 10/23/15 documents R9's BIMS (brief interview mental score) as a "3" and has the diagnoses that include dementia with behavior disturbances. Any BIMS under "8" is considered not to be interviewable.

On 1/21/16 at 4:10 PM, E2 (Director of Nursing) stated that the side rails on the beds are enablers for positioning and not assessed as restraints. E2 stated many of the residents and/or family members request the use of the side rails. E2 stated that the beds are old and the side rails cannot be removed because the beds would fall apart. Asked about alternating the side rails, one up and one down, he agreed that could be done.

On 1/22/16 at 9:15 AM, E2 (Director of Nursing) stated there are 39 residents in the facility who use full length bilateral side rails. All have been assessed to have side rails as enablers not restraints.

The facility's restraint policy labelled 'Restraints" documents physical restraints is defined as any manual method or physical or mechanical device, material or equipment attached or adjacent to resident's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

On 1/19/16 R3 was observed in bed with full

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length side rails up. R3 was noted to move half way to his right side but does need assistance with some bed mobility. The bed was noted to be up and no mats were on the floor. The resident appeared comfortable and without discomfort. The resident chart noted the resident with a recent significant condition change and recently placed on hospice.

On 1/20/16 R14 was noted in bed with full length side rails up. R14 was noted to move side to side but does require assistance. R14 is able to sit up from a supine position and use the side rails to assist in movement.

On 1/20/16 at 1:30 PM, review of resident records for R3 and R14 was conducted. Review of the chart for R3 noted, "On 10/15/2015 at 3:59 PM chart notes "falls: has a history of falls at night, history of climbing over side rails: none, ability to release rails: unable to release, side rail availability on bed: easily available, reason for side rail use: request of resident, reason for recommendation: resident wants side rails up." Resident R14 review of chart on 1/13/16 notes "history of climbing over side rail: none, ability to release side rail: unable to release, side rail use: bilateral full side rails, reason for side rail use: resident wants side rail, reason for request of use: request of family, reason for recommendation: safety concerns, bed mobility resident wants side rails up."

On 1/13/16 at 3:48 PM, R14's chart notes "Reason for assessment: Significant change in condition. Is there a device in use: Yes. Is device a restraint: yes. Limitations: Ambulation, transfer ability trunk control standing balance/ability. restraint required: yes If yes, why: Dr order and

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F 221	Continued From page 5 consent obtained for positioning and bed mobility and transfers." The chart notes the assessment but refers to restraint as an enabler and not a restraint although it recognizes that the resident is able to move and now restrained in movement by not being able to remove restraint. On 1/21/16 at 1 PM E2 (Director of Nursing) stated, "Last survey had the same issue come up. We corrected this by assessing the resident and filled out both the enabler paperwork and restraint forms. However, when we came to Section P of the Minimum Data Sheet, the documentation does not note restraint. The device is an enabler. As the facility is older the beds are old and the rails are basically full length. The physician has given the order that this device is being used for positioning."	F 221		
F 280 SS=D	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	F 280		

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F 280	Continued From page 6 each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to develop, implement, evaluate and review the care plan quarterly and as needed for one (R4) resident reviewed for identified offender in the sample of 19 residents. Findings include: On 01/19/16 at 2:30 pm, R4 was identified as residing in the same room as R1. On 1/19/16 at 2:09 pm, E13 (R4's Social Worker) stated that R4 interacts well with other residents and no behavior concerns have been observed. On 1/20/15 at 8:30 am, E13 (R4's Social Worker) stated he didn't know that R4 was a sex offender until 1/19/16. R4's Face Sheet indicates that R4 is a resident at the facility since 02/29/13 . R4's diagnoses includes history of Transient Ischemic Attack, History of falls, Osteoarthritis, Dysthymic Disorder, Hypertension, Left sided Plural Effusion, History of renal carcinoma, Nephritis and Nephropathy, Joint Disease, Generalized Weakness, Organic Brain Syndrome, Neurotic Anxiety, Depressive Disorder. Benign Prostatic Hypertrophy, Cerebral Infraction without Residual Deficit per R4's face sheet. Review of R4's Sex Offender Evaluation/Risk	F 280		

