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	6016463	A. BUILDING: _____ B. WING _____	04/19/2016

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LIFE'S JOURNEY MATTOON	300 LERNA ROAD SOUTH MATTOON, IL 61938

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S 000	Initial Comments Second Probationary Licensure Survey Statement of licensure Violations	S 000		
S9999	Final Observations 330.230a)2) 330.230b)1) Section 330.230 Information to be Made Available to the Public By the Licensee a) Every facility shall conspicuously post or display in an area of it accessible to residents, employees, and visitors the following: 2) A description, provided by the Department of complaint procedures established under the Act and the name, address, and telephone number of a person authorized by the Department to receive complaints; b) A facility shall retain the following for public inspection: 1) A complete copy of every inspection report of the facility received from the Department during the past five years; This requirement was not met as evidenced by the following: Based on observation, record review, and interview, the facility failed to properly post complaint procedures and failed to retain required inspection reports available for public inspection. This affects all 15 residents in the facility. Findings include: On 4/13/2016 at 10:30 AM no complaint procedures were posted in the facility. E5 (Housekeeping Manager) stated "To my knowledge...No...We have nothing else posted in	S9999		

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S9999	Continued From page 1 this building." On 4/13/2016 at 1:19 PM in the "A" living room, a sign on the wall stated "Survey results are in desk drawer." Survey results were not observed in the desk drawer or surrounding areas. At 1:20 PM, E1 (Administrator) and E7 (Kitchen Manager) could not locate the inspection reports. The resident room roster dated 4/12/16 lists a census of 15 residents. ---------- ----------(AW) 330.715a) 330.715b) 330. 715 Request for Resident Criminal History Record Information a) 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) b) 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. These requirements are not met as evidenced by the following: Based on record review and interview, the facility	S9999		

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S9999	Continued From page 2 failed to conduct criminal history background checks pursuant to the Uniform Conviction Information Act for one of six sampled residents (R106) and five supplemental residents (R108, R109, R110, R111, and R112) admitted after the change of ownership of 9-1-15 and failed to check the Illinois Department of Corrections sex registrant search page for one of six sampled residents (R106) and four supplemental residents (R108, R109, R110, and R111). The finding includes: E10, Business Office Manager stated on 4-13-16 at 9:45 A.M. the facility was not conducting resident criminal history background checks and E10 was not aware the checks were to be conducted. No documented evidence was found that resident criminal history background checks were conducted for six residents (R106 ,R108, R109, R110, R111, and R112) admitted after the change of ownership of 9-1-15. Five residents' (R106, R108, R109, R110, and R111) business files were reviewed with E10. No documented evidence was found to support that the Illinois Department of Corrections sex registrant search was conducted for R106, R108, R109, R110, and R111. ---------- ----------(B) 330.720b) Section 330.720 Admission and Discharge Policies b) No resident determined by professional evaluation to be in need of nursing care shall be admitted to or kept in a sheltered care facility. Neither shall any such resident be kept in a distinct part designated and classified for sheltered care.	S9999		

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S9999	Continued From page 3 These requirements are not met as evidenced by: Based on observation, record review and interview, the facility failed to follow their policy and facility licensure parameters, by failing to arrange for the transfer of five (R101, R102, R103, R105, R106) residents in need of a higher level of care. R101, R102, R103, R105, and R106 are five of six residents reviewed for pressure ulcers and increased need for activities of daily living in the sample of six. Findings include: 1. The Physician Order Sheet dated April 2016 for R101 includes an order for a Stage IV (four) pressure ulcer/wound treatment every Monday and Thursday. R101's Service Plan/Care Plan documents the following: R101 requires total assistance for all activities of daily living (ADL's), and total assistance for transfers. R101 is not able to self propel in the wheelchair. R101 has a facility acquired Stage IV pressure ulcer to the left illium. A local Wound Center Note documents on 4/11/16 that R101's pressure ulcer is categorized as a Stage IV and has a large amount of exudate (drainage), the wound status is documented as - open and measuring 0.2 centimeter (cm) x 1.0 cm x 0.4 cm. On 4/14/16 at 3:40 pm a dressing change to R101's left illium was completed by Home Health Nurse Z3, Registered Nurse. Z3 confirmed the wound at a Stage IV. On 4/12, 4/13 and 4/14/16 at 11:50 to 12:30 pm, R101 was totally fed by facility staff. R101 is not able to self-propel in the wheelchair and is brought to and from the dining area on the above dates and times. 2. The Physician Order Sheet dated April 2016 for R102, includes the following care areas: Hospice Care, Stage III (three) Pressure Ulcer Treatment and Mechanical Lift.	S9999		

