STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145689	A. BUILDING _____ B. WING _____	02/19/2016

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF ELK GROVE VILLAGE	1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0164 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Keep each resident's personal and medical records private and confidential.** Based on interview and observation the facility failed to provide privacy durding care to one of four residents (R5) in the sample of 24. The Findings include: On February 9, 2016 at 10:30AM, R5 was observed being transferred from her bed into the bathroom with a sit-to-stand device by E17 and E18 Nures's aides). R5's roommate was present in the room. The privacy curtain was not drawn, the window covering was not drawn, and R5's entire lower extremities were exposed. When E17 and E18 were transferring R5 back from the bathroom, E17 and E18, R5's lower extremities were fully exposed with a diaper applied. The privacy curtain was open and R5's roommate was present. R5 stated on February 9, 2016 at 10:47 AM, that it bothers and embarrasses her to be transferred with just a diaper on and in front of her roommate. E5 (nurse) stated on February 9, 2016 at 12:00PM any care like bedside care for transfer, staff must provide privacy, close privacy curtain, window curtain and the door.
F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop a complete care plan that meets all of a resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to develop and implement individualized comprehensive care plans to address the healing and prevention of pressure sores, pain control and use of antipsychotic medication. The facility also failed to integrate the hospice care plan with the facility care plan and failed to implement an individualized plan of care for safe mechanical transfers. This applies to eight residents (R4, R5, R6, R8, R10, R11, R13, R14) reviewed for care plans in the sample of 24. The findings include: 1. R6 has a BIMS (brief interview for mental status) score of 13 out of 15 on the January 31, 2016 MDS (minimum data set) showing him to be mostly cognitively intact and interviewable. On February 8, 2016 at 12:00 PM, E10 (treatment nurse) stated R6 came in to the facility with an abrasion on his right heel and abrasions on his buttocks. E10 stated she had not seen R6 in about two days. E10 stated she was not aware of any sores on R6's left heel. E10 came into R6's room and observed both heels to have large draining black/brown colored wounds on each heel. E10 then stated R6's buttock wound was not a pressure sore it was an abrasion because its not on a bony prominence. When asked how R6 obtained the abrasion E10 stated she didn't know. E10 stated the interventions R6 had in place to prevent pressure ulcers were skin protectant to his buttocks, air dispensing mattress, and to offload the heels with cushioned heel protector boots. E10 looked in R6's room and confirmed with R6 he did not have any heel protecting boots since his arrival in the facility. On February 10, 2016 at 8:30 AM, R6 was receiving a nebulized inhaled treatment in his room via a face mask. R6 complained the mask was bothering his right ear. E13 (RN) stated to R6 the treatment was almost done but did not attempt to check the area. R6 was then noted to have a reddened open area behind his left ear. R6 was visualized on multiple visits with the oxygen tubing around his ears and the padded area to have been below his ear on both sides. R6's initial care plan dated January 24, 2016 documents R6 to be at risk for alteration in skin integrity related to steroid therapy, Braden risk and recent hospitalization . The goal was to decrease breakdown risk. The interventions listed were application of barrier cream to buttocks, diet and supplements, encourage repositioning as needed, float heels as able and provide pressure reducing devices on chair and bed. R6's risk factors were not identified and individualized interventions were not put into place. There is no guidance to staff on how or when to float the heels or what to float heels with or what as needed means. R6 came in with a right heel sore which is not addressed in the care plan. There are no individualized interventions to heal that wound and prevent others. There are no interventions put in place to prevent pressure sores behind the ears from the oxygen tubing. There is no mention of any of R6's wounds on the skin care plan and the only identified risk factor was steroid therapy. R6's revised care plan dated February 5, 2016 documents R6 is at risk for adverse effects secondary to anticoagulant therapy. The goal is documented as R6 will have no adverse effects. The interventions are not individualized to R6's needs. The interventions are to administer medication as ordered, obtain labs, obtain vital signs, report adverse effects and use a soft tooth brush. There are no interventions related to the multiple skin tears and bruising to both his arms. There are no interventions related to protecting R6 from these injuries. The care plan problem related to steroid therapy has a goal to have no adverse effects. The interventions listed are to administer medications, encourage to wear long sleeves when