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S 000	Initial Comments Annual Licensure Survey Licensure Survey for Subpart S: SMI Validation Survey for Subpart U: Alzheimer Unit	S 000		
S9999	Final Observations Statement of Licensure Violations 300.696 a.) c.) 2.) 7.) 300.1210 d.)1) 2.) 300.1210 d.) 6.) 300.1630 a.) 3.) 300.1640 e.) 300.2210 b.) 1.) 2.) 9.) 300.3200 f.)1.) 300.3200 l.) Section 300.696 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) Each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services (see Section 300.340): 2) Guideline for Hand Hygiene in Health-Care Settings	S9999		

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S9999	Continued From page 1 7) Guidelines for Infection Control in Health Care Personnel This REQUIREMENT was not met as evidenced by: Noncompliance resulted in three deficient practices: A. Based on observation, record review, and interview, the facility failed to cleanse an environmental surface to prevent potential transmission of microorganisms. This failure has the potential to effect one resident (R7) in a sample of nine and 10 residents (R13, R14, R36, R37, R56, R57, R59, R61 and R62) in a supplemental sample who are independently mobile. B. Based on observation, record review, and interview, the facility failed to follow their procedure for handling of soiled items for one of one resident (R4) reviewed for perineal care in a sample of nine. C. Based on observation, record review and interview, the facility staff member (E24) failed to wash hands or use sanitizer between the administration of medications to four residents (R35, R36, R14, and R37) on the supplemental sample. Findings include: A. On 1/21/15 at 9:40 a.m., during tour, there were two smears of a brown thick substance measuring approximately two centimeters in diameter and about 12 inches apart on the hallway floor in the center of the seven West hallway. There were wheel tracks through the brown substance leading to the shower room door, which was closed. E3 (ADON - Assistant Director of Nursing) was present. When asked if the brown substance was stool, E3 (ADON) stated, "Yes it is." E3 (ADON) stopped	S9999		

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housekeeping staff who were waxing resident rooms in the hallway and asked that the hallway be cleaned. On 1/21/15 at 9:55 a.m., E3 (ADON) again requested a housekeeper be made available to clean the seven west hallway floor. An overhead page requested a Housekeeper come to the area.

On 1/21/15 at 10:00 a.m., after the tour of the West hallway, the brown substance remained on the hallway floor. From 9:40 a.m. to 10:05 a.m., several staff members walked over the substance, wheeled a clean linen cart and two soiled linen hampers over the area. On 1/21/14 at 10:05 a.m., R7 propelled R7's wheelchair using both hands on the wheelchair wheels down the hallway wheeling through the brown substance on the hallway floor.

At 10:05 a.m., E12 (Housekeeping) arrived on the seven West hall. E12 then dust- mopped the entire hallway. E12 then began wet mopping at the end of the hallway closest to the nurses' station and proceeded wet mopping through and past the brown substance on the floor for about six more feet. E12 then took the wet mop to the housekeeping cart and removed the mop head with un-gloved hands and placed it in a bag attached to the Housekeeper cart.

A policy titled Standard Precautions dated 12/09 states, "Standard Precautions apply to: 1. Blood, 2. All body fluids, secretions, and excretions except sweat; regardless of whether or not the contain visible blood. Standard Precautions are designed to reduce the risk of transmission of microorganisms from both recognized and unrecognized sources of infection in facilities.... 8. Environmental Control: Ensure that the facility has adequate procedures for the routine cleaning

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and disinfection of environmental surfaces, beds, bed rails, bedside equipment and other frequently touched surfaces and ensure that these procedures are being followed.

On 1/22/15 at 2:34 p.m., E3 (ADON) provided a highlighted list of residents (R13, R14, R36, R37, R56, R57, R59, R61, and R62) and indicated that the highlighted residents are independently mobile in the seven West hallway.

On 1/22/15 at 12:53 p.m., regarding cleaning bowel movement on the floor, E2 (DON - Director of Nursing) stated, "I would expect that to be cleaned right away and not take 20 minutes to clean. The housekeeper should have removed the bowel movement, then cleaned the area."

