

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

PRINTED: 09/26/2008  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>145856</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/18/2008</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALL FAITH PAVILION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3500 SOUTH GILES AVENUE CHICAGO, IL 60653</b>	
(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  Annual Recertification  An extended survey was conducted.  Complaint investigations: 0883939/IL37062-No Deficiencies  Validation Survey for Subpart U: Alzheimer Unit. The facility is in compliance with Subpart U, 77 Illinois Administrative Code Section.	F 000		
F 253 SS=E	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 observations and interviews, the facility failed to provide housekeeping and maintenance in order to maintain a sanitary, orderly and in good repair resident environment on four of four floors where residents reside and the lower level for the following reasons: no thermometers in the medication refrigerators; unsanitary storage of resident personal care equipment; broken and soiled care equipment and furniture; soiled floors and walls and pervasive urine odors.  Findings include:  1. On 9/17/08 during the Environmental tour of the facility with E7(Environmental Service Manager) that started at approximately 1:50pm, the following observations were made: Basement Compressor room- One burlap bag of towels	F 253		
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 253	<p>Continued From page 1</p> <p>were observed on the floor; Basement Central Nursing Supply (CNS)- Two cases of care equipment were observed sitting on the hallway floor, outside of CNS. The top box was open and heel protectors were observed in the box. Inside two cases of 7 ounce cups, one case of one ounce cups and one open case of nebulizer were observed stored on the floor.</p> <p>-Basement Restorative room-Under the sink pots, pans, coffee and sugar were observed stored next bottles of disinfectants, stain removers, deodorizer, dishwashing liquids, electrical cords and other none food items. E16 (Restorative Supervisor) was interviewed and asked if the sugar and coffee is used to make coffee for residents. E16 stated, "Yes". Basement Seegar Hall (lower level)-The room which is used for activities of the more independent resident was sparsely furnished.</p> <p>4th floor Nurse's Station-one case of open is disposable incontinent pads stored on the floor; 4th floor Pantry-one case of open disposable incontinent pads stored on the floor. Stored under the sink were two cases of enteral feeding sets. Expired enteral feeding (8/2008) was observed stored on the counter and in the wall cabinet with enteral feeding that was not expired; 4th floor Soiled Utility room-three soiled enteral feeding pumps were observed stored under the sink; Room 410-The floor/wall junctures were heavily soiled with a build up of dirt. Coffee had been spilled on the east wall of the room next to the window. A pervasive urine odor was observed in the bathroom; 4th floor hallway outside of day room two wheelchairs with torn arm rests were observed.</p>	F 253			

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F 253	<p>Continued From page 2</p> <p>3rd floor Pantry room-No thermometer in the resident freezer. Stored under the sink was an ice maker, slow cooker and cannister labeled "straws"; 3rd floor Soiled Utility-Stored under the sink were several disposable incontinent pads and four plastic wash basins; 3rd floor North tub/shower room - The smell of smoke and ashes on the floor were observed in the tub room section. Used towels and washcloths were on the floor in one shower stall, along with a soiled piece of clothing; 3rd floor day room-A heavy build up of dirt at the floor/wall junctions was observed. The refrigerator was observed with food. 12 chairs in the room were either heavily soiled, torn seats, cigarette holes or broken backs. The white plastic garbage container was split in two places; 3rd floor Partition door at the elevator-two large holes were observed in the door; 3rd floor Clean Utility room-two bags of resident personal clothing was observed on the floor.</p> <p>2nd floor Pantry-the ice scoop was observed sitting on the counter in it's holder. Both were heavily soiled; 2nd floor Day Room-heavy build up of dirt and debris in and around the sink cabinet. The white plastic garbage container was split in two places.</p> <p>1st floor Pantry-No thermometer in the medication refrigerator; 1st floor Soiled Utility room-No thermometer in the specimen refrigerator; 1st floor Day Room-Heavy build up of dirt in and around the sink cabinet; 1st floor Conference room-19 cases of adults briefs and 37 cases of vinyl gloves were stored on the floor.</p> <p>2. During the initial facility tour on 9/15/08 between 9:30 AM and 10:30 AM with E3 (Assistant Director of nursing), E12 (Nurse) and E13 (nurse), the following was observed in the</p>	F 253			

