STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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	Final Observations STATEMENT OF LICENSURE VIOLATIONS: 300.610a) 300.1210b)5) 300.1210d)6) 300.1220b)3) 300.3240a) Section 300.610 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 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. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. 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	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 1	S9999		

effort to help them retain or maintain their highest 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.

Section 300.1220 Supervision of Nursing Services
b) The DON shall supervise and oversee the nursing services of the facility, including:
3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months.

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 requirments are not met as evidenced by:

Based on interview and record review the facility failed to ensure safety and supervision to prevent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 2	S9999		

falls by failing to conduct a root cause analysis, provide assistance and implement interventions to prevent further falls.These failure affects one of six residents (R14) reviewed for falls in the sample of 15. These failures resulted in an additional fall for R14 which caused a fractured tibia requiring casting and surgery.

Findings Include:

R14's Physician's Order Sheet dated 8/1/13 documents diagnoses of Morbid Obesity, Osteoarthritis and Severe Lymphedema of the right lower extremity. The Physical Therapy Recertification note dated 7/2/13 documents that R14 requires the assist of two staff members for transfers. The Minimum Data Set dated 6/29/13 documents that R14 requires extensive assist of two staff members for toileting and transfers. On 5/20/14 at 10:30 AM E2 Director of Nurses was unable to provide a Care Plan for R14 for the time period between 6/2013 and 9/2013.

R14's Nurses Notes byE21's Licensed Practical Nurse (LPN) Nurses Note dated 8/2/13 document the following "Resident was transferring with walker and assist of one to bed this evening. Resident stated she lost her balance when her right leg went out on her, the Certified Nurses Aide transferring her, lowered resident to the floor.....five staff members to get resident off floor and back in bed."

The Nurses Notes dated 9/9/13 document that R14 was again lowered to the floor after her leg gave out during a transfer on that date. The Incident Report dated 9/9/13 documents that on that date E16 Certified Nurses Aide was assisting R14 to transfer from the toilet when R14's right leg gave out. The report states that E16 then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 3	S9999		

lowered R14 to the floor. However R14's legs were bent up under her and would not allow her to go all the way to the floor. The report goes on to state that E16 then picked up R14 as best as he could then lowered her to the floor again. The Nurses Notes dated 9/9/13 document that six staff members were required to transfer R14 to a chair. The same Nurses Notes document that at that time R14's right ankle was "off to the side." R14 was transferred to the local hospital emergency department. The X-ray report dated 9/10/13 documents that R14 had a fracture of her right fibula.

Z1 Orthopedic Trauma Physician's note dated 9/16/13 documents that due to R14's nonambulatory status and weakness she was not a candidate for surgery and a cast was applied to R14's lower leg. Z2 Orthopedic Surgeon's Consultation Note dated 12/19/13 documents that R14's right ankle fracture still remained unstable at that time. Z2's Operative Report dated 12/21/13 documents that on that date R14 under went a closed reduction of her right ankle fracture with application of external fixation.

On 5/19/14 at 2:15 PM E16 stated that he was transferring R14 by himself on 9/9/13 when she fell and broke her ankle. On 5/21/14 at 10:10 AM E17 Occupational Therapy Assistant and E18 Physical Therapist stated that the 7/2/13 Physical Therapy note indicates that R14 required the assist of two staff members for transfers. At that time E18 stated that R14's transfer status varied from day to day so transferring her with two staff members would be the safest.

On 5/20/14 at 10:00 AM E2 Director of Nurses could not provide documentation of an investigation or root cause analysis of R14's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 4	S9999		

8/2/13 fall. E2 also could not provide a care plan documenting new interventions implemented after the 8/2/13 fall. At that time E2 stated that the charge nurse should start the investigation by completing an Accident and Incident form after a resident falls. On 5/20/14 at 10:25 AM E21 stated she did not remember if she completed the initial fall investigation form after R14 fell on 8/2/13. On 5/20/14 at 10:30 E2 stated she did not know if an investigation was conducted after R14's fall on 8/2/13. E2 further stated that an appropriate post fall intervention would be to transfer R14 with a mechanical lift until a physical therapist could evaluate her. On 5/20/14 at 10:00 AM E18 Physical Therapist could not provide a physical therapy evaluation performed during the month of August 2013.

The undated Accident/Incident Policy states that all accidents/incidents involving a resident will be investigated and the investigation will be documented on the Accident/Incident form. The Policy further states that at the time of the incident the nurse must start an intervention and document the intervention put in place.

