

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

PRINTED: 04/10/2009  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145972</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/20/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROVENA COR MARIAE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114</b>		
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F 000	INITIAL COMMENTS	F 000			
F 164 SS=D	<p>Annual Licensure and Certification Survey</p> <p>No extended survey was conducted.</p> <p>483.10(e), 483.75(l)(4) PRIVACY AND CONFIDENTIALITY</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 164			

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 164	Continued From page 1 Based on observation and record review the facility failed to ensure that staff maintained a resident's (R3) privacy by not providing coverage, exposing the resident from the waist down while giving care.  This is for 1 of 14 residents.  The example includes:  R3 is a 93 year old resident whose diagnoses include Trans-ischemic Attack, Seizures, Hypernatremia, Hypertension, Kidney Disease, Mental Disorder, Depression, and Anemia, according to the 3/09 Physician Order Sheet (POS). R3's Minimum Data Set of 3/1/09 shows that the resident is completely dependent upon staff for bathing.  On 3/17/09 at 10:50 AM, E5, E6, & E7 (Certified Nursing Assistants) were observed giving morning care to R3. The resident was lying in bed. Her slacks were pulled to her ankles, leaving her completely exposed from her waist on down. No attempts were made to cover the resident to protect her privacy.  The facility's Residents' Rights for People in Long Term Care Facilities states, "Your medical and personal are private. Facility staff must respect your privacy when you are being examined or given care."	F 164			
F 242 SS=E	483.15(b) SELF-DETERMINATION AND PARTICIPATION  The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both	F 242			

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F 242	Continued From page 2 inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.  This REQUIREMENT is not met as evidenced by: Based on confidential and Group interviews and record review (R6, R15, R10, R16, R8) the facility failed to reasonably accommodate residents' preference of not having laboratory tests administered early in the morning. This applies to 5 residents.  The examples include:  During the Group Interview on 3/18/2009 at 10am, the following comments were made: "I don't like being woken up for laboratory test that early. Sometimes they come in at 4 or so to do lab test. Can't get back to sleep. We don't eat until 8, so why do we have to get lab tests so early? I am sleeping and they come in to take blood. I can't get back to sleep. Is it necessary for them to take my blood so early? I am still in bed."  Review of residents' charts (R8, R6, R10, R16) show routine laboratory test are performed at 5am in the morning, (Therapeutic Drug Test, Complete Blood Counts, Urinary Analysis, Comprehensive Metabolic Panel.)	F 242			
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and	F 246			

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F 246	<p>Continued From page 3</p> <p>preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Observation and Interview, the facility failed to provide a wheel chair with arm rests at a height fitted for R8 to promote increased functioning and comfort. This contributed to poor position and poor body alignment.</p> <p>This is for 1 of 14 residents reviewed. (R8)</p> <p>The examples include:</p> <p>R8 is a 94 year old female resident with diagnoses to include Gout, Herpes Zoster of Nervous System, Edema, Intertrochanteric Fracture and Abnormal Gait according to the 3/09 Physician Order Sheet (POS).</p> <p>On 3/17/09 at 10:15 AM, R8 was observed in the lounge area attending an activity . R8 was sitting low in the wheel chair with rounded shoulders leaning forward. The arm rests of the wheel chair were 2 inches below R8's shoulders. R8 was unable to place her arms on the rests and reposition herself or sit back in the wheel chair.</p> <p>After surveyor questioned staff about R8, E10 (Occupational Therapist) evaluated R8's wheel chair fit (at 12:00 PM), and lowered the arm rests for R8. At 2:10 PM, E10 returned R8's adjusted wheel chair. When R8 sat in the wheel chair she immediately placed her arms on the arm rests and leaned back in the chair, placing her in</p>	F 246			

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F 246	Continued From page 4 correct body alignment. R8 had a large smile on her face. The surveyor asked R8 how her wheel chair felt and she stated "much better, this is nice."  During an interview on 3/17/09 at 2:30 PM, E1 (Administrator) stated "I can't believe we didn't catch that." On 3/19/09 at 1:30 PM, E10 acknowledged re-assessing R8's wheel chair and lowering the arm rests on 3/17/09. At this time, E1 verified R8's positioning in her wheel chair and the height of the arm rests were not conducive to maintaining her highest level of functioning.	F 246			
F 253 SS=C	483.15(h)(2) HOUSEKEEPING/MAINTENANCE  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to keep the kitchen equipment (top of oven, shelf over grill, mixer, deep fryer, ansul system, coffee carafes and ice machine) and beverage preparation storage shelves clean. This has the potential to affect food served to all residents (70) in the facility.  The examples include:  During the Kitchen tour on 3/17/09 between 10:30 and 11:20AM the following observations were made in the kitchen with E11 (Dietary Manager): 1. The hood over the convection ovens had lint	F 253			

