PRINTED: 09/28/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	146064 B. WING				09/2	21/2016		
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE SS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	;	F 00	00				
F 157 SS=J	F157, F224, F278, F2300.1230 a)1)2)3)b)d  Complaint Investigati F157, F224, F278, F2300.1230 a)1)2)3)b)d  A partial extended su 483.10(b)(11) NOTIF (INJURY/DECLINE/F)  A facility must immed consult with the resid known, notify the resior an interested famil accident involving the injury and has the pointervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a nexisting form of treatment); or a decist the resident from the §483.12(a).  The facility must also and, if known, the resor interested family means the same properties of the same properties.	on #1665318 / IL88542 - 282, F309, F441, F496, and I)1)2)f)j)5)k)4)5)  rvey was conducted. Y OF CHANGES ROOM, ETC)  iately inform the resident; ent's physician; and if ident's legal representative y member when there is an eresident which results in tential for requiring physician cant change in the resident's esychosocial status (i.e., an, mental, or psychosocial reatening conditions or ); a need to alter treatment ed to discontinue an ment due to adverse commence a new form of sion to transfer or discharge facility as specified in  promptly notify the resident sident's legal representative nember when there is a ommate assignment as	F 1:	57				
	regulations as specifi	Federal or State law or ed in paragraph (b)(1) of		TITLE			(YE) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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.

Facility ID: IL6005508

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		03/21/2010
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F 157	the address and pho	ord and periodically update one number of the resident's or interested family member.	F 1	57		
	by: Based on record reviated to notify the prodeliscence for one of reviewed for wounds failure resulted in modehiscence and an extreatment for R1. Duabdominal wound be internal abdominal p the wound causing sof R1. The facility all physician of changes	s in the sample of five. This ore surgical wound eight day delay in wound uring this time R1's ecame infected, with R1's ain pump protruding through subsequent Sepsis and death so failed to notify the s in condition for one of three wed for changes in condition				
	the facility remains of level two. The facili evaluating the effect for resident skin and	was removed on 9/20/16, but of compliance at severity ty is in the process of iveness of staff re-education wound assessments, ts, change in condition and				
	Findings include:					

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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		372172010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUS CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157	documents the follo Infarction due to En Cerebral Artery, Ab Osteoporosis with O Vertebra, Hemipleg unspecified side, M Neuromuscular Dys Urinary Tract Infection R1's Care Plan date has potential for impresselfMonitor/documents of skin injustification, maceration Doctor)." The Care documents R1 "has skin integrity of the (pain pump placem documentation to in area of skin breaked type of tissue and echanges or observation of the extensive assist mobility, toileting, a Assessment dated risk for skin breaked. The undated facility Assessment on all withe response to nur	order Sheet dated August 2016 wing diagnoses: Cerebral abolism of Unspecified normal Posture, Age-Related Current Pathological Fracture, ia Unspecified Affecting the uscle Weakness, afunction of bladder, and on.  ed 6/21/16 documents "(R1) pairment to skin integrity r/t kin and picks at ment location, size and ury. Report abnormalities, (signs and symptoms) of an etc. to MD (Medical Plan dated initiated 6/29/16 a potential/actual impairment to abdomen r/t surgical wound ent)Weekly treatment include measurement of each own's width, length, depth, exudate and any other notable attions."  Set (MDS) dated 7/14/16 agnitively intact and requires tance of two staff for bed and bathing. R1's Skin 7/14/16 documents R1 is at	F 18	57			

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	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
noted and approprial Upon any assessmentified possessmentified promptly Physician (sponsor) medical/nurse supresident's changes condition  R1's Nurse document aware of pump that ago; left round pump that ago; left round possessmentified possess	te treatmen of change in vent will be up romptly to opplemented  ty's undated "policy documotify the real of changes mental condition of changes mental condition of changes on status"  see Notes do to "MD (Medopen skin and the patient stated and the patient stated 8/20/16 is about 1-2 m in width."  at 11:20 are in width."  at 11:20 are in stated Z3 areat Infection of R1's oper Z3 stated Z3 ract Infection of R1's wound is. Z3 stated Z3 undatable belough a vental could have been the stated Z3 areas and zated Z3 areas areas areas and zated Z3 areas areas and zated Z3 areas are	ian will be notified for an torder to be implemented wound status the pdated, the physician will be btain treatment orders that ."  I "Change in Resident uments "Our facility shall sident, his or her Attending e, and representative in the resident's ition and/or statusThe rge nurse will record in the cord information relative to ent's medical/mental  ated 8/20/16 at 8:31 pm dical Doctor) called to make rea around internal pain tes was placed a few weeks MD cell phone; waiting for message." R1's Nurses at 8:37 pm document "the cm (centimeters) in length	F 18	57			

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F 157	(RN)/Pain Center, was found on 8/20, have been notified had R1 seen at the to evaluate and giv notified us that (R1 pump."  On 9/8/16 at 11:05 Nurse, LPN, stated wound is found on is notified. The Prir and family and we orders."  On 9/12/16 at 2:20 stated no one notif 8/20/16. Z4 review 8/20/16 and stated cleaned with Norm or betadine and not the did R1's skin at there was a small I pump area. E1 stated E14 should measured the wou Primary Care Physical Seen Seen Seen Seen Stated E10 pump and the wound and the orders. E9 stated	5 am Z1, Registered Nurse stated when R1's open area /16 the pain center should. Z1 stated "We would have e pain center for the doctor (Z2) re orders for treatment. No one has an open area over the am E14, Licensed Practical E14 stated when an open a resident the "Wound doctor mary Care Physician is notified then implement treatment  pm Z4 (Wound Physician) red E8 nurses note dated R1's wound should have been al Saline, or wound cleanser, t soap and water.  am E1, Administrator stated E1 9/7/16. E1 stated E14 said assessment on 8/26/16 and bandage over the internal sted E14 should have looked orders for the wound. E1 have looked at the wound, and, and called Z3 (R1's	F1	57		

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F 157	Assistant (CNA) statchird shift (8/28/16) stated R1 said " I do "looked sweaty." R gown that had a bro looked and it (brown (R1's) right abdome dressing was full. T saturated and it (dragown. I didn't smell (R1)." E12 stated E for R1 before inform Nurse (LPN) of R1 v E12 stated "I told Edressing over pump left R1's room. E12 get residents up for days. I asked (E11, LPN) if I can get (R1 stated "Me (E12) and wheelchair." E12 stated E12 therefor breakfast. E12 stated E12 therefor breakfast. E12 stated E12 therefor breakfast. E12 stated E12 brought "placed (R1) in the reformal put (R1) back in helped me put (R1) stain was coming the never complained. told E11 about (R1's	m E12, Certified Nursing ted E12 "came in early on the petween 2-3:00 am. E12 on't feel good." E12 stated R1 was wearing a hospital wn stain. E12 stated "I a stain) was the dressing on a over the pump. The he whole dressing was sinage) came through on the an odor. I put clean gown on 12 continued to provide care ing E13, Licensed Practical wound dressing and drainage. I3 about the drainage on R1's area." E12 stated E12 then stated when it was time to day shift "I was (R1's) aide on Licensed Practical Nurse, I) up. E11 said 'Yes." E12 d E18 got (R1) up into the ated R1 still had the same is saturated with brown stain. In took R1 to the dining room stated "(R1) was groggy. In the color of urine. E12 R1 from the dining room and from until all the residents agroom. Then about 11:00 into bed. Another aide (E18) back into bed. The brown rough (R1's) gown. (R1) I changed (R1's) gown and I is dressing. The next thing I ince) were coming to get (R1)."	F 1	57		

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F 157	worked from 10:00 8/28/16. E18 stated that worked with R1 looking right. She (towel and washed h (E13, LPN) that (R1 self." E18 stated E and gave R1 a breakfast. E18 stated E18 went to help E breakfast. E18 stated E12 got R1 or (R1) from the bed to ready for breakfast. needed more help to the company of t	am E18, CNA, stated E18 pm on 8/27/16 to 6:00 am on d E18 was one of the CNAs l. E18 stated R1 "wasn't R1) was sweating and I got a ner face then I went and told l) wasn't looking her normal 18 saw E13 go into R1's room athing treatment. E18 stated 12, CNA, get R1 up for led there was a brown stain on ated the brown stain came lessing on R1's right side. E18 cleaned up then "we pivoted to the wheelchair" to have R1 E18 stated R1 stood up "but than usual."  pm E13, LPN, stated E13 m on 8/27/16 to 6:00 am on d "I was (R1's) nurse. E13 know if R1 had a dressing or of one ever informed me that g over the pain pump."  of pm E17 CNA stated E17 on the day shift from 6:00 am lated "I saw (R1) during ling room. (R1) looked a little w whether she ate or not." he after breakfast E12 walked	F 157	· ·	
	E17 stated sometim past me and mentic E17 stated "(R1) wa and I smelled an oc There was drainage side. It was dark brike an open sore. had oxygen on. (R				

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F 157	was not (R1's) normal It wasn't like her to be fussing with clothes a say. So this wasn't h was close to 9:00 am E20 (CNA) went to go Nurse (LPN)). E11 ca (R1) was smiling earl concerned about (R1 then I left (R1's) room.  On 9/12/16 at 1:08 pr worked on 8/28/16 frostated R1's dressing wet." E20 stated she "smelled like infection drainage was "brown R1's gown. E20 stated LPN) and (E11) looked.  On 9/8/16 at 4:00 pm R1's nurse on 8/28/10 day shift. E11 stated information that R1 hover the internal pum abdomen when came one reported to me u when E12, CNA or Edrainage, nasty smell with drainage on (R1'room) and removed to pump) and the pain p skin." E11 stated R1'1/2 inches by 1 1/2 in not measure the area area (R1's wound) wi and left it (wound) op "having difficulty brea	II. She always talked a lot. e quiet. She was always and always had something to er normal." E17 stated "This . So I stayed with (R1) and et (E11 Licensed Practical ame and said to me that y in the morning. (E11) was ) and looked at the drainage	F	157		

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F 157	was 98.2 degrees Fabeats per minute. Eshift nurse, said to Estrouble breathing. Este trouble breathing. Este drainage at the p (E13) knew about it. called (ambulance) the (R1's Primary Care Fhad the pain pump for R1's Nurses Notes documents " (Z3, R1' called, order received for evaluation."  R1's Hospital Emerge 8/28/16 documents "EMS (Erstated that the patien and SOB (Shortness the patient has a pain her abdomen."Paabdominal wall with eR1's Ambulance Incid 8/28/16 at 12:46 pm. 12:48 pm "Going Segoing downhil (downled documents "FOUN (Nursing Home) AND STAFF STATES SHE WITH THE PT. RN SPUMP A COUPLE DOUT OF THE INCISI APPROX 4 1/2 INCH	was 60/40, Temperature hrenheit, and Pulse was 76 11 stated E13, LPN/night 11 that "(R1) was having 13 did not say a word about ump site. Don't know if I did (R1's) vitals myself and hen called family then Z3 thysician)." E11 stated R1 or years for back pain.  ated 8/28/16 at 12:47 pm s Primary Care Physician) to send pt (patient, R1) out  ency Room report dated to arrived at the emergency to a spin. The report mergency Medical Services) to (R1) is septic with fever of Breath). EMS stated that in pump on the right side of hin pump partially exposed in erythema"  dent Log Report dated esponse to the facility on The report documents at otic-Pain Pump draining hill). The report "Narrative" D PT (Patient, R1) IN NH O RN (Registered Nurse) EIS NOT REAL FAMILIAR ETATES PT HAD A PAIN AYS AGO AND IT HANGING	F	157				

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F 157	Continued From page (Lower Right Quadra IS VERY DISTENDE TOUCH "  On 9/12/16 at 8:46 ar Ambulance Service, sfacility on 8/28/16 the normal nurse and har Z5 stated the nurse the you this and pulled (stated R1's abdomina "looked as if it happe wound) did not look li (R1's) abdomen was and clammy. (R1) has was in Septic Shock. very lethargic. In 26 anything like this. Ne hanging out. Half of out of (R1's) wound. about six (6) inches leand three (3) inches out."	nt of Abdomen)PT LRQ D, RED AND HOT TO  m Z5, Paramedic for stated when arrived at the nurse stated "I am not the nded me (R1's) DNR sheet." hen said to Z5 "Let me show R1's) dressing back. Z5 al wound was dry and ned days ago. It (the ke a fresh wound. Very red. distended. (R1) was cool ad every indicator that (R1) (R1) was non-verbal and years I've never seen ver seen a pain pump the pain pump was hanging The opening (wound) was ong and 1 1/2 inches wide of the pump was hanging					
	R1's Emergency Room "Disposition" dated 8/28/16 documents "Patient (R1) brought in from nursing home for evaluation of change in mental status and shortness of breath with fever. She (R1) has intrathecal pain pump extruding from the abdominal wall with erythema and discharge around it (pump) septic workup done (Z2, R1's Pain Clinic Physician, Surgeon) was contacted and will be coming to remove the pain pump" The report documents "Sepsis Signs and Symptoms: Hyperthermia Altered Mental Status Tachycardia Sepsis Status: Severe Sepsis: S & Sx (Signs and Symptoms) + Organ dysfunct (dysfunction)" electronically signed by Z14 Emergency Physician Provider.						