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F 253	Continued From page 3 hallways and rooms of the second floor/skilled unit: strong, pervasive urine odor in the south end hallway; unlabeled bedpans and wash basins times (2 to 4) stacked on top of each other stored on the floor of the toilet rooms - 200, 210, 211 and 221; dirty linens piled up in the toilet room floor of room 213. A used wet wash cloth left on top of air conditioner in room 219; Tube feedings poles (currently, unit has 11 tube feedings) with dried white and brown colored spills on the body and base of the poles; IV (Intravenous) pole base was rusted and dark brown in color; several resident room floors noted with a heavy accumulation of dust and debris, especially in the corners; several residents bedside tables with new and old spills of food and other debris; Activity/Day/Dining Room Area, the counter with a large area of a pool of light colored liquid, the sink and the cabinet has dark stains and dried spills. The wall plaster and paint (where the paper towel dispenser is) is peeling or ripped off.	F 253			
F 323 SS=E	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.	F 323			

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F 323	Continued From page 4  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to assure that it is free of accident hazards by failing to assure that staff are adequately trained in handling liquid oxygen and failed to assure that staff follow facility policy on filling portable oxygen tanks. The facility also failed to assure that a resident does not fill portable oxygen tanks in bedroom (R10). The facility also failed to assure that a resident is appropriately supervised while smoking to assure that smoking does not occur when resident has oxygen on per nasal cannula (R10). The facility also failed to assure that one resident (R10) who has been identified as a problem smoker, who smokes while oxygen is running, is appropriately supervised while smoking and has interventions in place to address this situation.  The facility also failed to maintain a hazard free environment for the following reasons: -Facility staff failed to removed from the basement oxygen room a actively venting liquid oxygen tank in a timely manner; A live electrical switch located inside the basement oxygen room; bathtub without a non-slip surface; "Oxygen In Use" signs were not posted; Lighter at resident bedside on the 2nd floor where residents on the floor receive oxygen; storage of breakable items on overbed light coverings; not maintaining hot water temperatures below 110 degrees Farenheit (F); medications at bedside without physician orders and free standing oxygen tank.	F 323			

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F 323	<p>Continued From page 5</p> <p>Findings include:</p> <p>1. On 09/15/08 at approximately 2:30p.m. E9 (Housekeeper) was observed in room 116-3 with R10. E9 was observed shaking and jarring a portable oxygen container which was attached to a liquid oxygen cylinder. A very large amount of vapor was observed coming from the cylinder. E9 and R10 stated the portable tank was probably frozen onto the cylinder.</p> <p>Surveyor interviewed E9 on 09/15/08 regarding filling portable oxygen tanks and E9 stated it is the Nurse's responsibility to fill portable oxygen tanks for residents. At approximately 2:45p.m. E11 (Staff Nurse) was interviewed and stated that R10 fills his own portable oxygen tanks from the liquid oxygen cylinders in his bedroom. R10 was interviewed on 09/15/08 at approximately 3:30p.m. and stated he has been filling his own portable tanks since he has come to the facility (February 2008). E9 was again interviewed on 09/18/08 at 4:25p.m. and stated on 09/15/08 he was trying to help R10 fill the portable oxygen tanks. E9 stated the only training he had regarding filling the tanks was from R10. E9 did state he was inserviced 09/18/08 on proper filling of portable oxygen tanks and that trained nurses should be filling the tanks in the designated oxygen rooms.</p> <p>Facility Policy for Liquid Oxygen was reviewed which states: Only Licensed Nurses who have been trained in the procedure will fill portable liquid oxygen tanks. The portable tanks will be filled in a designated area which is ventilated, with the appropriate firewall rating. In this facility the designated area is the oxygen rooms on each floor or in the oxygen room in the basement. The</p>	F 323			

