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	IL6013601	A. BUILDING: _____ B. WING _____	03/07/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARBOR HOUSE	760 OLD MCHENRY ROAD WHEELING, IL 60090

(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 Sheltered Care Licensure Survey	S 000		
S9999	Final Observations Statement of Licensure Violations 330.163g) 1 of 10 Licensure Section 330.163 Alzheimer's Special Care Disclosure A facility that offers to provide care for persons with Alzheimer's disease through an Alzheimer's special care unit or center shall disclose to the Department or to a potential or actual client of the facility the following information in writing on request of the Department or client: g) Activities available to clients at the facility; This regulation is not met as evidenced by: Based on observation, interview and record review, the facility failed to plan , implement and evaluate the provision of individualized activities to meet the needs, abilities and preference for residents. This has the potential to affect all 41 residents residing at the facility identified (by the facility) as needing memory/dementia care. Findings include:	S9999	Attachment A Statement of Licensure Violations	

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On 3/4/2019 at 9:00 A.M., the facility's main entrance has posted an advertisement showing "Memory Care Facility."

On 3/4/2019 at 9:30 A.M., V1 (Administrator) stated that they are licensed for 48 beds for memory care. However, there were 41 residents in the facility with diagnoses of dementia and are receiving dementia care program.

During the 2 days observation on 3/4/2019 at 10:00 A.M., 11:00 A.M., 1:00 P.M. 3:00 P.M. and 3/5/2019 at around same time in house #2, R102, R103, R107, R108, R109, R110, R111, R113 and R114 were sitting in their wheelchair in the lounge area /dining room either dozing off or others were lying on the couch asleep. R116 and R118 were wandering around. R116 had attempted to use exit door and triggered the exit door alarm twice. There was no activity going on. V5 (Certified Nurse Assistant) turned the music on but residents were not engaged. R107, R108, R109, R110 and R117 were asleep on the couch in the lounge room/dining room. V4 (Lead CNA) also was present during these observations. V4 and V5 stated that the facility had no activity director/staff to provide structured, functional activities to residents since the CNAs were doing other tasks such as laundry, washing dishes, and housekeeping aside from their job as a CNA. V4 and V5 stated that they do try their best providing activity whenever they can amidst their multiple tasks.

On 3/6/2019, at 10:00 A.M., V1 (Administrator) said that she did not follow her dementia program because the facility had no activity director/staff to provide activity geared toward residents with dementia.

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S9999	Continued From page 2 (C) 2 of 10 Licensure 330.230b)1) Section 330.230 Information to be Made Available to the Public By the Licensee 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 regulation is not met as evidenced by: Based on observation, interview and record review the facility failed to post a complete copy of its inspection reports available to the public. This failure has the potential to affect all of the 41 residents as listed on the facility census. Findings include: On 3/4/19, at 9:30 am, the survey results in a notebook, posted in Building #1, (which houses the facility's administrative offices, as well as 16 residents) was incomplete. The facility consists of 3 separate buildings, each with the capacity for 16 residents. Record review of the Department's survey history for the facility shows that surveys were conducted on 4/27/18 (Annual Licensure) and 11/20/18 (Licensure Follow-Up.) These survey results were not included in the facility's notebook of inspections, made available to the public. On 3/4/19 at 11:00 am, V1 (Administrator) explained that "visitors" will sometimes take	S9999		

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surveys out of the survey book.

On 3/4/2019 at 9:30 A.M., V1 (Administrator) stated that they are licensed for 48 beds for memory care. However, there were 41 residents in the facility.

(AW)

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330.710a)
330.710c)1)

Section 330.710 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 with the involvement of the administrator. The written policies shall be followed in operating the facility and shall be reviewed at least annually by the Administrator. The policies shall comply with the Act and this Part.

c) The written policies shall include, but are not limited to, the following provisions:

1) Admission, transfer and discharge of residents, including categories of residents accepted and not accepted, residents that will be transferred or discharged, transfers within the facility from one room to another, and other types of transfers.

This regulation was not met as evidenced by:

Based on observation, interview and record review, the facility failed to have policies and

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procedures regarding assessments of residents to determine eligibility of placement in the sheltered care.

This applies to 4 of 4 residents (R102, R103, R104 and R105) reviewed for ADL care.

