STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED					
		IL6005698	B. WING		05/1	4/2015			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
MOORIN	GS HEALTH CENTER	! IHF	BARN LANE ON HTS, IL						
(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 CROSS-REFERENCED TO THE APPRODEFICIENCY)	(X5) COMPLETE DATE				
S 000	Initial Comments		S 000						
	Annual Licensure S	Survey - Sheltered Care.							
	the Sheltered Care	th Center is in compliance with Facilities Code (77 Illinois e 330) for this survey.							
S9999	Final Observations		S9999						
	Statement of Licensure Violations: 300.696 a)c)2 300.1210 b)4)d)4) 300.7060a)								
	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 III. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 III. 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 Based on observation, interview, and record review the facility failed to wash hands during incontinence care and a dressing change. This applies to 1 of 4 residents (R101) observed for hand hygiene in the total sample of 20.								

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

TITLE

05/28/15

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
IL6005698		B. WING	B. WING <b>05</b> /		14/2015		
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
MOORIN	IGS HEALTH CENTER	? THE	BARN LANE ON HTS, IL				
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\$9999	The findings included According to the Calincluding Demential and Obsessive-Corplan showed she haskin/tissue integrity her Activities of Dai On 05/11/2015 at 3 care E24 (Certified cleaned R101's from hand using a washer holding the wet incompleted incompleted in the several times during washing her hands also applied protect gloves again without assisted E26 (Registerssing change. Defended in the site. The facilities standation of the site of	e: are Plan R101 had diagnoses with Behaviors, Dysphagia mpulsive Disorder. Her care ad a potential risk for impaired , she needed assistance with lly Living. :32pm during incontinence Nursing Assistant/CNA) nt perineal area with her right cloth in a circular motion while ontinence brief in her left hand. lloves and donned new gloves g incontinence care without between glove changes. E24 tive barrier cream, changed ut washing hands then stered Nurse/RN) during a buring the dressing change to nee, E26 removed the soiled he area, removed gloves and without washing her hands, em silver and a new dressing ard precautions policy dated Staff is to use gloves where cts, body fluids, or body handled. Gloves should be lesidents. Hands should be ly after gloves are removed. 0:30am E2 (Director of facility does not have a policy he did provide a copy of what when teaching the staff e. The instructions include to n of the perineal area moving Do not move from back to of introducing germs from the urethra, a primary source of	S9999				

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STATE FORM 6899 C9SK11 If continuation sheet 2 of 6

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
IL6005698		B. WING		05/	14/2015	
NAME OF	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, S	STATE, ZIP CODE		
MOORIN	IGS HEALTH CENTER	761 OL	D BARN LANE			
WOORIN	IGS HEALTH CENTER	ARLING	GTON HTS, IL	60005		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
S9999	Continued From pa	ge 2	S9999			
	(B)					
	Continued From page 2  (B)  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:  4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene. 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:  4) Personal care shall be provided on a 24-hour, seven-day-a-week basis. This shall include, but not be limited to, the following:  A) Each resident shall have proper daily personal attention, including skin, nails, hair, and oral hygiene, in addition to treatment ordered by		h es s on			

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PRINTED: 07/23/2015 FORM APPROVED

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NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE					
	761 OLD BARN LANE								
MOORIN	IGS HEALTH CENTER	, THE ARLINGTO	ON HTS, IL	60005					
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S9999	Continued From pa	ge 3	S9999						
S9999	additional baths and for satisfactory pers Based on observati review the facility fa Activities of Daily L This applies to 1 of for activities of daily The findings include According to the Caincluding Dementia and Obsessive-Complan showed she haskin/tissue integrity, her ADLs, and had The care plan includencourage R101 to as scheduled and a On 05/11/2015 at 1 asleep in bed with his shoulder. R101 had which looked like so and on her right shoulder. R101 had with long fingernails On 05/12/015 at 2 wheelchair in the acwith long fingernails On 05/12/015 at 10 nursing assistants is facial hair on showe activities staff can first R101's ADL Verifica and no baths were between 04/12/2015. The facilities Activiti 12/1/12 included "Etheir abilities in Activincludes: Bathing, I resident who is una Daily Living receive	d hair washes as necessary conal hygiene. on, interview, and record illed to provide assistance with iving (ADLs) for one resident. 14 residents (R101) reviewed iliving in a total sample of 20. Etc. The Plan R101 had diagnoses with Behaviors, Dysphagia inpulsive Disorder. Her care at a potential risk for impaired a she needed assistance with a tendency to scratch herself. It ded an intervention to consistently receive showers according to her routine. It too many to make the provided and the pr	S9999						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
IL6005698		B. WING		05/14/2015		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	30,1	<del>-</del>
MOORIN	GS HEALTH CENTER	? THE	BARN LANE ON HTS, IL			
(X4) ID	SUMMARY STA		ID ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
S9999	Continued From pa	ge 4	S9999			
ı	and oral hygiene.					
	(B) Section 300.7060 E a) The environment shall support the fu impaired residents. behaviors, maximiz safety, and encoura by compensating for disease process in resident's care plan This Requirement v Based on observati	Environment t (cultural, social, and physical) nctioning of cognitively It shall accommodate the functional abilities, promote tage residents' independence or losses resulting from the accordance with each the accordance				
	review the facility failed to keep a safe environment by leaving an unlocked/unattended treatment cart and medication room accessible to cognitively impaired residents residing in the Alzheimer's Unit of the facility.  This applies to three residents (R4, R28 and R106) out of 25 residents residing in the					
	· ·	er's Unit of the facility.				
ı	The findings include	e:				
	Unit/Alzheimer's Ur E1 (Administrator), and E10 (Housekee propped open in the medication room wileft unlocked and ultreatment cart containers of presc such as Lidocaine of creams. The medicabinets that has medicabinets that has medicabinets and cabinets that has medicabinets that has medicable to the control of the con	mental tour of the Special Care nit on 05/13/2015 at 1:30 P.M., E9 (Maintenance Director) eping Director), the door was a medication room. Inside the as a treatment cart that was nattended by a staff. The ained multiple tubes and ribed ointments and creams bintments and Metronidazole cation room has unlocked nultiple boxes of syringes with II of Aspirin tablets, couple of				

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AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA  IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
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\$9999	electric razors, hair shampoos and a m  E8 (Registered Nur unlocked medication observation. E8 st treatment cart and to 1 have to use the way observation, there was residents that were medication room.  On 5/14/2015 at 11 Nursing) provided at that has a behavior Alzheimer's Unit. To three residents ider Alzheimer's Unit (Resident's rooms.  The current care play wanders around the resident's rooms.  The current care play has tendency to was series and a medication of the current care play has tendency to was series.	dryer, couple containers of outhwash.  se) hurriedly came to the n room during this ated "I forgot to lock my the medication room because ashroom." During this were cognitively impaired close to the unlocked  :00 A.M., E2 (Director of a list of cognitively impaired of wandering around the the list showed there were natified as wanderers in the 4, R28 and R106).  an 5/13/2015 showed R4 a unit, going in and out of an 5/13/2015 showed that R28 ander within the unit.	S9999			

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