STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145608	A. BUILDING _____ B. WING _____	07/31/2015

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF SOUTH HOLLAND	2145 EAST 170TH STREET SOUTH HOLLAND, IL 60473

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0252 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide a safe, clean, comfortable and homelike environment.** Based on interviews and observations the facility failed to keep facility free of strong urine odors on one unit of the building. This has the potential to affect 14 of 15 residents on a supplemental sample residing on that unit. (R33, R34, R35, R36, R37, R38, R39, R40, R41, R42, R43, R44, R45, R46) Findings include: Observations made throughout the days of 7/27/15, 7/28/15, 7/29/15, 7/30/15, and 7/31/15 noted a consistent and strong urine odor in the initial hallway of the Briarwood unit. On 7/30/15 at 11:00 A.M. Z2 (R4's family) stated that the facility has had a problem with urine odors on the Briarwood unit. On 7/30/15 at 9:00 A.M. Z3 (R9's family) stated that there is a continuous problem with consistent urine odors on the Briarwood unit. On 7/30/15 at 2:25 P.M. E11 (Maintenance director) stated that the odors on Briarwood unit have been an ongoing issue.
F 0280 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Allow the resident the right to participate in the planning or revision of the resident's care plan.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to revise a care plan to reflect the development of a stage 3 pressure ulcer, and failed to include resident specific interventions for the care and treatment of [REDACTED]. Findings include: R19's Minimum Data Set assessment ((MDS) dated [DATE] documents R19 is in a persistent vegetative state requiring total assistance of one to two staff members for all activities of daily living, including bed mobility. A Pressure Ulcer Prevention Pathway policy dated 2013 documents that a turn/reposition schedule should be initiated for residents at risk for pressure ulcers or residents who currently have pressure ulcers. R19's wound care progress note dated 7/21/15 and signed by Z1 (Wound Physician) documents Z1 examined a New coccyx stage 3 pressure ulcer on that date. R19's care plan dated 5/13/15 documents R19 has interventions for the treatment of [REDACTED]. The care plan also includes interventions to address, Skin alteration at coccyx related to impaired mobility, incontinence, friction. The care plan does not include interventions specific to R19's stage 3 pressure ulcer. R19's care plan interventions include, Encourage and assist as needed to turn and reposition . The care plan does not include a turn/reposition schedule. On 7/29/15 at 10:10a.m. E2 (Director of Nurses) stated E2 is responsible for verifying the accuracy of residents' care plans. E2 also verified R19 requires total assistance of staff for activities of daily living. E2 stated R19 has pressure ulcers which requires for R19 to be turned/repositioned by staff every two hours. E2 stated E2 was not aware R19's skin alteration to the coccyx, as was listed on the care plan, was actually a stage 3 pressure ulcer, or that R19's stage 3 pressure ulcer had worsened to an unstageable pressure ulcer.
F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	**Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to utilize a pressure ulcer risk assessment to individualized interventions for the prevention of pressure ulcers, and failed to provide care and services to prevent the development/or worsening of a pressure ulcer for one of 11 residents (R19) reviewed for pressure ulcers in a sample of 24. These failures resulted in R19 developing a stage 3 pressure ulcer to the coccyx which worsened to an unstageable pressure ulcer. Findings include: R19's Braden Scale for Predicting Pressure ulcer Risk dated 5/12/15 documents R19 is at very high risk for developing a pressure ulcer. R19's Minimum Data Set assessment ((MDS) dated [DATE] documents R19 is in a persistent vegetative state requiring total assistance from one to two staff members for all activities of daily living, including bed mobility. A Pressure Ulcer Prevention Pathway policy dated 2013 documents that a turn/reposition schedule should be initiated for residents at risk for pressure ulcers or residents who currently have pressure ulcers. R19's Skin Worksheets dated 7/02/15 to 7/13/15 document R19 had redness to the coccyx/buttocks on 7/02/15 which developed into an open area on 7/13/15. R19's Skin Worksheets dated 7/16/15 to 7/23/16 continue to document open areas to R19's coccyx/buttock. R19's wound care progress note dated 7/21/15 and signed by Z1 (Wound Physician) documents Z1 made an initial examination of R19's New coccyx stage 3 pressure ulcer on that date. The progress note also documents that at the time of Z1's examination, R19 was wearing a soiled incontinence brief with, .bed sheets soaked with urine, No dressing on coccyx. On 7/28/15 at 10:35a.m. Z1(Wound Physician) stated R19's pressure ulcer to the coccyx was preventable. Z1 stated R19 is totally dependent on staff for turning and repositioning. Z1 stated that despite R19 receiving nourishment through a gastrostomy tube, Z1 did not think poor nutrition was the cause of R19's pressure ulcer. Z1 proceeded to enter R19's room for a weekly examination of R19's pressure ulcer to the coccyx. Z1 pointed to a round wound to R19's coccyx measuring 2cm (centimeters) x 2.5cm x 0.5cm deep which had a yellow/tan wound bed. Following the examination, Z1 stated R19's wound had worsened from a stage 3 pressure ulcer to an unstageable pressure ulcer since Z1's initial examination of the wound 7/21/15. Z1 also pointed to an extensive, irregularly shaped, open area to R19's left buttocks which had a deep pink wound bed. Z1 stated Z1 was not certain if the open area to R19's left buttock was caused from incontinence, friction, or pressure. Z1's wound care progress note dated 7/28/15 documents R19's, New coccyx stage 3 pressure ulcer appears unstageable now .Etiology pressure, moisture. Increased in size. R19's care plan dated 5/13/15 includes interventions to address, Skin alteration at coccyx related to impaired mobility, incontinence, friction. The care plan does not include interventions specific to R19's stage 3 pressure ulcer to the coccyx. R19's care plan interventions include, Encourage and assist as needed to turn and reposition . The care plan does not include a turn/reposition schedule.