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S9999	Continued From page 4 The Service Plan for R102 dated 12/9/13 is not updated with R102's current Activities of Daily Living (ADL) information and what staff assistance is needed. On 4/13/16 at 3:45 PM hospice and facility skin assessment records were reviewed and Z1, Hospice Nurse stated R102's Stage III right buttock Pressure Ulcer was facility acquired on 7/28/15. Hospice Notes dated January 2016 show the dressing being changed by the Hospice Nurse. On 2/18/16 a new order for R102's right buttock treatment was changed to daily and as needed. The Treatment Administration Record dated 3/2016 documents that there was no treatment done on 3/25, 3/29 and 3/30/16 to R102's right buttock Stage III pressure ulcer. On 4/13/16 at 3:45 pm Z2, Hospice Nurse stated that R102's dressing is ordered to be changed daily and as needed. Z2 stated that facility nurses change R102's dressing on the days that hospice does not come, usually on weekends. On 4/12/16 at 10:35 am, E3, Licensed Practical Nurse (LPN) stated that R102 is a Hospice resident, needing total care in all ADL's. E3 acknowledged that R102 has a facility acquired Stage III pressure ulcer to the right buttock. E3 stated Hospice Nurse, Z2 Registered Nurse, completes the pressure ulcer treatment three times a week and the facility does the treatment on the other four days for R102. On 4/14/16 at 10:45 am, R102 was transferred from a geriatric chair to the bed via mechanical lift by Z4, Hospice Certified Nursing Assistant and E6, Resident Specialist. On 4/12, 4/13 and 4/14/16 during the noon meal at 11:50 am to 12:30 pm, R102 was totally fed by facility staff. 3. The Physician Order Sheet dated April 2016 for R103 documents the following care areas:	S9999		

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S9999	Continued From page 5 Hospice Care and a pressure ulcer treatment to the sacral area. A facility report titled "Weekly Skin Report" dated 1/13/16 documents Stage II (two) pressure ulcer to R103's sacral area measuring 1.5 cm x 1 cm x 0.3 cm. A facility report titled "Wound Treatment Sheet" dated 4/8/16 documents the wound as closed. On 4/13/16 at 2:45 pm a dressing was removed from R103's sacral area by E3, LPN. R103's sacral area was red extending out to the bilateral buttocks. The sacrum had an open area measuring approximately 1.3 cm in length by 0.3 cm wide. E3 stated "that must have just opened." A Hospice Note dated 3/26/16 documents the Stage II pressure ulcer as resolved. There is no further documentation by Hospice on the pressure ulcer for review. R103's Service Plan dated 11/13/15 is not updated with R103's current ADL information. Hospice Notes dated March 2016 document R103 as requiring total care and assistance in all ADL's. A Nursing Note dated 4/8/16 documents that R103 is totally dependent upon staff for all ADL's. On 4/12, 4/13 and 4/14/16 at 11:40 am to 12:30 pm, R103 was totally fed by facility staff. On 4/13/16 at 1:15 pm, R103 was transferred from a geriatric chair to the bed per two staff assistance with a gait belt. 4. The Physician Order Sheet dated April 2016 documents R105 as a Hospice patient with a pureed diet. R105's Service Plan dated March 2016 documents R105 as totally dependent upon staff for all ADLs and transfers. On 4/12/16 at 9:45 am, E1 Administrator stated that R105 does not bear weight and is transferred with maximum staff assistance to a geriatric chair when not in bed.	S9999		

