

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/25/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 145222	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 02/20/2009
NAME OF PROVIDER OR SUPPLIER WOODSTOCK RESIDENCE			STREET ADDRESS, CITY, STATE, ZIP CODE 309 MCHENRY AVENUE WOODSTOCK, IL 60098		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	F 000			
F 241 SS=E	<p>Annual Licensure and Certification survey</p> <p>No extended survey was done.</p> <p>Complaint Investigations 0970195/IL39202-F281 0970251/IL39271-no deficiency</p> <p>483.15(a) DIGNITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, the facility failed to ensure that residents are cared for in a manner that shows respect for each resident's dignity in the area of proper grooming for 6 residents (R21, R22, R23, R24, R25, and R26.)</p> <p>Findings include:</p> <p>During the initial tour on the first day of survey R21, R22, and R23 were observed with a thick, heavy growth of facial hair. The second day of the survey they were noted to have been shaved as they desired.</p> <p>R22 a female resident was observed on tour to be dressed in soiled clothing and having a strong urine odor. R22 asked to be taken to the bathroom and was noted to have been incontinent when removed from her chair.</p> <p>During three days of survey, R25 was observed</p>	F 241			

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

TITLE

(X6) DATE

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

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F 241	Continued From page 1 to be up and about dressed in soiled clothes. Her top was noted with spills and stains all three days.	F 241			
F 279 SS=D	R26 a totally dependent female resident was observed for two days of the survey with facial hair growth. 483.20(d), 483.20(k)(1) COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure that the care plans of the facility and the hospice organization are coordinated to provide the most comprehensive plan to meet the needs of the	F 279			

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F 279	<p>Continued From page 2</p> <p>resident for 2 or 3 residents sampled (R1 and R7.)</p> <p>Findings include:</p> <p>R1 and R7 both residents under the same hospice service, were observed during the three days of survey from 2/17-2/19/09.</p> <p>During record review it was observed that the medical record contained only a brief entry that read : "RN visit by Hospice." There was not any elaboration or detail. The care plan was reviewed and found to not have any notes that described the coordination of services between the facility and the hospice service. There was no indication of who was responsible for what areas of service to the resident.</p> <p>The separate hospice books kept at the nurses station contained only notes by the hospice CNA that told the date she visited, if a shower or other service was provided, and how the resident appeared or interacted with them that day. There were no care plans in this supplemental book for either R1 or R7.</p> <p>There was also some confusion in the facility documentation for R1. The dietician notes state that the feeding could not be more than a certain amount according to hospice, but there was no documentation by hospice as to the rationale for this information.</p> <p>When the hospice nurse came to visit on 2/19/09, she was interviewed and stated that she had never been contacted by the facility to attend a care conference and that she kept her own notes and would leave more detail in the future. She did not appear to understand the need to coordinate services and care in order to achieve</p>	F 279			

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F 279	Continued From page 3	F 279			
F 281 SS=E	<p>the best benefit for the resident.</p> <p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, the nursing staff do not always initial medications as given at the time of administration from review of December 2008 and January 2009 MARs (medication administration records) filed in resident charts on both wings for 16 residents.</p> <p>Examples include: R1 was missing a January 1, 2009 6am glucose level per accucheck sheets.</p> <p>R3 had Novolin 70-30 6am dose not signed for on 1/11/09 and 1/17/09, and then subsequently failed to indicate if Glipizide was given 1/11/09 and 1/17/09 instead.</p> <p>R5 did not have a Protonix signed out for 1/1/09 and failure to record Blood Pressure on Thursdays for 1/8/09, 1/15/09, 1/29/09. (The only BP done was for 1/22/09.)</p> <p>R8 had no nurse initials on 1/2/09 for Trileptal dose.</p> <p>R12 is missing an initial for ASA and Loratadine doses on 1/4/09.</p> <p>R13 was missing nurse initials as given for Oyster Cal with D on 1/3/09, 1/11/09, 1/18/09,</p>	F 281			