in and out of bed due to fragile skin. These interventions were not observed to be in place February 9, 2016 through February 11, 2016. On February 10, 2016 at 10:15 AM, E10 (treatment nurse) stated this is the way the care plans print out when you choose pressure sore. E10 stated they are not custom care plans. The facility policy and procedure guide dated January, 2013 and titled,Skin Practice Guide shows under, Initial Plan of Care, Upon completing the initial plan of care, a resident specific care plan to include prevention, management and interventions with measurable goals shall be developed. This was also not evident in R6's plan of care. 2. R8 has a stage 4 pressure ulcer and is currently in hospice. R8's initial care plan related to alteration in skin integrity dated October 12, 2015 and updated care plan of January 11, 2016 documents alteration in skin integrity related [MEDICAL CONDITION] and a history of pressure ulcer. There are no other risk factors identified. There are no measurable goals for this pressure ulcer. The only goal is to decrease or minimize the breakdown risks. The interventions listed such as, application of barrier cream, diet and supplements, encourage repositioning as needed and observe skin condition are not resident specific interventions to promote healing and further deterioration of the current pressure sore. 3. R14 was identified as receiving hospice services according to the electronic medical record. R14 facility generated care plan does not include what responsibilities hospice has in implementing the care plan. A binder was located at the nurse's station with hospice notes and care plan. R14's interventions for pain are not coordinated with the facilities care plan to indicate what medications are to be used for what level of pain. 4. R13 was admitted to the facility on [DATE]. R13 has a care plan for pain initiated on December 01, 2015 with a revision date of February 09, 2016. The care plan states R13 has generalized pain related to [MEDICAL CONDITION], disease process,

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

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F 0279 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) immobility and muscle weakness. The goal is for R13 to have a numeric pain level of zero. In the intervention section there are no specifics related to what type of pain, location, non-pharmalogical interventions or other relieving factors to be implemented. The two different pain medications being given,[MEDICATION NAME]es to both shoulders every 12 hours and Tylenol 1000 mg (milligrams) are not even mentioned in the care plan. R13 has no comprehensive pain assessment and there is no plan of how to attempt to achieve a pain goal of zero. There is also no documentation of the effectiveness of the current interventions. 5. R10 was admitted to the facility on [DATE] with orders for [MEDICATION NAME] 25 mg, three times per day. R10 has a care plan for antipsychotics documenting a risk for adverse reactions related to their use with a goal to show improvement in mood/behavior. However, the care plan does not identify an [DIAGNOSES REDACTED]. There are no specific behaviors identified to be monitored. There is no baseline behavioral assessment upon R10's admission. There is no plan for gradual reduction or elimination of the medication. Also, the adverse reactions listed in the care plan are and non specific. 6. R4 is receiving 75 milligrams of [MEDICATION NAME] per day. R4's care plan states she is taking anti-psychotic medication to assist with mood/ behavior management. There are no behaviors identified. There is no plan for a gradual dose reduction. Surveyor: Point, Susan 7. E4 (assistant director of nursing) stated on February 9, 2016 at 2:50PM, R11 was admitted to the facility on [DATE] with a right hip brace following a fracture at home and had no skin issues until February 2, 2016 when a small wound was identified on the lower right leg. On February 2, 2016 at 11:47 PM, nurse's note states a skin check was performed on R11 and an open area to the right posterior ankle, 1.0 x 1.5 x 0.5 moist with scant discharge was observed. The skin surrounding area was reddened and swollen. Nurse's note dated February 4, 2016 at 11:46PM states Noted skin surrounding wound has bruising which was not present during initial assessment on February 2, 2016. The Nurse Practitioner note dated February 5, 2016 said this wound declined to an unstageable pressure ulcer of right Achilles r/t brace measuring 2.0 x 3.5 x 0, Base 80% pink, 20% slough, and serosang drainage. E4 was asked to provide R11's wound care plan since admission. E4 presented a care plan dated February 5, 2016, three days after the initial identification of the right Achilles pressure sore. There was no care plan identifying immediate interventions put in place to prevent this wound from declining to an unstageable wound within the first three days of it's development. 8. R5's card file with an admitted [DATE] documents under Restorative care / ADL's (Activities of Daily Living) ADL assist- Usually One person with extensive level of assist. Transfers with sit to stand lift. R5's current care plan has no guidance for staff related to transfers.
