| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F 354 | Continued From page 18<br><br>The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the Facility failed to provide a registered nurse for at least 8 consecutive hours a day, 7 days a week.<br><br>Findings include:<br><br>1. During a review of the Facility August 2007 nursing schedule, it was noted that there was no registered nurse in the Facility on 8/4, 8/13, 8/19, 8/20, 8/22/07.<br>During an interview with E2, Director of Nurses, on 9/10/07, it was stated that she was unaware that a registered nurse is required for at least 8 hours a day, 7 days a week. E2 stated that the Facility is in the process of hiring additional nurses.<br>A review of the Facility census report for the month of August 2007 shows that the Facility census was above 60 on the above listed dates. | F 354 | | |
| F9999 | FINAL OBSERVATIONS<br><br>LICENSURE VIOLATIONS<br><br>300.610a)<br>300.680a)<br>300.680c)<br>300.682a)1)<br>300.682i)<br>300.682j)<br>300.1210b)6)<br>300.1230a) | F9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 19 | F9999 | | |

300.3240a)
300.3240b)
300.3240c)
300.3240d)
300.3240e)

Section 300.610 Resident Care Policies
a) The facility shall have written policies and procedures, governing all services provided by the facility which 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. These policies shall be in compliance with the Act and all rules promulgated thereunder. These written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, as evidenced by written, signed and dated minutes of such a meeting.

Section 300.680 Restraints
a) The facility shall have written policies controlling the use of physical restraints including, but not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, wheelchair safety bars and lap trays, and all facility practices that meet the definition of a restraint, such as tucking in a sheet so tightly that a bed-bound resident cannot move; bed rails used to keep a resident from getting out of bed; chairs that prevent rising; or placing a resident who uses a wheelchair so close to a wall that the wall prevents the resident from rising. Adaptive equipment is not considered a physical restraint. Wrist bands or devices on clothing that trigger electronic alarms to warn staff that a resident is leaving a room do not, in and of themselves, restrict freedom of

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 20 | F9999 | | |

movement and should not be considered as physical restraints. The policies shall be followed in the operation of the facility and shall comply with the Act and this Part. These policies shall be developed by the medical advisory committee or the advisory physician with participation by nursing and administrative personnel.

c) Physical restraints shall not be used on a resident for the purpose of discipline or convenience.

Section 300.682 Nonemergency Use of Physical Restraints
a) Physical restraints shall only be used when required to treat the resident's medical symptoms or as a therapeutic intervention, as ordered by a physician, and based on:
1) the assessment of the resident's capabilities and an evaluation and trial of less restrictive alternatives that could prove effective;

i) A resident wearing a physical restraint shall have it released for a few minutes at least once every two hours, or more often if necessary. During these times, residents shall be assisted with ambulation, as their condition permits, and provided a change in position, skin care and nursing care, as appropriate.

j) No form of seclusion shall be permitted.

Section 300.1210 General Requirements for Nursing and Personal Care
b)6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 21<br>and assistance to prevent accidents.<br><br>Section 300.1230 Staffing<br><br>a) Staffing shall be based on the needs of the residents, and shall be determined by figuring the number of hours of nursing time each resident needs on each shift of the day. This determination shall be made separately for both licensed and nonlicensed nursing personnel.<br><br>Section 300.3240 Abuse and Neglect<br>a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident.<br><br>b) A facility employee or agent who becomes aware of abuse or neglect of a resident shall immediately report the matter to the facility administrator.<br><br>c) A facility administrator who becomes aware of abuse or neglect of a resident shall immediately report the matter by telephone and in writing to the resident's representative.<br><br>d) A facility administrator, employee, or agent who becomes aware of abuse or neglect of a resident shall also report the matter to the Department.<br><br>e) Employee as perpetrator of abuse. When an investigation of a report of suspected abuse of a resident indicates, based upon credible evidence, that an employee of a long-term care facility is the perpetrator of the abuse, that employee shall immediately be barred from any further contact with residents of the facility, pending the outcome of any further investigation, prosecution or | F9999 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 22 | F9999 | | |

disciplinary action against the employee.