The findings include:

During the survey, R102, R103, R104 and R105 were observed needing skilled nursing care such as pressure ulcer/open wounds, gastric tube, indwelling catheter. V7 (Registered Nurse/Home Health Nurse) stated that R104 requires skilled nursing care due to a pressure ulcer, continuous gastric tube feeding and monitoring of the indwelling catheter that shows abnormal urine output.

During the incontinence care, it was observed that R102's scrotum was reddened and excoriated with multiple small openings. V3(LPN) was called by V5(CNA) to check R102's scrotum. V3 checked R102's scrotum. V3 stated that the multiple openings was from the extreme excoriation. V3 stated he will call the physician for treatment order for the open wounds. At present R102 only has order for a skin protectant to prevent from breakdown.

During the incontinence care, V3 (Licensed Practical Nurse) was called by V5(CNA) because R103 has a foam dressing that was not intact and was not covering R103's pressure ulcer on the sacrum.

On 3/5/19 at 11:45 AM, V2 (LPN) opened R105's large buttock dressing which showed opened unstageable pressure wounds located on both buttock areas. There was packing on each

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wound. R105 had left heel with dark, hardened scab which was opened to air. R105 had an indwelling urinary catheter.

V2(LPN) said that the Hospice Care Nurse comes 2 X a week to do catheter and pressure wound treatment and the facility nursing staff were responsible to do the care the rest of the week.

On 3/6/2019 at 10:00 A.M., V1 (Administrator) stated that when the resident was admitted to the facility, they end up staying at the facility regardless of a change in medical status.V1 did not provide any policy regarding assessments of residents for appropriate placement in sheltered care.

"No Violation"

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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.

This Requirement was not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide assessment

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and professional evaluation to determine the appropriateness of residents' admission to the facility.

This applies to 4 of 4 residents (R104, R105, R102 and R103) reviewed for admission requirement.

The findings include:

1) R104 was readmitted to the facility directly from the hospital on February 6, 2019 with diagnoses including Dementia, Psychosis, Atrial Fibrillation, Blind Left Eye, Hypertension, Seizure, Metabolic Encephalopathy. The Nursing Admission Assessment reflected that R104 had reddened buttocks but no open areas identified anywhere. The admission showed that R104 had gastrointestinal feeding tube and indwelling urinary catheter.

There was no evaluation and assessment of R104's needs and appropriateness to stay in the sheltered care.

The Plan of Care sheet dated 2/6/19 showed that R104 was totally dependent for ADLs (activities of daily living) such as personal hygiene, bathing, incontinent, dressing, turning and repositioning. There was no monitoring of the urinary indwelling catheter

The NN (Nurse's Notes) dated 2/19/19 showed that R104 was observed with left heel blister. The POS (physician order sheet) dated 2/19/19 showed the following order: "Left heel blister-clean with wound cleanser, paint with betadine, non-adherent pack, 4 X 4 gauze, wrap with kerlix, change every 2 days." On 3/1/19, the NN reflected that R104 developed an intact blister on

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the right heel. The POS dated 3/1/19 showed the following order: "Betadine 10% solution, apply to right heel with wet gauze of betadine solution, then foam and secure with stretching gauze every 2 days. Apply heel protectors."

On 3/5/19 at 9:30 AM, V2 (LPN-Licensed Practical Nurse) said that the HHN (Home Health Nurse) visits and provides care such as GT (gastrointestinal tube), indwelling urinary catheter and wound treatment to R104 twice a week (Tuesdays and Thursdays). The facility nursing staff provides the care the rest of the week. V2 stated that R104 was totally dependent on the staff for ADLs (activities of daily living).

2) R105 was admitted to the facility on 9/25/15 with diagnoses including Dementia, Bipolar Disorder, Depression, Mania with Psychosis, Hypertension. R105 was admitted to Hospice Care and was being visited twice a week.

On 3/5/19 at 11:45 AM, V2 (LPN) opened R105's large buttock dressing which showed opened unstageable pressure wounds located on both buttock areas. There was packing on each wound. R105 had left heel with dark, hardened scab which was opened to air. R105 had an indwelling urinary catheter.

V2 said that the Hospice Care Nurse comes 2 X a week to do catheter and pressure wound treatment and the facility nursing staff were responsible to do the care the rest of the week.

3. On 3/5/2019 at 10:30 A.M., V5 and V6 (CNAs; Certified Nurse Assistants) provided incontinence care to R103. R103's disposable incontinence brief was heavily soaked with urine with strong urine odor.