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F 157	9/2/16 documents "Rin to ED (Emergency evaluation of fever, sl mental status. Patier Infected pump pocket and expression of pur (Right Lower Quadrar explanted on 8/28/16 hospital course, patie clinical condition dete and pronounced dead (12:59 pm) "(Final I likely due to pain pum HCAP (Healthcare as Complicated UTI (Uri Acute Respiratory Fa fibrillation with RVR: a nonoliguric: due to se (Cerebral Vascular Acresidual weakness 6. requiring intrathecal pimplantation 6/2016 (signed by Z7(Hospital R1's "State of Illinois Worksheet" dated 9/6 death occurred on 9/2 and documents "Sept of death, certified by 3/10/2/16 at 9:15 ar Hospitalist/Physician	ge Summary report dated eason for Admission-brought Department) for further nortness of breath, altered at (R1) was noted to have with dehiscence of wound mp through wound in RLQ nt)Intrathecal pain pumpSubsequently during nt's (R1's) symptoms and rioratedPatient expired to n 9/2/16 at 1259 hours Diagnoses: 1. Septic Shock: up site infection and/or sociated pneumonia) and/or nary Tract Infection2. filure, Hypoxic: 3. Atrial 4. Acute Kidney Injury, ptic shock 5. History of CVA coident, Stroke) with right Dementia 7. FBSS; programmable pain pump June 2016) electronically list/Physician).  Certificate of Death 1/16 documents R1's date of 2/16 as a hospital inpatient ic Shock" as the R1's cause 27.	F 15			
	Septic Shock. Z7 sta	ted the primary site of R1's pain pump. Z7 stated the				

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F 157	Physician/Surgeon) seen at the clinic on brought into the emithe "pump breaking metal portion of the anything like this to appeared to be day. The edges (of the widdn't look fresh. I chow (R1) was chang noticed."  On 9/14/16 at 10:05 documentation in Riwas reached for tree E2 stated "If a wour become infected, see when E12 (CNA) for on 8/28/16 (on their reported to the nurshave moved R1 urbe moved and the protified for R1's charassessment and wothere was no documentation or care for that addressed R1's assessment and tree progress notes.  On 9/19/16 an Immediate in the progress notes.	m Z2 (R1's Pain Clinic stated R1 was fine when 8/1/16. Z2 stated R1 was ergency room on 8/28/16 with through the wound and the pump exposed. Never seen break open like this. It is and days in the making. Yound) were retracted and cannot for the life of me know ged and bathed and no one of the state of t	F 1	57		

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F 157	Immediate Jeopard The surveyor was a	bump. E1 was notified of the y on 9/19/16 at 3:30 pm.  ble to confirm through record	F 18	57		
	following actions to  Nurses will or have Director of Nursing Wound policy and the wounds, resident of Physician notification education for licens 9/19/16 on physician change of wound of site condition change with treatment orde received the educat from the schedule of The licensed nurses physical assessment on 9/19/16 and skin 9/16/16, 9/17/16, 9/ residents. The Adm reviewing all progree notification of woun pump sites. The fawith an implantable survey. The Admin with all day shift and Certified Nursing As resident conditions 9:30 am and 2:30 p  2) R2's Physician's 12:49pm document Left Hip Surgery, Al	Progress Note dated 9/1/16 at s R2's diagnoses including				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		TE SURVEY MPLETED
		146064	B. WING			C <b>9/21/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COI 2650 NORTH MONROE STREET DECATUR, IL 62526		9/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 157	R2's Progress Notes document "The orde Coumadin (Anticoag triggered the followir alerts/warnings: Drug Multiple Vitamins Tal Trazodone HCL (Hyd (Antidepressant) H Tablet (Pain) and F (Antacid)" There is (R2's Physician) or Z Physician) were noti R2's Progress Notes document " {R2} con Noted facial grimacin Noted guarding, rubid during movement." That Z3 or Z15 were R2's Progress Notes document R2 was seevaluation of the left previous fracture wabruised and warm to returned to the facilit Postoperative Hema and Supratherapeutic Ratio (INR).  R2's Emergency Cal Instructions dated 9 Coumadin today and Call {Z15} with result further Coumadin us	ease and Atrial Fibrillation.  Is dated 9/1/16 at 7:28pm In you have entered In dulant) Tablet 4mg has Ing drug protocol Ing to Drug Interaction Daily Indichloride) Tablet Indichloride) Tablet Indichloride HCL Tablet	F 19	57		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		) DATE SURVEY COMPLETED
		146064	B. WING			C
NAME OF PE	ROVIDER OR SUPPLIER	140004	B. Wille	STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		09/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF COR  (EACH CORRECTIVE ACTION S  CROSS-REFERENCED TO THE A  DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 157	document "{R2} has a hip {R2} has bruisin and down {R2's} left s documentation that Z bruising.  R2's Progress Notes document, "receive office r/t (related to) r (Prothrombin Time)/II PT 31.0 INR 2.9, Couwas given new orders (milligrams) PO (by m R2's Progress Notes document, "Coumadi receiving new Coumadocumentation that Z given the Coumadin 2 2mg as ordered.  On 9/20/16 at 2:10pm	a surgical area on {R2's} left g and redness in this area side." There is no 3 was notified of the left side dated 9/6/16 at 5:45pm d an order from {Z15's} esident's {R2's} PT NR results from this morning imadin was held last night is of Coumadin 2mg	F	157		
F 224 SS=J	R2's condition on 9/4 stated she could not to find R2 receiving Court Court Court Court 2 properties of R3.13(c) PROHIBIT MISTREATMENT/NE  The facility must developlicies and procedure	GLECT/MISAPPROPRIATN  elop and implement written  es that prohibit t, and abuse of residents	F2	224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		146064	B. WING _			C 09/21/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526	<b>I</b>	03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	Continued From page	ge 15	F 2	224		
	by: Based on record re neglected to follow a Assessment Policy Assessment Policy notification of a resi policy for one of five wounds on the sam failures resulted in F untreated for eight ( infected, R1's interr protruding through to Septic Shock and R  These failures result Jeopardy.  While the immediace the facility remains a level two. The faci evaluating the effect for resident skin and physical assessment physician notification  Findings include:  The untitled facility Policy and Procedu skin is the body's fire	dent's Change in Condition residents (R1) reviewed for ple of five residents. These R1's abdominal wound left 8) days. The wound become al abdominal pain pump he wound, with subsequent 's death.  Ited in an Immediate  Y was removed on 9/20/16, but of compliance at severity ity is in the process of tiveness of staff re-education in wound assessments, ats, change in condition and				
	continually inspect t signs of pressure ul abnormalitiesRes	nd irritationPurpose to the resident's skin for early the development and other dents who are determined evelopment of pressure ulcer				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		146064	B. WING _		<del></del>	09/	/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	MANOD			2650	NORTH MONROE STREET		
LINCOLN	WANUR			DEC	ATUR, IL 62526		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFI: TAG	×	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	COMPLETION DATE
F 224	Continued From p	age 16	F	224			
	will have a head-to	o-toe skin assessment done by					
	a licensed nurse w	eekly and documented on the					
	Treatment Adminis	stration Record (TAR)"					
		ty policy titled "Wound					
		y and Procedure" documents "It					
		facility to do ongoing wound					
		wounds in order to determine					
	-	rsing care and treatment					
		cument an accurate, ongoing					
		unds in the medical					
	recordProcedure						
	ulcers, and/or othe						
		dmission nursing assessment,					
		sment or identified at any other					
		ted wound assessment will be					
		licensed nurse for all wounds,					
		ments in the skin integrity. 3. A					
		wound will be noted and the					
		otified for an appropriated be implemented. 4. A weekly					
		sessment of each wound will					
	be done until heal						
		stage, measurements,					
		aling process, and condition of					
	_	Upon any change in wound					
	_	nent will be updated, the					
		otified promptly to obtain					
		nat will be implemented. 6.					
		updated with changes."					
	The facility's unda	ted "Change in Resident					
		locuments "Our facility shall					
		resident, his or her Attending					
		nee, and representative					
		ges in the resident's					
		ndition and/or statusThe					
		charge nurse will record in the					
		record information relative to					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146064	B. WING_			C 09/21/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, C 2650 NORTH MONR DECATUR, IL 625		09/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)	
F 224	changes in the reside condition or status.  R1's Physician Order documents the follow Infarction due to Emb Cerebral Artery, Abnot Osteoporosis with Cu Vertebra, Hemiplegia unspecified side, Mus Neuromuscular Dysfu Urinary Tract Infection  R1's Minimum Data S documents R1 is cognithe extensive assistant mobility, toileting, and documents R1 has arrand is at risk for press Assessment dated 7/risk for skin breakdow  R1's Care Plan, initiated revision on 6/21/16, dopotential for impairmed (related to) fragile skin selfMonitor/docume treatment of skin injur failure to heal, s/sx (sinfection, maceration Doctor)." Care Plan Edocuments R1 "has poskin integrity of the absurgical wound (pain treatment documenta of each area of skin bedepth, type of tissue as	Sheet dated August 2016 ng diagnoses: Cerebral olism of Unspecified rmal Posture, Age-Related rrent Pathological Fracture, Unspecified Affecting the icle Weakness, nction of bladder, and n.  et (MDS) dated 7/14/16 nitively intact and requires nce of two staff for bed bathing. The MDS nindwelling urinary catheter sure ulcers. R1's Skin 14/16 documents R1 is at rn.  ed on 12/18/15 with a ocuments "(R1) has nt to skin integrity r/t n and picks at nt location, size and y. Report abnormalities, igns and symptoms) of etc. to MD (Medical Focus initiated 6/29/16 otential/actual impairment to	F 2	24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		146064	B. WING _			C <b>09/21/2016</b>
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 224	Nursing Assistant) s from 2:00 pm to 10:0 noticed a small "ope was for (R1's) pump little piece of silver." what it was and "it s nurse (E8)."  On 9/12/16 at 4:59 p (RN), stated the CN. 8/20/16 reported to over the pain pump. looked and saw an could see the metal stated E8 left a mes Care Physician) cell informed the oncom open area over the pnot heard from (R1's could not remember nurse. E8 stated "Wnurse) that (R1) had (oncoming nurse) di R1's Nurses Notes of documents "MD (Me aware of open skin a pump that patient stago. left message of not appear irritated. soapy water, and an applied to protect from to reply to phone med dated 8/20/16 at 8:3 is about 1-2 cm (cerc cm in width."	om E12 CNA (Certified tated E12 worked on 8/20/16 00 pm. E12 stated E12 n wound where the incision (right abdomen) and saw a E12 stated E12 didn't know cared me. I went and told the om E8, Registered Nurse A (E12) that put R1 to bed on E8 that R1 had an open area E8 stated "I went in and opening in (R1's) skin and I part of the pain pump." E8 sage on Z3's (R1's Primary phone. E8 stated E8 ing, night shift nurse of R1's pain pump site "since I had be) doctor. " E8 stated E8 the name of the night shift //hen I said (to oncoming pain pump surgery she	F 2	24		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTION  NG			PLETED
		146064	B. WING _			1	C <b>21/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, C 2650 NORTH MONR DECATUR, IL 625		1 00/	21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH C	VIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD B EFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	R1 had internal pain Z1 stated R1 and wa 8/1/16 and "at that til abdomen was healed return to the clinic for there were no other incision site was head dressing.  On 9/8/16 at 11:20 a Physician) stated Z3 Urinary Tract Infection unaware of R1's ope 8/20/16. Z3 stated Z7 regarding R1's woun messages. Z3 stated pump should have be doctor (Z2, R1's Pair No one notified me."  On 9/12/16 at 2:20 p stated no one notified 8/20/16. Z4 reviewe 8/20/16 and stated R cleaned with Normal or betadine and not so On 9/12/16 at 11:25 stated when R1's ope 8/20/16 the pain cennotified. Z1 stated "No seen at the pain center evaluate and give or notified us that (R1) pump."  On 9/12/16 at 2:40 p	Hospital Pain Clinic, stated pump replaced on 6/27/16. s last seen at pain clinic on me the pump wound in the d." Z1 stated R1 was to r follow up on 9/1/16 and nstructions. Z1 stated R1's led and did not require a m Z3 (R1's Primary Care saw R1 on 8/8/16 for a n. Z3 stated Z3 was n abdominal wound on 3 had nothing faxed d and received no phone d "any concerns with the pain een directed to the pain clinic n Clinic Physician/Surgeon). m Z4 (Wound Physician) d Z4 of R1's wound on d E8 nurses note dated 1's wound should have been Saline, or wound cleanser,	F:	224			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION  G	, ,	OATE SURVEY COMPLETED
		146064	B. WING _			C 09/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	treatment order from the order to send (R E2 stated there show with E8 (off going nu (E21, RN).  On 9/12/16 at 1:20 pstarted working at the stated "I didn't know 8/28/16. No nurse eddressing or a wound "(E8, RN) never told open wound and the came on duty)."  On 9/8/16 at 3:35 pr Nurse (LPN) stated 8/20/16. E15 stated pump on right side of the site during my shan open area. No oprevious shift that the R1)."  On 9/8/16 at 9:30 ar R1 a shower on 8/22 white dressing on the E12's right lower abdressing "must have because I gave her as aw R1 on 8/26/16 of stated "I did (R1's) second (R1) had a dressing was clean, dry, intace E14 did not remove	nen E8 did not receive a n Z3. E2 stated "I would give 1) out (to emergency room). Uld have been communication urse) and the oncoming nurse om E21, RN, stated E21 re facility on 8/11/16. E21 (R1) had a pain pump till ever told me (R1) had a le or a pain pump." E21 stated me on 8/20/16 about (R1's) e call to the doctor (when a le or a pain pump. If the extension of abdomen. I did not check hift. I don't know if (R1) had ne reported to me from the ere was a skin issue (for m E12 CNA stated E12 gave 2/16. E12 stated R1 had a re right side and pointed to dominal area. E12 stated the shad a water proof cover	F 2	24		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		146064	B. WING			1	21/2016
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F 224	Continued From page		F:	224			
	that the dressing was according to orders fr Physician/Surgeon at "As far as I know we that dressing (over R I don't' recall (R1's) control of the R1's Physician Order not document orders.  On 9/8/16 at 2:55 pm in early on the third sam. E12 stated E12 roommate sometime heard R1 called "(E12 stated R1 "looked swup. (R1) was wearing was brown stain (on the minute that (R1) had looked and it was the abdomen over the puth of the whole dressing with the distance of the R1 (R1's bed bath and prestated R1 did not have stated E12 rolled R1 R1's bed bath and prestated R1 did not have stated E12 then called pull (R1) up in bed." to get E13, Licensed E12 remained with R room. E12 stated "I to get E13 st	was under the impression not to be removed" om Z2 (R1's Pain Clinic). E14 stated were not allowed to touch 1's pain pump incision site). For a pain pump incision site pain pump incision site pain pump site.  S Dated August 2016 does for R1's pain pump site.  E12 CNA stated E12 "came hift (8/28/16) between 2-3:00 was providing care to R1's before 4:00 am when E12 (2)." E12 stated "I went to to you need (R1)?' E12 I don't feel good." E12 eaty and let me wash (R1) g a hospital gown that there the gown) and thought for a a BM (bowel movement). I dressing on (R1's) right mp. The dressing was full. was saturated and it ugh on the gown. I didn't clean gown on (R1)." E12 onto R1's right side to finish ovide perineal care. E12 e a bowel movement. E12 d for E18, CNA, to "help me E12 stated (E18) then went Practical Nurse. E12 stated 1 until E13 came in R1's old E13 about the drainage					
	E12 then left R1's roo	r pump area." E12 stated om. E12 stated when it was up for day shift "I was (R1's)					

