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F 463	Continued From page 47 Supervisor stated he was unaware that emergency nurse calls were not registering at the nurse's station call reception panel for the designated room. E8 stated that the emergency nurse calls are supposed to register for each numbered room on the panel as well as the central bathing/shower room. At this time E8 checked the function of the nurse call system and verified it was not working as designed. E8 stated it was unknown how long the system had not been working properly. E8 stated that the facility relies on an outside contractor to troubleshoot and repair such malfunctions.	F 463		
F9999	FINAL OBSERVATIONS Licensure Violations 300.615e) 300.615f) Determination of need screening and request for resident criminal history record information. e) In addition to the screening required by Section 2-201.5(a) of the Act and this Section, a facility shall, within 24 hours after admission of a resident, request a criminal history background check pursuant to the Uniform Conviction Information Act for all persons 18 or older seeking admission to the facility, unless a background check was initiated by a hospital pursuant to the Hospital Licensing Act. Background checks shall be based on the resident's name, date of birth, and other identifiers as required by the Department of State Police.	F9999		

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F9999	Continued From page 48 f)The facility shall check for the individual's name on the Illinois Sex Offender Registration website at www.isp.state.il.us and the Illinois Department of Corrections sex registrant search page at www.idoc.state.il.us to determine if the individual is listed as a registered sex offender. This requirement was not met as evidenced by the following: Based on interview and record review the facility failed to ensure that Criminal Background Checks were initiated within 24 hours of admission for 10 of 11 new admits reviewed (R5, R14, R21, R28, R31, R41, R42, R43, R44, R45). The facility failed to inquire to the Illinois Department of Corrections Sex Registrant search page to determine their status as a registered sex offender for 11 of 11 new admissions reviewed (R5, R14, R21, R25, R28, R31, R41, R42, R43, R44, R45). Findings include: 1. Documentation maintained on file by E25, Medical Records reflected that Criminal Background Checks were not initiated within 24 hours of admission for ten of the following new admissions: R5, admitted 9-23-11, background check initiated 9-26-11 R14, admitted 9-17-11, background check initiated 10-12-11 R21, admitted 10-23-11, background check	F9999		

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F9999	Continued From page 49 initiated 10-27-11 R28, admitted 11-8-11, background check initiated 11-14-11 R31, admitted 11-9-11, background check initiated 11-14-11 R41, admitted 11-26-11, background check initiated 11-28-11 R42, admitted 10-20-11, background check initiated 10-24-11 R43, admitted 10-10-11, background check initiated 10-12-11 R44, admitted 9-21-11, background check initiated 10-12-11 R45, admitted 9-6-11, background check initiated 10-12-11 E25 stated on 12-9-11 at 12:30 p.m. that she was unaware that the background checks had to be initiated within 24 hours of admission. 2. Admission records supplied by E25 for the 11 most recent admissions were devoid of information related to inquiry to the Illinois Department of Corrections website to determine their status as a registered sex offender. E25 stated on 12-8-11 at 3:30 p.m. that she was responsible for new admissions screening but was not aware of the need to check this source. E25 stated she had not done so for R5, R14, R21, R25, R28, R31, R41, R42, R43, R44, and R45, all admitted since 9-6-11.	F9999		

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F9999	Continued From page 50 (B) 300.1210b)4) 300.1210d)5) 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. Restorative measures shall include, at a minimum, the following procedures: 4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain	F9999		

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F9999	Continued From page 51 good nutrition, grooming, and personal hygiene. d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 5) A regular program to prevent and treat pressure sores, heat rashes or other skin breakdown shall be practiced on a 24-hour, seven-day-a-week basis so that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that the pressure sores were unavoidable. A resident having pressure sores shall receive treatment and services to promote healing, prevent infection, and prevent new pressure sores from developing. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to have policies and procedures regarding Pressure Sore Prevention and Treatment that provided staff with a working knowledge of how to properly reposition a resident to relieve pressure. Supervisory staff were unable to demonstrate accurate knowledge of correct repositioning. Staff were not provided ongoing continuing education related to pressure sore prevention and treatment. These failures resulted in one of two residents (R3) reviewed	F9999		

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with Stage IV pressure sores in the sample of fourteen, to be left without benefit of repositioning, for six hours and 45 minutes. These failures resulted in an Immediate Jeopardy.

Findings include:

The listing of residents with current pressure sores dated 12/6/11 which was completed by the facility documents R3 with Stage IV pressure sores acquired "In House." A report of surgical consult dated 9/15/11 describes "extensive" tissue involvement of both the coccyx and right hip pressure sores, with "slight bone necrosis over the coccyx."
.

