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S 000	Initial Comments Annual Licensure and Certification Survey LICENSURE VIOLATIONS:	S 000		
S9999	Final Observations 300.610a) 300.1010h) 300.1210a) 300.1210b) 300.1210d)3)5) 300.1220b)2)3) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1010 Medical Care Policies h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the	S9999	Attachment A Statement of Licensure Violations	

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health, safety or welfare of a resident, including, but not limited to, the presence of incipient or manifest decubitus ulcers or a weight loss or gain of five percent or more within a period of 30 days. The facility shall obtain and record the physician's plan of care for the care or treatment of such accident, injury or change in condition at the time of notification.

Section 300.1210 General Requirements for Nursing and Personal Care

a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the resident's guardian or representative, as applicable. (Section 3-202.2a of the Act)

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.

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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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record.

5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing.

Section 300.1220 Supervision of Nursing Services

b) The DON shall supervise and oversee the nursing services of the facility, including:

2) Overseeing the comprehensive assessment of the residents' needs, which include medically defined conditions and medical functional status, sensory and physical impairments, nutritional status and requirements, psychosocial status, discharge potential, dental condition, activities potential, rehabilitation

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S9999	Continued From page 3 potential, cognitive status, and drug therapy. 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. (Section 2-107 of the Act) These regulations are not met as evidenced by: Based on observation, interview and record review the facility failed to provide services to promote the healing of pressure ulcers for three of four residents (R18, R16, R14) reviewed with pressure ulcers, on the sample of 12. The facility failed to reposition, monitor, evaluate the effectiveness of treatment of the pressure ulcers and identify/implement pressure relieving interventions to promote healing. These failures resulted in R18 developing multiple avoidable	S9999		

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pressure ulcers and the deterioration of the ulcers without timely treatment.

Findings include:

The facility Wound and Ulcer Policy and Procedure dated 2/27/17 documents the following: " High Risk Protocol: Residents with existing ulcers will be deemed as high risk for impaired skin integrity despite the Braden Risk Assessment Score....Specialty mattress (low air loss, alternating pressure, etc.) with enhanced pressure reducing/relieving properties may be placed on the resident's bed as indicated....The resident may be placed on a turn and position schedule if clinically indicated..Approaches will be placed in the resident's care plan.....Assessment of progress toward healing is completed at least weekly and the physician is notified at least monthly of progress toward healing. If there is regression, the physician is notified of the condition change....."

1. R18's MDS (Minimum Data Set) dated 12/29/16 documents diagnoses of Hypertension, Diabetes, Dementia, Neuropathy, Atrial Fibrillation and Cerebrovascular Accident and there is no terminal diagnosis documented. The MDS documents R18 has severe cognitive impairment and requires extensive assistance with transfer and is totally dependent for bed mobility and toilet use.

The Skin Risk Assessment dated 12/29/16 documents that R18 is at moderate risk for skin breakdown. The Wound Documentation Report dated 12/31/16, 1/25/17, 2/1/17 and 2/21/17 documents a unstageable pressure ulcer on the left heel which was acquired in the facility on 7/7/16. On 3/8/17 at 12:15pm the skin on R18's

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left heel was intact with no open areas. On 3/8/17 at 12:15pm E4, RN (Registered Nurse) verified that R18's left heel is healed. On 3/8/17 at 12:10pm E2, DON (Director of Nursing) stated that a air mattress was put on R18's bed yesterday (3/7/17) and prior to yesterday there was a regular mattress on R18's bed. E2 verified that for a high skin risk assessment a specialty mattress is to be used per protocol.

The Care Plan dated as revised on 3/8/17 documents that R18 has pressure ulcers to the buttocks/coccyx area with the following interventions: 3/7/17- low air loss mattress on bed; 3/7/17-lay down after meals; 1/17/17-protective leg boots on when up; 3/7/16-turn and reposition and 7/7/16-float heels and apply protective boots when in bed.