1, 7		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		146064	B. WING			C 9/21/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2650 NORTH MONROE STREET DECATUR, IL 62526	ZIP CODE	9/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 224	Nurse, LPN) if I can E12 stated "Me (E1: the wheelchair." E1 dressing on that wa E12 stated E12 ther for breakfast. E12 s (R1's) eyes were clo (catheter) was drain E12 stated E12 bround "placed (R1) in residents were out of 11:00 am, I put (R1) (E18) helped me pubrown stain was cor (R1) never complair and I told (E11) about think I know they (at (R1)."  On 9/13/16 at 9:20 a worked from 10:00 p 8/28/16. E18 stated She (R1) was sweat washed her fact the that (R1) wasn't lool stated E18 saw E13 R1 a breathing treat to help E12, CNA, g stated there was a be E18 stated the brow dressing on R1's rig R1 cleaned up then stated R1 stood up usual."  On 9/12/16 at 1:40 p worked from 6:00 pp.	ge 22 ed (E11, Licensed Practical get (R1) up. E11 said 'Yes." 2) and (E18) got (R1) up into 2 stated R1 still had the same s saturated with brown stain. In took R1 to the dining room stated "(R1) was groggy. In the dining room stated the firm the dining room stated the firm the dining room the room until all the In the dining room. Then about In back into bed. Another aide to the dining room. Then about In back into bed. The ming through (R1's) gown. Index. I changed (R1's) gown. Index. I changed (R1's) gown and (R1's) dressing. The next In the month of the dining right. It wasn't looking	F2	224			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146064	B. WING_			C 19/21/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		312112016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	not. E13 stated E13 treatment that morning nasal cannula at two stated R1's oxygen is before the breathing breathing treatment. Informed me that (R1 pain pump."  On 9/12/16 at 12:40 worked on 8/28/16 or to 2:00 pm. E17 state breakfast in the dining sleepy. I don't know E17 stated sometime past me and mention E17 stated "(R1) was and I smelled an odo There was drainage is side. It was dark brolike an open sore. (Finad oxygen on. (R1' could shake her head was not (R1's) normal it wasn't like her to be fussing with clothes as asy. So this wasn't him was close to 9:00 am E20 (CNA) went to go to me that (R1) was second (E11) was concerned the drainage then I let on 9/12/16 at 1:08 provided on 8/28/16 fin stated R1's dressing wet." E20 stated E20	gave R1 a breathing or gave R1 a breathing on and put oxygen on per (2) liters per minute. E13 aturation level was 90% treatment and 96% after the E13 stated "No one ever ) had a dressing over the one E17, CNA stated E17 on the day shift from 6:00 am ed "I saw (R1) during groom. (R1) looked a little whether she ate or not." after breakfast E12 walked ed (R1) wasn't feeling good. In in bed lying on her back or like a sore or something. In (R1's) gown on the right was breathing hard and so eyes were closed. (R1) dibut wasn't talking. This al. She always talked a lot. In equiet. She was always and always had something to be normal." E17 stated "This is so I stayed with (R1) and et (E11). E11 came and said smiling early in the morning.	F 2:	24		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IPLE CONSTRUCTIC	N	(X3) DATE COMP	SURVEY PLETED
		146064	B. WING _			1	C <b>21/2016</b>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRES  2650 NORTH MC  DECATUR, IL		1 00.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	ROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B S-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	R1's gown. E20 stat LPN) and (E11) looked On 9/8/16 at 4:00 pm Nurse (LPN) stated E8/28/16 during the 6 stated E11 did not rehad a dressing or drapump site in R1 lower on duty. E11 stated after lunch (on 8/28/2 CNA, told me (R1) had around (R1) pain pur gown. I went in (into the dressing (over the pump was sticking on R1's open wound was inches. E11 stated Earea. E11 stated E11	ish looking" and leaked onto ed "I remember telling (E11, ed at it (R1's dressing)."  In E11, Licensed Practical E11 was R1's nurse on am to 2 pm day shift. E11 ceive any information that R1 ainage over the internal er right abdomen when came "No one reported to me until I6) when E12, CNA or E17, and drainage, nasty smelling mp with drainage on (R1's) R1's room) and removed e pain pump) and the pain aut of the skin." E11 stated as about 2 1/2 inches by 1 1/2 E11 did not measure the eleaned the area (R1's Saline and gauze and left it stated R1 was "having E11 stated R1's oxygen 196%. E11 stated R1's Blood Temperature was 98.2 and Pulse was 76 beats per E13, LPN/night shift nurse,	F2	224	DEPICIENCY)		
	following: at 12:44 pr	ated 8/28/16 document the n "vs (Vital Signs) t degrees Fahrenheit) p					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	, l			
		146064	B. WING	B. WING		C <b>09/21/201</b>	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY 2650 NORTH MONROE DECATUR, IL 62526	STREET	09/21/201	0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)		ETION
F 224	Pressure) 60/40." a Primary Care Physici send pt (patient, R1) 12:49 pm "das (Deca called to transport pt. (local hospital) for ev documents "das here (local hospital) per st  R1's Hospital Emerge 8/28/16 documents R room on 8/28/16 at 1 documents "EMS (Er stated that the patien and SOB (Shortness the patient has a pair her abdomen." R1's documents "Distende Bowel Sounds: Other exposed in abdomina  R1's Ambulance Incic 8/28/16 documents R 8/28/16 at 12:46 pm. 12:48 pm "Going Sep B/P (Blood Pressure) (Pulse) 76- 96% on 2 minute) and going do "Narrative" document R1) IN NH (Nursing R Nurse) STAFF STATE FAMILIAR WITH THE A PAIN PUMP A COU HANGING OUT OF THAS HX (History) OF DNR (Do Not Resuso Support) ASSESSME VITALS OBTAINED A	at 12:47 pm " (Z3, R1's an) called, order received to out for evaluation."at tur Ambulance Service) to er (emergency room) at aluation."at 1:00 pm resident transported to retcher for evaluation."  ency Room report dated the arrived at the emergency regency Medical Services) to (R1) is septic with fever of Breath). EMS stated that a pump on the right side of abdominal assessment at Non-Tender: Normal regency regency regency law in the report dated response to the facility on the report documents at a pump draining and 60/40 R (Respirations) 28 P LPM (Liters of oxygen per with (downhill). The report residency in FOUND PT (Patient, Home) AND RN (Registered ES SHE IS NOT REAL E PT. RN STATES PT HAD IPLE DAYS AGO AND IT THE INCISION SITE. PT CA (Cancer) AND IS A citate). ALS (Advanced Life ENT PERFORMED AND	F	224			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED			
		146064	B. WING	B. WING		C <b>09/21/2016</b>
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE 2650 NORTH MONROE STREE DECATUR, IL 62526		09/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATI FICIENCY)	(X5) COMPLETION DATE
F 224	HANGING OUT OF I (Lower Right Quadra (Oxygen) SAT (Satur (Liters)/NC (Nasal Cad DISTENDED, RED APLACED ON CARDI. (Sinus Tachycardia, INCREASED TO 88% SIGNIFICANT CHANDON 12/16 at 8:46 at Ambulance Service, facility on 8/28/16 the normal nurse and haz 5 stated the nurse to you this" and pulled (stated R1's abdomina "looked as if it happe wound) did not look I (R1's) abdomen was and clammy. (R1) has was in Septic Shock. Very lethargic. In 26 anything like this. Ne hanging out. Half of out of (R1's) wound. about six (6) inches I and three (3) inches out."	NCISION SITE IN LRQ nt of Abdomen) PT O2 ation) 80% ON O2 2 L'S annula)PT LRQ IS VERY ND HOT TO TOUCH. PT AC MONITOR WITH ST apid heart rate). PT O2 SAT 6 AND PT BP HAD NO IGE"	F2	224		
	nursing home for evastatus and shortness (R1) has intrathecal pabdominal wall with around it (pump). Pa (Intravenous) fluids s	luation of change in mental of breath with fever. She pain pump extruding from the erythema and discharge tient was hypotensive and IV tarted and septic workup ormal WBC (White Blood				