B. On 1/21/14 at 1:00 p.m., E10 and E11 (CNA's - Certified Nursing Assistants) transferred R4 to the bathroom to perform incontinence care. E11 removed R4's incontinence brief and placed the brief on the floor of the bathroom.

A policy titled Perineal Cleansing dated 9/21/10 states, "7. Place soiled items in plastic bag."

On 1/22/15 at 3:10 p.m., E2 (DON - Director of Nursing) stated R4's brief should have been bagged and E11 should not have placed R4's incontinence brief on the floor.

C. On the noon medication pass of 1/21/2015 in the main dining room, E24, Licensed Practical Nurse, administered medications to four residents (R35, R36, R14, and R37) without washing hands or using hand sanitizer between each resident on this medication pass.

On 1/21/15 at 11:40 a.m., E24, LPN, stated, "I

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don't have any hand sanitizer on this medication cart. The facility does not provide sanitary gel to staff on the medication carts."

On 1/21/15 at 2:45 p.m., E2, Director of Nurses, stated, "We do supply sanitizing gel and staff are expected to use sanitary gel between residents on a medication pass or wash hands."

The facility Medication Administration Policy revised 7/3/13 under Procedure states "Appropriate hand washing or use of an alcohol based gel must be performed throughout the medication pass...
Hand washing between every resident is not required according to CDC (Center for Disease Control) guidelines. It is acceptable to use an antiseptic gel type solution between residents."

Section 300.1210 General Requirements for Nursing and Personal Care
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:
1) Medications, including oral, rectal, hypodermic, intravenous and intramuscular, shall be properly administered.
2) All treatments and procedures shall be administered as ordered by the physician.
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.
This REQUIREMENT is not met as evidenced by:
Noncompliance resulted in two deficient practices:

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A. Based on observation, record review and interview, the facility failed to verify G-tube (gastrostomy tube/gastric feeding tube) placement prior to administering medication and fluid to one of one resident (R9) in a sample of 9 reviewed for gastrostomy tube use.
B.) Based on observation and interview, the facility failed to ensure the safety of residents by inappropriately storing hazardous sharps and toxic chemicals. This failure had the potential to affect two confused and ambulatory residents (R10 and R11) on the supplemental sample.
Findings include:
A.) On 1/22/15 at 11:40 am, E13 (LPN/Licensed Practical Nurse) prepared R9 for administration of a medication and water flush through R9's feeding tube. E13 poured up 10 ml (milliliters) of liquid Reglan per physician order. E13 pulled up 30ml of water into the feeding tube syringe and pushed it through R9's feeding tube. E13 was asked what the facility protocol is for checking placement of a feeding tube prior to administration of fluids and medications. E13 stated, " Oh, I didn't check placement. I checked placement this morning. But I will check it now if you would like me to. I have to go get my stethoscope first." E13 returned with the stethoscope in hand, attached the syringe to the feeding tube and aspirated (pulled stomach fluids into the syringe). E13 then checked the placement of the feeding tube by instilling air into the tube while listening with the stethoscope. E13 stated, "Yes I heard that. The tube is in correct placement." E13 then administered the Reglan and the required water per physician order.
The facility policy titled, "Administration of Medication via a Feeding Tube," dated April 2007, includes the following: (Prior to administering medications) "Procedure: 13. Check for tube placement by checking for residual. If no residual