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F 253	<p>Continued From page 5</p> <p>and debris build-up on top of the ovens, below the range vents.</p> <p>2. The Ansul system piping over the grill/range had visible lint attached to it</p> <p>3. The shelf above the grill/range had a build up of lint/dust on top and underneath.</p> <p>4. Grease build up was noted on the back of the grill.</p> <p>5. The back splash of the large floor mixer had white food splashes on it. E11 stated that the mixer had not been used today.</p> <p>6. Grease was on the back splash of the deep fryer. E11 said the fryer had not been used today and it is supposed to be cleaned after each use.</p> <p>7. Approximately 14 silver and white coffee carafes stored in the beverage area had coffee remains (liquid coffee and grounds). E11 said that the carafes should be cleaned after use. Spilled sugar/sugar sub granules were on one of the shelves with sliding doors in the beverage area. Staff was not working in the area during the observation.</p> <p>8. The inside of the ice machine had red/brown coloration on the piece of stainless steel in front of where the ice cubes drop into the storage area.</p> <p>On 3/17/09 at 11:20AM, E11 was asked about cleaning schedules and daily check off of tasks to be done. E11 said each dietary position has daily tasks assigned to them. E11 said no one checks off that the tasks are completed. Each week the cooks complete 'Monitor 6 Dietary Department Sanitary Score' sheet. They give them to the dietitian who checks the kitchen sanitation once a month.</p> <p>The policy entitled Dietary Department Sanitation Policy states:</p>	F 253			

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F 253	Continued From page 6 under bullet #2 - All counters, shelves and equipment will be kept clean under bullet #6 - Ice which is used on connection with food or drink will be from a sanitary source and will be handled and dispensed in a sanitary manner.	F 253			
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to follow physician orders (R4, 6, & 7), failed to safely assist in resident transfers (R2, 4, &7), and failed to ensure that nursing staff (Registered Nurse, or Licensed Practical Nurse) administer Oxygen therapy.  This is for 4 (R2, 3, 6, & 7) of 14 residents reviewed.  The examples include:  1. R7 is a 92 year old resident whose diagnoses include, Congestive Heart Failure, Coronary Artery Disease, and Hypertension, according to the 3/09 Physician Order Sheet (POS). The POS shows that the resident is on Oxygen, and it is to be titrated for the resident to maintain an Oxygen Saturation of 94%.  The resident's Falls careplan of 2/25/09 shows that the resident is a fall risk due to an unsteady gait and poor safety awareness. A facility incident report for R7 shows that on 11/10/08 the	F 281			

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F 281	<p>Continued From page 7</p> <p>resident fell in her room. She was ambulating from the bathroom (in her room) with a walker and standby assistance.</p> <p>On 3/17/09 at 1:45 PM, E5 (Certified Nursing Assistant) was observed ambulating the resident, with a rolling walker, from the bathroom to her bed. E5 did not apply a gait belt to the resident. While ambulating the resident, she held onto the back of the resident's shirt. After assisting the resident to bed, E5-CNA administered the resident's Oxygen. The Oxygen was observed to be on 3 liters/minute.</p> <p>On 3/17/09 at 3:10 PM, E3 (RN) said that the staff should use gait belts anytime ambulating a resident. On 3/19/09 at 10:07 AM, E5 (Restorative Nurse) said that the resident needs to have a gait belt on when being transferred and during ambulation.</p> <p>On 3/18/09 at 10:00 AM, E14 (LPN) said that R7 is on continuous Oxygen and that it needs to be titrated to maintain her saturation at 94%. E14 said that Oxygen Saturation levels are checked every shift. She said that the resident's Oxygen Saturation on 3/17/09 (first shift) was 93%. She could not tell the surveyor if the resident's Oxygen Saturation level reached 94% on the first shift. She could also not tell the surveyor at what time the level was checked.</p> <p>The facility could not provide a policy on Oxygen administration. The Fourth Edition Medical-Surgical Nursing text book (Lewis, Collier, Heitkemper - 1996, page 647) under Oxygen Therapy states, "...Used clinically it is considered a drug...". The Handbook of Geriatric Nursing Care (Springhouse - 1998 - pages 410 &amp;</p>	F 281			