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F 323	<p>Continued From page 6</p> <p>designated oxygen refill location will be marked with an oxygen sign.</p> <p>Under no circumstances are the portable oxygen tanks to be refilled in a residents room or any area where residents are present. Residents will not be allowed to refill their portable oxygen tanks. Nurses Aides are not allowed to refill portable oxygen tanks. Nursing staff were inserviced on 09/16/08 regarding liquid oxygen tanks and refilling portable tanks by Z3, from the facilities oxygen provider services.</p> <p>Surveyor interviewed Z3 on 09/16/08 at 10:15a.m. Z3 stated portable tanks should only be filled by nursing staff in the designated oxygen rooms. No resident should fill tanks and tanks should never be filled in a bedroom. Z3 stated if a portable tank becomes frozen to the cylinder it should be turned off and eventually tank will be able to be removed.</p> <p>On 09/16/08 at approximately 11:30a.m. Surveyor observed E14 (Staff Nurse) respond to R10's request to refill his portable oxygen tank. E14 went in to R10's room and began to refill portable tank from the free standing liquid oxygen cylinder in R10's bedroom. Surveyor informed E14 she could not fill tank in bedroom. Surveyor immediately informed E2 (Co-Administrator) of observation.</p> <p>On 09/18/09 at 9:30a.m. R10 was observed by Surveyor sitting in wheelchair in front of the facility with an oxygen tank on wheelchair, nasal cannula on face and smoking a cigarette. Two Surveyors went back to the front of the building and observed R10 as previously stated. E17, Psycho-Social Rehab Coordinator (PRSC) was also in front of building. Surveyor asked E17 if</p>	F 323			

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F 323	<p>Continued From page 7</p> <p>the oxygen was on and E17 said 'Hey (R10's name) is the oxygen on?' R10 responded yes and surveyor observed oxygen at approximately 3.5 liters. Surveyor asked E17 if it was acceptable for R10 to smoke with oxygen running and E17 stated 'no.'</p> <p>E1 and E2 were immediately informed of the situation.</p> <p>R10's care plan does indicate smoking with oxygen as a problem for R10 however there are no interventions to address this situation other than to educate R10 on the hazards of smoking with oxygen running.</p> <p>2. On 9/17/08, during the Environmental tour of the facility with E7 (Environment Service Manager) that started at approximately 1:50pm, the basement Oxygen storage room was inspected. The room was fully loaded with liquid oxygen tanks at the time of the observation. Twelve liquid oxygen tanks were among the other tanks stored in the room. One of the liquid tanks (Serial Number 599740018) was venting a grayish-white cloud of oxygen from the relief valve. The valve was making a loud hissing sound. E7 informed surveyor that their supplier had just filled the tanks and it was releasing excess oxygen.</p> <p>This room has two windows that were not open. A small vent (less than 12x12) was observed in the ceiling to the back of the room. The light switch to the ceiling light is located inside this room. The light was on at the time of the observation. E7 did not remove the venting tank from the room.