On 12/6/11 at 11:15 a.m. E12 and E13, Certified Nurse Assistants (CNA) transferred R3 from her bed into a sitting position in her wheelchair, and propelled her to the dining room. R3 remained in sitting position in her wheelchair through 12:35 p.m.(based on observation of fifteen minute intervals or less). At 1:30 p.m. and 2:45 p.m. R3 was seated in her wheelchair at her bedside, with the wheelchair tilted slightly backwards (approximately 15 to 20 degrees backward from an upright 90 degree sitting position). At 3:30 p.m. R3 was seated in her wheelchair in the hallway in a sitting position. At this time R3 indicated she had not been out of her wheelchair since before lunch. At 3:35 p.m. E14 and E15 both stated R3 was already up in her wheelchair when they came on duty at 2:00 p.m. and that they were now taking R3 to the dining room for supper. R3 remained sitting in the wheelchair

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until 5:20 p.m. (based on observation of 15 minute or less intervals). At 5:30 p.m. E15 stated staff are to turn R3 every two hours. E15 stated that she adjusted R3's wheelchair slightly when she pushed R3 out in the hallway at approximately 3:15 - 3:20 p.m. E15 continued, "It wasn't a whole lot because she does fall forward if we put her up straight. E15 estimated she had adjusted R3's wheelchair only fifteen degrees. At 6:00 p.m. E14, E15 and E17 CNAs prepared to transfer R3 from her wheelchair to her bed using a mechanical lift. All three CNAs agreed R3 had not been taken out of the wheelchair since they came on duty at 2:00 p.m.. E17 stated she, E16,CNA and E15 had manually lifted R3 up using the mechanical lift sling when R3 had finished eating supper. E17 explained they had changed R3 from sitting upright in her wheelchair to leaning to her right hip while sitting in her wheelchair. E17 stated she considered this change "repositioning."

On 12/6/11 at 6:00 p.m. R3 was transferred from her wheelchair to bed. R3 had been in a sitting position without benefit of repositioning since 11:15 a.m. (six hours 45 minutes). A large amount of loose bowel movement (BM) was oozing out from the right side of R3's incontinent brief. The lower half of the coccyx dressing was heavily soiled with BM. Eighty percent of the right hip pressure sore dressing was saturated with bright red drainage. A curved red indentation approximately 6 inches in length was present across R3's lower hips, representative of the urinary catheter. E15 and E17 confirmed the indentation was representative of the catheter. An indentation approximately twelve inches in length and 0.5cm (centimeters) in width was

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present on R3's right hip, approximately 3cm from the right hip pressure sore. This was representative of the elastic leg opening of the incontinence brief. A deep red indentation, approximately 6 - 8 inches, representative of the catheter tubing was present on R3's right inner thigh. A two inch long indentation, representative of the urinary drainage catheter, was present on R3's pubis. At 6:15 p.m. E18, LPN entered the room and confirmed the indentations from the catheter and catheter tubing. At this time E18 stated staff consider the tilting of R3's wheelchair as repositioning. E18 identified four new pinpoint open areas adjacent to R3's coccyx pressure sore.

On 12/7/11 at 8:30 a.m. E18 stated she had measured R3's pressure sores on 12/6/11: The right hip was 2cm x 1cm with 7cm of tunneling; the coccyx was 6cm x 4.5cm with undermining of 1.5cm at 3 o'clock, 0.6cm at 9 o'clock and 1.0cm at 12 o'clock. On 12/7/11 at 8:40 a.m. E18 stated she had called the Wound Clinic on 12/6/11 to request they see R3 today as the right hip tunneling had increased from 5cm to 7cm.

On 12/7/11 at 9:45 a.m. Z1, Clinical Wound Manager, for the Wound Clinic stated knowledge of R3's pressure sores. Z1 stated the Wound Clinic does not specify how often a resident is to be repositioned, but leave that to the facility staff. Z1 stated she would expect staff to turn and reposition R3 at least every two hours, and more often if indicated, based on the resident's individual needs. Z1 defined "repositioning" as relieving pressure from a site or area. Z1 stated momentarily lifting R3 with the mechanical lift sling to shift R3's weight to her right hip was not

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repositioning as the length of time is not adequate to allow for capillary refill. Z1 stated that leaving R3 in a sitting position in the wheelchair and slightly tilting the chair was not repositioning.