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		146064	B. WING _			C 09/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 224	BUN (Blood Urea N (Z2, R1's Pain Clinic contacted and will b pump" The report and Symptoms: Hyp Mental Status, Tach minute). Sepsis State (Signs and Symptom (dysfunction)"elect Emergency Physicial R1's Hospital Discher (dysfunction)"elect Emergency Physicial Tischer (dysfunction)"elect Emergency Physicial Complete (dysfunction)"elect Emergency Physicial Tischer (dysfunction)"elect Emergency Physicial Complete (dysfunction)"elect Emergency Physicial Complete (dysfunction)"elect Emergency Physicial Discher (dysfunction)"elect Emergency Physicial Complete (dysfunction)"elect Emergency Physicial Discher (dysfunction)	emia of 24. Renal failure with itrogen) 49, Creatinine 4.1 c Physician, Surgeon) was e coming to remove the pain documents "Sepsis Signs perthermia >38.3, Altered ycardia >90bpm (beats per latus: Severe Sepsis: S&Sx ens) + Organ dysfunct tronically signed by Z14 en Provider.  Arge Summary report dated Reason for Admission-brought by Department) for further shortness of breath, altered ent (R1) was noted to have est with dehiscence of wound ump through wound in RLQ ent)Intrathecal pain pump 6Subsequently during ent's (R1's) symptoms and terioratedPatient expired end on 9/2/16 at 1259 hours Diagnoses: 1. Septic Shock: mp site infection and/or rinary Tract Infection)Blood	F2	224		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		146064	B. WING	B. WING		C <b>09/21/2016</b>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST 2650 NORTH MONROE ST DECATUR, IL 62526	•	09/21/2016	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFII TAG	(EACH CORRECT CROSS-REFEREIT	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA' DEFICIENCY)		
F 224	requiring intrathecal primplantation 6/2016 (signed by Z7(Hospital R1's "State of Illinois Worksheet" dated 9/6 death occurred on 9/2 and documents "Seprof death, certified by On 9/12/16 at 9:15 ar Hospitalist/Physician Certificate) stated R1 Septic Shock. Z7 states Septic Shock was the pain pump site was in On 9/7/16 at 3:46 pm Physician/Surgeon) seen at the clinic on 8 brought into the emerithe "pump breaking the "pump breaking the "pump breaking the anything like this to be appeared to be days The edges (of the word didn't look fresh. I can how (R1) was changen noticed."  On 9/14/16 at 10:05 as aw R1's original prodocumented R1's opesite measuring 1-2 cm was no "User Defined is to be completed on found. E2 stated E8 UDA on 8/20/16. E2	Drogrammable pain pump June 2016) electronically elist/Physician).  Certificate of Death 6/16 documents R1's date of 2/16 as a hospital inpatient tic Shock" as the R1's cause Z7.  m Z7 (R1's in Charge on Death came into the hospital with eted the primary site of R1's e pain pump. Z7 stated the enfected.	F2	224			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI 2650 NORTH MONROE STREET DECATUR, IL 62526	•	3372 1720 10	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 224	Administration Recor E2 stated if R1 had a then E14 should hav on the skin assessme physician orders for were no physician or treatment then E14 sorders and documen E2 stated when E12 dressing on 8/28/16 should have reported and should not have nurse found R1 safe there was no document treatments or care for that addressed R1's assessment and treatments or care for that addressed R1's assessment and treatments or care for that addressed R1's assessment and treatments or care for the thing and the second in R1 was reached for treatments are careful in the second infected, septimized in the second infected in the second infected to assessment, wound notification. R1's word days resulting in wouth the expulsion of an in was notified of the Im 9/19/16 at 3:30 pm.	d that R1's skin "was intact." In dressing on at that time the documented the dressing tent and reviewed R1's Interestment. E2 stated if there ders for R1's wound Inhould have called Z3 for ted in the progress notes. (CNA) found R1 with leaking (on the night shift) E12 If to the nurse immediately been moved R1 until the to be moved. E2 stated tentation, assessments, und in R1's medical record wound since the initial thment on 8/20/16 in the stated there is no 's record that a physician thment orders for R1's wound. It is not treated it (wound) can otic, necrotic."	F 22	24			

PRINTED: 09/28/2016 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				P WINC			C
		146064	B. WING			09/	21/2016
NAME OF PE	ROVIDER OR SUPPLIER  MANOR			2	TREET ADDRESS, CITY, STATE, ZIP CODE 650 NORTH MONROE STREET DECATUR, IL 62526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 224	The Director of Nursin licensed nurses on the evaluation and treatment have not return call at the schedule until edulicensed nurses conducted residents on 9/16/16, 9/19/16. In addition to check and additional by licensed nurses enevaluated by a licensed	emove the immediacy:  Ing (DON) educated all  e Wound policy including tent on 9/15/16. Two nurses and have been removed from fucation is completed. The fucted skin audits on all full 9/17/16, 9/18/16, and full of the resident's weekly skin fishin check will be completed full insuring resident's skin will be full ed nurse twice a week for	F	2224			
F 278 SS=D	and/or Nurse Manage resident skin audits a weekly. 483.20(g) - (j) ASSES ACCURACY/COORD The assessment mus resident's status.	nd do random audits	F	278			
	assessment is complete Each individual who cassessment must sign that portion of the assument Medicare and willfully and knowingly false statement in a re-	professionals.  ust sign and certify that the eted.  completes a portion of the n and certify the accuracy of					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS' AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		PLE CONSTRUCTION  G	, ,	OATE SURVEY OMPLETED		
		146064	B. WING			C 09/21/2016
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 278	willfully and knowing to certify a material aresident assessment penalty of not more trassessment.  Clinical disagreemer material and false statement false to accurately a dietary assessment frand R3) reviewed for the sample of five.  Findings include:  1) R2's Physician's F12:49pm documents Left Hip Surgery, Alz Hypertension, Cereb Coronary Artery Disestatement R2 has a pressure area measurement.  R2's Dietary Assessing documents R2's skindord R2's Spietary Assessing R2's Spietary R2's Spieta	essment; or an individual who by causes another individual and false statement in a is subject to a civil money than \$5,000 for each at does not constitute a atement.  To is not met as evidenced and record review, the facility assess skin conditions on the for two of five residents (R2 accuracy of assessments in Progress Note dated 9/1/16 at R2's diagnoses including the heimer's Disease, rovascular Accident, the ase and Atrial Fibrillation.  Cated 9/8/16 at 10:54am Stage 2 left heel open uring 10 cm (centimeter) by 4 ment dated 9/8/16 at 2:39pm as intact.  The progress Note of Nursing assessment did not document are serviced as a service of the serviced at the s	F 2'	78		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
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NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526	1 03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION
F 278	documents R3's dia Deficiency, Chronic Heart Failure and C R3's Skilled Documents R3 has a R3's Dietary Evaluar R3's Skin is intact. The dietician evaluated on 9/21/16 at 10:40 stated she would exputritional needs recommendations be stated E26, Quality wounds and gives a Manager who then a concerns. E2 verified dietician assessment The facility's undate Policy documents, "(significant) change documentation should condition supplem Manager will notify to conditions Pressu	o Report dated 9/12/16 gnoses including Vitamin D Ischemic Heart Disease, olostomy.  entation dated 7/6/16 an abdominal wound.  tion dated 7/13/16 documents there is no documentation that red R3's abdominal wound.  am, E2, Director of Nursing pect the dietician to assess garding wounds and make ased on those needs. E2 Assurance nurse monitors the report to the E24, Dietary notifies the dietician of skin d there is no documented at for R3's abdominal wound.  d Dietary Documentation Admit, Quarterly and Sig	F 2'	78	
F 282 SS=E	PERSONS/PER CA The services provided by	eVICES BY QUALIFIED  RE PLAN  ed or arranged by the facility  qualified persons in  ch resident's written plan of	F 2	32	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
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F 282	Continued From pag	ue 33	F 2	82		
	by: Based on record refailed to administer of physician orders and orders for administrate failures affect three or residents reviewed five residents reviewed five residents and or reviewed for accuracy sample of five.  Findings include:  1. R1's Skin Assess documents R1 is at R1's Physician Orded documents the follow Infarction due to Em Cerebral Artery, Abn Osteoporosis with C Vertebra, Hemiplegia unspecified side, Mu Neuromuscular Dyst Urinary Tract Infection R1's Care Plan date has potential for imp (related to) fragile sk selfMonitor/docum treatment of skin injutailure to heal, s/sx (infection, maceration Doctor)."	risk for skin breakdown.  r Sheet dated August 2016 ving diagnoses: Cerebral bolism of Unspecified iormal Posture, Age-Related urrent Pathological Fracture, a Unspecified Affecting the iscle Weakness, function of bladder, and on.  d 6/21/16 documents "(R1) airment to skin integrity r/t				
	documents R1 is cog	gnitively intact and requires ance of two staff for bed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		` '	COMPLETED			
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NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 2650 NORTH MONROE STREET DECATUR, IL 62526	E	03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 282	mobility, transfers, to On 9/4/16 at 3:46 pr Nurse (LPN) stated on the right elbow in at the facility on 1/19 in the wheelchair an R1's normal posture stated R1's right elbo frame as R1 entered resident's wheelchair stated R1 wore a "spelbow to above the eprotect the elbow." I covered the dressing and dressing treatme anything under the esleeve. E14 stated 'am aware of that was elbow."  R1's Administration documents "Res whealed."  R1's Progress Notes "New order obtained being seen by (E8, Note have red, weeping R elbow. (Z8) gave elbow with NS, cover foam pads, and wrap F/U (follow-up)with of R1's Progress Notes "Res was transported Dermatologist) offices."	bileting, and bathing.  In E14, Licensed Practical R1 has had an open wound termittently since E14 started b/15. E14 stated R1 would sit d lean to the right, which was because of R1's back. E14 bw would bump the door If the room or bump other is or hallway railing. E14 becial sleeve from below the below with a very thick pad to E14 stated that the sleeve g but when the elbow healed ents ended there wasn't below to hold up the special 'there was nothing else that I is used to protect (R1's)  Note dated 5/1/2015 byound to (right) elbow  a dated 5/4/15 documents I post Res (resident, R1) Wound Physician). Res cont g, warm to touch dermatitis to new orders to, Cleanse R or rash with Nystop, apply by with Kerlix BID. Res also to dermatology"  a dated 6/25/15 documents d via facility transport to (Z12, e. (Z13) nurse from Z12's and ADON (Assistant Director	F 2	82		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 282	(treatment) changes not providing adequal (Z12's) staff refuses Res RUE (Right Uppassess RUE until tx staff (Z13) cont (conot providing adequal R1's "Wound Care S8/31/15 documents lelbow. The evaluating presents with a would (secondary) to traunduration. There is mand 50% yellow necentimeters (cm) with and 50% yellow necentimeters (cm) with a continuent (cm) with a continuent (cm) with a continuent (cm) of the cont	on Res R (right) elbow and ate care(Z13) stated that to remove tx (treatment) to per Elbow) and will not is removed from facility ontinued) to accuse staff of ate care"  Specialist Evaluation" dated R1 has a wound on the right on report documents "(R1) and of the right, sec an elbow of at least 24 days noderate serous exudate."  O x 1.8 x not measurable h moderate serous exudate rotic, 50% granulation tissue. Its that wound progress is  d 11/23/15 documents "(R1) with open area of R (right) ment as ordered"  lated 10/2/2015 documents /t (related to) intrathecal pain nument. Pump was not elbow wound infection.  Subservations" dated cuments R1's "Skin is warm,	F 2	82		

STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING			(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 282	room) to have that eg 9/30/15 R1's elbow draining. Z1 stated dressing "nothing of was "damp with dra next at the Pain Cer had open elbow work center Physician/St the wound clinic at (Z1 stated on 5/2/16 healed and R1 was pump changed on 6 pump could not be owned was healed.  The following inform prescribed for R1's September 2015, O December 2015, and documentation foun Administration Reconstitution of the documents R1's ord 2% "Apply to to righ and evening shift for with gauze and wray Administration Reconstruction of the documents R1's righ Bactroban was not stated the treatment with 9/3/15, 9/4/15, and stated or control of the documents an order Ointment 250 unit/Garage and with gauze and wray and stated or control of the documents an order Ointment 250 unit/Garage and with gauze and wray and stated or control of the documents an order Ointment 250 unit/Garage and wray and stated or control of the documents an order Ointment 250 unit/Garage and wray and stated or control of the documents an order Ointment 250 unit/Garage and wray and stated or control of the documents an order Ointment 250 unit/Garage and wray and stated or control of the documents an order Ointment 250 unit/Garage and wray and stated or control of the documents an order Ointment 250 unit/Garage and wray and stated or control of the documents and order Ointment 250 unit/Garage and wray and stated or control of the documents and order Ointment 250 unit/Garage and wray and stated or control of the documents and order Ointment 250 unit/Garage and wray and stated or control of the documents and order Ointment 250 unit/Garage and wray and stated or control of the documents and order Ointment 250 unit/Garage and wray and stated or control of the documents and order Ointment 250 unit/Garage and wray and the documents and order Ointment 250 unit/Garage and wray and the documents and order Ointment 250 unit/Garage and wray and order Ointment 250 unit/Garage and wray and order Ointment 250 unit/Garage and wray and order Ointment 250 unit/Garage and wr	sent to ER (Emergency evaluated." Z1 stated that on wound was still open and was there was a 4 x 4 gauze significance" and the gauze nage." Z1 stated Z1 saw R1 ater on 10/8/15 and R1 still and. Z1 stated Z3 (Pain argeon) "insisted (R1) go to local hospital) for treatment." R1's elbow wound was scheduled to have the pain ation is a listing of treatments right elbow wound in changed until the elbow ation is a listing of treatments and that the treatment word that the treatment word that the treatment word that the treatment of the elbow topically every day ar wound for 10 days. Cover to with kerlix." R1's Treatment and dated September 2015 at elbow treatment for signed off (initialed by nurse) as done on 9/1/15, 9/2/15,	F 2	32		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG	' '	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE A CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 282	wound. Cleanse wou Saline)/gauze. Apply Moisturize arm with of Apply santyl and bact to wound only; cover silver; apply foam and pad/dressing cover); with tape." R1's Treadated September 20 delbow treatment as disigned off on 9/14/15.  R1's Physician Order documents R1's order documents R1's order document 250 unit/Grelbow topically every wound. Cleanse wou Saline)/gauze. Apply apply wet to dry dreskerlix, secure with tape Administration Record documents R1's right described above was treatment was done of 10/16/15, 10/20/15, 110/30/15.  R1's Physician Order documents R1's order documents R	and with NS (Normal skin prep to wound edges. erave (moisturizing cream); troban (antibiotic ointment) with calcium alginate NO d ABD (Abdominal wrap with kerlix and secure atment Administration Record 15 documents R1's right escribed above was not secure atment Administration Record 15 documents R1's right escribed above was not secure atment Administration Record 15 documents R1's right escribed above was not secure atment and 10/6/15 for Santyl am (gm) "apply to right evening shift for open elbow and with NS (Normal santyl to affected area, sing change daily wrap with the secure at the secure a	F 2	282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146064	B. WING			C 9/21/2016
NAME OF P	ROVIDER OR SUPPLIER	1,000		STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		9/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 282	that the treatment wa 10/16/15, 10/20/15, a R1's Physician Order documents R1's order clean right elbow with Aquacel AG, pack turnesidol on periwound change every two (2) every two days for all Treatment Administration November 2015 document as described that the treatment was 11/29/15.  R1's Physician Order documents R1's order Normal Saline, apply 12 O'Clock use resid with kerlix, change every day shift every integrity. R1's Treatment as disigned off that the treatment as displayed as a series of the treatment was a series of the treatment was a series of the treatment was a series of the treatment as displayed as a series of the treatment was a series of the treatment was a series of the treatment as displayed as a series of the treatment was a series of the treatment as displayed as a series of the treatme	ed above was not signed off is done on 10/7/15, 10/9/15, and 10/23/15.  The start date for 11/25/15 to in Normal Saline, apply innel at 12 O'Clock use skin wrap with kerlix, in days or prin every day shift tered skin integrity. R1's ation Record dated uments R1's right elbow and above was not signed off its done on 11/25/15 and its done on 11/25/15 for poly to right elbow was not eatment was done on 11/216/15.  The start date of 12/12/15 for poly to right elbow topically ing shift for wound and pack th Aquacell. R1's Treatment id dated December 2015 it elbow treatment as a not signed off that the in 12/24/15, 12/27/15,	F 28	32		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCT A. BUILDING  A. BUILDING			, ,	ATE SURVEY DMPLETED		
		146064	B. WING _			C 09/21/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526	1	3072112013
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	_	ers dated January 2016	F 2	82		
	apply to right elbow evening shift for wo wound with Aquace Administration Reco documents R1's rig described above wa treatment was done 1/8/16 and 1/9/16 n	ord dated January 2016 Intelbow treatment as It is not signed off that the It is on the day shift on 1/6/16, It is or was treatment signed off as It is not display the order				
	documents R1's ord Powder to apply to shift. R1's Treatme dated January 2016 treatment as descri	ers dated January 2016 der dated 1/11/16 for Nystatin right elbow topically every day nt Administration Record documents R1's right elbow bed above was not signed off vas done on 1/11/16, 1/12/16, 20/16 and 1/21/16.				
	documents R1's ord (wound dressing) to transdermally every prophylaxis remove Normal Saline; Comperiwound skin, pla cover with foam or git doesn't fall down dressing every two treatment for Actico pharmacy until 1/7/Administration Record documents R1's rig described above was	der dated January 2016 der dated 1/4/16 for Acticoat der papply one application day shift every two days for dressing and cleanse with tinue using antifungal to ce Acticoat to wound bed, gauze and secure bandage so off wound; Change entire days and as needed. R1's at was not obtained from the 16. R1's Treatment ord dated January 2016 ht elbow treatment as as not signed off that the e on 1/4/16, 1/6/16, 1/8/16,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED		
		146064	B. WING				C (24/2046
NAME OF P	ROVIDER OR SUPPLIER	1.0001		2650 NO	ADDRESS, CITY, STATE, ZIP CODE RTH MONROE STREET UR, IL 62526	1 09/	21/2016
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 282	1/10/16, and 1/12/16 R1's Physician Order documents R1's order clinic to see res (resident practitioner). Dressing facility at all. May rein remove original dress clinic only."  On 9/7/16 at 4:10 pm stated resident's wou on the Treatment Adrinitialed by the nurse E9 stated "to my und initials (by the nurse) done."  2. R3's Hospital Encadmitted to the hospi with the diagnoses of ascending colon, Abordones surgery, Intracta with nausea, vomiting R3's Physician Order documents an abdom to start on 6/17/16 for change twice daily. Of (Normal Saline) and smoistened gauze in with dressing and secure Monitor for s/s (signs redness and swelling Administration Recontreatment was discording the signs of the s	as dated January 2016 or dated 1/24/16 for "Wound dent, R1) per (Z11, Nurse ing not to be changed in inforce dressing but do not sing. To be done per wound in E9, Registered Nurse, and treatments are recorded ininistration Record and that performs the treatment. The information in the it (treatment) wasn't in it (treatment) wasn't in it (treatment) wasn't in it (treatment) wasn't in it (it is it is	F:	282			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED	
		146064	B. WING _			C 09/21/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526	<u> </u>	03/21/2010
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	abdominal wound to abdominal wound to with ABD pad."  R3's Treatment Adn June 2016 document treatment was not swas done on 6/20/16/26/16 (on day shift R3's Treatment Adn August and Septem abdominal wound to that the treatment was 8/12/16, 8/15/16, 8/8/25/16, 8/26/16, 8/26/16, 8/26/16, 8/26/16, 8/26/16, 8/26/16, 8/31/16, and 9/1/16  On 9/7/16 at 11:26 at (Director of Nursing signed off on the result of the page	t 250 unit/GM (gram) Apply to opically every day shift for op with moist gauze and cover ministration Record dated at R3's abdominal wound igned off that the treatment 6 (evening shift), 6/25/16 and ft).  Ininistration Record dated aber 2016 document R3's reatment was not signed off was done on 8/3/16, 8/8/16, 17/16, 8/21/16, 8/22/16, 31/16, and 9/1/16.  In E5, Registered Nurse ing to R3's Treatment ord dated August 2016 "there in that (R3's) dressing was 8/8/16, 8/12/16, 8/15/16, 22/16, 8/25/16, 8/26/16,  In an and 1:45 pm E2 DON (), stated treatments are	F 2			
	the treatment wasn' Wet to dry dressing not documented as and 6/26/16. E2 co treatment was not d 8/3/16, 8/8/16, 8/25/16, 8/26/16, 8/	o initials for the treatment then t done. E2 confirmed R3's for the abdominal wound was done on 6/20/16, 6/25/26, nfirmed that R3's Santyl locumented as done on /16, 8/15/16, 8/17/16, 8/21/16, 31/16 and 9/1/16. E2 stated ed it didn't happen."				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		146064	B. WING			C 09/21/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2650 NORTH MONROE STREET DECATUR, IL 62526	ODE	09/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 282	cleansing R3's abdor Saline and E5 picked placed it into a contal packed the gauze int E5 then secured the R3's wound.  On 9/20/16 at 10:12 Physician Order for the treatment "did not sale stated E5, RN, shoul abdominal wound."  3. According to the ellist, R5 has multiple of Dementia, Chronic Colisease and Non-prefereceives Hospice services Hospice services (No 9/8/16 at 10:00ar Nurse) did the treatment wound was a pea-size removed the dressing packing. E4 reported wound was packing and dressing to covered the contains the chronic wound was packing and dressing to covered the contains the chronic wound was packing and dressing to covered the contains the chronic wound was packing and dressing to covered the contains the chronic wound was packing and dressing to covered the contains the chronic wound was packing and dressing to covered the contains the chronic wound was packing and dressing to covered the contains the chronic wound was packing to covered the contains the chronic wound was packing to covered the contains the chronic wound was packing to covered the contains the chronic wound was packing to covered the contains the chronic wound was packing to covered the chronic wound the chronic wound was packing to covered the chronic wound was packing to covered the chronic wound was packing to covered the chronic wound the chronic woun	n E5, Registered Nurse, after minal wound with Normal dup the sterile gauze and iner with Normal Saline and to R3's abdominal wound. abdominal pad covering am E2 DON stated R3's the abdominal wound y to pack the wound." E2 do not have packed R3's electronic Medical Diagnosis diagnoses including obstructive Pulmonary essure Chronic Ulcer, and	F2	282		
	the bottle labeled So- solution. E4 lightly p covered with foam dr The electronic Physic doctor) dated 8/30/16 wound with normal si	line)gauze, and wet it from dium Hypochlorite (bleach) acked the wound and ressing.  cian's Order by Z4 (wound 5 states, "Cleanse right hip aline. Loosely pack top of . DO NOT PACK THE				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		146064	B. WING		00%	
NAME OF PROV	VIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD 2650 NORTH MONROE STREET DECATUR, IL 62526	•	21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
Eldron Ous the social three soc	ressing daily and P n 9/8/16 at 12:20ar sed for R5's treatm e lodoform gauze a plution, and packed e Physician's Orde dministration record (30/16 and stated, ' e Dakin's solution. rder." n 9/8/16 at 1:00pm onfirmed that R5's to not that E4 should h he untitled facility p policy and Procedure policy of this facility to r signs of injury and ontinually inspect the gns of pressure ulco anormalitiesResid at RISK" for the de fill have a head-to-te licensed nurse were reatment Administration he undated facility as the policy of the facesessment on all w the response to nurs odalitiesA descrip	over with bordered foam RN (as needed."  m, E4 looked at the bottles ent and confirmed she took and wet it with the Dakin's I the wound. E4 looked at er and the TAR (treatment d) and found the order dated 'They changed it. It was just I didn't even look at the I didn't even loo	F 28	32		