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During the incontinence care, V3 (Licensed Practical Nurse) was called by V5 because R103 has a foam dressing that was not intact and was not covering R103's pressure ulcer on the sacrum. R103 being soaked with urine and exposed to urine moisture was not an ideal environment for R103's pressure ulcer to heal and prevent infection.

4. On 3/5/2019 at 10:45 A.M., V5 and V6 provided incontinence care to R102. R102's disposable incontinence brief was heavily soaked with urine with strong urine odor.

During the incontinence care, it was observed that R102's scrotum was reddened and excoriated with multiple small openings. V3 was called by V5 to check R102's scrotum. V3 checked R102's scrotum. V3 stated that the multiple openings was from the extreme excoriation. R102 being soaked with urine and exposed to urine moisture was not ideal for R102's excoriation to heal. V5 and V6 both stated that R102 and R103 were assisted by night shaft staff to be up for the day. V5 and V6 also stated that R102 and R103 were not provided with incontinence care since 7:00 A.M. This was more than 3 hours that R102 and R103 not being attended regarding incontinence care, pressure ulcer and excoriation.

The facility's policy dated 11/2002 regarding "Incontinent/Perineal Care" shows to provide incontinence care/perineal care for residents to prevent infections and odors."

(B)

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S9999	Continued From page 9 5 of 10 Licensure 330.790a) 330.790c)1) Section 330.790 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. c) Depending on the services provided by the facility, 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, as applicable (see Section 330.340): 1) Guideline for Hand Hygiene in Health-Care Settings This Requirement was not met as evidenced by: Based on observation, interview and record review, the facility failed to follow infection control practices during incontinence care, pressure sore treatment and medication pass. This applies to 3 of 6 residents (R104, R102, R103) observed during incontinence care, pressure sore treatment and medication pass in the sample of 6 and one	S9999		

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resident (R106) in the supplemental sample.

The findings include:

1) On 3/4/19 at 12:20 PM, V2 (LPN-Licensed Practical Nurse) prepared R106's oral medication of Buspirone 20 mg = 2 tablets from the plastic container. V2 dropped one tablet on top of the medication cart. V6 picked up the tablet with gloved hand, cleaned it with tissue paper and administered it to R106.

2) On 3/5/19 at 1:35 PM, during pressure wound treatment, V7 (Home Health Nurse) lifted both legs of R104 and placed on top of the wedge pillow with gloved hands. V7 moved the garbage can with the same gloved hands. V7 removed the contaminated gloves, donned clean gloves but did not perform hand hygiene. V7 proceeded to remove the old dressings from R104's bilateral feet. V7 cleansed both of the resident's heels with liquid cleanser and pat dried. V7 removed the contaminated gloves, donned new gloves without hand hygiene. After measuring the left heel unstageable pressure wound, V7 applied Betadine solution directly to the left heel, covered with Betadine soaked gauze, foam dressing and secured with gauze roll. V7 removed the soiled gloves, donned new gloves without performing hand hygiene. V7 continued to cleanse and treated R104's right heel

3. On 3/5/2019 at 10:30 A.M., V5 and V6 (CNAs, Certified Nurse Assistants) provided incontinence care to R103. V5 and V6 washed their hands in R103's bathroom sink prior to providing care. V5 washed his hands with soap and water for 10 seconds. After washing his hands, V5, with his bare hands had touched the faucet to turn off the water. There was no paper towel available to dry

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his hands and also to use as barrier turning the faucet to shut the water off. V6 also washed his hands for 10 seconds. V6 also had touched the faucet to turn the water off using his bare wet hands. R103's disposable incontinence brief was heavily soaked with urine. The incontinent brief pad was noted with urine odor. V5 took a pair of gloves from his pocket, and started wiping R103's buttocks and bilateral groins with moistened wipes. V5 failed to wipe R103's penile shaft, head of the penis and lower part of the scrotum. After the incontinence care, V5 and V6 washed their hands for 10 seconds and then turned the faucet off with their bare hands. V5 and V6 both stated that "most of the residents' bathrooms have no paper towel dispenser and no paper towel available to dry our hands after hands washing."

During the incontinence care, V3 (Licensed Practical Nurse) was called by V5 because R103 has a foam dressing that was not covering R103's pressure ulcer on the sacrum. V3 washed his hands during the pressure ulcer care. However, during the hand washing before and after wound care, V3 had touched the faucet to turn the water off with his bare hands. V3, V5 and V6 have crossed contaminated their hands during hand-washing since there was no paper towel to serve as clean barrier to turned the faucet off.

