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	146076	A. BUILDING _____ B. WING _____	07/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE INN OF CLINTON	**1 PARK LANE WEST CLINTON, IL 61727**

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F9999	FINAL OBSERVATIONS PROBABTIONARY LICENSURE SURVEY: Section 300.1020 Communicable Disease Policies e) Infection control responsibilities 2) Each facility shall adhere to the recommendations of the U.S. Public Health Service contained in the publication entitled " Guidelines for the Prevention and Control of Nosocomial Infection." This publication may be obtained from the Center for Infectious Diseases, Centers for Disease Control, U.S. Public Health Service, Department of Health and Human Services, Atlanta, Georgia 30333. This publication includes the following guidelines: B) "Guideline for Handwashing and Hospital Environmental Control" (January 1, 1985). Section 300.1210 General Requirements for Nursing and Personal Care a) The facility must 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 assessment and plan of care. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet	F9999		

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the total nursing and personal care needs of the resident.

3) All nursing personnel shall assist and encourage residents so that a resident who is incontinent of bowel and/or bladder receives the appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. All nursing personnel shall assist residents so that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis:

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.

These REGULATIONS are not met as evidenced by:

Based on observation, record review, and interview, the facility failed to provide adequate services in the areas of incontinence care, pressure sores, and handwashing for 1 of 15 sampled residents (R8) by using incorrect technique for incontinence care, contamination of

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pressure sores during incontinence care, failure to remove gloves following incontinence care before touching other items, and by failure to implement measures as recommended to treat pressure sores.

Findings include:

1. According to admission records and the current Physician's Order Sheet (POS), R8 has multiple diagnoses including Scoliosis, Hip Replacement Arthropathy, Anemia, Osteoporosis, and Abnormal Weight Loss. POS and nurses notes reviewed from 5/1/05 to present indicate that R8 has Stage II pressure ulcers on the coccyx and left hip. Dietary notes of 7/16/05 state that R8's July weight is 77 pounds. Observation on 7/27/05 at 9:00 a.m. indicated that R8 requires extensive assistance for transfers and bed mobility.

On 7/27/05 at 9:00am R8 was observed being transferred to bed and then receiving incontinence care. Upon removal of the brief, a small Duoderm dressing was noted at the top of the coccyx area and a small Stage II open area on the lower coccyx that was not covered. There was also a Stage II on the lower left hip, almost at the ischium, that was not covered. In doing the incontinence care, E6, Certified Nurses Aide, first washed the meatus and down the perineum, then repeated the downward strokes several times with the same area of the washcloth. Then with the same washcloth, E6 washed the groin, the entire length of each thigh, and then the buttocks. E6 washed the open areas at this time with the same washcloth. E6 repeated the same with two more rinse washcloths - wiping the

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perineum, thighs, and buttocks with same washcloth, and using that cloth on the pressure sores. E5, Licensed Practical Nurse, stated at 12 :30pm on 7-27-05 that both the areas on the coccyx and the hip were supposed to be covered by Duoderm.

After E6 completed the incontinence care, she left her soiled gloves on while touching the bedside table, handling clean linens, siderails, the heel protector, the pillow under R8's head, the stuffed animal that R8 holds, and the call light .

During observation of the transfer on 7/27/05 at 9 :00 a.m., no pillow or pad was observed in the seat of the wheelchair, and no padding was noted on the arms of the chair. Nurses notes dated 5/23/05 at 9:13am state that a new Physician's Order was received for Occupational Therapy (OT) to treat R8's pressure sores. A sheet titled, "Occupational Therapy Screening Form" dated 5/16/05 states the following: "pt. referred to skilled OT per Nsg (nursing) request d /t (due to) decub. ulcers. Pt. is able to self propel in current w/c (wheelchair) - however has {no} pressure relieving cushion, uses a pillow at this time. Pt. would benefit from skilled OT to provide new cushion to chair for {increased} pressure relieving and wt. (weight) distribution. Also OT to provide w/c adaptations {after} placement of cushion for maintaining most appropriate position in w/c. . ." The section for, "Existing Adaptive Equipment" listed a standard w/c with lamb's wool on both armrests and a pillow in the seat. None of these interventions were observed to be in place at the time of the transfer, nor on observation again at 4:00pm on 7/27/05 when R8