AND DLAN OF CORRECTION IDENTIFICATION NUMBER		PLE CONSTRUCTION  G	(XX	3) DATE SURVEY COMPLETED		
		146064	B. WING			C <b>09/21/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526	I	03/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 282	be notified promptly to that will be implement.  4. R2's Physician's P. 12:49pm documents. Left Hip Surgery, Alzl Hypertension, Cerebic Coronary Artery Dise.  R2's Progress Notes document R2 was se evaluation of the left previous fracture was bruised and warm to returned to the facility. Postoperative Hemat and Supratherapeutic Ratio (INR).  R2's Emergency Care Instructions dated 9/Coumadin (Anticoagu INR tomorrow. Call {2 Physician} with result further Coumadin use document, "receive office r/t (related to) in (Prothrombin Time)/II PT 31.0 INR 2.9, Couwas given new orders (milligrams) PO (by m. R2's Progress notes documents, "Coumadin ceeiving new Coumadin energial of the progress notes of t	rogress Note dated 9/1/16 at R2's diagnoses including neimer's Disease, rovascular Accident, ase and Atrial Fibrillation.  dated 9/5/16 at 4:42pm nt to the hospital for an hip. R2's left hip site of a noted to be swollen, touch. At 8:36pm, R2 with diagnoses of oma of subcutaneous tissue and International Normalized  e Center Discharge 5/16 document, " Hold ulant) today and get repeat Z15, R2's Orthopaedic and further instructions on e"  dated 9/6/16 at 5:45pm d an order from {Z15's} esident's {R2's} PT NR results from this morning imadin was held last night is of Coumadin 2mg nouth) daily"  dated 9/6/16 at 5:59pm din 4mg was given prior to adin order." R2 was given e receiving the order to	F 28	32		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146064	B. WING			l	C
		146064	B. WING	_		09/	21/2016
NAME OF PE	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
LINCOLN	MANOR				2650 NORTH MONROE STREET		
					DECATUR, IL 62526		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 282	Continued From page 45		F	282			
	stated she would exp administer Coumadin based on the PT/INR	n, E2, Director of Nursing ect the nurses to wait to until an order is received lab results.  Medication Administration					
	•	Verify Physician order					
F 309 SS=J	483.25 PROVIDE CA	RE/SERVICES FOR	F	309			
	provide the necessary or maintain the higher mental, and psychoso	eceive and the facility must y care and services to attain st practicable physical, ocial well-being, in comprehensive assessment					
	by: Based on record revifailed to assess, treat one of five residents (the sample of five resresulted in R1's abdorfor eight (8) days. Th R1's internal abdomin	ew and interview the facility, and provide services for R1) reviewed for wounds on idents. These failures minal wound left untreated e wound become infected, all pain pump protruding ith subsequent Septic n.					
	These failures resulte Jeopardy.	d in an Immediate					
	_	was removed on 9/20/16, it of compliance at severity					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
		146064	B. WING _			C <b>09/21/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 2650 NORTH MONROE STREET DECATUR, IL 62526	CODE	03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 309	level two. The facilit evaluating the effective for resident skin and physical assessment physician notification.  Findings include:  R1's Physician Order documents the follow Infarction due to Embarce Cerebral Artery, Abnoto Osteoporosis with Culvertebra, Hemiplegia unspecified side, Mus Neuromuscular Dysfu Urinary Tract Infection.  R1's Minimum Data Stocuments R1 is cog	y is in the process of veness of staff re-education wound assessments, s, change in condition and  Sheet dated August 2016 ing diagnoses: Cerebral volism of Unspecified ormal Posture, Age-Related arrent Pathological Fracture, Unspecified Affecting the scle Weakness, unction of bladder, and n.  Set (MDS) dated 7/14/16 nitively intact and requires	F3	309		
	mobility, toileting, and documents R1 has all and is at risk for pres Assessment dated 7/ risk for skin breakdov  R1's Care Plan initiat "(R1) has potential for/t (related to) fragile selfMonitor/docume treatment of skin injurfailure to heal, s/sx (sinfection, maceration Doctor)." Care Plan documents R1 "has pskin integrity of the all surgical wound (pain	n indwelling urinary catheter sure ulcers. R1's Skin 14/16 documents R1 is at wn.  ed on 6/21/16 documents r impairment to skin integrity skin and picks at ent location, size and ry. Report abnormalities, iigns and symptoms) of				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		146064	B. WING _			C 09/21/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2650 NORTH MONROE STREET DECATUR, IL 62526	DE	03/21/2010
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 309	depth, type of tissue	ge 47 I breakdown's width, length, e and exudate (drainage) and hanges or observations."	F3	309		
	R1 's TAR (Treatme	ent Administration Record) skin check was completed on				
	Nursing Assistant) s from 2:00 pm to 10: noticed a small "ope was for (R1's) pump little piece of silver."	pm E12 CNA (Certified stated E12 worked on 8/20/16 00 pm. E12 stated E12 en wound where the incision o (right abdomen) and saw a ' E12 stated E12 didn't know scared me. I went and told the				
	(RN), stated the CN 8/20/16 reported to over the pain pump looked and saw an could see the metal stated E8 left a mes Care Physician) cel informed the oncom open area over the not heard from (R1' could not remembe nurse. E8 stated "V nurse) that (R1) had (oncoming nurse) d	pm E8, Registered Nurse IA (E12) that put R1 to bed on E8 that R1 had an open area . E8 stated "I went in and opening in (R1's) skin and I part of the pain pump." E8 ssage on Z3's (R1's Primary I phone. E8 stated E8 ning, night shift nurse of R1's pain pump site "since I had s) doctor. " E8 stated E8 r the name of the night shift When I said (to oncoming d pain pump surgery she idn't know."  dated 8/20/16 at 8:31 pm				
	documents "MD (Maware of open skin pump that patient singo. left message of	edical Doctor) called to make area around internal pain tates was placed a few weeks on MD cell phone. Skin does Cleanse with iodine, warm				

AND DUAN OF CORDECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		146064	B. WING _			C 09/21/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526	•	03/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	applied to protect from to reply to phone mediated 8/20/16 at 8:3	ge 48 Attibiotic ointment and dressing om infection. Waiting for MD essage." R1's Nurses Notes 7 pm document "the opening of timeters) in length and 0.5	F3	009			
	Policy and Procedur skin is the body's fin policy of this facility for signs of injury an continually inspect t signs of pressure ulabnormalitiesResi "AT RISK" for the dewill have a head-to-a licensed nurse we	policy titled "Skin Assessment re" documents "Intact, healthy st line of defense. It is the to monitor the skin integrity di riritationPurpose to he resident's skin for early cer development and other dents who are determined evelopment of pressure ulcer soe skin assessment done by ekly and documented on the ration Record (TAR)"					
	Assessment Policy is the policy of the far assessment on all with the response to nurs modalitiesTo docu assessment of wour recordProcedure	I. The presence of wounds, skin abnormalities will be nission nursing assessment, ment or identified at any other d wound assessment will be tensed nurse for all wounds, ents in the skin integrity. 3. A bound will be noted and the ified for an appropriated e implemented. 4. A weekly essment of each wound will					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		146064	B. WING			C <b>9/21/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		3/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 309	surrounding skin. 5. status the assessment physician will be notificated treatment orders that Care Plan will be upon The facility's undated Condition" policy door promptly notify the rephysician or designe (sponsor) of changes medical/mental condition or status.  On 9/6/16 at 3:30 pm Registered Nurse at R1 had internal pain Z1 stated R1 and was 8/1/16 and "at that tir abdomen was healed return to the clinic for there were no other incision site was head dressing. On 9/12/16 Nurse at Pain Clinic, pain pump for several Intractable Lumbar B  R1's Hospital Pain M Instructions" dated 8/1 (one) month." R1's report from the Pain Integrated the pain Integrated from the	age, measurements, and process, and condition of Upon any change in wound and will be updated, the fied promptly to obtain a will be implemented. 6. Idated with changes."  I "Change in Resident auments "Our facility shall asident, his or her Attending are, and representative in the resident's are in the resident's are in the resident's are in the resident's are made of the cord information relative to ent's medical/mental  In and 9/8/16 at 11:25 am Z1, Hospital Pain Clinic, stated pump replaced on 6/27/16. Is last seen at pain clinic on the pump wound in the cord." Z1 stated R1 was to a follow up on 9/1/16 and anstructions. Z1 stated R1's led and did not require a cord at 8:30 am Z1, Registered stated R1 had an internal all years for Chronic	F 30	09		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 2650 NORTH MONROE STREET DECATUR, IL 62526		0/2 1/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 309	Physician) stated Z3 Urinary Tract Infection unaware of R1's open 8/20/16. Z3 stated Z regarding R1's wound messages. Z3 stated pump should have bedoctor (Z2, R1's Pain No one notified me."  On 9/12/16 at 2:20 pustated no one notified 8/20/16. Z4 reviewed 8/20/16 and stated R2 cleaned with Normal or betadine and not so  On 9/12/16 at 11:25 a stated when R1's open 8/20/16 the pain cent notified. Z1 stated "V seen at the pain cent evaluate and give ord notified us that (R1) if pump."  On 9/12/16 at 2:40 P Nursing), stated E8 s R1's open wound wh treatment order from the order to send (R1 E2 stated there shou with E8 (off going nur (E 21, RN). E2 state R1's wound with Norm	m Z3 (R1's Primary Care saw R1 on 8/8/16 for a n. Z3 stated Z3 was n abdominal wound on 3 had nothing faxed d and received no phone I "any concerns with the pain een directed to the pain clinic Clinic Physician/Surgeon).  m Z4 (Wound Physician) I Z4 of R1's wound on I E8 nurses note dated I's wound should have been Saline, or wound cleanser, oap and water.  am Z1, RN/Pain Clinic, en area was found on	F 30			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		146064	B. WING			C
NAME OF PI	ROVIDER OR SUPPLIER	1,000		STREET ADDRESS, CITY, STATE, ZIP COD  2650 NORTH MONROE STREET  DECATUR, IL 62526	•	09/21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 309	On 9/12/16 at 1:20 P started working at the stated "I didn't know 8/28/16. No nurse ever dressing or a wound stated "(E8, RN) never (R1's) open wound a (when came on duty)  On 9/8/16 at 3:35 PM Nurse (LPN) stated E8/20/16. E15 stated pump on right side of the site during my shan open area. No on previous shift that the R1)."  R1's shower/skin not does not indicate "Ye R1's skin was intact. document that R1 ha pump site on right ab  On 9/8/16 at 9:30 am R1 a shower on 8/22 white dressing on the E12's right lower abd dressing "must have because I gave her a did not see any drain gave no indication the E12 stated R1 was a R1 had a urinary cath urine without odor.  On 9/8/16 at 11:05 at saw R1 on 8/26/16 of	M E21, RN, stated E 21 e facility on 8/11/16. E 21 (R1) had a pain pump till ver told me (R1) had a or a pain pump." E 21 er told me on 8/20/16 about and the call to the doctor ." I E15, Licensed Practical E 15 worked the day shift on "I knew (R1) had a pain abdomen. I did not check iff. I don't know if (R1) had he reported to me from the here was a skin issue (for  diffication sheet dated 8/22/16 here sheet does not he day shift on the sheet dated 8/22/16 here was a skin issue (for	F3	309		