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 complete a comprehensive, individualized assessment of residents skin; develop and implement interventions including positioning to promote healing of wounds and prevention of new pressure sores. This applies to four of five residents (R6, R8, R11, R13) reviewed for pressure ulcers in a sample of 24. This resulted in R6 acquiring an unstageable wound to his left heel, a wound to his buttocks and a worsening unstageble wound to the right heel. The findings include: 1. R6 has medical [DIAGNOSES REDACTED]. R6 also has a BIMS (brief interview for mental status) score of 13 out of 15 on the January 31, 2016 MDS (minimum data set) showing him to be cognitively intact and interviewable. On January 8, 2016 at 8:00 AM, during the facility initial tour, R6 was in his room laying in bed with the head of the bed at a 45 degree angle. R6 had multiple dark purple bruising and skin tears to both arms. R6 stated he is on long term anticoagulants and oral steroids. R6 stated he didn't have any long sleeve shirts or anything to protect his arms. R6 was also noted to have a flat pillow under his legs with both heels resting on the bed. R6 stated he had burning pain in both heels and and his butt. When asked if he had any sores he stated, I'm not really sure. On February 8, 2016 at 11:35 AM, E12 (CNA) was providing incontinence care for R6. R6's rectal area and buttocks were cleansed and R6 had open red areas on both sides of his buttocks. R6 stated they were tender. E9 (RN, Registered Nurse) then came in to apply a skin protectant to the area and stated the wound looked like a stage II pressure ulcer. E9 stated the treatment nurse is the one who monitors these. E12 then removed both socks and R6 had large black areas on both heels. There was no dressing, offloading or heel protectors on R6. There were sero-sanguinous stains on R6's bed sheets under his heels. R6 stated he had heel protectors on in the hospital but not since his admission to the facility. R6 was stood up on both feet with socks on and was transferred to the wheelchair which had a pressure relieving cushion on it and a pillow was placed on top of the pressure relieving cushion. On February 8, 2016 at 12:00 PM, E10 (treatment nurse) stated R6 came in to the facility with an abrasion on his right heel and abrasions on his buttocks. E10 stated she had not seen R6 in about two days. E10 stated she was not aware of any sores on R6's left heel. E10 came into R6's room and observed large black/brown colored wounds on both heels. E10 stated R6's buttock wound was not a pressure sore it was an abrasion because its not on a bony prominence. There is no documentation, measurements or assessments of R6's buttock wounds. When asked how R6 obtained the abrasion E10 stated she didn't know. E10 stated the interventions R6 had in place to prevent pressure ulcers were skin protectant to his buttocks, air dispensing mattress, and to offload the heels with cushioned heel protector boots. E10 looked in R6's room and confirmed with R6 he did not have any heel protecting boots since his arrival in the facility. R6 was seen again on February 9, 2016 and February 10, 2016, in his room. On February 9, 2016 in the morning R6 was seen with heel protector boots on. On February 9, 2016 in the afternoon R6 was seen in the wheel chair sitting on a pillow on top of his pressure relieving pad. On February 10, 2016 in the morning, R6 was seen in bed with no heel protector boots and no offloading of his heels. On February 10, 2016 afternoon, R6 was seen in his wheelchair sitting on a pillow on top of his pressure relieving cushion On February 10, 2016 at 8:30 AM, R6 was receiving a nebulized inhaled treatment in his room via a face mask. R6 complained the mask was bothering his right ear. E13 (RN) stated to R6 the treatment was almost done but did not attempt to check the area. R6 was than noted to have a reddened open area behind his left ear. R6 was seen on multiple visits with the oxygen tubing around his ears and the padded area to have been below his ear on both sides. R6's admission assessment dated [DATE] documents the the skin assessment as: Left iliac crest bilateral oblique region with moderate skin rashes. There is no documentation of any abrasions to the buttock area. The assessment also documents the right heel has a small (approximately quarter sized) brown/black colored wound. There are no other skin abnormalities documented. The Braden score is documented as 19 (low risk) at that time. The next Braden score was done February 7, 2016 and documents R6 to be at risk with a score of 15. R6's admission note dated January 24, 2016 documents: Several wounds found on R6's body. See nursing assessment. There are no measurements or any other comprehensive assessments on these skin alterations/wounds. R6's TAR (treatment