Turn Schedule records for R3 document R3 was up in the chair from 11:00 a.m. through 5 p.m. on 12/7/11. The Turn Schedule records do not list R3's position for 3 p.m. through 9 p.m. on 12/4/11, 7 a.m. through 1 p.m. on 12/3/11, 3 p.m. through 9 p.m. on 12/2/11 and 11/29/11, 7a.m. through 1 p.m. on 11/26/11 and 11/27/11, and 11a.m. through 9 p.m. on 11/25/11 and 11/18/11.
(A)

300.1210b)
300.1210b)5)
300.1210d)6)

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. Restorative measures shall include, at a minimum, the following procedures:
5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest

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practicable level of functioning.
d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis:

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 and assistance to prevent accidents.

This REQUIREMENT is not met as evidenced by:

Based on record review and interview, the facility failed to use a gait belt when ambulating and transferring a resident, which required the assistance of one staff person and a gait belt, for one of 6 (R1) residents reviewed for falls, in a sample of 14. This failure resulted in R1 falling and sustaining a right eye laceration, which required sutures, and multiple facial fractures.

Findings Include:

An Incident/Event Report dated 8/18/11, documents R1 was "ambulated to DR (Dining Room) with assist of 1 CNA (Certified Nursing Assistant). CNA had (R1) stand at table while she pulled out chair. (R1) took step backwards, lost her balance and fell to the floor." The Incident/Event Report further indicates R1 sustained a laceration over her right eye and was sent to the Emergency Room for evaluation. The Outcome/Conclusion, on the Incident/Event Report, documents human error as the "root

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cause" of R1's fall and "CNA let go of resident for a few seconds and (resident) lost balance and fell."

A Hospital History and Physical dated 8/18/11, documents R1 presented to the Emergency Room for evaluation, after falling "face front" and "landing onto the ground hitting her head." The Hospital History and Physical documents R1 received sutures to a laceration above her right eye. A facial CT (Computerized Tomography) dated 8/18/11, documents R1 sustained facial fractures of the right zygomatic arch, right lateral orbital wall, posterior lateral right maxillary wall and a fracture of right nasal bone.

On 12/06/11 at 2:19 p.m., E2 (Director of Nursing) stated she completed the investigation into R1's 8/18/11 fall and determined the Certified Nursing Assistant (E5) that was transferring R1 did not use a gait belt.

On 12/07/11 at 10:40 a.m., E5 (Certified Nursing Assistant) stated, the evening of 8/18/11, she assisted R1 ambulate, from her chair by the Nurses Station to the Dining Room. E5 stated R1 would ambulate with "hand in hand" assistance. E5 stated, when she and R1 arrived at the table, she "let go" of R1 to pull out the chair and placed a pressure alarm on the seat. E5 stated R1 lost her balance and fell, injuring her face. E5 stated she did not utilize a gait belt when ambulating and transferring R1 on 8/18/11. E5 stated she was "unaware" R1's Plan of Care instructed staff to utilize a gait belt when ambulating/transferring the resident.

(B)

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300.1620a)
300.1630a)e)

Section 300.1620 Compliance with Licensed Prescriber's Orders
a) All medications shall be given only upon the written, facsimile or electronic order of a licensed prescriber. The facsimile or electronic order of a licensed prescriber shall be authenticated by the licensed prescriber within 10 calendar days, in accordance with Section 300.1810. All such orders shall have the handwritten signature (or unique identifier) of the licensed prescriber. (Rubber stamp signatures are not acceptable.) These medications shall be administered as ordered-by the licensed prescriber and at the designated time.

Section 300.1630 Administration of Medication

a) All medications shall be administered only by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents.

e) Medication errors and drug reactions shall be

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immediately reported to the resident's physician, licensed prescriber if other than a physician, the consulting pharmacist and the dispensing pharmacist (if the consulting pharmacist and dispensing pharmacist are not associated with the same pharmacy). An entry shall be made in the resident's clinical record, and the error or reaction shall also be described in an incident report.

This REQUIREMENT is not met as evidenced by:
Based on record review and interview, the facility failed to follow physician's orders and withhold a prescribed blood thinner prior to a medical procedure, for one of one (R13) residents reviewed for medication errors on the sample of 14. By not withholding R13's blood thinner for the appropriate number of days prior to the procedure, R13 experienced Lower Gastrointestinal Bleeding, which required hospitalization and a blood transfusion.

Findings include:

A Physician's Order Sheet dated 6/01/11, documents R13 had the diagnosis of Atrial Fibrillation and was prescribed Coumadin (Blood Thinner) 4 mg (milligrams) daily. A Colonoscopy Preparation instruction sheet dated 6/15/11, indicates R13 was scheduled for a colonoscopy on 6/21/11 at 10:00 a.m. The Colonoscopy Preparation instructs staff to "FIVE DAYS PRIOR TO YOUR EXAM: Take NO ASPIRIN or products containing aspirin, NO ANTI-INFLAMMATORY MEDICATIONS, TYLENOL IS PERMITTED. Take NO BLOOD THINNERS."