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F 281	<p>Continued From page 4</p> <p>1/2/09. R13 was missing evidence of administration for Omeprazole on 1/11/09, 1/23/09 and 1/24/09.</p> <p>R16 was missing MAR initials for Prednisolone on 1/3/09.</p> <p>R18 did not have evidence of 6am glucose level done on 1/1/09.</p> <p>R19 had missing initials for Aricept on 12/18, 12/3/08. Colace and Citalopram and Trazodone and Risperdal had no evidence for administration on 12/18/08. No evidence Coumadin was given on 12/18/08 12/20/08, and 12/21/08. There is a missing initial for Depakote 12/22/08.</p> <p>R22 has no initials for Neurontin on 12//4/08 and no evidence Humalog was given on 12//14/08 and 12/28/08. R22 also has missing initials on 12/5/08 for Levothyroxine. R22 has no signature for Pepcid 12/23 and 12/25/08. Tylenol was not evidenced as given on 12/4 and 12/9/08. No evidence this resident received Fosamax on 12/8, 12/22, 12/29 as the only doses given is reflected as 12/1 and 12/15/08 . Further review shows Trental not given 12/4 and 12/28. dilantin record open for 12/4/08. potassium appears to have been omitted or not signed out on 12/19/08.</p> <p>R24 has no evidence in MAR that Novolin was given 1/3/09 and 1/24/09</p> <p>R25 had no evidence that Synthroid was given on 1/909.</p> <p>R27 had no evidence in MAR that Phenytoin given 1/18 and 1/19/09 and Potassium Chloride</p>	F 281			

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F 281	Continued From page 5 1/19/09 R29 has missing oxygen saturation records for 1/5, 1/6, 1/7, 1/8, 1/9, 1/14, 1/15, 1/19, 1/20, 1/21, 1/22, 1/23/09 mainly on the night shift. Prilosec initials are missing for 1/7/09, 1/9/09 and Combivent 1/6/09. R30 had no accucheck records from 12/24/08 through 1/9/09. R31 had no nursing initials in the MAR for MOM on 1/7/09 and failure to supply a required snack and milk on 1/28/09.	F 281			
F 315 SS=D	483.25(d) URINARY INCONTINENCE Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation of the resident, the facility failed to assure that resident who has an indwelling catheter has an acceptable medicable reason for the use of the indwelling catheter on one out of one resident in the sample using a catheter. (R1) Findings include:	F 315			

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F 315	Continued From page 6 During initial observation and the subsequent observation, R1 was noted with a indwelling catheter. R1 records indicate that R1 has had a catheter since 4/19/08. There has been no assessment to determine the continued use of the catheter for the resident and no acceptable medical reason was provided for its use. During this time frame, R1 did develop infection on the urine with Enterococcus Sp on 6/27/08. On 2/18/08, a urinary catheter assessment form was placed on R1's chart stating "terminal illness which makes positioning or clothing changes uncomfortable or which is associated with intractable pain." R1 was placed on hospice but review of residents chart reflects no documentation of pain nor assessment of pain. No pain medications have been used. R1 has diagnosis that include traumatic brain incident, vegetative state and CVA. E2 indicated on interview that the assessment was not accurate. The catheter was then discontinued 2/19/08.	F 315			
F 318 SS=D	483.25(e)(2) RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation of the resident, the facility failed to provide the necessary services and preventive measures to prevent contractures on one out five residents sampled with ROM (Range of Motion)	F 318			

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F 318	<p>Continued From page 7 needs (R1).</p> <p>The lack of intervention lead to the development of contractures on R1.</p> <p>Findings include:</p> <p>R1 has diagnoses that include: Hypertension, Seizure Disorder, Traumatic Brain Injury, Vegetative State, CVA.</p> <p>R1's record review show restorative nurse assessments reflect no contractures on any extremities and to continue with their regimen. Last restorative progress note for January 15, 09 by E3 and the restorative CNA charted " Resident is tolerating passive range of motion very well with no discomfort or pain. RCNA has noticed upper extremities with more movement." R1's care plan identified problem as "Decreased strength in all extremities due to impaired mobility" and goal "will receive three reps of PROM with strength increase by 12-25-08" Goal charted as met and changed to "will receive 5-10 reps of PROM and with strength increase by 3-24-09." There are no assessments of R1's actual ROM limitation.</p> <p>R1 was observed for two days with both hands in a curled "C" position with no appliances being used. ROM was checked with E3 on 2/18/09 at 10 am. The left hand fingers show limitation with obvious contractures on 4th and fifth fingers. The right thumb is on extended position and contractured with difficulty flexing. A follow up assessment was done by E2. E2 documented on R2's joint mobility assessment sheet reflecting moderate to severe limitations on all the joints of all the extremities.</p>	F 318			