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F9999	Continued From page 12 was in the w/c by the TV room. Section 300.2100 Food Handling Sanitation Every facility shall comply with the Department's rules entitled "Food Service Sanitation" (77 Ill. Adm. Code 750). These REGULATIONS are not met as evidenced by the following: 750.820g) When chemicals are used for sanitizing, they shall not have concentrations higher than the maximum permitted under 21 CFR 178.1010, and a test kit or other device that accurately measures the parts per million concentration of the solution shall be provided and used. Based on observation and interview, the facility failed to ensure that the quaternary amnionia sanitizing solution was being used at 200 parts per million (ppm) in accordance with the manufactory's labeled directions in the three compartment sink. Finding include: During tour of the Dietary Department on 7-26-05 at 11:30 a.m., the three compartment sanitizer was tested. The quaternary sanitizer concentration was 400 ppm. At that time E3, Dietary Supervisor, stated that the sanitizer dispensing system was preset, and the facility	F9999		

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F9999	Continued From page 13 could adjust the concentration. 750.800b) To prevent cross-contamination, kitchenware and food contact surfaces of equipment shall be washed, rinsed, and sanitized after each use and following any interruption of operations during which time contamination may have occurred. Based on observation, the facility failed to maintain the manual can opener, the meat slicer, and the popcorn popper clean and sanitized. Findings include: During initial tour of the Dietary Department on 7-25-05 at 10:00 a.m., the manual can opener blade had a heavy accumulation of dried and moist food residue. The finish of the blade was worn. During tour of the Dietary department on 7-26-05 at 11:30 a.m., the meat slicer blade had accumulated greasy residue along the cutting edge of the blade. The motor housing had meat residue on it. E3, Dietary Supervisor, stated at that time, that the meat slicer had not been used for a few days. During tour of the Activity Room, the electric popcorn popper was observed with an accumulation of grease residue inside and outside the kettle and on the ceiling of the popper . 750.120a) At all times, including while being	F9999		

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F9999	Continued From page 14 stored, prepared, displayed, served, or transported, food shall be protected from potential contamination, including dust, insects, rodents, unclean equipment and utensils, unnecessary handling, coughs and sneezes, flooding, drainage, and overhead leakage or overhead dripping from condensation. Based on observation, the facility failed to ensure that overhead contamination did not occur from the 4 ceiling air conditioners, the ceiling exhaust ventilation, and the condensation line in the walk-in freezer. Findings include: During tour of the Dietary Department on 7-25-05 at 10:00 a.m., condensation was dripping from the ceiling air conditioner onto the floor, dripping on the preparation table and on the mixer. An accumulation of dust, lint, and grease was on the inside of the exhaust ventilation hood, on the filter, and on the outside front of the hood. The condensation line in the walk- in freezer had an ice formation on the line and ice formed on the outside of the food boxes under the line. Section 300.2920 Mechanical Systems d) Thermal Hazards. Any surface exceeding a temperature of 140 degrees Fahrenheit (such as radiators, hot water or steam pipes, baseboard heaters, or therapy equipment) that is accessible to residents shall be provided with partitions, screens, shields, or other means to	F9999		

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F9999	Continued From page 15 protect residents from injury. 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 REGULATION is not met as evidenced by the following: Based on observation and interview, the facility failed to ensure that the 180 degrees Fahrenheit surfaces of the lids for the steam table in 1 of 3 pantries were not available to residents. Finding include: During tour of the 300 Wing Dining Room on 7-26 -05 at 9:50 A.M., the pantry serving window was up about 6 inches. The steam table was just inside the window and surfaces of the lids were hot to the touch. Thermal labels were placed on the surfaces and the labels recorded temperatures of over 180 degrees Fahrenheit. On 7-26-05 at 11:45 A. M., E3, Dietary Supervisor, stated the steam table on the 3 wings are turned on and are left on until after the noon meal. During initial tour of the 300 wing, surveyor was informed that confused and ambulatory residents reside on the wing. ---------- LICENSURE FINDINGS FOR COMPLAINT 0562799: Section 300.1010 Medical Care Policies	F9999		

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F9999	Continued From page 16 h) The facility shall notify the resident's physician of any accident, injury, or significant change in a resident's condition that threatens the 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 b) General nursing care shall include at a minimum the following and shall be practiced on a 24-hour, seven day a week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 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. Section 300.3220 Medical and Personal Care Program f) All medical treatment and procedures shall be administered as ordered by a physician. All new physician orders shall be reviewed by the	F9999		