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S9999	Continued From page 6 On 4/12, 4/13 and 4/14/16 at 11:30 am to 12:30 pm, R105 was fed a pureed/liquid diet through a straw by staff. 5. R106's April 2016 Physician's Order Sheet documents R106's diagnosis to include Dementia. R106's Physician's Certification form dated 9-18-15 on admission documents " two staff (assistance) with a gait belt for transferring. " R106's Face Sheet documents the admission date as 9-18-15. Z5, R106's prior Physician, documents on 2-9-16 " . . .the patient presents for Dementia, also had face to face for wheelchair due to cognitive changes and difficulty bearing weight. . . " R106's Service Plan dated 9-18-15 documents " transferring as total assist of 2 (staff) assist with gait belt " and " mobility/ambulation as total assist of 1 (staff) assist with a wheelchair." On 4-14-16 at 3:20 E9, Resident Specialist and E8, Certified Nurses Aide (CNA), transferred R106 with a gait belt from a recliner to her wheelchair. R106 was in her wheelchair on 4-14-16 at 8:30 am during breakfast, then assisted in her wheelchair by staff to a recliner. On 4-14-16 at 11:05 am with E6, Resident Specialist and E8, R106 was transferred with a gait belt from the recliner to the wheelchair. R106 was unable to bear weight alone. On 4-14-16 at 1:22 while R106 was sitting in her wheelchair in the living room where E8 stated R106 was not able to ambulate independently in her wheelchair. A facility policy titled "Admission, Continued Residency and Discharge Policy" dated 8/6/07 documents the following: "The resident may continue to reside at (facility) except.... when the resident is bedridden for (7) seven consecutive days or longer. The resident has stage 2, 3 or stage 4 pressure sores or other extensive wounds. The resident requires space, equipment, and/or furniture beyond normal accommodations,	S9999		

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S9999	Continued From page 7 for example, a lift to transfer a resident who is temporarily bedridden. The Physician or Advanced Practice Nurse determines that skilled nursing services are necessary for an extended period of time (usually will be in excess of 30 days of treatment)." ---------- ----------(B) 330.770a) 330.770b)1)2)3) 330.770d) 330.770k)1)2) Section 330.770 Disaster Preparedness a) For the purpose of this Section only, "disaster" means an occurrence, as a result of a natural force or mechanical failure such as water, wind or fire, or a lack of essential resources such as electrical power, that poses a threat to the safety and welfare of residents, personnel, and others present in the facility. b) Each facility shall have policies covering disaster preparedness, including a written plan for staff, residents and others to follow. The plan shall include, but not be limited to, the following: 1) Proper instruction in the use of fire extinguishers for all personnel employed on the premises; c) Fire drills shall be held at least quarterly for each shift of facility personnel. Disaster drills for other than fire shall be held twice annually for each shift of facility personnel. Drills shall be held under varied conditions to: 1) Ensure that all personnel on all shifts are trained to perform assigned tasks; 2) Ensure that all personnel on all shifts are familiar with the use of the fire-fighting equipment in the facility; and 3) Evaluate the effectiveness of disaster plans and procedures. d) Fire drills shall include simulation of the	S9999		

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S9999	Continued From page 8	S9999		

evacuation of residents to safe areas during at least one drill each year on each shift.
k) Coordination with Local Authorities
1) Annually, each facility shall forward copies of all disaster policies and plans required under this Section to the local health authority and local emergency management agency having jurisdiction.
2) Annually, each facility shall forward copies of its emergency water supply agreements, required under Section 330.2620(d), to the local health authority and local emergency management agency having jurisdiction.
These requirements were not met as evidenced by the following:
Based on interview and record review, the facility failed to complete the required number of fire and disaster drills, failed to complete a resident evacuation simulation for at least one fire drill during the year, and failed to train staff working in the facility on the use of fire-fighting equipment, and failed to coordinate disaster policies and plans with local authorities. These failures affect all 15 residents in the facility.
Findings include:
Facility fire records (undated) for 2015/2016 document the facility failed to complete 3 out of 4 required fire drills for first shift (missing drills for the first, third, and fourth calendar quarters), failed to complete 3 out of 4 required drills for second shift (missing drills for the first, second, and third quarters), and failed to complete 1 out of 3 required drills for third shift (missing a drill for the second calendar quarter).
The facility failed to complete one required disaster drill for first shift, failed to complete two disaster drills for second shift, and failed to complete two disaster drills for third shift.
On 4/14/2016 at 2:05 PM, E12 (Maintenance) acknowledged the facility did not complete any