administration record) for January and February 2016 documents, Body audit every day shift, every 7 days for skin observation. There is an x checked on every day it was done but no details are documented about the skin assessment. R6's care plan dated January 24, 2016 documents R6 to be at risk for alteration in skin integrity related to steroid therapy, Braden risk and recent hospitalization . The goal was to decrease breakdown risk. The interventions listed were barrier cream to buttocks, diet and supplements, encourage reposition as needed, float heels as able and pressure reducing device on chair and bed. R6's risk factors were not identified and individualized interventions were not put into place. There is no guidance to staff on how or when to float the heels or what to float heels with or what as needed means. R6 came in with a right heel sore. This is not addressed in the care plan. There are no individualized interventions to heal

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F 0314 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) that wound and prevent others. R6 uses oxygen and there are no interventions put in place to prevent pressure sores behind the ears from the oxygen tubing. On February 10, 2016 at 10:15 AM, E10 stated R6 came in with a discoloration of his right heel. E10 stated she did not assess R6 until a couple of days after he was admitted . E10 stated she did not write any assessment notes on R6 at that time of initial assessment. E10 stated she reviewed the sore and skin history with R6's wife and was told R6 always had scaly skin issues with his feet and if you pulled them off they would bleed. E10 stated when she observed the wound on the right heel on 2/8/16 it did look different than initially and the left heel wound was newly acquired. E10 stated she then had the nurse practitioner look at the wounds. E10 stated none of R6's wounds are considered pressure ulcers. R6 had a history of [REDACTED]. E10 stated concerning R6's arms that are bruised and have multiple skin tears, the physician ordered a [MEDICATION NAME] to be put on the skin tears. E10 stated for protection they just try to be careful during care. They can apply sleeves for protection or ask R6's wife to bring in long sleeve shirts. When asked why none of those interventions were in place E10 stated, I can't answer that. The first wound notes from the Nurse practitioner are dated February 8, 2016 and document, asked to see R6 due to open wounds on heels. This is over two weeks from the initial identification of the right heel wound and the first time the wounds were measured and documented as assessed. The description is: Right heel: full thickness ulcer/ abrasion , base 80% dark purple, 20% pink, small amount of sero-sanguineous drainage, no malodor, surrounding skin peeling/scaly. Measurements are 7.0 CM x 2.7 CM x O CM. R6's initial assessment on admission did not have measurements but was described as small quarter sized. Left heel : Full thickness ulcer/abrasion base 90% pink, 5% slough,5% purple, scant sero-sanguineous drainage, no malodor, surrounding skin peeling/scaly. Measurements: 1.7 CM x 1.0 CM x 0 CM. R6's nursing notes were reviewed from admission January 24, 2016 until February 10, 2016. On January 27, 2016 there is a nursing note that documents, Assessed bilateral heels and feet. Skin dry with diffuse areas of flaky tissue. Intact reddened bunion area on the lateral side of ball of right foot. R6 complains of pain to right side heel of the right foot when the foot is flat on the bed. Will elevate right heel with pillows when R6 is in bed. RN to re assess in the morning. The next skin related nursing note is January 29, 2016 which documents R6 complained of pain on his buttocks and was put to bed to get pressure off buttocks but refused to be turned. Neither of these days shows a thorough assessment was done of these areas nor was there any documentation that the physician was notified. There is no re-evaluation of these areas or interventions. On February 10, 2016 at 11:15 AM, Z2 (Physician) stated the Nurse practitioner had notified him on February 8, 2016 about R6's heel wounds Z2 stated these are from his feet being dependent on the mattress. Z2 stated R6 does have some degree of PAD (peripheral artery disease) but not to the extent to cause this. Z2 stated if it was related to PAD he would expect the wounds to start in his toes not the heels. The heel wounds are definitely pressure related. Z2 stated the wounds could definitely have been prevented by getting him out of bed or keeping pressure of his heels. Z2 stated he was not made aware of the wound on R6's buttocks. Z2 stated he was told R6 had a rash from the hospital not a wound. The facility policy dated January 2013 titled, Skin Practice Guide, documents the purpose of the guide is to describe the process steps for