STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145518	A. BUILDING _____ B. WING _____	09/16/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAR KA NURSING HOME	201 SOUTH 10TH STREET MASCOUTAH, IL 62258

(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 000	INITIAL COMMENTS Annual Licensure/Certification Survey.	F 000		
F 280 SS=E	LICENSURE SURVEY FOR SUBPART S: SMI 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation interview and record review, the facility failed to review and revise care plans for 4 of 13 residents (R3, R6, R1, R4) reviewed for care plans in the sample of 13. Findings include:	F 280		10/6/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 280	Continued From page 1 1. On 9/13/11 at 9:30 AM R4 was in his room lying on his bed. R4 stated he recently returned from the hospital and had pneumonia. R4's physician's order dated 9/9/11 documented he returned from the hospital with pneumonia. R4's physician's order, dated 9/9/11, documented he should have Levofloxacin (an antibiotic) 750 milligrams every 48 hours. R4's Care Plan dated 9/9/11 did not address R4's diagnoses of Pneumonia and his need for an antibiotic. 2. On 9/13/11 at 9:40 AM R3 was lying in his bed. R3 was wearing a pressure relieving boot on his right foot. R3's Wound Management Report dated 9/8/11 documented "Continue to off load pressure with (pressure relieving) boot." R3's Care Plan dated 6/20/11 documented "(R3) currently has a diabetic ulcer to his right great toe measuring 1.5 centimeters x 1 centimeter with necrosis." The care plan had not been revised to address the pressure relieving boot. 3. On 9/13/11 at 12:25 PM, R6 was seated in a wheelchair in the Dining Room. E3, Assistant Director of Nursing (ADON), was feeding R6 lunch. R6's pureed food was served in individual bowls. R6's intake of the solid foods was poor. She was offered and received extra house supplement. R6's Care Plan listed a problem identified on 2/21/11, "....at risk for weight loss R/T (related to) she has poor appetite @ times." The goal listed is, "(R6) current weight is 124.8. She will have no more than 3 lb. weight loss by next review date".	F 280		

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F 280	Continued From page 2 The goal date on the Care Plan is 8/23/11. There is an update to the Care Plan dated 6/28/11, which listed "Pureed Diet - serve diet as ordered.". R6's August Weight documented on the facility's Weight Variance Log is 120.8 pounds. R6's September weight on the Weight Log documented a weight of 111.6 pounds, a 10.6 pound weight loss (-8.4% of body mass) in one month. R6's Care Plan was not updated to address the weight loss of 10.6 pounds. 4. The Specialized Wound Management note dated 9/1/11 documented R1 had a scrotal pressure ulcer and "Staff reports area is due to patient sitting up in his wheelchair and not wanting to lay down." The care plan dated 6/1/11 for the problem "at risk for impaired skin integrity" has no documentation to address R1's non-compliance with repositioning. On 9/14/11 at 11:00 AM, E2 Director of Nurses (DON), stated the scrotal pressure ulcer could be a scratched area rather than pressure ulcer or could be from him sitting up in wheelchair. He preferred to be up in wheelchair. He would shift positions in wheelchair with encouragement. He allowed peri care but didn't want to lie down in bed. 5. The Fall Risk Assessment for R1 dated 6/1/11documented R1 at high risk. The care plan dated 6/1/11 for the problem at risk for falls, has no documentation of direction for how many staff to transfer R1. The Minimum Data Set (MDS) dated 5/31/11, documented R1 to need extensive assist of 2 or more for transfer.	F 280		