The undated Weight Log provided by the facility on 1/7/17 documents R18's weight as follows: October 2016-162; November 2016-155.7; December 2016-156 and January 2017-145. The Physician's Order dated 1/14/17 documents an order for Megace (appetite stimulant) 2 cc (cubic centimeters) every am. The Registered Dietician (RD) Z5 Progress Note dated 2/10/17 documents a weight of 146 pounds as being stable for one month, with a 10.5% weight loss in six months. Z5 RD recommended to increase the Medication Pass to 90cc twice daily. There is no weight available for March 2017.

The Laboratory Report dated 1/27/17 documents R18's total protein as 7.2 and albumin as 3.8, which is in the normal range for both.

The electronic Progress Note dated 1/28/17 documents that R18 returned from the hospital with a "pressure ulcer on the Rt. (right) upper

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buttocks, also a line bruise noted on rt. upper buttocks, 1.5 inches long, dark in color...."

The Wound Documentation Report dated 12/31/16 documents an initial assessment for the development of a in-house Stage 2 pressure ulcer on the right upper buttock (coccyx) measuring 0.6 cm (centimeter) by 0.5cm by a depth of 0.1cm with no drainage. The electronic Progress Note dated 12/31/16 documents Z2, Physician was notified of the pressure ulcer. The Physician Order dated 12/31/16 states to clean with wound cleanser and apply Optifoam dressing every five days until healed.

The electronic Progress Note dated 1/1/17 documents a Stage 2 pressure ulcer in the right ischial crease measuring 0.5cm by 0.5cm by 0.1cm depth. The note documents the wound was cleaned with wound cleanser and optifoam dressing was applied. The Wound Documentation Report dated 1/8/17 documents the right ischial crease pressure ulcer is healed.

The Wound Documentation Report dated 1/25/17 documents the Stage 2 pressure ulcer on the upper right buttock/coccyx as measuring 1.2cm by 1.2cm by 0.2cm depth with scant drainage, no odor and granulation tissue present. There is no documentation in the record found that Z2 was notified of the increasing size of the ulcer until 1/29/17. The Physician's Order dated 1/29/17 documents to clean the the wound with wound cleanser and apply Optifoam every five days and as needed. On 3/8/17 at 4:00pm E2, DON and E17, Regional RN verified R18's pressure ulcer on the right upper buttock/coccyx doubled in size and there was no notification of Z2. E1 Administrator and E17 stated they would expect documentation of notification to be on the Wound

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S9999	Continued From page 7 Documentation Report (wound assessment) or in the progress notes. The Wound Documentation Report dated 2/1/17 documents the Stage 2 pressure ulcer on the upper right buttock/coccyx as measuring 3.5 cm by 1.5cm by 0.3cm depth, with moderate drainage, no odor and no slough or necrosis present. The Wound Documentation Report dated 2/1/17 documents an initial assessment for a new Stage 2 pressure ulcer on the right lower buttock measuring 1.0cm by 1.0cm by 0.1cm depth. There is no documentation found in the record that Z2 was notified of the increasing size of the upper buttock/coccyx ulcer or the new ulcer on the lower right buttock. On 3/8/17 at 4:00pm E2 and E17 verified R18's ulcer deteriorated and Z2 was not notified. The Wound Documentation Report dated 2/21/17 documents the Stage 2 pressure ulcer on the upper right buttock/coccyx as measuring 3.0cm by 1.4cm and depth UTD (unable to determine), with slough present, scant drainage and no odor. The Wound Documentation Report dated 2/21/17 documents the Stage 2 pressure ulcer on the lower right buttock as measuring 0.5cm by 1.5cm with scant drainage. There is no documentation found that Z2 was notified of the deterioration (slough present) of the upper right buttock/coccyx pressure ulcer. There is no documentation in the record of any pressure ulcer measurements between 2/1-2/21/17. On 3/8/17 at 4:00pm E2 and E17 verified there was no assessment documented in R18's record of the pressure ulcers between 2/1-2/21/17. E2 and E17 verified there was deterioration of R18's ulcers during that period, with no notification to Z2 or treatment change.	S9999		

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The Physician's Order dated 2/26/17 documents an order for treatment to the two pressure ulcers on the right buttocks as follows: Clean with wound cleanser, apply skin prep around the wounds, apply Santyl to wound beds and cover with optifoam daily.

