

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ARCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910
--	--

(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
S 000	Initial Comments Annual Licensure Survey Licensure Survey For Subpart S :SMI	S 000		
S9999	Final Observations Statement of Licensure Violations: Section 300.615 e) and f) Determination of Need Screening and Request for Resident Criminal History Record Information e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police. (Section 2-201.5(b) of the Act) f) The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. (Source: Amended at 35 Ill. Reg. 11419, effective June 29, 2011) These requirements are not met as evidenced by: Based on record review and interview, the facility failed to initiate a criminal history background check within twenty-four hours after admission for one resident (R110) on the supplemental sample. Findings include:	S9999		

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ARCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910
--	--

(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	<p>Continued From page 1</p> <p>The facility's undated Admissions list documents R110 was admitted to the facility on 4/15/15. The facility's undated Profile Face Sheet confirms R110 was admitted to the facility on 4/15/15. The facility's background check information paperwork dated 4/20/15 documents the facility did not initiate a Uniform Conviction Information Act (UCIA/ name based) background check until 4/20/15. This same information paperwork documents the facility did not initiate an Illinois Sex Offender Registration website check nor an Illinois Department of Corrections sex registrant search until 4/20/15.</p> <p>On 5/28/15 at 9:30 AM E1, Administrator, stated, "The CHIRP (Criminal History Information Response Process) system was down for four days."</p> <p>On 5/28/15 at 9:30 AM E4, Business Office Manager stated, "I did not initiate the background checks because the CHIRP system was down for four days." At 10:05 AM E4 stated, "I did not know there were any alternatives to do the background checks." E4 concluded, "The checks are my responsibility and it was my fault, I should have known to find out if there were alternatives."</p> <p>(AW)</p> <p>Direct Care Staffing Section 300.1230 b) Section 300.1230 d)1)2) Section 300.1230 j)5) Section 300.1230 k)</p> <p>b) The number of staff who provide direct care who are needed at any time in the facility shall be based on the needs of the residents, and shall be determined by figuring the number of hours of direct care each resident needs on each shift of the day.</p> <p>d) Each facility shall provide minimum direct</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ARCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910
--	--

(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	<p>Continued From page 2</p> <p>care staff by:</p> <p>1) Determining the amount of direct care staffing needed to meet the needs of its residents; and</p> <p>2) Meeting the minimum direct care staffing ratios set forth in this Section.</p> <p>j) Skilled Nursing and Intermediate Care For the purpose of this subsection, "nursing care" and "personal care" mean direct care provided by staff listed in subsection (f).</p> <p>5) Effective January 1, 2014, the minimum staffing ratios shall be increased to 3.8 hours of nursing and personal care each day for a resident needing skilled care and 2.5 hours of nursing and personal care each day for a resident needing intermediate care. (Section 3-202.05(d) of the Act)</p> <p>k) Effective September 12, 2012, a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. Registered nurses and licensed practical nurses employed by a facility in excess of these requirements may be used to satisfy the remaining 75% of the nursing and personal care time requirements. (Section 3-202.05(e) of the Act)</p> <p>These requirements are not met as evidenced by:</p> <p>Based on record review and interview, the facility failed to meet staffing requirements for non-licensed personal care staff for 12 of 14 consecutive days reviewed. This failure has the potential to affect all 78 residents in the facility.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ARCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910
--	--

(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	<p>Continued From page 3</p> <p>Findings include:</p> <p>On 5/26/15 at 3:45 pm, E1 Administrator provided a staffing spreadsheet dated 5/12/15 through 5/25/15. The spreadsheet documents the average daily census for that period as 6.14 skilled residents and 74.50 intermediate residents. The calculations total 210 hours minimum is needed for direct care staff in a 24 hour period. Of the 210 hours, 160 hours is needed for non-licensed direct care staff in a 24 hour period. The staffing spreadsheet and working schedules document the following staffing failures:</p> <p>5/12/15 - 153 hours of non-licensed direct care staff, resulting in a shortage of 7 hours. 5/14/15 - 157 hours of non-licensed direct care staff, resulting in a shortage of 3 hours. 5/15/15 - 131 hours of non-licensed direct care staff, resulting in a shortage of 29 hours. 5/16/15 - 90 hours of non-licensed direct care staff, resulting in a shortage of 70 hours. 5/17/15 - 101 hours of non-licensed direct care staff, resulting in a shortage of 59 hours. 5/18/15 - 150 hours of non-licensed direct care staff, resulting in a shortage of 10 hours. 5/20/15 - 138 hours of non-licensed direct care staff, resulting in a shortage of 22 hours. 5/21/15 - 145 hours of non-licensed direct care staff, resulting in a shortage of 15 hours. 5/22/15 - 141 hours of non-licensed direct care staff, resulting in a shortage of 19 hours. 5/23/15 - 86 hours of non-licensed direct care staff, resulting in a shortage of 74 hours. 5/24/15 - 86 hours of non-licensed direct care staff, resulting in a shortage of 74 hours. 5/25/15 - 113 hours of non-licensed direct care staff, resulting in a shortage of 47 hours.</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ARCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910
--	--