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F 281	<p>Continued From page 8</p> <p>411) states, "When monitoring a patient's response to a change in oxygen flow, check the pulse oximetry monitor...20 to 30 minutes after adjusting the flow...When oxygen therapy is initiated, record the date and time of oxygen administration; the oxygen flow rate; the patient's vital signs, skin color, respiratory effort, and breath sounds...".</p> <p>3. R4 is a 95 year old female resident with diagnoses to include Weakness, Deconditioning, Spinal Stenosis and Gastrointestinal Bleed according to the 3/09 Physician Order Sheet (POS).</p> <p>On 3/17/09 at 10:55 AM, E13 (Licensed Practical Nurse-LPN) was observed transferring R4 from her wheel chair to the commode. E13 grabbed R4 by the back of her slacks at the waist band and pulled them upwards to assist R4 in standing and transferring.</p> <p>At 11:05 AM, after R4 was finished on the commode, E13 called for assistance from E8 (Certified Nursing Assistant-CNA) to transfer R4 back to her wheelchair. E8 entered the room with a gait belt over her right shoulder and looped under her left arm. E13 and E8 transferred R4 by lifting her under the arm pits and never applied the gait belt.</p> <p>During an interview on 3/17/09 at 11:20 AM, E3 (Assistant Director of Nursing-ADON) verified that using a residents clothing for a transfer is inappropriate. On 3/19/09 at 10:00 AM, E4 (Restorative LPN) stated R4 is to be transferred with use of a gait belt. R4's care plan dated 2/8/09 shows an intervention of "use assistive devices for ambulation as assessed/ordered."</p>	F 281			

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F 281	<p>Continued From page 9</p> <p>4. The Physician's Order Sheet (POS) dated 3/09 show an order for R4 to have Knee High Anti-Embolism Stockings to be placed on in the AM and off at HS.</p> <p>On 3/17/09, R4 was observed wearing ankle high cotton socks. R4's lower extremities had some edema and the stocking line was visible in her skin. On 3/17/09 at 11:35 AM, E3 (ADON) was asked why R4 was not wearing the physician ordered support stockings. E3 stated he was not aware as to why they were not on and would make sure they were placed on R4 immediately.</p> <p>5. R2's Physician Order Sheet dated 3/2009, list diagnosis of : Cataracts, Joint Pain, Cerebral Vascular Accident, Polyarthritis, Seizure, Clostridium Difficile.</p> <p>On 3/17/2008 at 10am R2 was observed sitting in a wheel chair in the physical therapy department, by the parallel bars wearing a gait-belt. E9 (Physical Therapist) was observed assisting R2 to a standing position by lifting R2 by the waist of her slacks, not by the gait-belt. R2's slacks were observed pulled up taut, the waist of slacks were at the mid back area.</p> <p>The Medicare Charting dated 3/16/2009 identifies R2's Musculoskeletal as: Unsteady Gait and Weakness.</p> <p>Following this observation, E1(Administrator) confirmed the technique used in R2's transfer was incorrect.</p> <p>The facility's system policy titled Risk/Safety--Resident Handling Lift Equipment/Number 62.3 ---Utilization states, 'Any patient/resident will not lifted, transferred, repositioned or otherwise assisted without the use of a recognized patient safely device, as determined by the lift/movement assessment'</p>	F 281			

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F 281	<p>Continued From page 10</p> <p>The Merck Manual of Geriatrics/Third Edition, copyright 2000, p273. 'Ambulation exercises: Before starting ambulation exercises some patients need to improve a joints' range of motion or muscle strength. Training may begin on the parallel bars, especially if the patient's balance is impaired. Some patients wear an assistive belt to help prevent falls.</p> <p>6. Review of the informed consent form dated 2/10/2009, shows R6's consent for an Intraocular Lens Implant of the left eye to be performed on 2/17/2009. The treatment Record shows an order dated 2/17/2009, 'To wear a protective shield over the left eye at bedtime for 4 weeks.' Review of an undated order shows, ' Must still wear metal shield tape over left eye at bedtime until 3/15/2009 . Order dated 3/11/2009, 'Wear metal shield at bedtime over left eye for 1 week, then discontinue. Order dated 3/11/2009, wear metal shield at bed time over left eye for one more week.'</p> <p>On 3/17/2009 at 8:30am, 9am, 10am, 11am, 1pm, 2pm 3pm 4pm R6 was observed not wearing the shield over the left eye. With E3 (Assistant Director of Nursing- Registered Nurse), present, R6 was interviewed at 4:05 on 3/17/2009 and stated, "The nurses have lost my eye shield. It's been missing two weeks. The nurses have looked everywhere but couldn't find it." E3 was unable to locate R6's shield on 3/17/2009. E2 (Director of Nurses) stated 3/18/2009 at 8am, she was unable to locate R6's eye shield.</p>	F 281			