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F 318	Continued From page 8	F 318			
F 319 SS=E	<p>483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and resident interview, the facility failed to assure that resident admitted with severe mental illness are assessed appropriately to provide the treatment and services accordingly on 4 out of 7 residents sampled with mental illness diagnosis. (R4, R10, R16, R13)</p> <p>Findings include:</p> <p>Review of R9, R10, R16 and R13 were identified with diagnosis of mental illnesses. Review of OBRA initial screening of the above residents shows they were done inaccurately. Example: R13's screening was not completed with part III</p>	F 319			

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F 319	Continued From page 9 left blank omitting the fact that resident has a severe mental illness(Schizophrenia) thus indicating the need for further completion of part IV. This was not done. The facility admitted the resident from another facility and did not assess her for her psychosocial need instead indicated that she is excluded because she has an added diagnosis of Dementia. Resident has exhibited behavior adjustment problems but has not been assessed to identify accurately what her psychosocial needs are and the type of treatments to be provided. R9 has a diagnosis of Psychosis. R10 has a diagnosis of Psychosis. R16 has a diagnosis of Schizoaffective disorder. The facility has not provided any screening and psychosocial assessment of the residents with severe mental illness by a qualified PRSC (Psychosocial Rehabilitation Service Coordinator) that resulted in care plan for these residents' psychosocial adjustment needs. The facility roster reflects 20 residents with psychiatric diagnosis excluding dementias and depression. During the survey, the facility staff including E1 indicated that currently the facility does not have Serous Mental Illness (SMI) nor do they have any psychosocial programs as all their residents with psych diagnosis are exempted due to the fact that they all have dementia. However, the facility has not done proper screening and assessment by a QMHP to determine what services are to be provided for their psychosocial adjustment for these residents with mental illnesses.	F 319			
F 322 SS=D	483.25(g)(2) NASO-GASTRIC TUBES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube	F 322			

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F 322	<p>Continued From page 10</p> <p>receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and observation of the resident, the facility failed to assure that resident with tube feeding receives the ordered treatment on one out of one resident in the sample (R1)</p> <p>Findings include:</p> <p>R1 was noted with tube feeding on receiving 50 cc per hour per pump of 2 cal HN. Review of tube feeding order "Two cal HN @ 50 cc/hr per g-tube x 18 hours- hold 1 hr before and 1 hr after Dilantin administration." Dilantin is scheduled at 6 am. The facility did not have any other scheduled stoppage. E5, nurse for R1 indicated that the tube feeding is continuous except for one hour before and after the Dilantin done by the night shift</p> <p>RD assessment reflect that R1 is calculated to receive 900 cc of the feeding for 24 hour giving the rational that R1 could not tolerate anything over this amount per day. RD also indicated on his assessment that this was based on hospice assessments of R1's tolerance. RD had increased the amount in the last 3 months but had to go back to 50 cc per hour due to resident's poor tolerance.</p> <p>Review of R1's Comprehensive Intake-output record for 2/2009 show daily intake average of</p>	F 322			