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Per The Colonoscopy Preparation instructions, R13 should not have received Coumadin 4 mg daily starting on 6/16/11. Medication Administration Records for June 2011 document that R13 received Coumadin (Blood Thinner) 4 mg daily 6/01/11 through 6/18/11, three days longer than she should have.

Nurses Notes dated 6/15/11 (2:30 p.m.), document Nursing Staff were aware R13 was scheduled for a Colonoscopy on 6/21/11 at 10:00 a.m. Nurses Notes dated 6/19/11 (2:00 p.m.), document "Received order of prep (preparation) for colonoscopy at earlier date. Pharmacy notified of needing Half-Lytely (and) Ducolax (after) hours, (due to) needing in a.m. (6/20/11)." Nursing Notes dated 6/20/11 (2:00 p.m.) document, "Res. (resident) was in shower when CNA (Certified Nursing Assistant) call me to shower rm (room). She just sat res. on shower chair when fluid started coming from rectum. fluid was bright red bld. (blood). (No) stool mixed in with fluid." At 2:45 p.m., Nursing Notes indicate R13's physician was notified of the rectal bleeding and "explained that the Coumadin did not get held until (6/19/11) Sunday, due to order coming in 6/19/11." The 6/20/11 Nursing Notes document R13 was sent to the Emergency Room.

An Employee Report of a written warning, dated 6/21/11, documents E21 (Licensed Practical Nurse) became aware R13's pre-operational orders should have "been initiated on 6/15/11, but were not." The Employee Report further documents E21 failed to notify the physician of the medication error and did not pass on the information to the Nurse on the following shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146023	A. BUILDING _____ B. WING _____	12/13/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARTHUR HOME, THE	**423 EBERHARDT DRIVE ARTHUR, IL 61911**

(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
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(B)

300.2090a)

Section 300.2090 Food Preparation and Service

a) Foods shall be prepared by appropriate methods that will conserve their nutritive value, enhance their flavor and appearance. They shall be prepared according to standardized recipes and a file of such recipes shall be available for the cook's use.

This REQUIREMENT is not met as evidenced by:

Based on observation, record review, and interview, the facility failed to ensure that 2 (8 to 10 pound turkey roasts) were rapidly cooled, from 135 to 70 degrees Fahrenheit (F.) within 2 hours and to 41 degrees Fahrenheit (F.) or below within 4 additional hours, after being cooked to prevent growth of disease causing microorganisms. The facility's failure has the potential to all 54 residents.

The finding includes:

During initial tour of the Dietary Department on 12-6-11 at 8:45 A.M., the Cook, E5 was asked what was the main course for the lunch meal. E5 said that it was turkey and she was about to slice the turkey. Two large whole turkey roasts had been cooked in the 6 inch high pan. The broth was in the pan and the pan had been tightly

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F9999	Continued From page 62	F9999		

sealed with aluminium foil. There was no labeling on the foil or the pan that listed any time and temperature information. E5 stated that she had no cooling information. E5 stated that she just removed the meat from the walk in refrigeration unit. E5 stated that the cook, E6 prepared and cooked the turkey a day earlier, on 12-5-11.

The internal temperature of the potentially hazardous food, turkey roasts was 45 degrees F. at 8:45 A.M., approximately 19 3/4 hours after it had been prepared. The temperature of a canned soft drink in the walk in unit was 38 degrees F..

The cook, E6 stated on 12-6-11 at 8:50 A.M., that she prepared the turkey roasts on 12-5-11. E6 stated the turkey was a raw meat product. E6 said that she placed the turkey in the oven at 7:00 A.M. on 12-5-11. E6 said that she checked the turkey at 12:00 P.M. and it was not completely cooked. E6 was going off duty, so, E6 told the afternoon cook, E7 to take the meat out when it done and cool it.

E7 stated on 12-6-11 at 9:20 A.M., the turkey was removed from oven around 12:45 P.M. - 1:00 P.M., set it on the counter for a while, covered it and put it in the walk in cooler.

At 9:25 A.M. E5 and E6 discussed using the turkey for the lunch meal. E5 decided not to use the turkey. A substitute was made for the turkey and the turkey was voluntarily destroyed.

The facility failed to follow their policy for cooling foods, failed to use methods to rapidly cool potentially hazardous food, and failed to monitor

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F9999	Continued From page 63 food temperatures while the food was cooling. As a result, the internal temperature of the turkey was potentially in an unsafe temperature range for nearly 20 hours promoting the growth of disease causing microorganisms. (A)	F9999		