</p> <p>3. On 9/18/08, at approximately 9:40am, the basement oxygen room was again inspected with</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>E7. The same venting liquid oxygen tank (Serial Number 599740018) was in the room. A hissing sound could still be heard coming from the relief valve, however the grayish - white cloud of oxygen was not present. The content gauge read three-quarters full. One quarter of the tank had vented to the room overnight and the ceiling light had been turned off. E7 finally had the tank removed from the room.</p> <p>On 9/17/08, during the Daily Status Meeting, E2 (Co Administrator) was asked for the facility's contractual agreement with their liquid oxygen supplier. E2 was asked who was responsible for maintaining the integrity of the liquid oxygen tanks. E2 informed the survey team that the facility is and that she could produce paperwork to that effect.</p> <p>On 9/18/08, E2 presented a contract from the supplier which clearly stipulates the facility's responsibilities pertaining to the integrity of the liquid oxygen tanks:</p> <p>2. Facility's Responsibilities. 2.2 Maintain Respiratory Therapy Equipment in clean and in good working order. 2.3 The Facility agrees to compensate Z1 (oxygen supplier) within sixty (60) days of reported misuse, abuse or damage for repairs to Respiratory Therapy Equipment necessitated as a result of Facility misuse, abuse, or damage caused to Respiratory Therapy Equipment."</p> <p>E2 presented a second paper from Z2. The subject matter consisted of the maintenance responsibilities of their drivers/warehouse personnel for Liquid Stationary Reservoirs:</p> <p>1. Visual Inspection: a. Broken Shroud/flow</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>control knob. b. Cold sweaty bottle or excessive venting from relief valve (vacuum problem). Some venting from relief valve is normal. c. QDV not deformed.</p> <p>On 9/17/08 the survey team asked E2 for the facility's policy and procedure for maintaining the liquid oxygen tanks. As of 9/18/08, E2 did not present to the survey team a written policy and procedure pertaining to the responsibilities of the facility staff in maintaining or monitoring the integrity of the tanks. No inservices were submitted to the survey team dated before the 9/15/08, showing that staff was inserviced on maintaining/ monitoring "Liquid Stationary Reservoir" tank integrity.</p> <p>4. During the initial facility tour on 9/15/08 between 9:30 AM and 10:30 AM with E3, E12 (Nurse) and E13 (nurse), the following hazards were observed in resident rooms on the second floor/skilled unit: Room 204-cigarette lighter at the bedside; Room 209, Oxygen tank in the room, no Oxygen sign noted on the door or door frame and Room 212, stored on the overbed light, two ceramic and three glass candle holders.</p> <p>5. On 9/17/08, during the Environmental tour of the facility with E7 (Environmental Service Manager) that started at approximately 1:50pm, the tub located in the south tub/shower room on the 3rd floor did not have a non-slip surface. The hot water temperature was above 110 degrees Fahrenheit (F) in the following locations: 2nd floor North tub/shower room, 113.5 degrees F; Resident room 209, 112.3 degrees F; Resident room 212, 113.0 degrees F.</p> <p>6. During facility tour on 09/15/08 at</p>	F 323			