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F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the facility failed to implement fall interventions for one of five residents (R1) reviewed for falls in the sample of 13. This failure resulted in R1 falling and being hospitalized with a laceration to his right eyebrow, a traumatic left intracranial hemorrhage, and subdural hematoma. Findings include: R1 was assessed by the facility as "High Risk" for falls on 6/1/11, with a score of 17 (10 or above indicates High Risk). R1's Care Plan dated 6/1/11, documented the problem of risk for falls, history of falls, incontinence and impaired cognition. The approaches and interventions of the Care Plan included (in part) a bed alarm, chair alarm, and siderails. R1's 5/31/11, Minimum Data Set (MDS) assessed him as needing extensive assistance of two or more staff for transfers. On 6/28/11, R1 was sent to the hospital after falling at the facility. The facility's Incident Investigation dated 6/28/11 documented (in part) "CNA (Certified Nurses Aide)...was attempting to	F 323		10/5/11

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F 323	Continued From page 4 assist him to stand.....she noted he was not assisting her, so she assisted him to lie back on his bed and she left room to get assistance. .....as the 2 (CNAs) entered room ...they noted resident lying face down beside his bed." There is no documentation that R1's bed alarm was activated or the siderails pulled up before the CNA left the room. The Hospital Discharge Summary dated 6/29/11 documented (in part), "This is a 82-year-old white male who was found down at the nursing home next to his bed. He had a laceration to his right eye. In the ER, he was found to be hypertensive with a blood pressure of 224/104 initially. CAT scan showed a small left frontal intracranial hemorrhage with minimal subdural hematoma. His eye laceration was repaired with sutures..." The facility's Incident Investigation dated 6/28/11 stated (in part) "All CNA's have been reminded and inserviced informally to be mindful of leaving a resident unattended even for a brief time - to ensure they will be safe until return." E2, DON, stated on 9/15/11 at 9:55 AM, that the CNA was attempting to get R1 up from bed, saw that she couldn't, and put him back to bed to get assistance. "She didn't turn the alarm back on when she left to get assistance. I'm assuming the siderails were put back up but it is not documented."	F 323		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State	F 425		10/7/11

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F 425	Continued From page 5 law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to dispose of expired insulin for 5 residents (R14, R15, R16, R17, R18) in the supplemental sample. Findings include: On 9/15/11 at 11:00 AM, the Oak Hall Medication Cart was observed with E5, Licensed Practical Nurse (LPN). There were 2 vials of Novolog insulin opened on 8/10/11 and 2 vials of Lantus insulin opened on 8/10/11 for R14 and R15. E5 stated the insulin was good for a month after it was opened. On 9/15/11 at 11:08 AM, the Ash Hall Medication Cart was observed with E6, LPN. There was 1 vial of Novolog insulin opened on 8/1/11. On 9/15/11 at 11:15 AM, the Walnut Hall	F 425		

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F 425	Continued From page 6 Medication Cart was observed with E6, LPN. There were 2 vials of Novolog insulin, one opened on 8/14/11 for R18, and one opened on 8/15/11 for R17. On 9/15/11 at 2:10 PM, E2 Director of Nurses (DON) stated, "some insulins are good for 42 days but those insulins are only good for 28 days." The 2011 Insulin Storage Recommendations from Z1 (Pharmacy) documented Novolog and Lantus insulins to be good for 28 days after being opened.	F 425		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a	F 441		10/7/11

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F 441	Continued From page 7 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to clean multiple-use blood glucose monitoring devices with an appropriate sanitizer to prevent potential contamination between residents for 2 of 13 residents (R3, R7) reviewed for blood glucose monitoring in the sample of 13, and 8 residents (R19, R16, R18, R21, R17, R15, R14, R20) in the supplemental sample. Findings include: On 9/15/11 at 11:15 AM, E5, Licensed Practical Nurse (LPN) entered R7's room to check R7's blood sugar reading. E5 obtained the blood sample, returned to her medication cart, and cleaned the monitoring device with a super sani cloth germicidal cloth. E5 stated this germicidal wipe was used to clean all blood glucose monitors between residents. E5 stated the germicidal wipe was placed on all three	F 441		

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F 441	Continued From page 8	F 441		

medication carts.