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S9999	Continued From page 9 additional fire or disaster drills and did not have records of staff extinguisher training. On 4/13/2016 at 11:50 AM, E5 (Housekeeping Manager) said E5 had not participated in any disaster or fire drills in the last six months. The undated facility disaster policy and procedures manual documents under Disaster Drills: "Fire drills are required to be run on each shift. Drills must be documented. Tornado drills must be conducted on February and May of each year (during high storm seasons). Tornado drills must be documented." On 4/14/2016 at 11:30 AM, E1 (Administrator) acknowledged the facility failed to forward copies of any facility disaster policies and plans or emergency water supply agreements to local authorities. ---------- ----------(B) 330.1110a) Section 330.1110 Medical Care Policies a) The facility shall have a written program of medical services approved in writing by the advisory physician that reflects the philosophy of care provided, the policies relating to this and the procedures for implementation of the services. The program shall include the entire complex of services provided by the facility and the arrangements to effect transfer to other facilities as promptly as needed. The written program of medical services shall be followed in the operation of the facility. This requirement is not met as evidenced by: Based on record review and interview, the facility failed to have a Physician Advisor or Consult agreement with a practicing Physician to assure implementation of medical services including the entire complex of facility services and the prompt transfers of residents when indicated. This has	S9999		

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S9999	Continued From page 10 the potential to affect all 15 residents in the facility. Findings include: On 4/13/16 facility policies, procedures and facility services documents did not have record of being approved or reviewed by a Physician. There was no contract between the facility and a Physician Advisor/Consultant available for review. On 4/13/16 at 10:00 am E1, Administrator/Regional Director stated that Z5, previous Medical Advisor had closed Z5's practice in February 2016. E1 stated the facility has been unable to procure an agreement with a Physician for the above services. On 4/12/16 at 9:30 am, E1 stated there were 15 residents residing in the facility. ---------- ----------(B) 330.1155A)1)2)3)4)5) Section 330.1155 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 330.Appendix E. In addition, an unnecessary drug is any drug used: 1) in an excessive dose, including in duplicative therapy; 2) for excessive duration; 3) without adequate monitoring; 4) without adequate indications for its use; or 5) in the presence of adverse consequences that indicate the drugs should be reduced or discontinued. (Section 2-106.1(a) of the Act) This requirement is not met as evidenced by the following:	S9999		

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S9999	Continued From page 11 Based on interview and record review the facility failed to consistently monitor and completely document behaviors warranting the use of an anxiolytic medication for one of one sampled residents (R106) on Psychotropic Medications in a sample of five. Findings include: R106's April 2016 Physician's Order Sheet (POS) documents medications to include Ativan 0.5 milligrams (mg) two times per day (BID) for Anxiety (ordered on 1-19-16) and Ativan 0.5 mg three times per day (TID) as needed (PRN) for Agitation (ordered on 1-8-16). On 4-18-16 at 9:12am E1, Acting Administrator stated the behavior documentation would be in the nurses notes or in the "hot" chart documentation book for the Nurses to document. Otherwise the Nurses document in the Nurses Notes in the resident record any behaviors. Review of the "hot" chart with E1 shows there was no behavioral documentation for R106 recorded. On 4-14-16 at 12:39pm E3, Licensed Practical Nurse (LPN) stated "(R106) really doesn't scream unless they are trying to do something with her, like move her or change her. But usually it's singing. If she does cry out we can calm her by talking to her." On 4-14-16 at 1:22pm R106 was singing loudly while sitting in the living room. E6, Resident Specialist went to R106 and spoke softly to which R106 responded. After E6 left R106, R106 returned to singing loudly at 1:25pm.	S9999		