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F 323	Continued From page 10 approximately 9:30a.m., a free standing oxygen 'E' tank was observed near R10's bed. Nursing staff was informed.  7. During facility tour on 09/15/08 at approximately 10a.m., an inhaler labeled Pro-Air was observed on the bedside table of R9. There was no physician order for R9 to have an inhaler at bedside.  8. During survey R10 was observed to have a medication bottle, labeled as Hydro-codone with acetaminophen 7.5mg. every six hours. Label indicated 30 tabs had been dispensed on 07/26/08 and was labeled with R10's name. At time of observation one tablet was in container. There was no physician order for R10 to have this medication at bedside.	F 323			
F 332 SS=E	483.25(m)(1) MEDICATION ERRORS  The facility must ensure that it is free of medication error rates of five percent or greater.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility has a medication error rate of 40.47%. During the medication observation pass on 09/16/08 42 medication opportunities were observed. After reconciliation with physician orders, 17 medication errors were found resulting in a 40.47% error rate for four of seven residents observed (R1, R7, R14 & R15) .  Findings include:  1. During medication pass on 09/16/08 at	F 332			

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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 332	<p>Continued From page 11</p> <p>8:25a.m., E5 (Staff Nurse) was observed to administer the following medications to R15 without any current physician orders for the medications: Tramadol 50mg., Isorbide 20mg., Prevacid 30mg., Magnesium Oxide 400mg. and a Multivitamin. During reconciliation with physician orders, R15 has current physician orders for the following medications which were not administered by E5 at the 8a.m. medication pass: Megace 800mg. daily at 8a.m., Ferrous Sulfate 325mg. twice daily at 8a.m. and 4p.m., Neutrophos 2 units daily at 8a.m., Aspirin 81mg. at 8a.m. and Senna twice daily at 8a.m. and 4p.m. During interview on 09/16/08 at approximately 11:30a.m. E5 stated the Megace and Neutrophos were not given because the meds were not available. E5 stated the Senna was not given because R15 was having frequent bowel movements however there was no documentation in nurses notes.</p> <p>2. During medication pass on 09/16/08 at 10:25a.m., E5 (Staff Nurse) was observed to administer Multivitamin liquid 5cc's to R7. Physician order is for Multivitamin 10cc. E5 also dispensed and crushed Prevacid 30mg. Solutab. Geriatric Dosage Handbook 12th Edition states Prevacid Solutab should be placed on tongue and not be swallowed whole or crushed. During reconciliation with physician orders, R7 has current physician orders for the following medications which were not administered by E5 during 8a.m. medication pass: Zinc Sulfate 220mg. daily 8a.m. and Calcium 500mg./5mls. three times daily 8a.m., 12p.m. and 4p.m.</p> <p>3. R14 has a current physician order for Docusate Sodium 100mg. at 8a.m. during medication pass on 09/16/08 E5 did not</p>	F 332			

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F 332	Continued From page 12 administer this medication to R14.  4. R1 has a current physician order for Hydrochlorothiazide 12.5mg. daily at 8a.m. During medication pass on 09/16/08 at approximately 9a.m. E6 (Staff Nurse) did not administer this medication to R1. R1 also has a current physician order for Protonix 40mg. EC at 8a.m. which was not administered during observations. On 09/16/08 during interview with E6 it was found that this order had never been transcribed to the Medication Administration Record (MAR) for September 2008. R1 has not received this medication for 16 days in September.	F 332			
F 333 SS=D	483.25(m)(2) MEDICATION ERRORS  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview the facility failed to assure it is free of significant medication errors. After reconciliation with physician orders three significant medication errors were found for two of seven residents observed during medication pass (R1 & R15).  Findings include:  1. R15 has a current physician order for Megace 800mg. daily at 8a.m. During medication pass on 09/16/08 E5 did not give R15 Megace. During interview E5 stated the Megace was not available however the medication is signed as administered on the MAR for 09/16/08. During interviews staff stated R15 is a very poor	F 333			

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F 333	Continued From page 13 eater and frequently pockets foot. R15 receives a soft diet. R15's weight on 09/03/08 was 87.5lbs. and weight on 09/18/08 (in presence of surveyor) was 82.5 lbs.  2. R1 has a current physician order for Protonix 40mg. EC at 8a.m. Protonix was not administered during medication pass on 09/16/08. On 09/16/08 during interview with E6 (Staff Nurse) it was found that this order had never been transcribed to the Medication Administration Record (MAR) for September 2008. R1 has not received this medication for 16 days in September.  3. During medication pass on 09/16/08 E5 (Staff Nurse) dispensed and crushed Prevacid 30mg. Solutab and administered to R15 with pudding. The Geriatric Dosage Handbook 12th Edition states Prevacid Solutab should be placed on tongue and is not be swallowed whole or crushed.	F 333			
F 469 SS=C	483.70(h)(4) PHYSICAL ENVIRONMENT- PEST CONTROL  The facility must maintain an effective pest control program so that the facility is free of pests and rodents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to maintain an effective pest control program for four of four floors where residents reside as well as in the kitchen.  Findings include:	F 469			

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F 469	<p>Continued From page 14</p> <p>During the four days of the annual survey (9/15 through 9/18/08) several small, black flying insects were observed on the 4 residents floors in the basement. These same small black flying insects were noted in the kitchen (food prep side and dishwashing/drying area).</p> <p>Per interview on 9/18/08 with E15 (food service supervisor), she informed surveyor that she would speak to the maintenance supervisor about the insects.</p> <p>Six months of receipts/slips from an outside pest control service was reviewed. The outside service treated for the flying insects and left instructions for facility staff on how to reduce the breeding. The instructions by the service were not carried out effectively to stop the breeding of the insects.</p>	F 469			