The Wound Documentation Report dated 3/3/17 documents the Unstageable upper right buttock/coccyx pressure ulcer as measuring 3.2cm by 2.0cm and depth UTD, with scant tan drainage with an odor. The report documents the ulcer as being necrotic with "dark brown around the edges and tan in the middle." The Wound Documentation Report dated 3/3/17 documents the Unstageable lower right buttock pressure ulcer as measuring 1.0cm by 0.5cm with slough present. There is no documentation in the record that Z2 was notified of the deterioration of the pressure ulcers. On 3/8/17 at 4:00pm E2 and E17 verified the deterioration of R18's pressure ulcers and no notification of Z2 of the deterioration. E2 and E17 stated Z2 was notified on 3/8/17 of the deterioration of R18's pressure ulcers.

On 3/7/17 at 2:20 and 3:40pm R18 was lying on her back in bed with her feet/heels resting on the bed. On 3/8/17 at 8:55, 9:03, 9:40, 9:50, 9:55, 10:19 and 10:23am R18 was sitting in the activity room sleeping in the wheelchair. R18's feet/heels were resting directly on the metal footrest of the wheelchair, with no protective leg boot in place. On 3/8/17 at 10:30am Z3 and Z4 , Agency CNA's (Certified Nurse Aides) transferred R18 to bed, positioning her on her back. R18's heels were resting directly on the mattress, with no protective boot on.

At 11:05 and 11:30am R18 remained in bed, on her back with her heels resting directly on the

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mattress. At 11:40am E4, RN removed the dressing from R1's coccyx/buttock pressure ulcers. Tan brown drainage was on the dressing and there was a foul odor present. E4 cleaned the ulcers and applied skin prep to the peri wound (skin around ulcers). E4 then measured R18's upper buttock/coccyx ulcer at 4.6cm by 1.8cm and depth UTD. The wound bed of the ulcer was completely covered with necrotic tissue. E4 then measured R18's lower buttock ulcer at 1.0cm by 1.0cm with a small amount of slough present. E4 then applied Santyl to both wound beds and placed an Optifoam dressing on both ulcers.

On 3/8/17 at 11:50am E4, RN verified that R18's air mattress was placed on the bed on 3/7/17. When asked how much drainage there was from the coccyx/buttock ulcers E4 stated, it's hard to tell how much drainage on the dressing, because of urine. E4 stated the dressing has been soaked with urine when she's changed it most of the time and E4 verified that she never notified Z2.

On 3/8/17 at 12:25pm E4 stated she had been thinking about the drainage on R18's dressing and was wondering, if it wasn't urine on the dressing, but a large amount of drainage. E4 stated the drainage has increased since the use of Santyl on the ulcers. E4 stated the dressing was intact and didn't smell of urine.

The Wound Documentation Report dated 3/8/17 documents the Unstageable upper right buttock/coccyx pressure ulcer measures 4.6cm by
1.8cm and depth UTD, with moderate drainage with an odor. The report documents the ulcer has necrosis which is "mostly black with a little tan slimy tissue."

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The Progress Notes dated 2/16/17, 2/23/17 and 3/2/17, identified as the Medicare Meeting Note, documents that R18 "...Being put in bed after meals for pressure relief to help heal ulcers..." This intervention was not placed on the care plan until 3/8/17.

On 3/8/17 at 4:00pm E2 and E17 verified the intervention identified in the Medicare Meeting Note, to put R18 to bed after meals for pressure relief should have been put on the careplan and implemented. E2 and E17 verified that R18's heels need to be floated with protective boots in bed and R18 needs protective leg boot on when up in the wheelchair.

The Physician (Z2) Progress Note dated 3/8/17 documents Z2 recommended a Multivitamin daily, Vitamin C daily, an indwelling urinary catheter and consultation with the Wound Clinic.

On 3/9/17 at 9:45am Z2, Physician stated if it's not documented that he was notified or made a response that he is unable to recall if they notified him about R18's pressure ulcers. Z2 stated normally if there is a deterioration (pressure ulcers), he will make a change in the treatment when notified. Z2 stated he doesn't expect any improvement of R18's ulcers. When told that staff didn't reposition, place an air mattress on the bed or monitor/measure R18's ulcers, Z2 was then asked if in his opinion the ulcers were avoidable, Z2 stated, "I can't say for sure." Z2 stated it "might have made a difference, do I feel that we should have followed the protocol, we should have tried." Z2 stated she's in the "endstage (of life) they deteriorate."