4. On 3/5/2019 at 10:45 A.M., V5 and V6 provided incontinence care to R102. V5 and V6 washed their hands in R102's bathroom sink prior to providing care. V5 washed his hands for 10 seconds. V5 had touched the faucet with his bare wet hands to turn the water off. There was no paper towel available to use as clean barrier turning the faucet off after hand washing to prevent contamination. V6 also washed his hands with soap and water for 10 seconds. V6 also

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turned the faucet off with his bare wet hands because there was no paper towel. R102's disposable incontinence brief was heavily soaked with urine. V5 took a pair of gloves from his pocket and started wiping R102's buttocks and bilateral groins with moistened wipes. V5 failed to wipe R102's penile shaft, head of the penis and the scrotal area. After the incontinence care, V5 and V6 washed their hands for 10 seconds and turned the faucet off with their bare hands.

During the incontinence care, it was observed that R102's scrotum was reddened and excoriated with multiple small openings. V3 was called by V5 to check R102's scrotum. V3 washed his hands prior to assessing the excoriation. However, during the hand washing before and after the wound assessment, V3 had turned the faucet off with his bare hands since there was no paper towel available. Again, V3, V5 and V6 have crossed contaminated their hands during hand washing since there was no clean barrier used to turn the faucet off.

The facility's policy dated 4/28/2018 regarding hand washing shows to wash hands for at least 15 seconds. The policy also shows to avoid touching the sink, faucet after washing hands since they might be contaminated. It also shows that after hand washing, dry hands with paper towels and use paper towel to turn off the water.

The facility's policy dated 11/2002 regarding "Incontinent/Perineal Care" shows to provide incontinent care/perineal care for residents to prevent infections and odors." The policy also showed to cleanse the shaft , head of the penis.

"C"

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S9999	Continued From page 13 6 of 10 Licensure 330.1120a) Section 330.1120 Personal Care a) Each resident shall have proper daily personal attention and care including skin, nails, hair, and oral hygiene, in addition to treatment ordered by the physician. This regulation is not met as evidenced by: Based on observation, interview, and record review, the facility failed to monitor resident's skin status to prevent decline in pressure wound. This applies to 3 of 5 residents (R104, R102 and R103) observed during pressure wound treatment The findings include: 1) On 3/5/19 at 9:30 AM, during medication pass observation through GT (gastrointestinal tube) with both LPNs (V2 and V3) in attendance, R104 had 2 dressings on both feet. The dressing on the left heel was in place with small amount of serous drainage. The dressing on the right was located on the ankle area. When asked by the surveyor, V2 (LPN) said that R104 had a blister on the right heel but did not have a wound on the ankle. V2 stated that the dressing might have moved when the CNA turned R104 to provide incontinence care earlier. When V2 lifted R104's right leg, the heel had a large fluid filled blister with a black center connected to a dark red streak discoloration. The center and edge of the wound was boggy. V2 said that the wound is now unstageable. V2 also said that the contracted Home Health nursing staff provides wound, GT	S9999		

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and catheter care 2 X a week and the facility nursing staff provided the care in between the home health visits. R104's indwelling urinary catheter tubing had turbid, cloudy urine with sediments. V2 stated that the Home Health staff comes on Tuesday and Thursdays. V2 also said that she will provide treatment on R104's right heel since the wound was exposed. R104's was not wearing any heel boots at that time and both feet were not offloaded. V3 did not verbalize what to do when R104's urine output become cloudy and turbid.

R104 was readmitted to the facility on February 6, 2019 with diagnoses including Dementia, Psychosis, Atrial Fibrillation, Blind Left Eye, Hypertension, Seizure, Metabolic Encephalopathy. The Nursing Admission Assessment reflected that R104 had reddened buttocks but no open areas identified anywhere. The admission showed that R104 had gastrointestinal feeding tube and indwelling urinary catheter.

The Plan of Care sheet showed that R104 was totally dependent for ADLs (activities of daily living) such as personal hygiene, bathing, incontinent, dressing, turning and repositioning.