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		146064	B. WING			·	0
NAME OF P	ROVIDER OR SUPPLIER	140004	<u> B. viiive</u>	S 2	STREET ADDRESS, CITY, STATE, ZIP CODE  1650 NORTH MONROE STREET  DECATUR, IL 62526	09/3	21/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	was clean, dry, intact E14 did not remove the did not recall if there was according to identify where you identify was according to orders from the physician/Surgeon at "As far as I know we was that dressing (over Richard I don't' recall (R1's) or (R1) was alert and or complain of pain." E wound is found on a ris notified. The Prima and family and we the orders."  On 9/8/16 at 9:45 am talked with E14 on 9/E14 did R1's skin assisthere was a small bar pump area. E1 stated for R1's physician or stated E14 should ha measured the wound Primary Care Physician On 9/8/16 at 2:55 pm in early on the third slam. E12 stated E12 roommate sometime heard R1 called "(E12 roommate sometime heard R1 called "(E12 stated R1 "looked swup. (R1) was wearing the properties of t	over pain pump area) that no drainage." E14 stated ne dressing. E14 stated E14 was a date recorded on the hen the dressing was was under the impression not to be removed" om Z2 (R1's Pain Clinic). E14 stated were not allowed to touch 1's pain pump incision site). The pain pump incision site interest, no fever and did not 14 stated when an open resident the "Wound doctor ry Care Physician is notified en implement treatment  E1, Administrator stated E1 rough and the said lessment on 8/26/16 and and age over the internal de E14 should have looked lers for the wound. E1 ve looked at the wound, and called Z3 (R1's	F	309			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		146064	B. WING _			C 09/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	looked and it was the abdomen over the property of the whole dressing (drainage) came the smell an odor. I put stated E12 rolled R R1's bed bath and property of the whole to get E13, License E12 remained with room. E12 stated "on R1's dressing over E12 then left R1's retime to get residential aide on days. I ask Nurse, LPN) if I can E12 stated "Me (E1 the wheelchair." E1 dressing on that was E12 stated E12 the for breakfast. E12 stated E12 the	d a BM (bowel movement). I he dressing on (R1's) right bump. The dressing was full. was saturated and it rough on the gown. I didn't to clean gown on (R1)." E12 onto R1's right side to finish provide perineal care. E12 have a bowel movement. E12 hed for E18, CNA, to "help me of E12 stated (E18) then went of Practical Nurse. E12 stated R1 until E13 came in R1's of I told E13 about the drainage for pump area." E12 stated when it was so up for day shift "I was (R1's) hed (E11, Licensed Practical of get (R1) up. E11 said 'Yes." (E12) and (E18) got (R1) up into of E12 stated with brown stain. In took R1 to the dining room stated "(R1) was groggy. Dised." E12 stated R1's of draining a brownish color of E12 brought R1 from the dining to t1:00 am I put (R1) back helped me put (R1) brown stain was coming on. (R1) never complained. I on and I told (E11) about the next think I know they	F3	09		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING  ———————————————————————————————————			(X3) DATE SURVEY COMPLETED			
		146064	B. WING _			C 09/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526	I	03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	that (R1) wasn't look stated E18 saw E13 R1 a breathing treating to help E12, CNA, go stated there was a b E18 stated the brown dressing on R1's right R1 cleaned up then stated R1 stood up "usual."  On 9/12/16 at 1:40 pworked from 6:00 pm 8/28/16. E13 stated stated E13 did not knot. E13 stated E13 treatment that morninasal cannula at two stated R1's oxygen shefore the breathing breathing treatment. informed me that (R1) pain pump."  On 9/12/16 at 12:40 worked on 8/28/16 of 0 2:00 pm. E17 stated breakfast in the dining sleepy. I don't know E17 stated sometime past me and mention E17 stated "(R1) was and I smelled an odd There was drainage side. It was dark brolike an open sore. (R1) had oxygen on. (R1)	in I went and told (E13, LPN) ing her normal self." E18 go into R1's room and gave ment. E18 stated E18 went et R1 up for breakfast. E18 rown stain on R1's gown. In stain came from the leaking at side. E18 stated E12 got ready for breakfast. E18 but needed more help than in mE13, LPN, stated E13 and on 8/27/16 to 6:00 am on in it was (R1's) nurse. E13 and put oxygen on per (2) liters per minute. E13 staturation level was 90% treatment and 96% after the E13 stated in it was in the day shift from 6:00 am sted in law (R1) during and put oxygen on per (I) had a dressing over the in the day shift from 6:00 am sted in law (R1) during and room. (R1) looked a little whether she ate or not. In the day shift feeling good. In it is a sore or something. In the day shift feeling good. In it is a sore or something. In the coffee and smelled in the coff	F3	09		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		146064	B. WING _			09/ <b>2</b>	:1/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z 2650 NORTH MONROE STREET DECATUR, IL 62526	IP CODE	00/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICE)	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
F 309	It wasn't like her to be fussing with clothes a say. So this wasn't h was close to 9:00 am E20 (CNA) went to get to me that (R1) was second the drainage then I led the drainage the I led the drainage was "brown R1's gown. E20 stated E20" smelled like infection drainage was "brown R1's gown. E20 stated EPN) and (E11) looked the drainage was "brown R1's nurse on 8/28/16 day shift. E11 stated information that R1 hover the internal pum abdomen when came one reported to me unwhen E12, CNA or Edrainage, nasty smell with drainage on (R1' room) and removed the pump) and the pain position." E11 stated R1 1/2 inches by 1 1/2 inches by 3 inches difficulty bread area (R1's wound) of "having difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty bread oxygen saturation lever the area and the difficulty	al. She always talked a lot. The equiet. She was always and always had something to the er normal." E17 stated "This This is so I stayed with (R1) and the E11. E11 came and said the early in the morning. The about (R1) and looked at	F	309			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION  A. BUILDING		' '	(X3) DATE SURVEY COMPLETED			
		146064	B. WING _			C <b>09/21/2016</b>
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	beats per minute. Is shift nurse, said to E trouble breathing. Et	ahrenheit, and Pulse was 76 E11 stated E13, LPN/night E11 that "(R1) was having E13 did not say a word about bump site. Don't know if I did (R1's) vitals myself and then called family, then (Z3) Physician)." E11 stated R1 or years for back pain.  dated 8/28/16 document the m "vs (Vital Signs) t (degrees Fahrenheit) p	F3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  NG	, ,	(X3) DATE SURVEY COMPLETED	
		146064	B. WING _			C 09/21/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	(Pulse) 76- 96% on minute) and going d "Narrative" documer R1) IN NH (Nursing Nurse) STAFF STAT FAMILIAR WITH THA PAIN PUMP A COHANGING OUT OF HAS HX (History) ODNR (Do Not Resus Support) ASSESSM VITALS OBTAINED APPROX 4 1/2 INCI HANGING OUT OF (Lower Right Quadra (Oxygen) SAT (Satu (Liters)/NC (Nasal COISTENDED, RED PLACED ON CARD (Sinus Tachycardia, INCREASED TO 88 SIGNIFICANT CHAIN ON 9/12/16 at 8:46 a Ambulance Service, facility on 8/28/16 th normal nurse and haz 5 stated the nurse you this" and pulled stated R1's abdomin "looked as if it happer wound) did not look (R1's) abdomen was and clammy. (R1) hwas in Septic Shock very lethargic. In 26 anything like this. New Ambulan of the property	e) 60/40 R (Respirations) 28 P 2 LPM (Liters of oxygen per ownhil (downhill). The report ints "FOUND PT (Patient, Home) AND RN (Registered TES SHE IS NOT REAL TE PT. RN STATES PT HAD THE INCISION SITE. PT THE INCISION SITE IN LRQ THE INCISION SI	F3	309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	' '	(X3) DATE SURVEY COMPLETED	
		146064	B. WING _			C 09/21/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526		03/21/2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	about six (6) inches and three (3) inches	ge 58 . The opening (wound) was long and 1 1/2 inches wide s of the pump was hanging	F3	009		
	8/28/16 documents nursing home for ev status and shortnes (R1) has intrathecal abdominal wall with around it (pump). P (Intravenous) fluids done. Patient has N Count) 9.7 but band BUN (Blood Urea N (Z2, R1's Pain Clinic contacted and will b pump" The report and Symptoms: Hyr Mental Status, Tach minute). Sepsis State (Signs and Symptor	om "Disposition" dated "Patient (R1) brought in from aluation of change in mental s of breath with fever. She pain pump extruding from the erythema and discharge atient was hypotensive and IV started and septic workup Jornal WBC (White Blood Jemia of 24. Renal failure with Jitrogen) 49, Creatinine 4.1 C Physician, Surgeon) was e coming to remove the pain documents "Sepsis Signs Derthermia >38.3, Altered ycardia >90bpm (beats per litus: Severe Sepsis: S&Sx ms) + Organ dysfunct ctronically signed by Z14 an Provider.				
	9/2/16 documents "I in to ED (Emergenc evaluation of fever, mental status. Patie Infected pump pock and expression of p (Right Lower Quadr explanted on 8/28/1 hospital course, patic clinical condition de and pronounced dea	arge Summary report dated Reason for Admission-brought y Department) for further shortness of breath, altered ent (R1) was noted to have et with dehiscence of wound ump through wound in RLQ ant)Intrathecal pain pump 6Subsequently during ient's (R1's) symptoms and terioratedPatient expired ad on 9/2/16 at 1259 hours Diagnoses: 1. Septic Shock:				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	PLE CONSTRUCTION  IG		(X3) DATE SURVEY COMPLETED		
		146064	B. WING _			C 09/21/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 2650 NORTH MONROE STREET DECATUR, IL 62526	•	03/21/2010	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 309	HCAP (Healthcare a Complicated UTI (U culture 8/28/16: coa Staphylococcus, Ur coli and Klebsiella pwound culture 8/28/Klebsiella pneumon Proteus mirabilis. 2. Hypoxic: 3. Atrial fit Ventricular Responsionoliguric: due to significate (Cerebral Vascular presidual weakness Back Surgery Syndiprogrammable pain (June 2016) electro (Hospitalist/Physicia R1's "State of Illinoi Worksheet" dated 9 death occurred on 9 and documents "Se of death, certified by On 9/12/16 at 9:15 Hospitalist/Physicia Certificate) stated Richard Septic Shock. Z7 si	imp site infection and/or associated pneumonia) and/or associated pneumonia) and/or associated pneumonia) and/or associated pneumonia) and/or associated pneumonia. Blood agulase-negative ine culture 8/28/16: Escherichi aneumoniae, Abdominal (16: Staphylococcus aureus, ia, Providencia stuartii, Acute Respiratory Failure, orillation with RVR (Rapid se): 4. Acute Kidney Injury, septic shock 5. History of CVA Accident, Stroke) with right 6. Dementia 7. FBSS (Failed rome); requiring intrathecal pump implantation 6/2016 nically signed by Z7 an).  S Certificate of Death (16/16 documents R1's date of (16/2/16 as a hospital inpatient ptic Shock" as the R1's cause of 27.  Am Z7 (R1's in Charge on Death (16/2) and (1	F 3	09			
	Physician/Surgeon) seen at the clinic or brought into the em the "pump breaking metal portion of the	m Z2 (R1's Pain Clinic stated R1 was fine when a 8/1/16. Z2 stated R1 was ergency room on 8/28/16 with through the wound and the pump exposed. Never seen break open like this. It					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
						(		
		146064	B. WING				21/2016	
NAME OF PROVIDER OR SUPPLIER  LINCOLN MANOR				2	TREET ADDRESS, CITY, STATE, ZIP CODE 650 NORTH MONROE STREET DECATUR, IL 62526			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 309	The edges (of the wo didn't look fresh. I ca how (R1) was change noticed."  On 9/14/16 at 10:05 a saw R1's original produced documented R1's opesite measuring 1-2 cm was no "User Defined is to be completed on found. E2 stated E8: UDA on 8/20/16. E2 check and documented Administration Record E2 stated if R1 had a then E14 should have on the skin assessment physician orders for the were no physician orders and document E2 stated when E14 should have reported and should not have I nurse found R1 safe there was no document treatments or care for that addressed R1's was reached for treatment in R1's was reached for treatments or care for the same progress notes. E2 should have reported and should not have I nurse found R1 safe there was no document treatments or care for that addressed R1's was reached for treatments or treatments or care for the same progress notes. E2 should not have I nurse found R1 safe there was no document treatments or care for that addressed R1's was reached for treatments or	and days in the making.  und) were retracted and nnot for the life of me know ed and bathed and no one  am E2 DON stated the E2 gress note by E8, which en area over the pain pump in x 0.5 cm. E2 stated there if Assessment (UDA) which all new open areas when should have completed a stated E14 did R1's skin ed on R1's Treatment d that R1's skin "was intact." dressing on at that time e documented the dressing ent and reviewed R1's reatment. E2 stated if there ders for R1's wound nould have called Z3 for ed in the progress notes. (CNA) found R1 with leaking on the night shift) E12 to the nurse immediately been moved R1 until the to be moved. E2 stated entation, assessments, and in R1's medical record wound since the initial timent on 8/20/16 in the tated there is no as record that a physician ment orders for R1's wound. is not treated it (wound) can	F	309				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION  NG	(X3	(X3) DATE SURVEY COMPLETED		
		146064	B. WING			C <b>09/21/2016</b>		
	NAME OF PROVIDER OR SUPPLIER  LINCOLN MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE  2650 NORTH MONROE STREET  DECATUR, IL 62526	ı	09/21/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR  (EACH CORRECTIVE ACTION SH  CROSS-REFERENCED TO THE AP  DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE		
F 309 F 341 SS=D	On 9/19/16 an Immedidentified. The immedidentified. The immedidentified. The immedidentified. The immediate and failed to obtain assess, treat and profor eight days resulting infection, and expulsing pump. E1 was notified. Jeopardy on 9/19/16. The surveyor was above and interview and interview and interview following actions to result of the wounds, resident chase the physician notification. Assistants (CNAs) observed and interview and interview and interview following actions to result of the wounds, resident chase the physician notification. Assistants (CNAs) observed and presidents on 9/19/16. Iticensed nurses also assessments on all results on 9/19/16. Check audits on 9/19/16. Check audits on 9/19/16. Check audits on 9/19/16. Check ensuring revaluated by a licens DON and/or Nurse more sident skin audits a weekly. The DON wicare plans. 483.65 INFECTION Check and fails and the properties of the pr	diate Jeopardy was diate jeopardy situation en the facility identified R1's and at the internal pain pump in physician orders, failed to vide services for R1's wound ag in wound drainage, on of an internal abdominal ed of the Immediate at 3:30 pm.  The to confirm through record that the facility took the emove the immediacy:  The een inserviced by E2, DON) on Skin Assessments, the evaluation and treatment of the inge in condition and the condition and that were reviewed by the licensed nurses conducted to on all residents on 9/19/16, the DON conducted skin the index of the index of the index of the index that were reviewed by the licensed nurses will the conducted skin the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index that were reviewed by the index of the index of the index of the index that index of the index of the index of the index that index of the index of the index of the index that index of the index of the index of the index that index of the index	F	141				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED			
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(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 441	Continued From page	ge 62	F 44	41				
	Infection Control Prisafe, sanitary and control to help prevent the of disease and infections.							
	Program under which (1) Investigates, continuous in the facility; (2) Decides what proshould be applied to	tablish an Infection Control ch it - ntrols, and prevents infections ocedures, such as isolation, o an individual resident; and ord of incidents and corrective						
	determines that a reprevent the spread isolate the resident. (2) The facility must communicable diserom direct contact will tract (3) The facility must	con Control Program esident needs isolation to of infection, the facility must exprohibit employees with a case or infected skin lesions with residents or their food, if cansmit the disease. exprequire staff to wash their erect resident contact for which licated by accepted						
		ndle, store, process and as to prevent the spread of						
	This REQUIREMEN	NT is not met as evidenced						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		146064	B. WING		09/21/201	16	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2650 NORTH MONROE STREET  DECATUR, IL 62526			
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE COMP	(5) LETION ATE	
F 441	review the facility fa and clean equipme treatment. This fail residents (R3) revies sample of five.  Findings include:  R3's Hospital Encoadmitted to the hos with the diagnoses ascending colon, A post surgery, Intractivith nausea, vomition R3's Physician Ord documents an abdot o start on 6/17/16 change twice daily. (Normal Saline) and moistened gauze in dressing and secur Monitor for s/s (sign redness and swelling redness and swelling residents.	unter documents R3 was pital on 7/29/16 at 12:34 pm of "Malignant neoplasm of bdominal wall abscess, Status etabel (Intractable) vomiting ng of unspecified type."  ers dated June 2016 ominal wound treatment order for "Wet to dry dressing Cleanse wound with NS d sterile gauze. Place sterile in wound, cover with dry ewith ABD (Abdominal pad). In sand symptoms) of infection, ing" R1's Treatment ord documents the above	F 44	, , , , , , , , , , , , , , , , , , ,			
	documents a treath for "Santyl Ointmer abdominal wound the abdominal wound the with ABD pad."  On 9/7/16 at 1:10 pustated E5 was going gathered supplies for the streath of	ers dated August 2016 nent order to start on 8/3/16 nt 250 unit/GM (gram) Apply to opically every day shift for op with moist gauze and cover om E5 RN (Registered Nurse), g to change R3's dressing and from the wound cart and E5 placed a tube of Santyl,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			، ا	C
		146064	B. WING				21/2016
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	21/2010
					2650 NORTH MONROE STREET		
LINCOLN	MANOR			DECATUR, IL 62526			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	ON (X5)	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 441	Continued From page	e 64	F	44 <sup>-</sup>	1		
		minal Pad, sterile gauze, and					
		ed to be children's scissors					
		directly onto R3's bedside					
		er. E5 did not ensure a clean					
	field for R3's dressing	g change. E5 applied gloves					
		d hygiene and removed R3's					
	old dressing stating t	here was a moderate					
		inous drainage on the soiled					
	dressing. E5 stated R3's open abdominal wound						
	was "beefy red with o						
	soiled gloves and ret						
	outside of R3's room						
		the top drawer of the wound					
		packet of cotton applicators.					
		d sanitizer to both hands on s's room and applied gloves.					
		and with Normal Saline and					
		contaminated gloves. E5					
	•	forming hand hygiene and					
		f Santyl (which was not					
		nd applied a small amount to					
	,	and applied into R3's					
		5 then picked up the sterile					
		nto a container with Normal					
	Saline and placed the	e gauze into R3's abdominal					
	wound. E5 then pick	ed up the unclean, plastic					
		l inefficiently trimmed off the					
		that was protruding from					
		nd. E5 had difficulty cutting					
		ze with the dull scissors. E5					
		ean scissors onto R3's bed.					
		minal pad to R3's wound and					
		g tape that E5 trimmed using					
		5 had placed on R3's bed.					
		contaminated gloves,					
		athered up supplies (Santyl,					
		minal Pad, sterile gauze, and to R3's bathroom and set					
	· · · · · · · · · · · · · · · · · · ·	orner of R3's lavatory					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
	146064 B. WING			C 9/21/2016				
NAME OF PROVIDER OR SUPPLIER  LINCOLN MANOR				STREET ADDRESS, CITY, STATE, ZIP COI  2650 NORTH MONROE STREET  DECATUR, IL 62526		9/21/2016		
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE		
F 441	regathered supplies cart placing supplies cart placing supplies.  On 9/7/16 at 1:30 pr have taken the (wou R3's room and then the cart. E5 stated to been cleaned with a on R3's sterile gauze returning the scissor stated E5 should have before returning to the applicators and each E5 stated by not was scissors there was a contamination.  The undated, untitle residents who are haveling the procedute chniqueThe dressum thands when entering Remove soiled dresswash hands. Apply 6 dressing change per side of the cart place of the ca	ned hand hygiene and and returned to the wound a back into the cart.  In E5 stated E5 should not nd cart) tube of Santyl into placed the santyl back into he scissors should have germicidal wipe before using e dressing and before to the wound cart. E5 we performed hand hygiene he wound cart for the cotton of time after removing gloves.	F 4-	,				
	with handwashing and dressing"  The undated, untitled "Handwasing is a state spread of infectious does not replace hand to fifteen-second hand performed under the	d policy documents andard practice to prevent the diseasesThe use of gloves ndwashingAppropriated ten						

DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′			(X3) DATE SURVEY COMPLETED	
146064					C <b>09/21/2016</b>	
NAME OF PROVIDER OR SUPPLIER  LINCOLN MANOR			STREET ADDRESS, CITY, STATE, ZIP 2650 NORTH MONROE STREET DECATUR, IL 62526		09/21/2010	
(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
gloves 483.75(e)(5)-(7) NUR VERIFICATION, RET Before allowing an individual, a facility must rethat the individual has requirements unless the employee in a training evaluation program a individual can prove the successfully completed competency evaluation evaluation program a has not yet been inclusted a facilities must follow individual actually been actually	SE AIDE REGISTRY RAINING  dividual to serve as a nurse receive registry verification met competency evaluation he individual is a full-time gand competency exproved by the State; or the mat he or she has recently and a training and meter program or competency exproved by the State and reded in the registry.  The program of the state and receive the information from every hed under sections 1819(e)  The program of the facility information on the individual.  The smost recent completion of the ency evaluation program, the individual compensation, the ete a new training and in program or a new in program.					
	nd record review, the facility					
	ROVIDER OR SUPPLIER  MANOR  SUMMARY STA (EACH DEFICIENCY REGULATORY OR L  Continued From page gloves  483.75(e)(5)-(7) NUR VERIFICATION, RET  Before allowing an inc aide, a facility must re that the individual has requirements unless t employee in a training evaluation program a individual can prove tl successfully complete competency evaluatio evaluation program a has not yet been inclu Facilities must follow individual actually bec  Before allowing an inc aide, a facility must se State registry establis (2)(A) or 1919(e)(2)(A believes will include ir  If, since an individual's a training and compet there has been a conf consecutive months d individual provided nu services for monetary individual must compl competency evaluatio competency evaluatio competency evaluatio competency evaluatio	ANOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 66 gloves  483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING  Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.  Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e) (2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual.  If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.  This REQUIREMENT is not met as evidenced	TOORRECTION  146064  B. WING_ROVIDER OR SUPPLIER  MANOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 66 gloves  483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING  Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry.  Facilities must follow up to ensure that such an individual actually becomes registered.  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TOENTIFICATION NUMBER:  146064  146064  146064  15 WING  SUMMANOR  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED FROM PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE CROSS-REFERENCE ACTORY OR LSC IDENTIFYING INFORMATION)  F 441  GROSS-REFERENCE CROSS-REFERENCE CRO	TONDER OR SUPPLIER  146064  146064  146064  146064  146064  15 STREET ADDRESS, CITY, STATE, ZIP CODE  2550 NORTH MONROE STREET  DECATUR, IL 62526  SUMMARY STATEMENT OF DEDICINCIES  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR I.SC IDENTIFYING INFORMATION)  Continued From page 66 gloves 483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING  Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program approved by the State and has not yet been included in the registry. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTR NG	UCTION	(X3) DATE SURVEY COMPLETED		
							С
		146064	B. WING _			09/	21/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE  2650 NORTH MONROE STREET  DECATUR, IL 62526			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 496	failed to complete verensure Certified Nursevaluation requirememember hired as a Cworking in the facility affect all 64 residents  Findings include:  E28, Certified Nursing Care Worker Registry documents E28 has, record."  E28's Background Crdocuments E28 has, on 9/21/16 at 2:10pm Manager stated E28's stated there were no employee file. E29 state registry on 9/21/1 Department of Public there are no Certified competencies on file	rification with registry to sing Assistant competency nts were met for one staff ertified Nursing Assistant. This has the potential to swho reside in the facility.  It is gassistant (CNA) Health of Check dated 9/21/16 and competencies on the competencies on the competencies on the competencies on the competencies in E29, Business Office as hire date was 7/24/13. E29 competencies in E28's ated she had just rechecked 6 and called the Illinois Health (IDPH) who verified Inversing Assistant (CNA) for E28.	F	196			