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F 280	Continued From page 7 Assessment dated 01/07/14 by Z1 (Clinical psychologist) evaluated R4 as a convicted and/or registered sex offender and as such requires an individual room with a private bathroom. This evaluation also indicates R4, as a High Risk offender, requires a single room in close proximity to the nursing station to permit ongoing visual monitoring. The level of observation should be sufficient for early detection of behavioral changes. Regular assessment is necessary to determine whether closer monitoring or more frequent individual contact is indicated. Review of R4's care plan since facility's last annual survey (12/18/14) until 01/19/16, the facility failed to address Z1's recommendation and also failed to have an assessment, quarterly evaluation or develop a care plan as needed or implement for R4's status as a High Risk offender.	F 280		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating	F 322		

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F 322	Continued From page 8 skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure standard of care in administoring medications through a Gastrostomy Tube (G-Tube) for 1 resident (R24) in the supplemental sample. Findings include: On 1/19/16 at 3:30 PM E4 (Licensed Practical Nurse / LPN) provided R24 medication via Gastrostomy Tube (G-Tube). R24 is to receive Risperdal 1 milligram per milliliter (mg/ml) 1 ml via her G-Tube twice a day. R24 is also to receive a Lactobacillus tablet, 1 tablet via her G-Tube. At 3:30 PM E4 approached R24 and introduced herself. E4 explained what she was about to perform. E4 stopped the enteral feeding, checked for G-Tube placement and flushed the tube. E4 then proceeded to administer the medications. E4 placed the medication into the Flush syringe and pushed the medications. E4 then flushed the tube post medication and restarted the enteral feeding." On 1/19/16 at 3:40 PM E4 stated, "Our procedure is to push medications via the syringe when administering meds through a G-Tube." On 1/19/16 at 3:50 PM E5 (LPN) and 4:00 PM E6 (LPN) stated, "G-Tube medication administration	F 322		

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F 322	Continued From page 9 is conducted via gravity drip (the process of allowing the medication to flow by itself using gravity)." On 1/20/16 at 9:00 AM E7 (LPN), E8 (Registered Nurse/RN), and E9 (LPN) stated "Medications are given by gravity drip." On 1/21/16 E2 (Director of Nursing) provided the G-Tube administration policy and procedure entitled "Enteral Tube Medication Administration" (not dated). The policy notes "Do not mix medications together." On 1/22/16 on 11:20 AM Central Management Services Memorandum November 12, 2012 Reference: S&C 13-02-NH notes "For administering medications via tube feeding the standard of practice is to administer each medication separately and flush the tubing between each medication."	F 322		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to administer medications as ordered. There were 25 opportunities with two errors resulting in a 8% error rate. This failure affects 1 of 10 residents (R24) observed during the medication pass.	F 332		

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F 332	Continued From page 10 Findings Include: On 1/19/16 at 3:35 PM E4 (Licensed Practical Nurse / LPN) was observed during medication pass. E4 provided medications for R24 (resident) via Gastrostomy Tube (G-Tube). R24 was to be provided Resperidal 1 milligram per milliliter (mg/ml). The order states give 1 ml of Resperidal via G-Tube at twice a day at 6 AM and 6 PM. In addition, R24 was to receive Lactobacillus 1 tablet crushed via G-Tube at 6 PM. E4 administered the medication at 3:35 PM. The medication was provided two and a half hours prior to the scheduled time of administration resulting in 2 medication errors and an 8 percent error rate. On 1/19/16 at 3:40 PM E4 (Licensed Practical Nurse / LPN) did not state why she administered the medication early. On 1/22/16 at 9 AM E2 (Director of Nursing) provided the Medication Administration Policy (undated). The policy notes "Medications are administered within 60 minutes of scheduled time, except before or after meal orders, which are administered precisely as ordered."	F 332		
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.	F 431		

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F 431	Continued From page 11 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 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 maintain count of narotic disposition, failed to properly utilize multi-dose vials, failed to discard single-use vial. These failures affected one (1) resident (R3) in the sample of 19, and eight (8) residents (R20, R21, R22, R23, R24, R30, R31, R32) in the supplemental sample. Findings include: On 1/20/16 at 10:30 AM E8 (Registered Nurse/RN) was requested to review the narcotic	F 431		

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count in her medication cart. During the count it was observed that R20, R21, R22, and R23 narcotic count were incorrect. Each of these residents' medication sheets noted one extra Lorazepam 0.5 mg tablet observed on the narcotic card verses the sign out sheet.

On 1/20/16 at 10:35 AM E8 stated, "I gave the medications when I passed meds at 8 AM. I have not signed out the medications yet."