The NN (Nurse's Notes) dated 2/19/19 showed that R104 was observed with left heel blister. The POS (physician order sheet) dated 2/19/19 showed the following order: "Left heel blister-clean with wound cleanser, paint with betadine, non adherent pack, 4 X 4 gauze, wrap with kerlix, change every 2 days." On 3/1/19, the NN reflected that R104 developed an intact blister on the right heel. The POS dated 3/1/19 showed the following order: "Betadine 10% solution, apply to right heel with wet gauze of betadine solution,

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then foam and secure with stretching gauze every 2 days. Apply heel protectors."

On 3/5/19 at 1:35 PM, V7 (Home Health Nurse) said that both heel blisters are now unstageable ulcer with the presence of eschar. The left heel wound measured: (L) = 6.5 cm (centimeter) X 6.0 cm (W). There was a black substance in the center of the heel. The right heel wound measured: (L) = 7 cm X 7 cm (W). V7 said that the HHA (Home Health Agency) was following R104 before the resident was sent out to the hospital. V7 stated that HHA resumed service on 2/12/19. V7 also said that he told the facility staff to offload both R104's legs on a pillow or a wedge bolster to prevent pressure on both heels.

The HHN (Home Health Nurse) notes showed that the agency resumed the skilled service on 2/12/19 for R104. The HHN notes dated 2/19/19 showed that R104 developed an unstageable pressure ulcer on the right heel with onset date of 2/18/19. The right heel ulcer measured (L) = 2.0 cm X (W) = 4.0 cm. On 2/21/19 visit, the right heel wound measured (L) = 3.0 cm X (W) = 4.0 cm increased in size to assessment showed that R104 developed pressure ulcer.

2. The POS (Physician Order Sheet) for the month of March 2019 showed that R102 is a 77 year old with diagnoses that included but not limited to Alzheimer's, dementia with behavioral disturbance, psychosis, history of glaucoma and anemia. R102 was admitted to the facility on 11/27/2015.

R102's "Nursing Summary Charting Form" showed the following:
-for the month of October and November 2018; R102 is "totally dependent on all areas of ADLs

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(Activities of Daily Living). No skin breakdown noted. Incontinence care rendered. Fed by staff. " -for the month of December 2018 /January 2019; R102 "is total assist, transfer of 2 with dependence with all ADL's. Right heel wound seen by podiatrist. Daily Betadine dressings. Right heel 1.0 cm x 0.7 cm. x 0.1 cm. OT (Occupational therapist/Physical Therapist initiated to assist with PROM (Passive Range of Motion), increase assistance with transfer with therapy for knee contracture."

The POS for the month of March 2019 showed that R102 had a physician order dated 2/28/2019 for a "barrier cream to be applied to posterior scrotum and buttocks twice a day for life to prevent skin breakdown."

The TAR (Treatment Administration Record) for the month of February and March 2019 showed that it was signed by the facility staff nurses that the barrier cream was provided. On 3/6/2019 at 11:45 A.M., V2 (Licensed Practical Nurse) stated that it was the facility's staff/nurses that provided the skin barrier ointment to R102.

The clinical chart showed no documentation that there was skin monitoring and assessment to determine if the skin barrier ointment remained the applicable treatment to treat R102's right heel and scrotum.

On 3/5/2019 at 10:45 A.M., V5 and V6 (Certified Nurse Assistants; CNA) provided incontinence care to R102.
R102's disposable incontinence brief was heavily soaked with urine. During the incontinence care, it was observed that R102's scrotum was reddened and excoriated with multiple skin openings throughout the scrotal area. V3 was

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called by V5 to check R102's scrotum. V3 stated that R102's scrotum looks painful due to the excoriation. V3 further stated that the multiple openings of the excoriation was inflamed due to the bright red color. As V3 added, he will notify the physician because skin barrier is not the applicable treatment due to the multiple skin breakdown. V3 also noted a persistent redness along the bony prominence on the left lateral foot measuring 4 cm. x 2 cm. and another persistent redness measuring 0.2 cm. x 0.2 cm. on the lateral side of the left 5th toe. V3 also added that these persistent redness were stage 1 pressure ulcers. Aside from the pressure ulcers on the left foot, V3 also noted an open wound just slightly above the right heel around the calcaneus bone. The open wound was measured as 0.5 cm. x 0.9 cm. The open wound was partially covered with unrolled 2x2 band aid. There was no date label as to indicate when the band aid was applied. There was a substance like a combination of coagulated blood and mucus that was coming from the open wound. V3 also added that he was not aware of this wound nor when the band aid was applied since it was not labeled with date. V3 also added that it was unbeknownst to him nor was there any documentation regarding monitoring of the scrotal excoriation, the 2 stage 1 pressure ulcers of the left foot and the open wound of the right upper heel.