These REGULATIONS were not met as evidenced by:

Based on interview and record review, the Facility failed to prevent the use of a physical restraint for 1 (R1) resident on the sample.

This failure resulted in facility staff utilizing a bed sheet to tie R1 into a chair in her room, for their convenience, and isolating her in her single bed room for over 2 1/2 hours, until her physician found her.

Findings include:

Facility incident investigation, dated 8/28/07, documents:
"These events occurred on the night shift, from 10:00 PM on 8/22/07, until 6:00 AM on 8/23/07. R1 slept until approximately 10:30 PM. R1 got up and began wandering the hallway and into other residents' rooms, and attempted to open the stairwell doors. R1 wouldn't stay in bed and go back to sleep. R1 wouldn't sit for very long. R1 repeatedly went into some of the alert residents' rooms so they repeatedly rang for staff to get her out of their rooms. Some of the alert residents were awakened more than once and were getting upset with R1.
At approximately 3:30 AM, the second floor Certified Nurses Aides (CNA's), E5 and E6, were ready to start their last rounds. E6 tried several interventions to get R1 to go back to bed and sleep. These included toileting and offering R1 a snack. R1 will often go back to bed and sleep after being toileted and/or given a snack. R1 would not stay in bed and kept getting up. At this

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 23 | F9999 | | |

time, the charge nurse was on first floor. The CNA's were concerned because R1 had been walking around since she got up at 10:30 PM. The CNA's knew that R1 was physically tired but they could not get her to stay still long enough to go back to sleep or rest in a chair. They were concerned that R1 might fall as a result of being on the go all night. They were also concerned that, as they cared for other residents, that they would not be able to keep her in sight and keep her from going into other rooms or possibly attempting to go out a stairwell door. The CNA's, concerned for R1's safety, decided she needed to be restrained in the resident's recliner. The CNA's took R1 into her room, sat her in her recliner and put a sheet around her waist and the recliner and tied the sheet at the back of the recliner."

During an interview with Z1, R1's physician, by telephone on 9/5/07, Z1 stated that he found R1 tied into her recliner with a sheet when he was doing rounds the morning of 8/23/07 at approximately 6:00-6:30 AM. Z1 said that when he walked into R1's room, she was very agitated and anxious. Z1 noted a sheet draped over R1's lap. The sheet was twisted at both ends and wedged into the articulation of the chair, around the back of the chair. Z1 said that R1 was completely soaked with urine, there was a large puddle of urine on the floor under R1's chair and all over the floor. Z1 said "I actually got my feet wet (from the urine)." Z1 said that he immediately went and told the nurse in charge to take care of R1 and Facility staff did take care of her right away. Z1 said that R1 remained agitated and anxious for awhile after being cleaned up. Z1 said that the Facility never calls him about R1 and he has received no calls from the Facility about

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 24 | F9999 | | |

R1 being agitated. Z1 further said "(The incident) was disappointing, I would hope someone would have called me or watched her closer - like putting her by the nurses station. It was not acceptable and no one that I talked to at the Facility felt it was acceptable."

During an interview with E5, CNA, by telephone on 9/5/07, it was stated that E5 and E6 were CNA's working the second floor on the night of 8/22-23/07. E6 was assigned to R1. E5 said that E6 kept putting R1 back to bed "time and time again," and R1 would not stay in bed. "We tried feeding R1 - nothing worked." E5 said that E4, the nurse on duty, knew R1 was getting up and down but E4 was on the first floor when R1 was going into other residents' rooms. E5 said that R1 kept going in alert resident's rooms and they were getting mad, and R1 would get mad when staff removed her from other residents' rooms. E5 said that R1 would get upset and try to fight them when they attempted to remove R1 from other residents' rooms. E5 said that R1 was also trying to go out the exit doors. E5 said that it was getting close to their last rounds and "we just didn't know what to do with her." E5 stated "I told E4 at 3:30 PM that we had tied R1 into her chair." E4 did not say anything except "Uh-Huh," which E5 said that she interpreted as confirming that E4 had heard what E5 had said to her. E5 said that she told E6 to check on R1 when they were finished with rounds, however E6 forgot as she was busy getting a dialysis resident ready for treatment. E5 said that Z1 must have found R1 sometime after 6:00 AM because E5 and E6 had completed their shift and left the Facility. E5 confirmed that she and E6 put R1 "in her big chair (rocker/recliner) and tied a sheet around her." E5 confirmed that R1 was left alone in her room from