2. R16's MDS dated 1/18/17 documents a diagnosis of Adult Failure to Thrive. The MDS

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documents severe cognitive impairment and extensive assistance with bed mobility. The Care Plan dated 2/5/17 documents a Stage 2 pressure ulcer to the coccyx.

The Wound Documentation Report dated 2/22/17 documents a initial in-house Stage 2 pressure ulcer of the coccyx measuring 1.0cm by 0.8 by 0.1cm.

The Wound Report dated 2/28/17 documents a Stage 4 pressure ulcer of the coccyx measuring 6.5 by 7.0cm by 0.3cm. The report documents "wound has appearance of kennedy ulcer. Peri.... intact however purple discoloration noted." The report documents scant amount of blood, no odor, irregular wound shape and no tunneling or necrosis.

On 3/6/17 at 4:15pm E5, LPN (Licensed Practical Nurse) verified that 2/22/17 was the initial assessment of R16's pressure ulcer to the coccyx and it was a very small Stage 2 ulcer. E5 stated the peri wound was red with discoloration. E5 stated then on 2/28/17 the pressure ulcer was a Stage 4. E5 stated when she measured the ulcer she measured the width and length of the purple area, but not the open ulcer which was surrounded by the purple discoloration. E5 stated she did measure the depth of the open area, which was 0.3cm.

On 3/7/17 at 8:45am E19, RN removed the dressing from R16's coccyx. E19 then measured the coccyx pressure ulcer at 1.6cm by 1.5cm with slough in the center and serous drainage. The open area was surrounded by a discolored area measuring 5cm by 4.8cm and surrounded by pink which blanched. E19 cleansed the wound, applied skin prep to the peri wound and then

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place silver alginate on the wound bed and applied an optifoam dressing.

On 3/7/17 at 9:45am E19 stated when she saw the coccyx pressure ulcer on 3/2/17 there was no slough, no drainage and there was one open area, approximately 1.5 by 1cm (not measured) and there were no small open areas around it. E19 stated the ulcer looks "much worse today" and thinks they need Santyl to debride the slough from the ulcer.

3. According to the current Physician's Order Sheet (POS) for 3/2017, R14 has multiple diagnoses including Dementia with Behaviors, Alzheimer's, Parkinson's, Dysphagia, Cerebral Infarction and Arteriosclerotic Heart Disease. The Minimum Data Set (MDS) dated 2/15/17 assesses R1 with severe cognitive impairment, a Stage I pressure ulcer with epithelial tissue, and requires extensive to total assistance for all activities of daily living. The POS listed a treatment order dated 3/1/17 for the left hip to cleanse area with wound cleanser and apply Optifoam every five days until healed.

On 3/6/17 at 10:00am, E2 (Director of Nursing) stated that R14 had a pressure ulcer to the left hip, acquired in the facility. R14 was not in bed at that time, and was up in the high-back specialty recliner chair in the activity room. At 12:15pm, R14 was in the dining room, up in the same recliner chair. No additional cushion was visible in recliner chair. R14 continued in the recliner chair in the dining room at 12:35 and 12:55pm. At 1:15pm, R14 was in the recliner chair in the same position in the activity room, and continued there at 1:30pm, 1:50pm, 2:15pm, 2:30pm, 2:50pm, 3:10pm, 3:30pm and 4:00pm. At

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ILLINOIS KNIGHTS TEMPLAR HOME	450 FULTON STREET P O BOX 49 PAXTON, IL 60957

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4:00pm, E15 (Registered Nurse/RN) stated, "yes, he (R14) must have been up all afternoon."

On 3/7/17, R14 was up in the recliner chair at 8:00am, and at 9:00am, 9:15am, 9:30am, 9:45am, 10:00am and 10:15am. At 10:15am, E16 (Certified Nurse Aide/CNA) stated she got R14 up in the chair at 5:30am that morning. At 10:25am, E16 and unnamed agency staff transferred R14 to bed per mechanical lift. R14 had a regular concave mattress with no specialty pressure-reducing mattress. R14's recliner chair also had no cushion in the seat that he had been sitting on since 5:30am.