R102's multiple skin alterations was left untreated because of lack of monitoring and documentation and updates with physician for applicable treatment.

3. The POS (Physician Order Sheet) for the month of March 2019 showed that R103 is a 60 year old with diagnoses that included but not limited to dementia, developmental delay,

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diabetes mellitus, hyperlipidemia, anxiety and sub-acute chronic right femoral fracture. R103 was originally admitted to the facility on 5/23/2016. R103 had several readmission from the hospital for a change in medical condition.

The nurse's notes dated 5/22/2018 shows that R103 was readmitted to the facility from hospital with diagnoses of polymicrobial sepsis/ bacteremia. There was a notation that R103 was noted with right heel blister with measurement of 5 cm. x 6 cm. length.

The nurse's notes dated 6/18/2018 shows that R103's right heel was noted with yellow green discharge. The wound measurement was 3.5 cm. x 4.2 cm. There was a physician order for a daily dressing to the right heel pressure ulcer. The TAR was signed that facility staff nurses provided the treatment. V2 also acknowledged that facility staff nurses provided the treatment to R103's pressure ulcer. There was no other documentation to determine a comprehensive assessment regarding the pressure ulcer.

The nurse's notes dated 7/19/2018 shows that R103 has "right heel wound." An order for a daily dressing to the right heel was ordered.

The "Admission Nursing Assessment" dated 9/5/2018 shows that R103 has an unstageable pressure ulcer of the right heel.

The POS for the month of March 2019 showed that R103 had a physician order dated 2/21/2019 for "Mepilex foam border 4x4 dressing. Apply topically to sacral area every 7-7 days and as needed." There was also an order for "orthotic boots, have floating of heels at all times."

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The nurse notes dated 2/201/2019 shows that sacral dressing change was changed with Mepilex dressing "for protection. Sacral area healed, no redness, or open area ..."

On 3/5/2019 at 10:00 A.M., as acknowledged by V2 and V3 (Licensed Practical Nurse), both stated that R103 has no existing wounds and that are all healed. The foam dressing was only for prevention of skin breakdown to the sacral area.

On 3/5/2019 at 10:30 A.M., V5 and V6 (CNAs; Certified Nurse Assistants) provided incontinence care to R103. R103's disposable incontinence brief was heavily soaked with urine. The incontinent brief pad was noted with urine odor.

During the incontinence care, V3 (Licensed Practical Nurse) was called by V5 because R103 has a foam dressing that was not covering the pressure ulcer of R103's sacrum. V3, V5 and V6 stated that the foam dressing was changed by the facility when it's needed to be changed. V3 removed the unrolled foam dressing. There was a persistent reddened area throughout R103's sacrum to the coccyx area. There were 2 open pressure ulcers on the sacrum and next to the coccyx. V3 stated that R103 had developed these 2 stage II pressure ulcers on the sacrum that was unbeknownst to him nor other staff like V5 and V6 when the 2 stage II pressure ulcers occurred. V3 further added that there was no skin assessment and monitoring of the sacral pressure ulcer. As V3 added, the redness around the sacrum to the coccyx was a stage 1 pressure ulcer and was changed either by an outside agency who only comes 2 times a week and then facility staff changes the foam dressing in between days that the outside agency was not available. V3 also stated that there was no skin

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comprehensive assessment for stage 1 pressure ulcer of the sacrum, and now as observed during the incontinence care there were 2 stage II pressure ulcers without treatment and was only identified when pointed out by the surveyor during the incontinence care observation.

Furthermore, it was observed that R103's right heel has an unstageable pressure ulcer. V2 and V3 had claimed on a previous interview that R103's pressure ulcer had healed and currently no skin alteration at all. Upon observation, it revealed that R103's right heal unstageable pressure ulcer was not healed and without treatment. V3 measured the right heel as 3.5 cm. x 6.4 cm. V3 assessed it as boggy, filled with fluid, peri wound edges was red inside the wound and outer edges were blackish in color. V3 also added that there was no skin monitoring and comprehensive assessment regarding the unstageable pressure ulcer of the right heel and the 2 stage II pressure ulcer of the sacrum that had deteriorated from stage I. V3 also stated that there was no treatment for these pressure ulcers and that he will call the physician.