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F 312 SS=E	<p><b>483.25(a)(3) ACTIVITIES OF DAILY LIVING</b></p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that residents receive peri-care, nail care, and hand hygiene.</p> <p>This is for 4 of 14 residents reviewed(R3, R4, R6, R16).</p> <p>The examples include:</p> <p>1. R3 is a 93 year old resident whose diagnoses include Transischemic Attack, Seizures, Hyponatremia, Hypertension, Kidney Disease, Mental Disorder, Depression, and Anemia, according to the 3/09 Physician Order Sheet (POS).</p> <p>R3's Minimum Data Set of 3/1/09 shows that the resident is completely dependent upon staff for all activities of daily living.</p> <p>On 3/17/09 at 10:50 AM, E5 (Certified Nursing Assistant) was observed giving peri-care to R3. E5 washed the residents peri area going from front to back and back to front, making several swipes. E5 did not fold the washcloth with each swipe. E5 used the same side of the contaminated washcloth each time.</p> <p>The Mastering Geriatric Care text book</p>	F 312			

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F 312	<p>Continued From page 12 (Springhouse, 1996 - page 219), under Managing Urinary Tract Infections states, "To prevent recurrent lower UTI's, teach an older woman to carefully wipe the perineum from front to back...".</p> <p>The facility could not provide a policy on peri-care. The facility's CNA Competency Checklist shows that they are to demonstrate proficiency in peri-care.</p> <p>On 3/17/09 at 10:50 AM, R3 was observed with her right hand clenched in a fist. E6 (CNA) opened the resident's hand. The resident's hand was observed to have a fetid odor. E6 verified the odor. She said that perhaps R3's cone for her right hand (not on the resident) was dirty and was the source for the foul odor. R3's fingernails were observed to be long, dirty, and jagged. E6 said that the resident's fingernails should be cleaned and trimmed on her shower day.</p> <p>The facility could not provide a policy on nail care. The facility's CNA Competency Checklist shows that they are to demonstrate proficiency in foot and nail care.</p> <p>2. R4 is a 95 year old female resident with diagnoses to include Weakness, Deconditioning, Spinal Stenosis and Gastrointestinal Bleed according to the 3/09 Physician Order Sheet (POS). R4's care plan dated 2/18/09 shows R4 is at risk for impaired skin integrity, urinary incontinence and has a history of pressure wounds .</p> <p>On 3/17/09 at 10:55 AM, E13 (Licensed Practical Nurse-LPN) was observed transferring R4 from her wheel chair to the commode. E13 grabbed R4 by the back of her slacks at the waist band and pulled them upwards to assist R4 in standing</p>	F 312			

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F 312	Continued From page 13 and transferring. R4's slacks and protective undergarment were urine saturated from the waist down to the back of her knees and half way around her legs. E13 washed R4's buttocks after using the commode but did not wash her peri-area or her legs. E13 began to put R4's urine soaked slacks back on her when discovering she needed to change them. New slacks were placed on R4 without washing her legs. R4's care plan states a moisture barrier should be applied due to episodes of incontinence. None was applied.  During an interview on 3/17/09 at 11:20 AM, E3 (ADON) stated it is absolutely necessary to provide thorough washing of the skin especially between the legs after an episode of incontinence. E3 verbalized the concern of potential skin break down with provision of poor peri-care. E3 also verified a nurse would be expected be even more conscientious of quality care. 3. R6 and R16 were observed on 3/17/2009 at 9am, in need of nail care and a complete shave. On 3/18/2009 R16 was again in need of a shave and nail care. On 3/18/2009, R16's family stated R16 needs more attention to his nails.	F 312			
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	F 318			