On 3/7/17 at 10:45am, E4 (RN) did the treatment for R14's pressure sore. The existing dressing was dated 3/4/17, and had dark serous drainage visible through the dressing. E4 stated at that time the dressing had "shadowing" and should be changed. Upon removing the dressing, the area directly on the left trochanter was very red approximately two inches around, with a center crater approximately 1/4 inch covered with whitish/gray slough. E4 confirmed that the dressing had serous drainage on it. E4 cleansed the area with wound cleanser and applied the Optifoam dressing as per order. E4 stated at that time that the area was "worse" because before when she first documented on 2/28/17, there was a small scab or flake over the center, and now the center was open. On 3/8/17 at 11/30am, E4 stated that the original measurements on 2/28/17 were of the entire reddened area, because the center was not open, but now the center is open and covered with slough. E4 stated it would still be unstageable due to the slough. E4 confirmed that she did not measure or document on the area when she changed the dressing on 3/7/17.

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S9999	Continued From page 14 The electronic Progress Notes dated 2/28/17 states R14 "noted to have a reddened area that blanches slowly on his lt (left) hip. It measures 3.5 x (by) 3.5cm (centimeters). Faint thin dry light tan scab present on 0.25% (percent) of wound. Wound cleansed. . .and optifoam applied. . . . " The Wound Documentation sheet dated 2/28/17 notes the area on the left trochanter as pressure type, 3.5 x 3.5cm with depth undetermined, and Unstageable. The peri-wound skin is described as "healthy and pink. . .round/oval crater like with regular firm edge. . ." No other Progress Notes or Wound Documentation was in the record regarding condition and description of the wound. No evidence was in the record that the physician was notified of the change in condition of the wound noted on 3/7/17. On 3/8/17 at 11:40am, Z1 (Hospice RN) confirmed that R14 had no special pressure-relieving mattress on the bed or cushion in the recliner chair, and they were to be ordered 3/8/17. R14's careplan dated 2/21/17 notes under the skin impairment includes the following interventions: "Skin care, preventative measures and/or impairment treatments as ordered/needed. . . .Pressure-relief management and preventative skin measures/barriers and turning as needed to minimize risks. Provide turning/repositioning/pressure- relieving assist. . . .as needed for proper position and comfort. . . Seek additional chair or bed padding if needed for comfort/pressure reduction. . . When applicable, provide weekly wound measurements as indicated. Report site decline to MD (medical doctor)." (B)	S9999		

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S9999	Continued From page 15 --- 300.670k)1)2)3) Section 300.670 Disaster Preparedness 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 300.2620(d), to the local health authority and local emergency management agency having jurisdiction. 3) Each facility shall provide a description of its emergency source of electrical power, including the services connected to the source, to the local health authority and local emergency management agency having jurisdiction. The facility shall inform the local health authority and local emergency management agency at any time that the emergency source of power or services connected to the source are changed. These requirements were not met as evidenced by the following: Based on record review and interview, the facility failed to provide evidence that the facility's disaster plan, the emergency water plan, and the details of the emergency power source has been supplied to and reviewed by the local health authority and local emergency agency. This	S9999		

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failure has the potential to affect 48 residents in the facility.

Findings include:

The facility's 3-12-2014 disaster plan was reviewed. No evidence was found that the facility's disaster plans for emergency water, emergency power, or the complete disaster plan were provided to local health authority or the local emergency agency for review.

E1, Administrator stated on 3-8-17 at 11:14 A.M. that E1 could not find evidence that the facility's disaster plan, emergency water plan and the source of emergency power was given to the local health authority and local emergency agency. E1 failed to provide any documented evidence that the facility's 3-12-2014 disaster plan, water plan, and loss of power plan were reviewed by the local authorities.

According to the Resident Census and Conditions of Residents dated 3-7-17, 48 residents reside at the facility.