During the 2 days survey, R102 and 103 were observed to be sitting in their reclining wheelchair on 3/4/2018 and 3/5/2018 at 10:00 A.M., and 10:30-10-45 A.M. Upon request by the surveyor for skin check, R102 and R103 were transferred via total lift transfer device to bed at 10:30 A.M. and 10:45 A.M. by V5 and V6. Both R102 and R103 were heavily soiled with urine. V5 and V6 stated that their shift starts at 7 A.M., and that R102 and R103 were already up for the day assisted by the night shift staff. V5 and V6 also added that they have not repositioned both R102 and R103 for pressure relief from their buttocks area. When R102 and R103 were transferred to

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bed for skin check, the seat cushion was deeply sunken and did not bounce back to its original form for pressure relief. It was around 3-4 hours that both R102 and R103 were sitting without being repositioned for pressure relief nor had they been provided with incontinence care to prevent moisture of their perineal area.

The undated facility policy for "Treatments and Wound Care Orders" shows:
-"8. All treatments and wound care orders will be communicated to the Resident Care specialist to provide continuity of care and to provide in-service training during resident ADL.
-"9. The Resident Care Specialist are required to provide accurate information to the Licensed Nurse on any changes in condition observed, related to the application of treatments or wound during ADL care.
-"10. Changes in condition related to the application of treatments or wound care will be noted in the residents' medical record and on the resident service plan."

"B"

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330.1530a)
330.1530b)1)
330.1530e)

Section 330.1530 Labeling and Storage of Medications

a) All medications shall be stored in a locked area at all times. Areas shall be well lighted and of sufficient size to permit storage without crowding. This area may be a drawer, cabinet, closet, or

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room. In those facilities where a licensed nurse dispenses medication to residents, medications may be stored in a locked mobile medication cart, which is made immobile when not in use by the nurse to dispense medication.

b) The key to the medicine area shall be the responsibility of, and in the possession of, the staff persons responsible for overseeing the self-administration of medications by residents.

1) The medicine area shall not be used for any other purpose. It shall not be located in residents' rooms, bathrooms, or the kitchen. However, for those persons whom the attending physician has given written permission to handle their own medication, medications may be stored in a locked drawer or cabinet in the resident's room.

e) Biologicals or medications requiring refrigeration shall be kept in a separate, securely fastened and locked container in a refrigerator, or in a locked refrigerator.

This regulation was not met as evidenced by:

Based on observation, interview and record review, the facility failed to store and lock medications at all times, ensure that key to the medication storage was in the possession only of staff persons responsible for overseeing medications and that medications were stored in an area for sole purpose of medication storage and not an office. The facility also failed to store medications that need to be refrigerated in an acceptable temperature.

This applies to all 41 residents residing in the building.

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S9999	Continued From page 23 Findings include: On 3/5/2019 at 2:05 P.M., V2 (Licensed Practical Nurse) was seen checking the house #2 refrigerator medication storage. The thermometer gauge reads 66 degrees Fahrenheit. There was water dripping from the ice compartment and the ice packs bags were melted. There was a water dripping from the ice compartment. The medication labels were blotted and barely readable. The following medications were: 1. Ativan 8 vials injectable (1 vial open) of R116 2. Tuberculin vials (open stock) 3. Novolog 1 vial insulin open no date label of R103 4. Humalog 1 vial of R108 5. Ativan 0.25 mg solution 21 ml. of R116 All these medications have pharmacy label with indication that they need to be refrigerated. The medications were warm to touch. On 3/6/2019 at 11:40 A.M., V8 (Pharmacy Nurse Consultant) stated that the medications that were labeled to be refrigerated should be stored in a refrigerator with a temperature of 36-46 degrees Fahrenheit to maintain the effectiveness and potency of the drug. On 3/4/2019 and 3/5/2019, there were 4 large brown bags full of medications in the nursing office. The medications inside the brown bags were for all residents in the facility for 2 weeks supply of their medications as V2 (Licensed Practical Nurse) stated. The nursing office was adjacent to the conference room. At 10:00 A.M. on 3/4/2018, V1 administrator opened the nursing office. V1 stated that she has the access to the nursing office with medications stored in the office. V1 also stated that she is not a Licensed personnel to dispense medications. V1 left the	S9999		

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nursing medications unlocked and unsupervised by the licensed staff by the facility. R118 had opened the conference twice trying to enter that leads to the nursing office with medications. V2 also had left the nursing office unlocked on 3/4/2019 at 10:30 A.M., and 3/5/2019 at 2:05 P.M., with medications still in the nursing office. The medications that were stored in the nursing office was unsupervised when V2 left the nursing office unlocked.