identification of residents at risk for developing pressure ulcers and identify interventions to assist with management of pressure ulcers and skin alterations. UnderMedical Guide Initiative, it shows residents admitted with skin alterations are evaluated by a health professional(MD, NP-Nurse Practitioner, or wound specialist) within 24 hours. This was not provided to R6. R6's Primary physician notes do not address or document any of his wounds. R6 was not seen by the NP until February 8, 2016, over two weeks since admission. The guide also documents under, Initial Plan of Care, Upon completing the initial plan of care, a resident specific care plan to include prevention , management and interventions with measurable goals. This was also not evident in R6's initial plan of care. The facility policy titled Skin Practice Guide. Dated January 2013 documents, the initial plan of care should have a patient specific care plan with measurable goals to prevent pressure ulcer development, promote healing and prevent infection. The policy under palliative care and advance care planning address the goals of wound care at the end of life. The interdisciplinary team, patient and family are involved in establishing those care plan goals and making decisions for future care. Care planning discussions are documented in the clinical record and integrated into the residents care plan. On February 9, 2016 at 2:50 PM, E4 (assistant director of nursing) stated R11 was admitted to the facility on [DATE] with a right hip brace following a fracture at home. R11 had no skin issues until February 2, 2016 when a small wound was identified on the lower right leg. Nurse's note dated February 2, 2016 at 10:33 AM, shows R11, complains of right lower leg pain. [MEDICATION NAME] given, effective result noted, wearing Newport brace on at all times, ambulatory with walker while in therapy. E4 said there is no documentation showing this complaint of pain was evaluated at the time. The next nursing entry is 12 hours later, on February 2, 2016 at 11:47 PM, and states a skin check was done at that time and an open area to the right posterior ankle, 1.0 x 1.5 x 0.5 moist with scant discharge, was observed. The Skin surrounding the area was reddened and swollen. E4 stated R11's brace remained on until February 4, 2016, even after staff identified the wound on February 2, 2016. Nurse's note dated February 4, 2016 at 11:46 PM, states, Noted skin surrounding wound has bruising which was not present during initial assessment on 2/2/16. Nurse Practitioner note dated February 5, 2016 at 1:39 PM, states, nursing staff noted unstageable pressure ulcer of right Achilles r/t brace yesterday. 2.0 x 3.5 x 0. Base 80% pink, 20% slough, serosang drainage. On February 9, 2016 at 2:50 PM, E4 stated R11's right Achilles pressure ulcer was a DTI (deep tissue injury) that opened up on February 5, 2016, and this is why the size doubled from over the course of two days. E4 confirmed R11 developed this wound in the facility, most likely caused by the brace. A Medical Practitioner Progress Note dated February 9, 2016 shows the right lower leg is described as an unstageable pressure ulcer as of the assessment on February 9, 2016: base 90% slough, 10% pink and small amount serosang drainage. R11 was sitting in her wheelchair on February 9, 2016 at 2:00 PM. The wound to R11's right Achilles was observed to be mostly slough with minimal amount of drainage. R11 said she thought the wound was caused by the brace she use to wear and it doesn't hurt as much as it use to. R13's electronic medical record under [DIAGNOSES REDACTED]. According to E10's (treatment nurse) note, R13 was found to have fluid filled blisters on both heels during ADL care on 12/08/15. The right heel was measured at 4.0 x 5.0 x 0 cm (centimeters), stage 2. The left heel measured 3.0 x 3.0 x 0 cm., stage 2. Z5, NP (nurse practitioner) documented both heels as stage 2 pressure ulcers and ordered skin prep daily, if blister ruptures discontinue skin prep and start [MEDICATION NAME] daily with dry gauze. Z5 also ordered pressure relieving boots when in bed. R13's initial care plan dated December 01, 2015 was reviewed. R13 was noted to be at risk for alteration in skin integrity related [MEDICAL CONDITION] and Braden identified risk areas for pressure ulcers. Interventions on the care plan were non specific. One intervention was to encourage to reposition as needed; use assistive devices as needed and float heels as able There were no specific devices listed to be used in the plan. R13's dressing change was observed on February 09, 2016 along with Z5 and E10 (treatment nurse). R13's pressure relieving boots were on the chair. Z5 stated the pressure relieving boots work better because they stay in place. However, the pressure relieving boots were not ordered until both of R13's heels broke down.