(B)

300.1230b)d)1)2)j)5)k)l)1)2)3)4)5)6)

Section 300.1230 Direct Care Staffing
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.
d) Each facility shall provide minimum direct care

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staff by:
1) Determining the amount of direct care staffing needed to meet the needs of its residents; and
2) Meeting the minimum direct care staffing ratios set forth in this Section.
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).
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)
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)
l) To determine the numbers of direct care personnel needed to staff any facility, the following procedures shall be used:
1) The facility shall determine the number of residents needing skilled or intermediate care.
2) The number of residents in each category shall be multiplied by the overall hours of direct care needed each day for each category.
3) Adding the hours of direct care needed for the residents in each category will give the total hours of direct care needed by all residents in the facility.
4) Multiplying the total minimum hours of direct care needed by 25% will give the minimum

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amount of licensed nurse time that shall be provided during a 24-hour period. Multiplying the total minimum hours of direct care needed by 10% will give the minimum amount of registered nurse time that shall be provided during a 24-hour period.
5) Additional Direct Care Hours Equal to at Least 75% of the Minimum Required
The remaining 75% of the minimum required direct care hours may be fulfilled by other staff identified in subsection (f) as long as it can be documented that they provide direct care and as long as nursing care is provided in accordance with the Nurse Practice Act.
6) The amount of time determined in subsections (l)(4) and (5) is expressed in hours. Dividing the total number of hours needed by the number of hours each person works per shift (usually 7.5 or 8 hours) will give the number of persons needed to staff each shift. Calculations shall not include time for scheduled breaks or scheduled in-service training. The number of residents used to calculate staff ratios shall be based on the facility's midnight census.

This requirement is not met as evidenced by the following:

Based on record review and interview, the facility failed to have the required minimum direct care staffing ratio for one of 14 days reviewed. This failure has the potential to affect all 48 residents residing in the facility.

Findings include:

On 2/1/17, E1 Administrator provided a staffing spread sheet for the period 2-19-2017 through 3-4-2017 documenting a daily average of 8.57 skilled care residents residing in the facility and a

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S9999	Continued From page 19 daily average of 39.14 intermediate care residents residing in the facility. The calculated total daily staffing requirement equals 130.42 hours for direct care staff. The facility's spread sheet for the period 2-19-2017 through 3-4-2017 documents 108.75 hours for direct care staff on 2-26-2017, a shortage of 21.67 hours. On 3-9-2017 at 9:20 AM, E1, the Administrator confirmed the hours on the facility's staffing spread sheet were accurate and acknowledged the shortage of direct care staffing hours on Sunday 2-26-2017. E1 stated that the facility had three staff call ins. E1 stated that staff were called to come in to work and two staffing agencies were also contacted. According to the Resident Census and Conditions of Residents dated 3-7-17, 48 residents reside at the facility. (B) ---------- 300.3260c) 300.3260c) Resident Funds The facility may accept funds from a resident for safekeeping and managing, if it receives written authorization from, in order of priority, the resident or the resident's guardian, if any, or the resident's representative, if any, or the resident's immediate family member any, such authorization shall be attested to by a witness who has no pecuniary interest in the facility or its operations and who is connected in any way to facility personal or the administrator in any manner whatsoever. (Section 2-201(2) of the Act)	S9999		

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This requirement was not met as evidenced by the following:

Based on record review and interview, the facility failed to ensure that Resident Trust Fund authorizations were witnessed by someone who has no connection with the facility for two of 12 residents (R3 and R4), on the sample of sixteen and 10 residents (R1, R9, R11, and R22 through R28) on the supplemental sample.

The finding includes:

On 3-7-17 at 2:25 P.M., the Resident's Trust Fund Authorizations were reviewed with E10, Business Office Manger. E10 provided the Resident "Trust - Current Account Balance" dated 3-6-2017 listing 18 individual residents' names and their account balances. Twelve of 18 Resident Trust Fund Authorizations, including R1, R3, R4, R9, R11, and R22 through R28's, were witnessed by facility employees. E10 stated that the 12 Resident Trust Fund Authorizations were witnessed by E10, E12 (Admission and Marketing), E13 (Former Admission and Marketing) and E14 (Former Administrator) who received a financial benefit from the facility. On 3-7-17 at 2:25 P.M., E10 stated that E10 was not aware that the Resident Trust Fund Authorizations were not to be witnessed by an employee.

(B)