The updated facility policy dated 6/15/2018 shows that medication requiring refrigeration is refrigerated with temperature ranging between 36-46 degrees Fahrenheit. The policy also shows that medications not in used should be kept in the locked closets and that they cannot be left in the office areas. It also shows that "Licensed personnel" shall have access to the medication closet."

On 3/4/2019 at 9:30 A.M., V1 (Administrator) stated that they are licensed for 48 beds for memory care. However, there were 41 residents in the facility.

"C"

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330.2210a)5

Section 330.2210 Maintenance

a) Every facility shall have an effective written plan for maintenance, including sufficient staff, appropriate equipment, and adequate supplies. Each facility shall:

5) Maintain all furniture and furnishings in a

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S9999	Continued From page 25 clean, attractive, and safely repaired condition. This Regulation was not met as evidenced by: Based on observation and interview, the facility failed to maintain an upholstered reclining chair, in a safely repaired condition. This failure affects 1 of 16 residents (R107) in the sample of 6. The findings include: On March 5, 2019, at 1::00 pm, R107 was laying on a large blue recliner lounge chair in the living area adjacent to the dining area, in building #2. The left arm rest of this chair was broken and was partially dislodged from frame of the chair, posing a risk of falling off of the chair. This was also witnessed by V2 (LPN), V3 (LPN) and V4 (Lead CNA). On 3/5/19 at 1:15 pm, V9 (Maintenance Director) explained; "I should have removed the chair right away." "AW" 9 of 10 Licensure 330.2220a)1) Section 330.2220 Housekeeping a) Every facility shall have an effective plan for housekeeping including sufficient staff, appropriate equipment and adequate supplies. Each facility shall: 1) Keep the building in a clean, safe, and orderly condition. This includes all rooms, corridors,	S9999		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Continued From page 26 attics, basements, and storage areas. This regulation was not met as evidenced by: Based on observation and interview, the facility failed to clean resident rooms in building #2 as often as necessary in order to keep them free form the dirt and debris. The findings include: On March 5, 2019 from 10:30 - 10:45 am, the floors of resident rooms 102 and 103 (in building #2) were soiled with debris. This was witnessed by V3 (LPN), V5 (CNA) and V6 (CNA). Additionally, a foul odor was detected in these rooms. On March 5, 2019, V2 (LPN) admitted that in addition to the care duties of the CNAs, they are required to conduct activities for the residents, serve meals and clear the tables of used plates, as well as required to fulfill housekeeping responsibilities. V2 further stated that she/he feels that the CNAs do not have enough time to meet all of the tasks they are required to do. On 3/5/19 at 3:00 pm, V1 (Administrator) stated that the facility outsources the responsibility of housekeeping to a housekeeping service which comes to the facility three times per week. She further stated that when the service does not come to the facility, the responsibility for housekeeping is expected by the facility's staff on duty. On 3/4/2019 at 9:30 A.M., V1 (Administrator) stated that they are licensed for 48 beds for memory care. However, there were 41 residents in the facility.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6013601	A. BUILDING _____ B. WING _____	03/07/2019

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S9999	Continued From page 27	S9999		

"AW"

10 of 10 Licensure

330.3940e)

Section 330.3940 Exit Facilities and Subdivision of Floor Areas

e) All exits, passageways, and exits through rooms shall be kept free of any item that would obstruct the exit route.

This regulation was not met as evidenced by:

Based on observations and interviews, the facility failed to keep the exterior exit, located in the southeast corner of building 2 in an unobstructed manner.

This applies to 2 of 6 residents (R102, R103) reviewed for safety concerns in the sample of 6 and 14 residents (R107, R108, R109, R110, R111, R113, R114, R115, R116, R117, R118, R119, R120, and R121)

Findings include:

On Monday March 4, 2019 at 2:44 PM the exterior exit door located in the southeast corner of building 2 was obstructed with a mechanical lift and an upholstered chair. At 3:30 PM, V1 (Administrator) corroborated that this door should not be obstructed.

16 residents (R102, R103, R107, R108, R109, R110, R111, R113, R114, R115, R116, R117, R118, R119, R120, and R121) reside in building #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 28 "AW"	S9999		