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is aspirated, verify placement by placing stethoscope over the stomach and instilling approximately 30cc of air. Auscultate for air installation, proceed if heard. "
R9's current Physician Order Sheet dated 1/1/15 notes a physician order to check G-tube placement and to administer all medications through the G-tube. R9's Care Plan, dated 11/6/14, includes an intervention to check G-tube placement (before using).
On 1/22/14 at 2:30 p.m., E2 (DON/Director of Nursing) said (E13) had not made (E2) aware (E13) had forgotten to check placement. E2 verified it is the facility's policy/procedure to check placement first. E3 (ADON/Assistant Director of Nursing) was present at this same time. E3 was noted to shake her head in agreement with E2.
B.) On 1/21/15 at 1:00 p.m., the East 700/800 shower room door was unlocked and propped open with a linen cart. The shower room contained a box of ten disposable razors and a chemical used for stripping/cleaning floors. The floor chemical (Phase 1 Floor Stripper) stated "Keep Out of Reach of Children" and "Corrosive" on the label.
On 1/21/15 at 2:15 p.m., E4 (Maintenance Director) stated that razors and floor chemicals should not be stored in the shower room.
On 1/22/15 at 9:23 a.m., E2 (Director of Nursing/DON) stated the razors and floor chemical had the potential to affect R10 and R11 because R10 and R11 are confused and ambulatory residents who live on the East wing.

Section 300.1630 Administration of Medication
a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in

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pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents.
3) Self-administration of medication shall be permitted only upon the written order of the licensed prescriber.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to evaluate one resident (R6) of nine residents on the sample reviewed for Self- Administration of Drugs.
Findings include:
On 1/22/15 at 11:30 a.m., an unlabeled Advair diskus was found on the bedside table in resident R6's room, with E5 (Licensed Practical Nurse) in attendance.
On 1/23/15 at 9:30 a.m., E5 stated "There was no order for bedside use of the Advair diskus until 1/22/15 at 12 noon. There was no previous order for self-administration of the Advair diskus during this admission."
The 12/28/14 Physician orders for (R6) documents: "Advair 250-50 Diskus - Inhale one puff by mouth twice daily."
On 1/23/15 at 9:15 a.m., (R6) would not comment on whether if she (R6) had participated in a self-medication program.
On 1/23/15 at 9:55 a.m., E2 (Director of Nurses) stated, "(R6) did not have a careplan entry to identify a self-medication program for an Advair Diskus. There is no available assessment for (R6) to evaluate Self-Administration of Advair Inhaler."
The facility's Self-Administration of Medication Program Procedure documents: "#2. An assessment will be completed identifying current level of functioning and strengths... #4. The self-administration medication program will be included on the Care Plan with measurable goals

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incorporated into daily care... #10. Medications may be kept at bedside only upon support of facility policy and successful completion of the Self-Medication Program."

Section 300.1640 Labeling and Storage of Medications
e) The key or access code to the medicine cabinet, medicine room, or mobile medication cart shall be the responsibility of, and in the possession of, the persons authorized to handle and administer medications, at all times.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to secure all medications and syringes by allowing unlicensed staff to have a key to the central supply closet, which stocked over the counter medications and syringes. This failure has the potential to affect 143 residents in the facility.
Findings include:
On 1/21/15 at 2:00 p.m., E4 (Maintenance Director), unlocked and entered the central supply closet on the 300/400 Hall.
The central supply closet was stocked with 1 milliliter (ml) insulin syringes, tuberculin syringes and 22 gauge by one inch syringes.
The supply closet also was stocked with enemas, Milk of Magnesium, Hydrogen Peroxide, Geri-Lanta, Acetaminophen 500 milligram (mg), Ibuprofen 200 mg, Tums, Acetaminophen 325 mg, Aspirin 325 mg, Multivitamin with minerals, multivitamin with iron, multivitamin, Vitamin C, Simethicone, chewable Aspirin 81 mg, Aspirin 325 mg Enteric Coated and Vitamin B Complex.
On 1/21/15 at 2:15 p.m., E4 (Maintenance Director) stated that E4 should probably not have access to the central supply room.
On 1/22/15 at 9:23 a.m., E2 (Director of Nursing) verified that medications should not be stored in

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the central supply room and that E4 (Maintenance Director) should not have a key to the room. E2 also stated that the central supply closet stores supplies for all residents in the facility.
The facility's Nurses Midnight Census Report, dated 1/21/15, documents 143 residents live in the facility.