(B)

300.615e) Determination of Need Screenings and Criminal Background Checks
. . . .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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 5	S9999		

Police.
This requirement is not met as evidenced by:
Based on record review and interview the facility failed to request a crminal history background check for two of ten newly admitted residents (R22, R23) on the supplemental sample. This failure has the potential to affect all 66 residents in the facility.
The findings include:
The facility "Resident Background Check Policy and Procedure states "It is the policy of this facility to complete all background checks for each resident as required...When a resident is admitted to this facility, an electronic name-based UCIA (Uniform Conviction Information Act) background check must be ordered within 24 hours, unless the resident was admitted from a hospital and the hospital notified the facility that the UCIA name check was ordered."
The facility resident admission summary dated 5/19/14 documents that R22 was admitted on Thursday, 5/14/14. The Criminal Background Check request sheet documents that this was fax dated to the Corporate Office on 5/15/14. A handwritten note on the form states "Submitted 5/19/14. No record 5/20/14".

The facility admission summary dated 5/19/14 documents that R23's admission date was Friday, 5/08/14. The Criminal Background Check request sheet documents that it was faxed to the Corporate office on 5/08/14. Handwritten on the form was "Submitted 5/14/14. No Record 5/15/14".

Administrative Assistant E14 stated on 5/20/14 at 4:30 pm that either Admissions E19 or Social Service E20 fill out the request for the resident background checks when a new resident is admitted. The request is then faxed to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 6 Corporate Office who is responsible to forward the request to ISP. Administrator E1 also confirmed on 5/20/14 at 5:00 pm that staff are to initiate the background checks even on weekends within 24 hours. The Resident Census and Conditions of Residents dated 5/19/14 documents a resident census of 66. (B) 300.625 c)1)2) Identified Offenders If the results of a resident's criminal history background check reveal that the resident in an identified offender as defined in Section 1-114.01 of the Act, the facility shall do the following: Immediately notify the Department of State Police, that the resident in an identified offender. Within 72 hours, arrange for a fingerprint-based criminal history record inquiry to be requested on the identified offender resident. . . These requirements were not met as evidenced by the following: Based on observation, record review and interview the facility failed to notify the Department of State Police and proceed with a fingerprint-based criminal history check for two of three residents (R15, R7) whose criminal background checks identified them as Sex Offenders. Failure to notify the State Police caused the facility to not have Criminal History Analysis of Risk (CHAR) for these residents. This failure has the potential to affect all 66 residents in the facility. The finding includes: According to the admission face sheet	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 7	S9999		

information R15 and R17 were admitted to the facility on 1-24-14. The Admissions and Marketing Director E19 stated on 5-20-2014 at 9:35 A.M. that according to the background checks, R15 and R17 are Identified Sex Offenders.

E19 stated on 5-20-14at that time that the facility did notify the State Police of R15 and R17's criminal background checks. However, the facility did not provide any documentation or evidence of the notification. The facility provided no evidence that a fingerprint-based criminal history background check was done. E19 also stated that the facility does not have CHAR reports for either R15 and R17. E19 called the State Police at that time and was informed that no notification was received regarding R15 and R17's criminal history.

Without CHAR assessments, the facility does not have a risk level to other residents -low, medium or high - to ensure needed precautions to protect the other residents.

On 5/20/14 at 10:00am, R15 propelled himself in the wheelchair in the living area. On 5/21/14, R17 independently ambulated to and from the activity/dining area at 11:50am and 12:30pm respectively. R17 has independent access to all residents in the facility.

The undated Resident Background Check Policy And Procedure lists a step by step procedure for the Identified Offenders Program that includes notifying the State Police and obtaining a Criminal History Analysis Risk Assessment for each resident that has criminal record.

The Resident Census and Conditions of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 8 Residents dated 5/19/14 documents a resident census of 66. (B) 300.1230 k) Staffing Effective September 12, 2012 a minimum of 25% of nursing and personal care time shall be provided by licensed nurses, with at least 10% of nursing and personal care time provided by registered nurses. This requirement is not met as evidenced by the following: Based on record review and interview the facility failed to have 10% of nursing and personal care time provided by a Registered Nurse for 2 of 14 days reviewed. This has the potential to affect all 66 residents residing in the facility. Findings include: The undated staffing spread sheet provided by E2, Director of Nursing(DON) on 5/21/14 at 10:30am documents the period of time reviewed for staffing was from 4/27/14 -5/10/14. The spread sheet documents an average of nine (9)skilled residents and 53 intermediate residents for that time period. The Minimum RN hours per 24 hour period are calculated to be 16.7 hours. The spread sheet documents the following hours per 24 hour period for RN's: 5/3/14- 11.5 RN hours 5/4/14- 11.0 RN hours. The schedule dated 5/1/12-5/31/14 confirms the hours worked by RNs on the preceding dates.	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6003206	A. BUILDING: _____ B. WING _____	05/22/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ASTA CARE CENTER - FORD COUNTY	1240 NORTH MARKET STREET PAXTON, IL 60957

(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 9 On 5/22/14 at 1:00 pm E2, DON, stated the RN hours listed on the spread sheet for each day are accurate. The Resident Census and Conditions of Residents form dated 5/19/14 states that 66 residents reside at the facility. (AW)	S9999		