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F 318	<p>Continued From page 14</p> <p>by: Based on observation, interview, and record review the facility failed to provide services to ensure that a resident (R3) does not experience a decline in range of motion to her right hand.</p> <p>This is for 1 (R3) of 14 residents reviewed.</p> <p>The example includes:</p> <p>R3 is a 93 year old resident whose diagnoses include Transischemic Attack, Seizures, Hyponatremia, Hypertension, Kidney Disease, Mental Disorder, Depression, and Anemia, according to the 3/09 Physician Order Sheet (POS).</p> <p>The resident's 3/1/09 and 1/27/09 Minimum Data Sets shows that the resident has no limited range of motion. R3's care plan of 1/19/09 documents that R3 has limited joint range of motion.</p> <p>On all days of the survey (3/17, 3/18, &amp; 3/19/09) the resident was observed with her right hand clenched in a fist. On 3/17/09 at 10:50 AM, a cone was observed on the resident's night stand. E5 (Certified Nursing Assistant) said that the cone was for the resident's hand because she keeps her hand clenched. E5 did not know if the cone was supposed to be on at all times. E8 (Rehabilitation CNA) said that the cone is supposed to be in the resident's hand at all times.</p> <p>On 3/19/09 at 10:30 AM, E4 (LPN - Restorative Nurse) verified that the resident is to have the cone in her right hand at all times. E4 said that the resident's fingers on her right hand are not contracted. E4 and the surveyor went to the resident's room. E4 asked the resident to open</p>	F 318			

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F 318	Continued From page 15 her right hand. The resident was not able to fully extend her fingers. E4 said that the resident's right hand and fingers were contracting. At 1:30 PM, E4 said that the resident would be re-evaluated for new interventions to prevent further contracture. At 2:00 PM, E10 (Occupational Therapist) assessed R3's right hand and fingers. E10 said that the resident's 3rd digit is contracted and requires intervention. E10 said, "She would benefit from stretching."E10 said they will need to keep the resident's hand open.	F 318			
F 323 SS=D	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 observation, interview, and record the facility failed to ensure that a resident (R3), at high risk for falls, had her call light within reach to alert staff for assistance.  This is for 1 (R3) of 14 residents reviewed.  The example includes:  R3 is a 93 year old resident whose diagnoses include Transischemic Attack, Seizures, Hyponatremia, Hypertension, Kidney Disease, Mental Disorder, Depression, and Anemia, according to the 3/09 Physician Order Sheet	F 323			

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F 323	Continued From page 16 (POS).  R3's Minimum Data Set of 3/1/09 shows that the resident is completely dependent upon staff for transfers and all activities of daily living.  R3's Potential for Falls careplan of 3/10/09 documents that the resident has been identified as being at high risk for falls. The careplan lists as an intervention to "insure the call light is in reach at all times".  A communication written to R3's physician shows that she was found on the floor, in her room, on 2/27/09 at 1:00 PM. The documentation states that the resident said, "I wanted to get out of bed to the chair."  On 3/17/09 at 10:00 AM to 10:50 AM the resident was in bed. The call light was observed laying on the floor. On 3/19/09 at 1:30 PM, E1 (Administrator) said that maybe the call light had fallen to the floor.	F 323			
F 353 SS=E	483.30(a) NURSING SERVICES - SUFFICIENT STAFF  The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.  The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:	F 353			

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F 353	<p>Continued From page 17</p> <p>Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel.</p> <p>Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.</p> <p>This REQUIREMENT is not met as evidenced by: Based on confidential and Group Interviews and record review, the facility failed to have staff to meet the needs of residents in the areas of: assisting in activities of daily living and receiving meal trays.</p> <p>The examples include.</p> <p>During confidential interviews and during the Group Meeting on 3/18/2009 at 10am, residents stated: "It takes 45 minutes or more to have the call lights answered. Right before meals, if we are on the toilet, we have to wait a while before they transfer us off. The aides walk right by the call lights when they are on. They've told us we are not assigned to you. What happens if I've fallen or get stuck in the bathroom? Someone might be in need of help or might be injured. We have seen the aides standing by the portable computers in the hall, and they don't go and answer the lights. They just keep standing by the computers. The aides will come in and turn off the light, and tell us they will be back. We don't put the light on again. We just wait, and sometimes that's a long</p>	F 353			

