STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6005292	A. BUILDING: _____ B. WING _____	C 06/08/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENA LIVING CENTER	1010 SOUTH LOGAN STREET LENA, IL 61048

(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) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations 300.630s) Section 300.630 Contract Between Resident and Facility s) The contract shall provide that if the resident is compelled by a change in physical or mental health to leave the facility, the contract and all obligations under it shall terminate on seven days notice. All charges shall be prorated as of the date on which the contract terminates, and, if any payments have been made in advance, the excess shall be refunded to the resident. These requirements were not met as evidenced by: Based on interview and record review, the facility failed to ensure resident funds were returned to the resident's designee within 30 days after the death of the resident. This applies to 1 resident (R1) reviewed for residents' fund. The findings include: R1's Physician Order sheet (POS) of June 2015 shows R1 has diagnoses that include dementia and basal cell carcinoma. R1's Minimum Data Set-MDS dated November 17, 2014 shows R1 has severe cognitive impairment. Nurses Notes dated January 2015 show R1 expired on January 5, 2015. On June 3, 2015 at 8:05 AM, Z1 (R1's daughter) said, " The facility is giving me the run around. My dad passed away last January 5, 2015. I paid $4,482.40 in advance for his stay in the facility. I called the facility on May 4, 2015. The staff said they will let corporate know. The next day, May 5, 2015, I received a call from the facility assuring me that I should receive the check in 2 weeks. Up to now (almost a month after I called and 4	S9999		

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S9999	Continued From page 1	S9999		

months after my dad died) I have not gotten the refund. I called the facility yesterday, June 3, 2015, and asked for the corporate phone number. The lady I spoke to said, she cannot give me the corporate phone number. I was able to find the corporate office phone number and the guy in the corporate office said they did not even know my dad passed away. "
On June 3, 2015 at 10:50 AM, E3 (Business Office Manager) stated, " When a resident expires, a notification is sent to corporate. Corporate then will check if there are any other charges the resident might have. If all is clear, then a check is mailed to the family. With regards to R1, he passed away last January, I have to look into it, I was off yesterday. "
On June 3, 2015 at 11:00 AM, E1 (Administrator) said there are no guarantees when a refund is sent to the family after a resident passes away, possibly 3 months. There is some accounting to be done like insurance premium, therapy billing and ancillary stuff to be cleared before the money goes back to the family.
On June 3, 2015 at 1:00 PM, E4 (Corporate Chief Financial Officer) said, " I know about R1. The facility dropped the ball. Corporate was not informed of R1's passing until May 5, 2015. It fell through the cracks, it happens." E3 said I expect the facility to inform corporate a week or two after a resident expires so we can facilitate things sooner. At times it takes 45 to 60 days minimum turn around before a refund is issued.
A facility document entitled Statement dated February 1, 2015 shows R1 had $4,482.40 on his account. Room and Board charged were deducted ($140.00). An amount of $3,919.20 remained in R1's account.
A facility document entitled Refund Authorization Form dated May 4, 2015 (approximately almost 4 month after R1 expired) shows a request refund

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S9999	Continued From page 2 in the amount of $3,919.20. At 2:00 PM, E3 showed the surveyor a copy of a check dated June 3, 2015 (almost 5 months after R1 expired) that was not yet issued to R1's daughter. (AW) 300.1210b) 300.1210d)6) Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures: d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents ' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. These requirements were not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a confused	S9999		

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S9999	Continued From page 3	S9999		

resident who wanders, did not come in contact with hazardous materials.
This applies to 1 resident (R1) reviewed for supervision.
The findings include:
R1's Minimum Data Set-MDS dated November 17, 2014 shows R1 has severe cognitive impairment. R1 uses a wheelchair for mobility.
On June 3, 2015, Z1 (R1's daughter) said, R1 picked up a " rat poison " (mouse bait device). He inserted his finger inside the mouse trap and licked his finger. I went to the facility and asked the staff. They don't seem to know what happened.
R1's POS (Physician Order sheet) of June 2015 shows R1 has diagnoses that include Dementia and Basal Cell Carcinoma. R1 expired on January 5, 2015.
Nurse's notes dated November 15, 2015 at 1 PM, documents: Resident was at the end of D hall. (R1 lived in B wing opposite hall of D wing) and found a pest trap with poison in it. R1 handled the trap then put his finger in his mouth. Certified Nursing Assistant-CNA saw resident doing this and took the trap away from the resident. Called Dr Rose on call. Advised me to call Pest Control. Called Pest Control stated acts like anticoagulant and just watch for signs of bleeding and bruising. Family aware.
On June 3, 2015 at 4:00 PM, E5 LPN (Licensed Practical Nurse) said, I was told that R1 picked up the bait at the end of the D hall. The bait was on the floor. I don't know why those were placed on the floor. R1 inserted his fingers then licked his finger. I called the doctor and the pest control and the family. I monitored him for bleeding. R1 had no bleeding that night.
A nurses note dated December 6, 2015 at 3:00 AM, " Resident has loose bloody stools noted this shift. " (Approximately 3 weeks after the

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S9999	Continued From page 4	S9999		

incident.)
A nurse's note dated December 7, 2015 at 9:00 PM, " Small amount of stringy/ bloody mucous stool. "
Nurse's notes dated December 8, 2015 at 2:05 PM " loose stool with blood x 1. "
Z2 (pest control) said the mouse traps are placed all over the building and that they go to the facility every week. The mouse traps are placed where residents cannot get into them said "I have no idea why the bait was on the floor on D wing."
At 3:00 PM, E1 (Administrator) said Pest Control Company comes to the facility quarterly. I don ' t think there are any mouse traps in the facility at this time.
At 4:00 PM, E7 (Housekeeping Supervisor) showed the surveyor a mouse bait device from B wing. E7 said the mouse traps are in all 4 halls. (A, B,C and D halls.)
The facility provided an MSDS (Material Safety Data Sheet) states potential to reduce clotting ability of the blood and causes bleeding.
R1's Care Plan initiated on November 25, 2014 shows R1 wanders throughout halls daily related to impaired safety awareness. Resident propels self in halls.
R1's care plan did not reflect that R1 came in contact with the poison trap. No additional interventions were added to the care plan.

(B)