The Technical Data Bulletin for this wipe described the wipe as, "a premoistened non-woven durable wipe containing a quaternary/alcohol based solution." The chemical composition listed active ingredients of n-Alkyl dimethyl ethybenzyl ammonium chloride and dimethly benzyl ammonium chloride.

Environmental Control of Clostritium difficile Fact Sheet, February 2009, Version 3 states (in part); "C-difficile spores are transferred to patients primarily via the hands of healthcare personnel who have direct contact with infected patients or who have touched a contaminate surface or item....A spore is a thick-walled resting cell produced by the organism to protect itself from unfavorable environmental conditions....spores can survive up to 5 months in the environment.....spores are more resistant than vegetative cells to surface disinfectants, the recommendation for cleaning environmental surfaces is the use of hypochlorite (bleach).....".

The facility's (Blood Glucose Monitoring Device) Cleansing and Disinfection Policy stated (in part), "All surfaces are to be cleaned with one wipe to remove any visibly soiled material and then a second wipe to disinfect the surface... " The product listed was the germicidal cloth observed on all medication carts.

On 9/15/11 at 3:15 PM, E2, Director of Nursing, stated that the facility would revise the (Blood Glucose Monitoring Device) Cleansing Policy and replace the germicidal cloths with bleach wipes. E2 stated the facility had 10 residents who were receiving glucometer readings on a routine basis. The residents with current orders for routine monitoring of blood sugar using the glucometer are R3, R7, R14,

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F 441	Continued From page 9 R15, R16, R17, R18, R19, R20, and R21.	F 441		
F9999	FINAL OBSERVATIONS LICENSURE VIOLATIONS 300.1210b) 300.3240a) Section 300.1210 General Requirements for Nursing and Personal Care 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. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These regulations are not met as evidenced by the following: Based on record review and interview, the facility failed to implement fall interventions for one of five residents (R1) reviewed for falls in the sample of 13. This failure resulted in R1 falling and being hospitalized with a laceration to his right eyebrow, a traumatic left intracranial hemorrhage, and subdural hematoma. Findings include: R1 was assessed by the facility as "High Risk"	F9999		

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F9999	Continued From page 10	F9999		

for falls on 6/1/11, with a score of 17 (10 or above indicates High Risk). R1's Care Plan dated 6/1/11, documented the problem of risk for falls, history of falls, incontinence and impaired cognition. The approaches and interventions of the Care Plan included (in part) a bed alarm, chair alarm, and siderails. R1's 5/31/11, Minimum Data Set (MDS) assessed him as needing extensive assistance of two or more staff for transfers.

On 6/28/11, R1 was sent to the hospital after falling at the facility. The facility's Incident Investigation dated 6/28/11 documented (in part) "CNA (Certified Nurses Aide)...was attempting to assist him to stand.....she noted he was not assisting her, so she assisted him to lie back on his bed and she left room to get assistance. .....as the 2 (CNAs) entered room ...they noted resident lying face down beside his bed." There is no documentation that R1's bed alarm was activated or the siderails pulled up before the CNA left the room.

The Hospital Discharge Summary dated 6/29/11 documented (in part), "This is a 82-year-old white male who was found down at the nursing home next to his bed. He had a laceration to his right eye. In the ER, he was found to be hypertensive with a blood pressure of 224/104 initially. CAT scan showed a small left frontal intracranial hemorrhage with minimal subdural hematoma. His eye laceration was repaired with sutures..."

The facility's Incident Investigation dated 6/28/11 stated (in part) "All CNA's have been reminded and inserviced informally to be mindful of leaving a resident unattended even for a brief time - to ensure they will be safe until return."

E2, DON, stated on 9/15/11 at 9:55 AM, that

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F9999	Continued From page 11 the CNA was attempting to get R1 up from bed, saw that she couldn't, and put him back to bed to get assistance. "She didn't turn the alarm back on when she left to get assistance. I'm assuming the siderails were put back up but it is not documented." B	F9999		