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F 353	Continued From page 18 time. It takes a long time for the trays to be passed. They are short of help. They're short handed here, all the time. I think they may be short aides at times. The shaving and care of the nails doesn't get done".	F 353			
F 363 SS=F	483.35(c) MENUS AND NUTRITIONAL ADEQUACY  Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.  This REQUIREMENT is not met as evidenced by: Based on observation,interview and record review the facility failed to prepare pureed corned beef, carrots and cabbage that maintained the natural flavors of the regular diet. The facility also failed to serve food at temperatures acceptable to residents.  This applies to the 69 residents who eat on the skilled unit, which includes 8 residents (R8, R10, R12, R16,17,18,19,20) receiving pureed foods.  The examples include:	F 363			

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F 363	<p>Continued From page 19</p> <p>At 10AM on 3/17/09 E12 (Cook/Assistant Food Service Supervisor) was observed preparing pureed foods for the noon meal. E12 was asked how she knows what thickness the food should be. E12 said she is looking for the food to be the consistency of honey.</p> <p>E12 had already started pureeing the corned beef. E12 said she used 10 large pieces of meat and had added some broth to the meat. E12 added an additional 1 3/4 cups broth and 1/2 cup (8 Tablespoons-T) of thickening agent.</p> <p>The pureed carrots were made with 2 1/2 - 3 cups of steamed carrots (cooked separately from the regular diets). E12 added approximately 3 cups of cooking liquid to process the carrots. E12 added 1/4 cup (4 T) and added an additional 1/2 cup of hot water from the hot water urn (kept hot to make coffee/tea).</p> <p>For the pureed cabbage E12 started with 8 cups of raw cabbage and steamed them until soft. Nothing was added during or after cooking, according to E12. E12 added approximately 4 cups of the liquid the cabbage released during cooking. Four and one half 1/8 cup measures (9T) of thickener was added to the pureed cabbage. When finished the product was very runny.</p> <p>The facility diet manual (dated 2002 - not current/within the last 5 years) contained preparation guidelines for pureed foods that has instructions based on 20 servings page 132. It breaks the directions down to 10 portions at a time. The instructions say to puree 5 cups of product, puree until smooth and add 5T of</p>	F 363			

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F 363	Continued From page 20 thickener. The diet manual description of pureed foods on page 133, says, "Blend to consistency of whipped topping or mashed potatoes". It also says, "Never use water. Choose liquids that will enhance flavor/aroma".  The recipes for the regular diets show that carrots and cabbage had melted butter/margarine added. This was confirmed by interview with E12 at 1PM on 3/17/09.  All foods for the noon meal on 3/17/09 were tasted at the midpoint of plating the food for the skilled unit at 11:50AM. The pureed corn beef tasted mildly of the regular corned beef (excellent flavor). The pureed cabbage and carrots had little of the taste of the regular carrots and cabbage. The flavor was diluted with all the liquid added during pureeing.  Residents interviewed during the group meeting on 3/18/09 at s10:00 AM, stated, "The hot food is always cold. The cold food like milk and fruit and orange juice is always warm." Residents said that the Swedish pancakes served for breakfast on the morning of 3/18/09 were cold. The surveyor noted that butter would not melt when placed on the pancakes.	F 363			
F 371 SS=F	483.35(i) SANITARY CONDITIONS  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371			

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F 371	<p>Continued From page 21</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to assure that the temperatures of the corned beef cooked on 3/16/09 were monitored and rapidly cooled to minimize the potential for food borne illness. The temperature of the meat was not monitored from 1PM on 3/16/09 to 8:30AM on 3/17/09 (20 1/2 hours). The facility failed to sanitize the bowl of the food processor after pureeing the meat and between the vegetables on 3/17/09.</p> <p>This applies to all 69 residents in the skilled unit.</p> <p>The examples include:</p> <p>At 9AM on 3/17/09 E12 (AM Cook) stated the corned beef for the noon meal today was already sliced and heating in the oven. E12 was asked how she prepared the corned beef. E12 said she cooked 6 pieces (13.5 pounds each per E11[Food Service Supervisor]) yesterday. They were in the oven from 7AM to 9AM. E12 said she didn't write down the temperatures but knows they were 170 degrees Fahrenheit (F). She covered them with a layer of plastic film, put foil on top and put them in the walk-in. At 1 PM (4 hours later) before she left she spot checked the meat temperatures and it was 160F. On 3/17/09 she took the meat out of the walk-in refrigerator and measured the temperature of a few pieces E12 said she remembered the temperatures of 3 pieces were 138- 140 F.</p> <p>E12 has current certification in Food Service Sanitation as displayed on the wall of E11's</p>	F 371			