On 1/22/16 at 9 AM E2 (Director of Nursing) provided the "Narcotic Administration" policy (undated). "Scheduled II Drugs and any other specific medications deemed necessary by the facility will be dispensed by the pharmacy along with an Individual Charting Record. This record will be maintained by the nursing staff at the time of each administration of the medication as follows: Place charting record in narcotic box or in charting record binder. Record each done at the time of administration. Confirm the amount of controlled drug remaining is correct prior to assembling required dose or administration: Date, Time, Dosage, Signature of nurse who administered dose, and Number of doses remaining."
On 1/20/16 at 1:40 PM, Main Street medication room was checked with E7, LPN (Licensed Practical Nurse) and noted the following: Lantus insulin pens for R24, R30 and R31 opened, but not labeled with date and time and nurse's initials. Lorazepam 2 mg/1 ml vial was opened and partially used for R3 but was not discarded.
On 1/20/16 at 1:50 PM, E7 stated she doesn't know why the multi-dose vials were not labeled but they were supposed to be discarded after 30 days of opening. E7 also stated Lorazepam 2 mg /1 ml vials are considered multi-dose vials and

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F 431	Continued From page 13	F 431		

since they only used half of it for R3, they are keeping the rest of medication for future use.
On 1/20/16 at 2:15 PM, Garden view medication room was checked with E8, RN (Registered Nurse). One Lantus insulin pen for R32 was found with an open date of 11/21/15 and discard date of 12/20/15.
On 1/20/16 at 2:20 PM, E8 (Registered Nurse) stated she doesn't know why the pen was still there, it should have been discarded. When asked about Lorazepam 2mg/ml vial, E8 (Registered Nurse) stated, "They consider the medication as multi-dose for as long it is given to the same resident, they keep the medication for future use when only partially used."
On 1/20/16 at 10:30 AM, R23's Morphine sulfate 20 mg/ml vial and Lorazepam 2 mg/ml vial were found with an expiration date of 10/15/15.
On 1/20/16 at 4:20 PM, E4 (LPN), stated opened insulin vials are good until expiration date.
On 1/21/16 at 3:45 PM, Z2 (Pharmacist) stated Lantus insulin pens are good only for 28 days once opened. Z2 also stated after calling the manufacturer of the Lorazepam 2 mg/1ml vial, it was found out that these vials are designed for single use only and the expectation is for the medication to be discarded even though it is only partially used.
Facility policy on "Utilizing a Multi-Dose Vial" dated April 2011 was reviewed. It documented "the vials will be labeled after opening with: 1. Resident's name 2. Date and Time 3. Nurse ' s initials."
Undated "Medication Room Storage Policy" indicated "No discontinued, outdated, or deteriorated medications are available for use in this facility. All medications are destroyed."
Undated "Vials and Ampoules" policy documented, "Ampoules and single-use vials are

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145967	A. BUILDING _____ B. WING _____	01/22/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR ESTATES NSG & REHAB	18300 S. LAVERGNE AVE TINLEY PARK, IL 60477

(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 14 discarded immediately after using according to facility policy."	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which 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	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 15 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure the proper cleaning of glucometers for five (5) residents (R24, R25, R26, R27, R29) in the supplemental sample. This has the potential to affect 22 residents receiving blood glucose monitoring. Findings include: On 1/19/16 at 3:30 PM E4 (Licensed Practical Nurse/LPN) performed an accucheck on R24. After the accucheck and medications were completed, E4 was observed cleaning the glucometer with an alcohol swab. On 1/19/16 at 3:35 PM E4 stated, "We clean our glucometer with an alcohol swab. We then let it air dry for 5 minutes. It will dry by the time I get to the next resident. Usually I clean the glucometer when I get to the next resident needing an accucheck." On 1/19/16 at 3:50 PM E5 (LPN) stated, "I cleaned my glucometer with hand gel." On 1/19/16 at 4 PM E6 (LPN) stated "I don't know how to clean the glucometer." On 1/20/16 at 9 AM, when asked how to clean a glucometer E7, (LPN) and E8 (Registered Nurse/RN) stated, "We have a specific wipe we use to disinfect the glucometer." E9 (LPN) stated, "I don't know."	F 441		

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F 441	Continued From page 16 On 1/20/16 at 10 AM E2 (Director of Nursing) provided the manufacturers cleaning policy for glucometers. The policy states that the glucometer needs to be cleaned between residents. E2 stated, "The facility uses the manufacturer's recommendation. However, there is a disinfectant wipe that is used here at our facility."	F 441		