F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that each resident who enters the nursing home without a catheter is not given a catheter, and receive proper services to prevent urinary tract infections and restore normal bladder function.** Based on record review and observation the facility failed to provide thorough incontinence care for one resident (R1) and failed to maintain one resident's (R5) urinary drainage bag at bladder level.

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F 0315 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) This applies to 1 of 9 residents reviewed for indwelling catheter and 1 observed for incontinence care in the sample of 24. The findings include: On February 9, 2016 at 10:30 am, R5 was observed sitting on the toilet with E17 and E18 (nurse's aides) present. R5's urinary drainage bag was hanging from the sit-to-stand lift next to her (R5). The height of the bag was higher than her bladder and urine was flowing back towards the bladder. After R5 had a bowel movement, E17 wiped R5's rectal area but did not provide any cleansing to the catheter. R5's urinary catheter care plan dated April 22, 2015 states to maintain drainage bag below bladder level. On February 9, 2016 at 10:10 am, R1 was assisted to the bathroom by E21 (nurse's aide). E21 removed R1's urine saturated diaper. After R1 voided on the toilet, E21 used one disposable cloth and briefly made one cleansing motion to the peri area despite the diaper having been saturated from the front to back. E21 also utilized the same pair of gloves during the entire procedure. E21 did not wash her hands or replace the dirty gloves with a clean pair after removing the saturated diaper.
F 0323 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to assess a resident for transfers to prevent accidents with a mechanical lift device. The facility also failed to transfer the resident in a manner that promotes safety for the resident. This applies to one of two residents (R5) reviewed for mechanical lift transfers in the sample of 24. The findings include: On February 8, 2016 at 11:35 AM, R5 was transferred from the wheel chair to the bed using the sit to stand mechanical lift by E15(CNA) and E16 (CNA). R5 was unable to support her lower extremities on the sit to stand lift. Both of R5's upper extremities were hanging freely on each side of her, instead of on the hand grips. R5 was grimacing during the transfer. On February 9, 2016 at 10:30 AM, while R5 was being transferred using the sit to stand mechanical lift. R5 was dangling from the sling and unable to grasp the hand bars. R5 stated the sling was in her armpit and was very uncomfortable. R5 stated the sling sticks under her armpits and it hurts her. R5 stated she disliked the sit to stand transfer and her armpits are the only thing supporting her during the transfer. On February 9, 2016 at 12:15 PM, E2 (DON) stated the transfer device type is decided upon as a multidisciplinary group decision. If the CNA feels the device is not working they need to notify E2 for reassessment. E2 confirmed there is no transfer assessment for R5. On February 9, 2016 at 12:15PM, E19 (Regional Nurse Educator) stated they do not keep the initial transfer assessment. It is not part of the permanent record. E19 stated when an initial assessment is done on admission we discuss it in the morning meeting. After the decision for the type of transfer is made it is transposed to the card file so staff are aware. R5's card file with an admitted [DATE] shows under Restorative care / ADL's(Activities of Daily Living) ADL assist- Usually One person with extensive level of assist. Transfers with sit to stand lift. R5's current care plan has no guidance for staff related to transfers. R5's MDS (Minimum Data Set) dated January 22, 2015 documents R5 to have a BIMS (Brief Interview for Mental Status) score of 10 out of 15 showing her to be moderately cognitively intact and interviewable. R5's MDS under transfers shows her to be an extensive transfer with two person assistance. The documented ROM (Range of Motion) limits, documents R5 to have impaired upper and lower extremities on both sides. The facility policy and procedure dated July 2015 and titled, Lifts and Injury Reducing Manual, documents, all residents classified as an extensive assist are transferred with the aid of a mechanical device. The policy also documents, depending on the residents condition and weight bearing abilities, a stand assist lift may be used as deemed appropriate by professional staff conducting resident screenings. The determination of which lift to use is noted in the residents care plan. The policy also states the use of a full sling lift may be substituted at the employee's discretion. However, the supervisor must be notified immediately as this may trigger a need for re-screening. The facility document titled, Patient Transfer Screening Worksheet dated July 2015 documents if the resident is able to tolerate bearing weight on their legs, sit at the edge of the bed with little to no support and have good upper body strength and able to follow commands then they are appropriate for the sit to stand mechanical lift. If there is a no answer to any of those then the resident is a candidate for the full dependent mechanical lift. R5 was unable to bear weight during transfers on two days and was very uncomfortable during the transfer. Administrative staff were not made aware, of R5's poor ability and difficulty with transferring via the sit to stand mechanical lift.