Section 300.2210 Maintenance
a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies.
b) Each facility shall: (B)
1) Maintain the building in good repair, safe and free of the following: cracks in floors, walls, or ceilings; peeling wallpaper or paint; warped or loose boards; warped, broken, loose, or cracked floor covering, such as tile or linoleum; loose handrails or railings; loose or broken window panes; and any other similar hazards. (B)
2) Maintain all electrical, signaling, mechanical, water supply, heating, fire protection, and sewage disposal systems in safe, clean and functioning condition. This shall include regular inspections of these systems. (A, B)
9) Maintain all plumbing fixtures and piping in good repair and properly functioning. (B)
This REQUIREMENT is not met as evidenced by:
Based on observation, record review and interview, the facility failed to maintain the toilet and attached grab bar unit in the 500/600 hall shower room in good repair. This failure had the potential to affect 20 residents (R10, R11, R38-R53, and R55 and R105) in the supplemental sample.
Findings include:
On 1/21/15, at 1:00 p.m., the toilet in the 500/600 hall shower/bathroom room was not secured to the floor, and the attached grabbar unit was loose

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as well.
On 1/21/15, at 2:15 p.m., E4 (Maintenance Director) stated that all 500/600 hall residents use the shower/bathroom.
The facility Nurses' Midnight Census Report, dated 1/21/15, documents that R10, R11, R38-R53 and R55 and R105 all reside on the 500/600 hall.

Section 300.3260 Resident's Funds
f) The facility shall purchase a surety bond, or otherwise provide assurance satisfactory to the Departments of Public Health and Insurance that all residents' personal funds deposited with the facility are secure against loss, theft, and insolvency. (Section 2-201(5) of the Act)
1) If a surety bond is secured, it must be issued by a company licensed to do business in Illinois, the amount of bond must be equal to or greater than all resident funds managed by the facility, and the obligee named in the bond must be the Illinois Department of Public Health or its assignees.
l) Unless otherwise provided by State law, the facility shall upon the death of a resident provide the executor or administrator of the resident's estate with a complete accounting of all the resident's personal property, including any funds of the resident being held by the facility. (Section 2-201(10) of the Act)
This REQUIREMENT is not met as evidenced by:
Noncompliance resulted in two deficient practices:
A.) Based on interview and record review, the facility failed to assure that the surety bond for resident trust funds was at or above the highest potential balance to protect the resident trust funds from misappropriation of the funds. This failure has the potential to affect 134 residents who have trust funds managed by the facility,

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which includes 6 of the 9 sample residents (R1-R6) and 128 residents on the supplemental sample (R1 to R6, R10 to R12, R18 to R20, R22 to R25, R27, R40, R42, R45, R47, R49 to R55, R58 to R60, and R63 to R153) who have trust funds.

B.) Based on interview and record review, the facility failed to refund the Resident Trust Fund balances upon death to the respective executors of estate for ten residents (R65, R68, R73, R74, R76, R77, R84, R88, R93, and R98) on the supplemental sample.

Findings include:

A.) The facilities document "Long Term Care Facility-Resident Fund Surety Bond No. 105812041," dated 12/5/12, documents $65,000.00 maximum of resident funds to be managed by the Principal at any time during such period.

The facilities records of resident Trust Fund Account History, dated 1/23/15, documents a ledger balance on 10/3/14, 10/4/14 and 10/5/14 in the amount of $76,687.28; a ledger balance on 11/3/14 in the amount of $75,493.34; a ledger balance on 12/3/14 in the amount of $75,838.44; a ledger balance on 1/2/15 through 1/4/15, in the amount of $78,327.79 and on 1/5/15 through 1/7/1, in the amount of $75,902.21.

On 1/23/15 at 9:00 a.m., E22 (Business Office Manager) confirmed that the Surety Bond amount needs to be increased to cover the overage because the $65,000.00 does not consistently cover the balance.