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F9999	Continued From page 17 facility's Director of nursing or charge nurse designee within 24 hours after such orders have been issued to assure facility compliance with such orders. (Section 2-104(b) of the Act) These REGULATIONS are not met as evidenced by: Based on record review and interview, the facility failed to promptly follow the Physician's Order to obtain a Computerized Tomography (CT) Scan, failed to assess a change in condition, and failed to notify the oncoming nursing staff and Physician of this change in condition for one of one sampled residents who had a change in condition (R15). These failures caused a delay in the medical treatment of R15's abdominal pain. R15 was found on the floor and expired before emergency response could be called. Findings include: According to the medical record face sheet, R15, an 89 year old resident, was initially admitted to the facility on 2/8/05, and was readmitted to the facility on 3/12/05 following hospitalization for a heart attack. Other diagnoses listed on the face sheet were Irregular Heart Rhythm, Stroke, Alzheimers, Anxiety, Hypertension, and Diabetes Mellitus. The Nurses Note dated 5/26/05 at 8:26 p.m. show that E9, Licensed Practical Nurse (LPN), charted "Resident (R15) is in bed all night refusing to get out of bed,.....complaint of stomach hurting, no redness or bruising noted,	F9999		

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F9999	Continued From page 18 abdomen soft, will continue to monitor." On 5/27/05 at 9:01 p.m., Physician, Z1, charted in the Progress Notes, ".....Patient has been complaining of some abdominal pain, no nausea, no vomiting, no diarrhea. (R15) is awake alert and confused; says her gut hurts at times. (R15) has a large pendulous abdomen with midline scar . (R15) does have some area which seem like an incisional hernia. It becomes more prominent with coughing. We will get a CT (Computerized Tomography) scan on her abdomen in the morning." Progress notes show that the nurse on duty that evening on 5/27/05, E8, LPN, did not write any progress notes regarding R15's abdominal pain or the plan to schedule the abdominal scan the next morning. The Physician's Order Sheet shows that this order was not transcribed to the Physician's Order Sheet. E8 stated at 3:00 p.m. on 7/27/05, "When {Z1} said that he wanted a CT scan of the abdomen, I thought that the Dr. ordered it so I did not. . . . I talked to {Z1} the next afternoon (5/28/05) at about 2:50 p.m. and informed him that the test had not been done and that I had dropped the ball. The Dr. ordered the CT scan to be done at the first available time. . . I took the first available (appointment) for the hospital to get it done, and I scheduled it for the following Tuesday." When questioned, E8 stated that he did not call the Physician back to inform him that the test would not be done until Tuesday . During interview with E2, Director of Nurses, on 7/26/05 at approximately 11:30 a.m., she stated that on the evening of 5/28/05, Z1 told E8 to get the CT scan done "as soon as he could."	F9999		

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F9999	Continued From page 19 Progress Notes show that on 5/28/05, E8 made a late entry regarding the resident's condition and the Physician's visit on the previous evening. The entry states, "2:50 p.m. late entry: resident complained of upper abdominal pain. Upon palpation found what appears to be a hernia the size of small apple midline at the uppermost upper quadrants. Notified MD(Medical Doctor) .....states he was going to have a CT scan in am for this resident (R15)." During interview with E10, the evening Certified Nurse Assistant (CNA) Shift Coordinator, on 7/28 /05 at approximately 11:00 a.m., she stated, that on 5/27/05, the Physician saw R15. "I know she was in a lot of pain. I took (Z1) to see the resident. When (Z1) pressed on the stomach area, you could see that (R15) was in pain. (Z1) gave an order to get a CT scan of the stomach." E10 also recalled that on the following evening 5/ 28/05, she observed R15 in the dining room just before supper time. E10 stated that R15 would sit and then stand up and say that (R15's) stomach hurt and that (R15) was in a lot of pain. "(R15) just kept saying that her stomach hurt". E 10 stated she paged E8, LPN, to come to the dining room and they both assisted R15 to bed. E10 also stated, "I do know that the resident was in a lot of pain." R15 was saying, "It hurts so bad . My stomach really hurts." E10 stated when R 15 was in the dining room, R15 "would put one hand on the stomach then hold on to the table with the other hand," and after she was put to bed, R15 would sometimes put both hands on the stomach area where it hurt. E10 stated "after (R15) was in bed, she remained restless, turning in the bed and laying on both ends of the bed to try to get comfortable."	F9999		