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 25 | F9999 | | |

3:30 PM until approximately 6:15 AM. E5 stated that the door to R1's room was partially open.

During an interview by telephone with E6, CNA, on 9/5/07, E6 confirmed what E5 had stated. E6 said that the night of 8/22-23/07 had been a particularly busy night. E6 said that that she and E5 were trying to give another resident a shower. E5 explained that one CNA stays on the floor and the other gives the shower, which leaves only one staff member on the floor. E6 said "We couldn't keep an eye on R1. E5 put R1 in her chair and tied her in. I checked on R1 an hour later and she was asleep in her chair. I forgot to get R1 out of the chair. I'm scared that R1 is going to get hurt - some nights we can't watch her, we're too busy to watch her."

R1 was originally admitted to the Facility on 10/15/03, with diagnoses, in part, of Alzheimer's Dementia, Degenerative Osteoarthritis and Depression. R1's most recent assessment, shows that she has short and long term memory problems, is moderately cognitively impaired for daily decision making skills, has repetitive physical movements daily, wanders daily, is independent in ambulation and is normally continent. R1's Facility plan of care, dated 7/28/07, identifies a problem of "At risk for wandering." The Approaches for this problem include "Allow to wander freely within facility but remove from area if annoying peers. Take on walks or allow to wander ad lib. Take resident to bathroom regularly." R1's Facility behavior tracking log was reviewed along with E12, Social Service Designee. R1's behavior tracking shows "0's" for the night of 8/22-23/07, which indicates that R1 had no behaviors, which was confirmed with E12.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 26 | F9999 | | |

Facility policy entitled "Nursing Protocol for Application of Physical Restraints" states "Restraint use in our Facility will only be considered to treat a medical symptom/condition that endangers the physical safety of the resident or other residents and under the following conditions:
1) as a last resort measure after a trial period where
less restrictive measures have been undertaken and
proven unsuccessful;
2) with a physician's order;
3) with the consent of the resident (or legal representative);
4) when the benefits of the restraint outweigh the identified risks. If restraint use is deemed necessary, the goal will be to use the least restrictive type of restraint for the shortest period
of time possible".
This policy further states that "In An Emergency: if a resident has unanticipated violent or aggressive behavior which would place him/her or others in imminent danger, a supervisory nurse may approve the use of a physical restraint. A confirming physician's order must be obtained and family notification be made no later than 8 hours after restraint has been applied."

Facility policy entitled "Abuse and Neglect Policy" defines Abuse as "any physical or mental injury or sexual assault inflicted upon a resident other than by accidental means. It is the willful infliction of injury, unreasonable confinement, intimidation or punishments with resulting physical harm, pain or mental anguish. Physical abuse includes, but is not limited to hitting, slapping, pinching, kicking

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 145475 | A. BUILDING _____ B. WING _____ | C 09/12/2007 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| ST ANN'S HEALTHCARE CENTER | 770 STATE STREET CHESTER, IL 62233 |

| (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) COMPLETION DATE |
|---|---|---|---|---|
| F9999 | Continued From page 27<br>and controlling behavior through corporal punishment. Involuntary Seclusion is separation of a resident from other residents, his/her room or confinement to his/her room against the residents or resident's legal guardian."<br><br>The Facility failed to follow it's own policies when R1 was restrained and isolated in her room.<br><br>(A) | F9999 | | |