The facility Trust Fund Balance Report, dated 1/21/15, documents that the facility holds monies for R1 to R6, R10 to R12, R18 to R20, R22 to R25, R27, R40, R42, R45, R47, R49 to R55, R58 to R60, and R63 to R153.

B.) The facility's "Trust Fund Balance Report," dated 1/21/15, documents the following balances

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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) COMPLETE DATE
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for residents that have expired or have been discharged for over 30 days from the facility: R65 ($20.00), R68 ($3,779.00), R73 ($645.48), R74 ($186.77), R76 ($477.66), R77 ($672.29), R84 ($90.61), R88 ($210.49), R93 (90.01), R98 ($5.01).
The "Long Term Care Facility Notifications" form documents the following residents passed away on the following dates: R65 (form date: 9/21/11) documents death occurred on 9/20/11; R68 (form date: 9/15/14) documents death occurred on 9/14/14; R73 (form date: 5/12/12) documents death occurred on 5/11/12; R74 (form date: 9/4/14) documents death occurred on 9/3/14; R76 (form date 3/5/12) document death occurred on 9/3/12; R77 (form date: 10/28/14) documents death occurred on 10/24/14; R84 (form date: 10/30/14) documents death occurred on 10/30/14; R88 (form date: 3/19/12) documents death occurred on 3/18/11; R93 (form date: 10/15/14) documents death occurred on 10/14/14; and R98 (form date: 3/31/14) documents death occurred on 3/30/14.
On 1/22/15 at 12:00 .m., E22 (Business Office Manager) stated that the Trust Fund Balance Report is accurate and that money has not been disbursed for the residents that have expired.

300.4090 f.) 2.) A.) B.) C.) D.) E.) F.) G.) H.)

Section 300.4090 Personnel for Providing Services to Persons with Serious Mental Illness for Facilities Subject to Subpart S
f) Psychiatric Rehabilitation Services Aides
2) If a facility does not employ PRSAs to provide psychiatric rehabilitation program services, the following minimum training shall be provided to certified nursing assistants (CNAs) within 30 days after the CNA's first day of employment:

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	IL6005797	A. BUILDING: _____ B. WING _____	01/27/2015

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S9999	Continued From page 13 A) Understanding the impact of serious mental illness; B) Understanding the role of psychiatric rehabilitation, including how to manage psychiatric disabilities and countering stigma and discrimination; C) Confidentiality; D) Preventative strategies for managing aggression and crisis intervention; E) Goals and function of case management; F) Appropriate verbal and physical interaction; G) Communication skills between staff and residents; and H) Basic psychiatric rehabilitation techniques and service delivery. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to provide the minimum training for psychiatric rehabilitation services to a Certified Nursing Assistant (CNA) responsible for psychiatric programing for residents requiring mental health services. This failure affects six residents (R12, R13, R14, R60, R108, and R109) requiring mental health services on the supplemental sample. Findings include: On 1/22/2015 at 10:15 a.m., E25 (Social Service Director/SSD) provided a list of residents requiring mental health services named "Subpart S," dated 1/9/15, documenting the following information: R12 was admitted on 12/14/10 with diagnosis of Bipolar Disorder; R13 was admitted 1/16/14 with diagnoses of Schizoaffective and Bipolar Disorders; R14 was admitted 12/26/14 with a diagnoses of Major Depressive Disorder and Bipolar Disorder; R60 was admitted on 7/31/13 with diagnoses of Bipolar Disorder and Schizophrenia; R108 was admitted on 3/6/14 with a diagnosis of Schizoaffective Disorder; and R109 was admitted on 11/25/14 with diagnoses of	S9999		