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S9999	Continued From page 12 Review of R106's Nurses Notes documents the following entries: 1-10-16 ". . .continued to yell out frequently. . . Ativan given. . ." 1-11-16 ". . .a lot of agitation . . .calling out refused lunch." 1-17-16 ". . .moderate calling out . . ." 1-17-16 ". . .calling out frequently. Multiple attempts to transfer self out of bed." 1-18-16 ". . .Very agitated. . ." 2-10-16 "Calling out noted - Quits when spoken to." No other entries of behaviors were documented for R106. The facility form Nurses' Progress Note dated 3-10-16 documents R106's Mood and Behavior Patterns as "No Behavior" and the Communication/Hearing Patterns as the mode of expression "singing." Additional Comments on this document include "Alert, spends most of (the) time singing. Confusion. Less screaming, more cooperation with (Activities of Daily Living), family visits. . ." The facility form Nurses' Progress Note dated 4-6-16 documents R106 has "No Behaviors." This progress note documents R106's mode of expression is "singing." Additional Comments on this document include ". . .Sings constantly except when sleeping. . ." The facility policy dated 1-18-16 Psychotropic/Antipsychotic Medication Policy documents ". . .that a neighbor (resident) not be given any unnecessary medications. An unnecessary medication used in the following ways. . . Without adequate monitoring. . ." R106's Service Plan dated 9-8-15 that has an	S9999		

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LIFE'S JOURNEY MATTOON	300 LERNA ROAD SOUTH MATTOON, IL 61938

(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 13 updated entry "3-31-16 Ativan BID, screaming." The facility form Patient Specific Controlled Substance Record documents R106's Ativan 0.5mg three times a day as needed documents staff administered this medication 10 times from 1-19-16 through 1-31-16 without documentation of behaviors. ---------- ----------(B) 330.1510 a)1)4) 330.1510 e)1) 3301710g) Section 330.1510 Medication Policies a) Every facility shall adopt written policies and procedures for assisting residents in obtaining individually prescribed medication for self-administration and for disposing of medications prescribed by the attending physicians. These policies and procedures shall be consistent with the Act and this Part and shall be followed by the facility. 1) Medication policies and procedures shall be developed with consultation from an Illinois registered professional nurse and a registered pharmacist. These policies and procedures shall be part of the written program of care and services. 4) If the facility elects to administer medications to some residents for control purposes, the medications shall be administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Medications shall not be recorded as having been administered prior to their actual administration to the resident. e) Medication Records 1) All medications used by residents shall be recorded by facility staff at time of use. Section 330.1710 Resident Record Requirements	S9999		

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S9999	Continued From page 14 330.1710 g) A medication administration record shall be maintained which contains the date and time each medication is taken, name of drug, dosage, and by whom administered. A medication administration record is not required for residents who have been approved by their physician to be fully responsible for their own medications under Section 330.1510(d)(2). These requirements are not met as evidenced by: 1. Based on observation, interview and record review, the facility failed to administer a medication (Levothyroxine) per pharmacy recommendations for two residents (R102 and R104); failed to administer R104's eye drops aseptically per facility policy; failed to document administration of R102's narcotic pain medication for 12 scheduled doses; and failed to administer R103's entire ordered dose of Parkinson's medication. R102, R103, and R104 are three of six residents reviewed for medications on the sample of six. R107 is one resident on the supplemental sample. The facility had three medication errors out of 20 opportunities for error, resulting in a 15.0% medication error rate. 2. Based on record review and interview, the facility failed to ensure documentation for narcotic administration was complete for one (R102) of six residents reviewed for medications in the sample of six. Findings include: 1a.) R104's Physician Order Sheet (POS), dated 4/1/16, documents an order for Levothyroxine 100 micrograms (mcg) one by mouth everyday, early AM. R107's POS, dated 4/1/16, documents an order for Levothyroxine 0.075 mcg one by mouth everyday, early AM.	S9999		