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 1) On 7/28/15 during a continuous observation from 11:00a.m. to 2:00p.m. R19 was laying in bed with R19's lower body and pressure ulcer flat against the bed. R19 was not repositioned by staff during that time. On 7/29/15 at 10:10a.m. E2 (Director of Nurses) stated E2 is responsible for verifying the accuracy of residents' care plans. E2 also verified R19 requires total assistance of staff for activities of daily living. E2 stated R19 has pressure ulcers which requires R19 to be turned/repositioned every two hours by staff. E2 stated E2 was not aware R19's skin alteration to the coccyx, as was listed on the care plan, was actually a stage 3 pressure ulcer, or that R19's stage 3 pressure ulcer had worsened to an unstageable pressure ulcer.
F 0328 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Properly care for residents needing special services, including: injections, colostomy, ureostomy, ileostomy, tracheostomy care, tracheal suctioning, respiratory care, foot care, and prostheses** Based on observation and record review the facility failed to prevent cross contamination during intravenous (IV) drug administration for one of one residents (R33) reviewed for intravenous drug administration in a sample of 24. Findings include: On 7/27/15 at 9:20p.m. E10 (Registered Nurse) was preparing to administer an IV medication through R33's left upper arm intravenous (IV) catheter. E10 applied gloves, cleansed the cap of R33's IV catheter port, then removed the sterile cap from the tip of the antibiotic administration tubing. E10 attached the antibiotic administration tubing to R33's IV catheter port. E10 realized E10 had not used normal saline to flush R33's IV catheter. E10 removed the IV administration tip from R33's IV catheter port then E10 held the tip of the IV administration tubing in E10's closed hand while E10 flushed R33's IV catheter. Without disinfecting the IV administration tubing tip, E10 reattached the tip to R33's IV catheter port then began infusing the medication. A policy on Infusion of Intermittent Medication dated 1/2009 documents the appropriate steps to prevent cross contamination when disconnecting IV tubing as, Disconnect administration set from needless valve adapter (IV catheter port) and attach sterile cap to cover the end of administration set. Set aside. On 7/29/15 at 10:10a.m. E2 (Director of Nurses) verified staff should not touch the end of IV administration tubing once the sterile cap has been removed. E2 verified the R33's IV administration tubing should not have been used to administer R33's antibiotic after E10 held the exposed end of the administration tubing in E10's hand.
F 0334 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop policies and procedures for influenza and pneumococcal immunizations.** Based on observation, interview, and record review the facility failed to ensure a resident was offered the influenza vaccine for one of five residents (R19) reviewed for influenza vaccines in a sample of 24. Findings include: An Influenza Vaccine information statement dated 2014-2015 documents influenza (flu) is the most prevalent, .usually between October and May. The information statement also documents, Flu vaccine is the best protection against flu and its complications. Flu vaccine also helps prevent spreading flu from person to person. An Influenza Screening and Immunization policy dated 5/2013 documents to screen for, Annual immunization against influenza for all adults. The policy also documents the facility's influenza immunization plan includes performing an influenza, .screen, distribute educational handouts, obtain signed consent forms, track acceptance and declinations .administer immunization. R19's electronic demographic sheet documents R19 was admitted to the facility 1/17/15. On 7/28/15 at 11:25a.m. R19's unsigned influenza vaccine consent/screen (undated) was located in R19's chart and had no information documenting that R19 had been screened for previous influenza vaccinations or that R19 was offered the influenza vaccination. An Immunization Report dated 7/27/15, which documents the dates residents' received the influenza vaccine, did not include R19's name. On 7/29/15 at 12:50p.m. E2 (Director of Nurses) verified the facility had no documentation R19 was screened, offered, received or declined the influenza vaccine at the time of R19's admission to the facility 1/17/15 to present.