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F 371	Continued From page 22 office.  According to the Illinois Food Code (1998), Potentially hazardous food shall be cooled: From 140 F to 70 F within 2 hours; and From 70 F to 41, or below within 4 more hours (or within a total of 6 hours).  On 3/17/09 at 11:15AM, E11 stated there have been no in-services on Hazard Analysis Critical Control Points (HACCP) during the past year.  After E12 pureed the corned beef (10:15AM on 3/17/09), she took the bowl of the food processor to the small prep sink by the range and rinse it out. E12 took it back to the processor and purred the carrots. E12 rinsed the carrots out of the processor bowl, returned to the processor and pureed the cabbage. The bowl was not sanitized between any of the pureeing.  The Illinois Food Code (1998) states, "The food contact surfaces of all equipment and utensils shall be sanitized by: 1) Immersion for at least one-half minute in clean, hot water at a temperature of at least 170 degrees Fahrenheit. ; or 2) Immersion for at least one minute in a clean solution containing at least 50 parts million of available chlorine as a hypochlorite and having a temperature of at least 75 degrees F, ; or 3) Immersion for a least one minute in a clean solution containing at least 12.5 parts per million of available iodine and having a pH not higher than 5.0 and having temperature of at least 75 F..."	F 371			
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY OF PHYSICIAN VISITS	F 387			

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145972</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  <b>03/20/2009</b>
NAME OF PROVIDER OR SUPPLIER  <b>PROVENA COR MARIAE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114</b>		
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F 387	<p>Continued From page 23</p> <p>The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.</p> <p>A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview and Record Review, the facility failed to ensure a resident (R12) was seen by the physician every 30 days for the first 90 days after admission and every 60 days after.</p> <p>This is for 1 of 14 residents reviewed. (R12)</p> <p>The examples include:</p> <p>R12 is an 83 year old female resident admitted to the facility on 10/14/09 with diagnoses to include Pleural Effusion, Edema, Hypertension, Hypothyroidism, Hyperlipidemia, and Chronic Obstructive Pulmonary Disease according to the 3/09 Physician Order Sheet (POS).</p> <p>Review of R12's chart on 3/18/09 could find no physician progress notes or evidence that R12 had been seen by a physician since her admission (5 months ago).</p> <p>E2 (Director of Nursing-DON) was interviewed on 3/19/09 at 9:00 AM. E2 stated R12 just slipped through the cracks and hasn't been seen by her physician since her admission.</p>	F 387			
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION	F 444			

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NAME OF PROVIDER OR SUPPLIER  <b>PROVENA COR MARIAE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3330 MARIA LINDEN DRIVE ROCKFORD, IL 61114</b>		
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F 444	<p>Continued From page 24</p> <p>The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure that staff wash their hands. The facility also failed to ensure that staff use and change gloves after providing peri-care to residents.</p> <p>This is for 2 (R3 &amp; R15) of 14 residents reviewed.</p> <p>The example includes:</p> <ol style="list-style-type: none"> <li>1. R3 is a 93 year old resident whose diagnoses include Trans-ischemic Attack, Seizures, Hyponatremia, Hypertension, Kidney Disease, Mental Disorder, Depression, and Anemia, according to the 3/09 Physician Order Sheet (POS). R3's Minimum Data Set of 3/1/09 shows that the resident is completely dependent upon staff for bathing.</li> </ol> <p>On 3/17/09 at 10:50 AM, E6 (CNA) was observed giving R3 peri-care. After completing the task, E6 did not remove her gloves and wash her hands. R3 straightened the bed covers, pillows, and touched other surfaces in the room.</p> <p>The facility's Infection Control policy states, "...Change gloves between tasks and procedures on the same resident after contact with material that may contain a high concentration of microorganisms. Remove gloves promptly after</p>	F 444			

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F 444	Continued From page 25 use, before touching non-contaminated items and environmental surfaces, and before going to another resident, and wash hands/hand hygiene immediately to avoid transfer of microorganisms to other residents or environments...".  2. On 3/18/2009 at 2:40pm R15 stated E15 (Certified Nursing Assistant) routinely provides personal hygiene without wearing gloves. R15 also stated, "I have asked E15 several times about the need for wearing gloves. E15 replies, I don't have them with me, and the gloves available in the rooms are too small. E15 also does not wash his hands between giving care to my room-mate and myself. I think he should wash his hands and wear gloves."	F 444			