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S9999	Continued From page 15 On 4/12/16, at 9:13 AM, E3, Licensed Practical Nurse (LPN), gave R104 one Levothyroxine tablet by mouth 30 minutes after E3 finished breakfast. On 4/13/16, at 8:45 AM, E3, LPN, gave R106 one Levothyroxine 0.075 mcg tablet by mouth during breakfast. During an interview on 4/13/16, at 9:20 AM, with Z1, Pharmacist, Z1 stated Levothyroxine is not recommended to be given with a meal, either 30 minutes before a meal or two hours after a meal. Z1 stated "early AM" means 30 minutes before AM medications on an empty stomach. Z1 also stated labs should be drawn to monitor the blood levels for Levothyroxine. On 4/13/16, at 10:00 AM, E3, LPN, stated there are no Thyroid Stimulating Hormone (TSH) labs in R104 or R106's charts and there are no doctors orders for TSH labs in either R104 or R106's charts. 1b.) R104's POS, dated 4/1/16, documents an order for Timolol 0.5% eye drops one drop each eye twice a day. On 4/12/16, at 9:13 AM, E3, LPN, administered Timolol 0.05% eye drops to R104 without the use of gloves. The facility's Medication Administration Policy, dated 1/28/16, states "gloves are to be worn as indicated i.e. (for example): eye drops...." On 4/13/16, at 1:38 PM, E3 stated E3 should have worn gloves while giving eye drops to R104. 1c.) R102's POS, dated 4/1/16, documents an order for Morphine 70 milligrams/milliliters (mg/ml), give 0.5 ml sublingual/by mouth three times a day (for pain). On 4/12/16, at 2:37 PM, R102's MAR was not signed out as being given by the nurse on the following days: 4/6, 4/7, 4/8, and 4/9/16. There is no documentation on the MAR as to why the	S9999		

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S9999	Continued From page 16	S9999		

medication was not given. There is no documentation in R102's nursing notes or "Hot Rack" notes why the medication was not given. The Controlled Medication log has no documentation of Morphine being given on the previously listed dates for R102. R102's diagnoses include: Hospice and Pressure Ulcer.

The facility's undated Storage, Documentation & Disposal of Controlled Medications Protocol documents "all controlled substances shall be checked for accountability at each change of shift using the Narcotic Shift Count Sheet", and "in the event that a discrepancy is noted in the count, the nurse shall immediately contact the Health Manager who will immediately begin an investigation". This policy also states "documentation of all controlled substances ... will be maintained on the individual count sheet; entries will be made...each time a controlled substance is administered; the nurse administering the medication will record...date and time drug is administered, amount of drug administered, remaining balance of medication, signature of nurse administering medication." Morphine is listed as a Schedule II (two;controlled) substance on this policy.

1d.) R103's POS, dated 4/1/16, documents an order for Sinemet 25/100 mg one by mouth every six hours (for Parkinson's).

On 4/12/16, at 2:25 PM, E3, LPN gave R103 Sinemet 25/100 mg by mouth. E3 crushed the medication and mixed it in pudding. E3 dropped approximately one-third of the pudding/medication mix onto R103's bed. E3 disposed of the remaining pudding/medication that was on the bed. On 4/12/16, at 2:25 PM, E3, LPN stated E3 doesn't know what else E3 would

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S9999	Continued From page 17 do about the medication thrown away. On 4/13/16, at 2:45 PM, E1 (Aministrator) stated the facility has no medication error policy. 2. R102's Physician Order Sheet (POS), dated 4/1/16, documents an order for Morphine 20 milligrams/milliliters (mg/ml), give 0.5 ml sublingual/by mouth three times a day. On 4/12/16 at 2:37 PM, R102's Medication Administration Record (MAR) was not signed out on the following days: 4/6, 4/7, 4/8, and 4/9/16. There was no documentation of why the medication was not signed as being given on the MAR. There is no documentation in R102's Nursing Notes/Hot Rack notes why the medication was not given. The Controlled Medication log has no documentation of Morphine being given on the previously listed dates for R102. On 4-14-16 at 10:38 a.m. E3, Licensed Practical Nurse, stated she noticed an incomplete entry on the MAR for R102's morphine and notified E2, Director of Nursing. R102's diagnoses include: Hospice and Pressure Ulcer. The facility's undated Storage, Documentation & Disposal of Controlled Medications Protocol documents "all controlled substances shall be checked for accountability at each change of shift using the Narcotic Shift Count Sheet", and "in the event that a discrepancy is noted in the count, the nurse shall immediately contact the Health Manager who will immediately begin an investigation". This policy also states "documentation of all controlled substances ... will be maintained on the individual count sheet; entries will be made...each time a controlled substance is administered; the nurse	S9999		