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F9999	Continued From page 20 The PRN (as needed) Medication Notes show that E8, LPN, did administer pain medication, Ultram 50 mg (milligrams) on 5/28/05. During interview with E8, on 7/27/05 at 3:00 p.m., he did confirm that he administered this medication. Although the time was not written on the PRN Medication Sheet, E8 thought it was around suppertime. The reason recorded for administering the medication was, "Complained of Body Aches." E8 stated that he did not recall why he gave the medication specifically, and confirmed that he had not recorded any results of the effectiveness of the medication on the Medication Sheet either. The facility's " Pharmaceutical Procedures" require, " Documentation of administration of PRN, as needed, meds shall contain results of administration..". The Progress Note History shows that E8 did not enter any nursing progress notes regarding R15's pain or pain medication given on this evening (5/28/05). E8 also stated in the interview, "I did not document any information about this because I didn't think it was that important." The facility's "Change in a Resident's Condition Policy" requires, "The nurse will notify the resident's attending physician when: There is a significant change in the resident's physical, mental or psychosocial status" and requires "The nurse will record in the resident's medical record any changes in the resident's medical condition or status" and also requires that the nurse " Communicate resident's status to oncoming Shift Nurse". During phone interview with E12, LPN, on 7/28/	F9999		

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05 at 9:30 a.m., she stated that she worked the night shift from 10:00 p.m. on 5/28/05 until 6:00 a .m. on 5/29/05. During the interview, E12 stated that on the night following the incident, 5/30/05, "(E10) the Shift Coordinator told her that (R15) was in so much pain in the dining room that (R15) was doubled over with her head on the table. . . I became aware of this situation through (E10) and not from the nurse on the evening it happened." E12 stated that at about 2:35 a.m. on the morning of the 29th, she was called down to R15 's room by E13, LPN. E12 said that when she got there, "(R15) was on the bathroom floor, face down and to the right, lying prone with a puddle of reddish brown fluid around the head." When questioned, E12 stated, "I was only there a few minutes I couldn't tell if the fluid was blood or not. It was a reddish-tinged brown. . . . If I had known that (R15) was in so much pain that evening and had known that (R15) was to have a CT scan, I would have called (Z1) and would have transferred (R15) by ambulance to a nearby hospital where the CT scan could be done."

On 7/28/05 at 10:30 a.m. E11, CNA, who found R 15 lying on the floor at 2:35 a.m. on 5/29/05 during bed checks, stated, "I found (R15) on the floor in the bathroom and saw the fluid on the floor. I thought it was blood, but the nurse (E13) said that it was bowel movement (BM)." E11 stated that R15 would take a few gasps and that when E13 tried to take vitals, she "couldn't get any."

During interview with E13, LPN, on 7/28/05 at 10: 00 a.m., she stated, "I was working with (E12). The CNAs said that the resident had fallen. The resident was laying on the bathroom floor in a big

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146076	A. BUILDING _____ B. WING _____	07/29/2005

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAWTHORNE INN OF CLINTON	1 PARK LANE WEST CLINTON, IL 61727

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED 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) COMPLETION DATE
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pool of brown emesis ...a big pool. The emesis was stool- it was brown and smelled like BM. (R 15) had several more small brown emesis after that. The resident was still breathing, but the color was draining out of her face. The resident died shortly after, before the ambulance could be called."

Progress Notes showed that E12 entered 5/29/05 at 3:51 a.m., "late entry for 0235; res. found lying on BR (bathroom) floor vomiting bloody fluid..... MD paged at 0245, at 0248 res had no P (pulse), no R (respirations) no B/P (blood pressure)....MD returned call and was given condition report."

During interview with Z1, Physician, on 7/28/05 at approximately 2:30 p.m., he stated he called the facility on 5/28/05 to find out the results of the CT scan which he had ordered for that morning. Z1 stated staff did not know that it was not ordered and that it was not done. Z1 stated he wanted the Xray done that morning after he came out late in the evening on 7/27/05 to specifically see R15. Z1 stated, "I thought it was pretty important. It could have changed the management of care. When I order something, I expect it to be done". Z1 stated R15's heart was in very poor condition, and he was not sure that R15 would have been a candidate for surgery. Z1 stated, "If I had know that the CT Scan was not going to be done the next morning, I probably would have sent the resident in that evening (5/27/05)."

On R15's Discharge Summary, Z1 documented Heart Attack (Myocardial Infarction), Stroke (Cerebral Vascular Accident), and Hypertension as the cause of death. During interview with Z1 on 7/28/05 at 2:30 p.m., he confirmed these

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F9999	Continued From page 23 diagnoses to be the cause of death, and also stated he could not have made another diagnosis without the test results. When questioned if R15 's death could have been due to a bowel obstruction, Z1 stated "When I saw the resident on 5/27/05 at 9:00 p.m., she did not have an obstruction. She could have developed one...we have no way of knowing."	F9999		