F 0371 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Store, cook, and serve food in a safe and clean way** Based on observation, interview and record review the facility failed to ensure that food preparation equipment and work space was kept free from contaminants and that stored food items were properly dated. These unsafe practices have the potential to effect all 137 residents in the facility. Findings include: During initial tour of the Dietary Department on 07/27/2015 at 06:34 PM accompanied by E7 Cook, the 24 compartment/muffin baking pans (6 individual pans) which were observed stacked on the clean storage rack were covered with a large amount of residual food debris. The sauté skillets, three 8, two 10 and one 14 which were stacked on the clean storage rack were completely covered inside/outside with grease and other residual food debris. The clean storage shelves also held full baking sheets. These 20 baking sheets were in varied stages of uncleanliness having a large amount of burnt food debris and greasy build up. The industrial ovens (3) used in the kitchen were observed with a large amount of burned and residual food debris on both sides and the bottoms. During the initial tour of the dietary department on 07/27/2015 at 06:34 PM accompanied by E7, Cook, the ceiling panels above the food preparation counters and the dishwashing area were covered with a moderate dirt/food buildup and the light covers contained winged insects/dirt and dust which could drop onto the food being prepared or the clean dishes. The heating vents also contained a large amount of dust and dirt build up. The kitchen door thresholds and floorboards included large amounts of black, greasy build up which extended throughout the entire kitchen in varying degrees. The industrial can opener was observed with a moderate build up of multicolored food particles, while the industrial meat slicer contained particles of food products between the blade and the blade guard. In addition, on 07/27/2015 at 06:34 PM, the dry storage and the food preparation area contained food storage bins which held food products including; Thickener for beverages, bread crumbs, sugar, flour, powdered milk and white rice which were not labeled with the date of opening. E7, Cook stated, There are no dates on these foods. The list of cleaning duties which was posted at the employee bulletin board was dated 07/24/2015 and did not include any indication of these tasks being completed. E7, Cook stated We are to complete these with our intials everyday and it looks like its been forgotten for a few days. The Centers for Medicare and Medicaid Services Form 672, Resident Census and Conditions, completed by facility on 07/28/2015 states there were 137 residents living in the facility at the time of the survey.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Have a program that investigates, controls and keeps infection from spreading.** Based on observation, interview, and record review the facility failed to prevent cross contamination during resident cares for two of 21 residents (R8, R22) reviewed for infection control practices in a sample of 24. Findings include: A Hand Hygiene policy dated 5/2013 states, Hand hygiene is the single most important measure for reducing of the spread of infection .some situations that require hand hygiene: before and after direct patient contact, before and after assisting a patient with personal care, before applying gloves, after removing gloves, after handling soiled or used linens, dressings, bedpans, catheters and urinals, after completing duty. 1. On 7/28/15 at 8:35p.m. E3 (Certified Nurse Aide) was assisting R22 with cares. E3 applied gloves, emptied R22's urinary

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F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) catheter bag, then without removing the soiled gloves or performing hand hygiene, E3 removed R22's shirt then performed incontinence care. E3 removed the soiled gloves, without performing hand hygiene, E3 assisted R22 to reposition and adjust the covers on R22's bed. E3 exited R22's room without performing hand hygiene. On 7/28/15 at 8:45p.m. E3 verified E3 did not removed soiled gloves or perform hand hygiene after emptying R22's urinary catheter bag, and providing R22 with incontinence care. 2. On 7/29/15 at 10:45a.m. E6 (Certified Nurse Aide/CNA) was assisting R8 with incontinence care. E6 applied gloves then cleansed R8's perineal and rectal areas. During R8's care, with the same soiled gloves, E6 sprayed wound cleanser onto the cleansing cloths in between wipes and touched R8's bare skin for repositioning. E6 exited R8's room without performing hand hygiene. On 7/29/15 at 10:56a.m. E6 stated I should have changed my (soiled) gloves before touching the (wound cleanser) or (R8's) skin .and washed in between glove changes .I guess I should have washed before leaving (R8's) room.