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S9999	Continued From page 18 administering the medication will record...date and time drug is administered, amount of drug administered, remaining balance of medication, signature of nurse administering medication." Morphine is listed as a Schedule II (two;controlled) substance on this policy. ---------- ----------(B) 330.1990a) 330.1990b) Section 330.1990 Food Preparation and Service a) Foods shall be prepared by appropriate methods that will conserve their nutritive value, enhance their flavor and appearance. They shall be prepared according to standardized recipes and a file of such recipes shall be available for the cook's use. b) Foods shall be attractively served at the proper temperatures and in a form to meet individual needs. This requirement was not met as evidenced by the following: Based on observation and interview, the facility failed to follow their diet spreadsheet for Mechanical Soft diet preparation and failed to properly prepare a puree diet. These failures affected two residents (R102, R105) reviewed for mechanically altered diets in the sample of six. Findings include: 1.) On 4/12/2016 at 12:20 PM, E13 (Cook) applied a mayonnaise dressing on top of ground baked chicken (cornflake chicken breast) for residents receiving a Mechanical Soft diet (R102). E13 said the kitchen uses a variety sauces on top of ground meat to soften them up including ketchup, barbeque sauce, and mayonnaise. The facility Diet Spreadsheet dated 4/4/2016 documents 2 ounces of gravy are to be applied to the ground baked chicken for Mechanical Soft diets.	S9999		

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S9999	Continued From page 19 On 4/12/2016 at 12:25 PM, the Mechanical Soft chicken was dry and was difficult to swallow. 2.) On 4/12/2016 at 11:48 AM, E7 (Kitchen Manager) said puree food should be like baby food consistency. At 12:15 PM, the pureed baked chicken tasted gritty and had large particles of unprocessed meat. The pureed chicken did not have a smooth texture and appeared similar in texture to the ground meat prepared for Mechanical Soft diets. According to R105's Physician Order Sheet dated 4-1-16, R105 receives a pureed diet. ----------(B) 330.2000 750.151 a) 750.151b) 750.800e) Section 330.2000 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750). This requirement was not met as evidenced by the following: Based on observation, interview, and record review, the facility failed to properly label opened food items in the refrigerator, effectively clean and sanitize a food transportation container, and failed to clean and sanitize food warmers used to hold food. This has the potential to affect all 15 residents in the facility. Findings include: 1. Section 750.151 Ready-to-Eat Potentially Hazardous Food, Date Marking a) On-Premises Preparation (prepare and hold cold) Except when packaging food using a	S9999		

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S9999	Continued From page 20 reduced oxygen packaging method, and except as specified in subsections (d) and (e) of this Section, refrigerated, ready-to-eat potentially hazardous food prepared and held in a food establishment for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, and maintained at 41°F or less for a maximum of 7 days. The day of preparation shall be counted as Day 1. b) Commercially Processed Food (open and cold hold) Except as specified in subsections (d)-(f) of this Section, refrigerated, ready-to-eat potentially hazardous food prepared and packaged by a food processing plant shall be clearly marked, at the time the original container is opened in a food establishment and, if the food is held for more than 24 hours, to indicate the date or day by which the food shall be consumed on the premises, sold, or discarded, based on the temperature and time combination specified in subsection (a) of this Section. On 4/12/2016 at 9:45 AM, three one-gallon opened containers of milk, one thirty-two ounce opened package of deli ham, and two five pound containers of opened cottage cheese located in the reach in cooler were not date marked with the date opened or the date to be discarded. E7 (Kitchen Manager) was present at this time and did not know when the food items were opened and acknowledged all the food should have been labeled with the dates opened. Posted on the reach in cooler door was an undated sign stating "All items must be labeled, dated, and sealed properly before putting into refrigerator."	S9999		