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F 322	Continued From page 11 1050 cc per day intake. The night shift has been recording an average of 350 cc tube feeding infused without holding the feeding for 2 hours for the Dilantin. R1 has been exceeding the amount ordered and recommended as the maximum tolerated by the resident. R1 has also been getting tube feeding over 18 hours daily as staff indicated they don't stop the feeding except for short period of time when they position or provide ADL care. Staff CNA indicated this to be around half hour for the whole shift. RD's evaluation did not review the intake which was exceeding the ordered amount and the continued the practice of going over 18 hours of feeding. R1 has not been assessed for his tolerance.	F 322			
F 323 SS=G	483.25(h) ACCIDENTS AND SUPERVISION The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on Record Review, Observation and Interview the facility failed to provide adequate supervision for one resident in the sample (R15) and one resident outside the sample (R17). This failure resulted in R15 sustaining a fractured hip and R17 was found in the unsafe construction area of the facility. Findings include; The record of R15, a 75 year old male admitted	F 323			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 12 to the facility with diagnoses including Alzheimer Dementia, Hypertension and Anxiety was reviewed. R15's record has an incontinence assessment dated 3/08 that states he is a candidate for a tolieting schedule. R15's record lacks documentation that a tolieting schedule was implemented. R15's plan of care for his "high risk for falls" dated 10/2/08 lacked documentation of his falls on 11/6/08, 11/22/08 with additional interventions to prevent R15 from falling again. R15's record contains an incident/accident report dated 11/6/08 that states R15 fell in his room, was found on the floor with a 3 inch long head laceration. R15 went to the hospital emergency room for sutures to his head. R15's record contains an incident/accident report dated 11/22/08 that states he went to his room to go to the bathroom unassisted and fell. This report also states that he complained of right hip pain and was transferred to the hospital and was found to have a fractured right hip and had to undergo surgical repair. R15's record contains an incident and accident report dated 12/8/08 that states "he got out of bed to go to the bathroom" and was found on the floor. None of these incidents were on R15's plan of care with additional/different interventions planned to prevent falls. R15's record has a Minimum Data Set dated 9/17/08 that states he required extensive assistance to ambulate and to use the bathroom. R15's record lacks a comprehensive plan of care to prevent falls, prevent future falls and meet his tolieting needs. R15 was observed in the dining room in his wheelchair that now had a chair alarm attached. In an interview with E4, a nurse consultant, she stated that R15's plan of care should have been updated after each incident and that he should have had a tolieting plan in place.	F 323			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 13</p> <p>The record of R17, a 68 year old male, admitted to the facility with diagnoses including Dementia, Congestive Heart Failure, Hypertension and Chronic Obstructive Pulmonary Disease was reviewed.</p> <p>R15's record contains documentation that he used a wheelchair for locomotion and is self-wheeled.</p> <p>On 2/19/08 at approximately 12:30 PM residents were milling around the 300/400 wing nurses station. One resident was asking to be taken to the bathroom. The person behind the desk at the nursing station replied that she would have to wait for a nurse of nurses aide. When this person was asked who she is, she stated that she is not employed at the facility. There was no other employee's at the nurses station at that time. The fire doors leading to the 400 wing of the facility were open. This wing of the facility is under construction with tools, materials and saws openly being used. R17 was found using an drill While observing R17 using this drill a workman was noted entering the facility by the "alarmed" exit door at the end of the 400 hallway. After this workman entered he "plugged" the alarm back into the socket in the wall.</p> <p>In an interview with several residents still in the dining room they stated that they go into the 400 wing all the time because the soda and snacks machines are in a room on the 400 wing.</p> <p>In an interview with E1, the administrator, he stated that residents should not be going into that wing and that workman should not be going out of that door.</p> <p>Before leaving the facility, E1 presented a plan to have a staff person posted at the 400 wing to ensure that residents are not entering this wing during the time that workers are present. When</p>	F 323			

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F 323	Continued From page 14	F 323			
F 365 SS=D	<p>the workers leave for the day the 400 wing fire doors will be locked to prevent entrance.</p> <p>483.35(d)(3) FOOD</p> <p>Each resident receives and the facility provides food prepared in a form designed to meet individual needs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that residents requiring thickened liquids receive the appropriate consistency of liquids to meet their assessed needs. This was for 3 of 7 residents with diet orders for thickened liquids (R18, R19, R20.)</p> <p>Findings include:</p> <p>On the first day of survey 2/17/09, the noon meal was observed in the assist dining room. During the observation it was noted that R20 and R19 were served thin "runny" liquids, not the Nectar thickened or Honey thickened liquids as ordered. During the meal observation, R20 was observed to be coughing during the meal. R18 who has a physician order for Pudding thickened liquids was noted on 2/17 to receive the appropriately thickened liquid, but on 2/18 the liquid was of a runny consistency and not as ordered. R19 was observed on 2/18/09 again at the noon meal. The Honey thickened liquids were not of the appropriate consistency being more runny than the prescribed thickness.</p> <p>The kitchen was checked and found to have a stock of commercially prepared prethickened liquids, but when served to the resident, they</p>	F 365			

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F 365	Continued From page 15	F 365			
F 366 SS=D	<p>were not shaken or stirred adequately to meet the residents needs.</p> <p>483.35(d)(4) FOOD</p> <p>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the menus the facility failed to provide a planned substitute to its residents</p> <p>Examples</p> <p>During the meal observation and interview with the dietary manager she did not have a complete substitute menu. On 2/18/09 the residents were served pork chops , oven baked potatoes and carrots not the mixed vegetables that was on the planned menu. The substitute was spaghetti; no other vegetable was available to the residents. R8, a renal patient, was given the oven baked potatoes which he is not to have.</p>	F 366			