(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	<p>Continued From page 4</p> <p>The facility's actual daily "Nursing Schedules" for 5/12/15 through 5/25/15 document the numbers of non-licensed direct care staff as documented in the spreadsheet numbers.</p> <p>On 5/27/15 at 12:25 pm E1, Administrator confirmed the hours were correct per the spread sheet provided. E1 acknowledged awareness of the staffing shortage due to staff being in training getting certificates for Nursing Assistants (CNA). E1 stated "I knew we would be short for that time period."</p> <p>On 5/27/15 at 1:15 pm E1 confirmed the census for 5/26/15 at 78 residents.</p> <p>(AW) Control of Medications Section 300.1650a) Section 300.1650 b) Section 300.1650 c) a) The facility shall comply with all federal and State laws and State regulations relating to the procurement, storage, dispensing, administration, and disposal of medications. b) All Schedule II controlled substances shall be stored so that two separate locks, using two different keys, must be unlocked to obtain these substances. This may be accomplished by several methods, such as locked cabinets within locked medicine rooms; separately locked, securely fastened boxes (or drawers) within a locked medicine cabinet; locked portable medication carts that are stored in locked medicine rooms when not in use; or portable medication carts containing a separate locked area within the locked medication cart, when such cart is made immobile. c) All medications having an expiration date that</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ARCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910
--	--

(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	<p>Continued From page 5</p> <p>has passed, and all medications of residents who have been discharged or who have died shall be disposed of in accordance with the written policies and procedures established by the facility in accordance with Section 300.1610. Medications shall be transferred with a resident, upon the order of the resident's physician, when a resident transfers to another facility. All discontinued medications, with the exception of those products regulated and defined as controlled substances under Section 802 of the federal Controlled Substances Act (21 USC 802), shall be returned to the dispensing pharmacy. Medications for any resident who has been temporarily transferred to a hospital shall be kept in the facility. Medications may be given to a discharged resident only upon the order of the licensed prescriber. These requirements are not met as evidenced by:</p> <p>Based on observation, interview and record review, the facility failed to secure and destroy discontinued controlled substances in accordance with facility policy for two residents (R108 and R109) on the supplemental sample.</p> <p>Findings include: R109's Physician Order Sheet (POS) dated 4/20/15, documents to dc(discontinue) Nucynta (Schedule II Narcotic) order. R109's Controlled Substances, Proof of Use Sheet dated 4/15/15 documents that the Nucynta Extended Release tablets were not given after the discontinued date. R108's POS dated 5/05/15 documents to dc Hydrocodone (Schedule II Narcotic) order. R108's POS dated 5/15/15 documents to dc Oxycodone (Schedule II Narcotic) order. R108's Controlled Substances, Proof of Use Sheets dated 5/5/15 and 5/15/15 document that</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ARCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910
--	--

(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	<p>Continued From page 6</p> <p>the Hydrocodone and Oxycodone Extended Release tablets were not given after the discontinued date.</p> <p>On 5/26/15 at 1:20 pm, R109's bubble pack which contained 28 Nucynta Extended Release, 50 milligram (mg) tablets, was sitting in a plastic, open basin, on the counter in the medication room. R108's bubble pack which contained 26 Hydrocodone/Acetaminophen (Schedule II, Opioid), 10/325 mg tablets, was sitting in a plastic, open basin, on the counter in the medication room. R108's bubble pack which contained 9 Oxycontin (Schedule II, Opioid) 10 mg, Extended Release tablets, was sitting in a plastic, open basin, on the counter in the medication room.</p> <p>On 5/26/15 at 2:45 pm, E2, Director of Nursing stated " I was not aware that those controlled substances had not been destroyed and were out in the open until (E3), Licensed Practical Nurse told me today. Those (R108 and R109 controlled substances) were dc'd (discontinued). They (Schedule II medication) should not have been left out. The controlled substance should remain locked up and counted until two nurses can destroy them."</p> <p>The undated facility policy "Controlled Substances" documents "It is the policy of (facility corporation) that all drugs listed as Schedule II drugs are subject to specified handling, storage disposal and record keeping. Responsibility: All Licensed Nurses. Procedure: Schedule II drugs are to be kept under two separate locks requiring two separate keys.....Upon discontinuation of the medication or non-return of the resident within 7 days, the scheduled drug may be destroyed in the presence of two licensed nurses's, Director of Nursing and a licensed nurse or the pharmacist and a licensed nurse with documentation and signature of both on the drug disposition record."</p>	S9999		

Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: IL6009823	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/28/2015
--	--	---	---

NAME OF PROVIDER OR SUPPLIER ARCOLA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 422 EAST FOURTH STREET, PO BOX 70 ARCOLA, IL 61910
--	--

(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	Continued From page 7 (B)	S9999		