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S9999	Continued From page 21 2. .Section 750.800 Cleaning Frequency e) Non-food-contact surfaces of equipment shall be cleaned as often as is necessary to keep the equipment free of accumulation of dust, dirt, food particles, and other debris. On 4/12/2016 at 10:43 AM in the kitchen, the facility food transport cart was soiled throughout the interior with darkened solid and liquid debris and smelled of rotten food. E5 (Housekeeping Manager) was present and stated "It definitely needs cleaned, I smell it." On 4/12/2016 at 11:00 AM in the "A" unit dining room, two food warmers located on the kitchenette countertop were each soiled with food debris in the bottom of the warmers' water wells. On 4/12/2016 at 11:21 AM in the "B" unit dining room, two food warmers located on the kitchenette countertop were both soiled with food debris in the bottom of the warmers' water wells. Chunks of partially dissolved food, including rice and corn, were also floating on the surface of the water of each warmer. On 4/12/2016 at 12:00 PM, E7 (Kitchen Manager) acknowledged "the steamers should be cleaned more often." E7 explained the unit staff had been cleaning the warmers in the past but E7 last cleaned them "a couple of weeks ago because apparently they weren't getting done." The resident room roster dated 4/12/16 lists a census of 15 residents. ---------- ----------(AW)	S9999		

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330.2220d)
330.3060r)
Section 330.2220 Housekeeping
d) All cleaning compounds, insecticides, and all other potentially hazardous compounds or agents shall be stored in locked cabinets or rooms. (B)
Section 330.3060 General Building Requirements
Every building shall:
r) Install partitions, screens, shields, or other means to protect residents from thermal hazards such as radiators, hot water or steam pipes, baseboard heaters, therapy equipment, or other surfaces accessible to residents which may exceed a temperature of 140 degrees Fahrenheit. Any protective device shall be designed and installed so that it does not present a fire or safety hazard or adversely affect the safe operation of the equipment.

This requirement was not met as evidenced by the following:

1. Based on observation, record review, and interview, the facility failed to properly store hazardous materials to prevent potential resident injury. This has the potential to affect all 15 residents in the facility.

Findings include:

On 4/13/2016 at 9:47 AM, one aerosol can of odor eliminator was in the unlocked sink cabinet in the "A" dining room. The can was labeled with the warning "If swallowed, do not induce vomiting. Get medical Attention."

E5 (Housekeeping Manager) was present and

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S9999	Continued From page 23 stated "they are not even supposed to have that in here, it's new, we just got that." E5 said the unit direct care staff keep taking items from the housekeeping supplies and were responsible for leaving the aerosol can in the cabinet. During tour, residents were observed in the area unattended. On 4/14/2016 at 11:30 AM, E1 (Administrator) confirmed all residents in the facility are cognitively impaired. 2. Based on observation, record review, and interview, the facility failed to maintain safe operating temperatures for two food warmers so as to not pose a thermal burn hazard. This has the potential to affect all 15 residents in the facility. Findings include: On 4/13/2016 at 9:27 AM, two food warmers located in the "A" unit dining room on the kitchenette countertop were turned on and each warmer's water well was covered with a metal pan. The surface temperature of the pan covering the West warmer was measured by thermal label to be 180+ degrees Fahrenheit and the water in the well was measured by thermometer to be 190 degrees Fahrenheit. The East warmer's water well measured 150 degrees Fahrenheit by thermometer. The warmers did not have any type of guard or shielding to prevent accidental resident contact. No staff was present in the dining room. On 4/13/2016 at 9:47 AM, E5 (Housekeeping Manager) acknowledged the food warmers were a burn hazard for residents.	S9999		

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S9999	Continued From page 24 During the survey, residents were observed in the area unattended. On 4/14/2016 at 11:30 AM, E1 (Administrator) confirmed all residents in the facility are cognitively impaired. The resident room roster dated 4/12/16 lists a census of 15 residents. ---------- ----------(AW)	S9999		