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Schizoaffective and Bipolar Disorders.
The Minimum Data Set Assessment, Section S, confirms primary and/or secondary Serious Mental Illness diagnoses for the following residents needing Psychiatric Rehabilitation Services: R12 (10/28/14), R13 (1/20/15), R14 (12/31/14), R60 (1/13/15), R108 (12/2/14), and R109 (12/3/14).
On 1/22/15 at 1:14 p.m., E25 (SSD) stated, "My Social Service Assistant is responsible for group programming for our residents who require Serious Mental Illness services. To my knowledge, (E27, Social Service Assistant) does not have a certificate for Psychiatric Rehabilitation Services Aide nor any additional training for this responsibility. I do not have any special certifications for Psychiatric Rehabilitation Services, either. My bachelor degree was in Sociology and Anthropology. I am not a Licensed Clinical Social Worker/Licensed Social Worker. I do not believe anyone at this facility has special certifications for Psychiatric Rehabilitation Services and we no longer have a consultant that comes to the facility for our psychiatric program."
On 1/22/15 at 1:16 p.m., E27 (Social Service Assistant) added, "When I started, I was trained by a consultant we had working at the facility for our Serious Mental Illness Services, but (the consultant) never provided the training required to become a Psychiatric Rehabilitation Services Aide."
On 1/23/15 at 9:15 a.m., E25 (SSD) stated, "(The Local Outpatient Social Service Agency) doesn't provide any programming activities for our SMI residents. The psychiatric group programs and activities are provided by (E27) at the facility. (The Local Outpatient Social Service Agency) just provides one-on-one counseling with a Psychiatrist and Counselor for these residents."

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300.7040 c.)
300.7050 a.) 4.)
Section 300.7040 Activities
c) Units with a census of more than 40 residents shall have a full-time activity professional who meets the requirements of Section 300.1410(c). Units with a census of 40 or fewer residents shall have an activity professional on duty at least 20 hours per week. This individual shall be responsible for providing activities and training staff in an ability-centered programming approach.
This REQUIREMENT is not met as evidenced by:
Based on observation, record review, and interview, the facility failed to provide professional activity services twenty hours weekly in the Dementia Unit. This failure has the potential to effect all 24 residents (three residents (R2, R3, R4) in a sample of nine and 21 residents (R15 - R34) in a supplemental sample) residing in the Dementia Unit.
Findings include:
On 1/21/15 at 10:30 a.m., an activity posting on the Dementia Care Unit states the following activities are provided daily: 9:00 a.m. Hand Massage/Nail Care or one on ones; 10:00 a.m. Coffee/Social Time; 10:30 a.m. Exercises; 1:30 p.m. Story Time; 2:00 p.m. Games; 2:30 p.m. Reminiscing; 3:00 p.m. Snack; 3:30 p.m. Ball/Balloon Toss; 4:00 p.m. One on one visits; 4:30 p.m. Sing-a-long; and 6:00 p.m. Relaxing Music.
On 1/21/15 at 10:30 a.m., and 1:30 p.m., and again on 1/22/15 at 10:00 a.m., the Dementia Unit staff provided the schedule activities.
On 1/22/15 at 9:45 a.m., E9 (Dementia Unit Director) stated activities on the Unit are provided by E9 and the CNAs (Certified Nursing Assistants) working on the Unit. E9 stated that E9

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is also a CNA. E9 indicated Activity staff in other areas of the facility do not provide the Dementia Unit at least twenty hours of activity services weekly.

Section 300.7050 Staffing
a) The unit shall have a full-time unit director.
4) The unit director shall obtain at least 12 hours of continuing education every year, especially related to serving residents with Alzheimer's disease and other dementia.
This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to ensure the Dementia Unit Director obtained the required continuing education. This failure has the potential to effect all 24 residents (three residents (R2, R3, R4) in a sample of nine and 21 residents (R15 - R34) in a supplemental sample) residing in the Dementia Unit.
Findings include:
On 1/22/15 at 9:30 a.m., E9 (Dementia Unit Director) stated (E9) was unaware of the requirement that (E9) obtain 12 hours of continuing education annually as the Dementia Unit Director.
On 1/22/15 at 11:30 a.m., E9's Personnel Record did not contain documentation to indicate E9 had received 12 hours of continuing education in the past year.
On 1/22/15 at 2:00 p.m., E9 verified E9 does not have the required 12 hours of continuing education.

(B)