F 0431 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Maintain drug records and properly mark/label drugs and other similar products according to accepted professional standards.** Based on observation and record review, the facility failed to label opened biologicals to ensure they were used within the appropriate time frame. This has he potential to effect any newly admitted residents on unit A who may need these biologicals. The Findings include: On February 9, 2016 at 12:35 PM the Section A mediation refrigerator had one vial of influenza vaccine that was open and undated. According to the manufacturer's recommendations, once the stopper of the multi-dose vile has been pierced the vial must be discarded within 28 days. A vial of tuberculin purified protein derivative PPD (Mantoux) was opened and undated. The manufacturer's recommendations state the product should be discarded after 30 days.
F 0441 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have a program that investigates, controls and keeps infection from spreading.** Based on observation, interview and record review the facility failed to provide a smooth, cleanable surface for proper cleansing of glucometer machines. The facility also failed to ensure staff wash hands and changed gloves during perineal care of residents This applies to five residents (R1, R8, R12, R18 and R20) reviewed for infection control in the sample of 24 and 20 residents (R25 - R44) in the supplemental sample. The findings include: During observation of medication pass on February 09, 2016 at station B, the glucometer was observed on the medication cart. At the bottom of the glucometer was a paper taped to the machine with the unit number on it. The tape was turned up slightly and the sticky side had unknown material stuck to it. E20, nurse stated the glucometer is shared with the other residents on the unit and is cleaned between usage per facility policy. E2, DON provided the manufacturer's guidelines and the facility policy for the cleanser used by the facility. The cloth in the container is impregnated with the cleansing solution and the glucometer is wrapped in the cloth. The cloth must remain in contact with the glucometer for at least two minutes. The taped portion of the glucometer would prevent that surface from being properly cleaned. The facility has four units with a total of 11 glucometers. In total there were five glucometers that had tape and/or paper adhered to the bottom or rear panel. MedBridge North has two glucometers and one of them had a taped surface. Medbridge South has four machines, three of which had taped surfaces. Station A has two machines that were not taped. Station B has three machines, two with no tape and one with tape on the surface. On February 8, 2016 at 1:15 PM, E24 (CNA) cleaned R8's rectal area and buttocks then applied a clean disposable incontinence brief. E24 did not change gloves or wash hands between the dirty and clean procedure. E24 then proceeded to assist staff with R8's wound care with the same soiled gloves.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145689	A. BUILDING _____ B. WING _____	**02/19/2016**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
MANORCARE OF ELK GROVE VILLAGE	**1920 NERGE ROAD ELK GROVE VILLAGE, IL 60007**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0441 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 4) On February 10, 2016 at 11:45 AM, E25 E24 and E25 (CNAs) were providing care to R18. E24 and E25 transferred R18 from the bed to the wheel chair. Gloves were worn by both CNA's. Both staff assisted R18 to get dressed and put on her shoes and touched multiple items in the room. Both CNA's removed their gloves and disposed of them and then left the room without washing their hands. Multiple hand sanitizers are placed in the hall and both CNA's were observed not using them. E25 stated she washes her hands after all care is complete. E25 also stated during incontinence care she uses double gloving so if the top pair are visibly soiled she removes those and has another pair underneath to continue on with clean tasks. E24 stated she also just washes her hands before she starts care and then after care is complete. On February 9, 2016 at 9:50 AM, E21(CNA) was assisting R1 with care. E21 assisted R1 to put on her compression stockings, shoes and assisted R1 to the wheel chair. E21 then assisted R1 to the toilet. R1 voided in the toilet and E21 used a moist wipe to clean R1. Only one pair of gloves were used throughout the whole care process. There was no handwashing or sanitizing done during this care time until care was completed. E21 stated she was always taught to wash hands before you put on gloves and when you remove them. E21 stated no one ever told her she needed to change gloves between tasks or wash her hands then. The facility policy document titled Precaution System' and dated May/2013 documents hand hygiene (handwashing or alcohol based sanitizer) is used before and after patient contact and after contact with the resident immediate environment.