STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145847	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
STEARNS NURSING & REHAB CENTER	3900 STEARNS AVENUE GRANITE CITY, IL 62040

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide assistance during meals and maintain hygiene and grooming for 4 of 7 residents (R5, R7, R8, R11) observed for activities of daily living (ADL) assist in the sample of 16. Findings include: 1. R5's Minimum Data Set ((MDS) dated [DATE] documents R5 requires 50 to 75 percent of assist from staff for personal hygiene including trimming of nails and shaving. On [DATE] at 1:18 PM, V7, Certified Nursing Aide (CNA), provided incontinence care to R5 in bed. R5 had multiple reddened scratch marks on his outer buttocks and perianal area and he was saying ouch every time V7 wiped over the scratch marks. R5 was noted to have long fingernails on both hands with dark brownish material under the nails. R5 was also noted with a stubble of a few days growth on his chin and lower part of the face. 2. R7's MDS dated [DATE] documents R7 is alert, oriented to person, place, time and situation and needs extensive assist from staff to do personal hygiene including shaving/removing facial hair. On [DATE] at 10:41 AM, R7 sat in her wheelchair in her room, her chin covered with coarse gray hair. R7 stated she needs help shaving her chin hair off. R7 stated she is not comfortable with hair on her face at all and getting embarrassed by it. 3. R8's MDS dated [DATE] documents R8 requires 50 to 75 percent help from staff to perform daily activities including eating and drinking. On [DATE] at 12:34 PM, R8 was observed in bed with the head of the bed elevated and a lunch tray in front of her on a bedside table. R8 was attempting to hold a sippy cup upright and drink from it and was unsuccessful. There was nobody with her in the room to assist her with feeding. At 12:48 PM and 12:56 PM, there was nobody in the room to assist R8 with her lunch. 4. R11's MDS dated [DATE] documents R11 needs cueing and supervision when eating. On [DATE] at 12:10 PM, 12:21 PM and 12:27 PM, during lunch service, R11 sat in the dining room with her lunch in front of her. R11 was biting her nails and looking around the dining room. None of the staff present in the dining room provided any cueing or supervision or encouraging R11 to take a bite. At 12:28 PM, R11 was taken out of the dining room. On 3/4/2020 at 10:21 AM, V16, CNA Supervisor, stated she started working as CNA supervisor 7 months ago and was providing inservice training to the aides on grooming and personal hygiene and expects them to check if fingernails need trimming and residents need shaving as part of daily routine care. On 3/5/2020 at 9:26 AM, V2, Director of Nursing (DON), stated the facility does not have a specific policy addressing activities of daily living (ADL) Assist/Grooming/Meal Assist.
F 0686 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate pressure ulcer care and prevent new ulcers from developing.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to and provide turning and repositioning to residents at risk for developing pressure ulcers for 4 of 4 residents (R5, R9, R10, R12) reviewed for pressure ulcer risk in the sample of 16. Findings include: 1. R5's Minimum Data Set (MDS), dated [DATE], documents R5 requires 50 to 75 percent assist from staff for bed mobility, transfers, and toilet use, has an indwelling urinary catheter, and is totally incontinent of bowel and is at risk for pressure ulcer development using formal and clinical assessments. R5's Care Plan, dated 2/31/2020, documents, I am at risk for altered skin integrity related to personal history of pressure injuries, incontinence and the need for assist with mobility. Approaches: Turn and reposition me as needed. R5 remained in his high back wheelchair from [DATE] at 9:10 AM until 1:15 PM without benefit of repositioning based on 15 minutes or less observation intervals. R5 remained in his high back wheelchair without the benefit of repositioning from 3/3/2020 at 7:48 AM until 10:31 AM based on 15 minute interval observations. 2. R9's MDS, dated [DATE], documents R9 requires 50 to 75 percent assist from staff to perform daily activities including bed mobility and transfer and is always incontinent of bowel and bladder and is at risk for pressure ulcer development using formal and clinical assessments. R9's Care Plan, dated 2/31/2020, documents, At risk for non-pressure and pressure related skin issues injuries related to [MEDICAL CONDITIONS], contractures to left hand, dementia, impaired mobility and incontinence. Approaches: Turn and reposition with care and activities. R9 remained sitting in her high back wheelchair from 3/3/2020 at 5:45 AM until 8:30 AM without the benefit of repositioning based on 15 minute observation intervals. 3. R10's MDS, dated [DATE], documents R10 is at risk for pressure ulcer development using clinical and formal assessment, requires extensive assist with most daily tasks including bed mobility, totally dependent on staff for toileting and transfers and is always incontinent of bowel and bladder. R10's Care Plan dated 12/31/19 documents, At risk for skin breakdown related to requiring total assist with bed mobility/transfers. Currently skin is intact. Approach:Needs assistance with turning and repositioning as needed. R10 remained sitting in her high back wheelchair from 3/3/2020 at 5:50 AM until 8:30 AM without the benefit of repositioning based on 15 minute observation intervals. 4. R12's MDS, dated [DATE], documents R12 is at risk for developing pressure ulcers using clinical and formal assessments, needs extensive assist from staff for bed mobility, totally depends on staff for transfers and toilet use, and is incontinent of bowel and bladder. R12's Care Plan, dated 1/30/2020, documents, At risk for pressure ulcer development related to needs assist with transfers/bed mobility and incontinence of bowel and bladder. Approaches: Assist me to turn and reposition during care and activities as needed. R12 remained in bed from 3/3/2020 at 5:35 AM until 8:45 AM without the benefit of repositioning based on 15 minute intervals. On 3/3/2020 at 10:21 AM, V16, CNA Supervisor, stated she provided inservice training to staff to check on residents every two hours, and turn and reposition them, whether in the chair or in bed, and making sure that they are kept clean and dry to prevent the development of pressure ulcers. On 3/5/2020 at 10:00 AM, V2, Director of Nursing (DON), stated the facility does not have a policy addressing turning and repositioning because it is as needed and individualized according to the needs of the resident. The Facility's Turning and Repositioning Program policy and procedure, dated 7/2018, documents, All residents will be turned and positioned as per plan of care in an organized system. Procedure: Turning schedule will occur at the same time. To protect resident's rights, turn schedules are not to be posted in the resident's rooms. Pocket cards or schedules on Pocket Care guides/Daily Care guides are to be used. All residents (unless reasons documented in the care plan) are to face the same direction at the same time.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide safe transfers, failed to analyze root causes of falls and provide progressive interventions to prevent recurrences of falls for 4 of 5 residents (R1, R3, R4, R5) reviewed for falls and safe transfers in the sample of 16. Findings include: 1. R5's Minimum Data Set (MDS), dated [DATE], documents R5 requires 50 to 75 percent of 2 staff assist for transfers. R5's Morse Fall Scale, dated 1/19/2020,

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 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) documents R5 is at high risk for falls. R5's Care Plan, target date 5/31/2020, documents, At risk for injuries related to functional deficits, [MEDICAL CONDITION], personal history of falls, and medication side effects. Approaches include: 11/10/19. transfer with 1 assist and slide board. The Care Plan does not reflect the most current level of functional assist as documented in the MDS. On 3/4/2020 at 8:46 AM, V15, Certified Nursing Aide (CNA), assisted R5 to transfer from his wheelchair to the bed. R5 had a swollen left knee and an amputated right foot. V15 placed R5 with his wheelchair very close to the edge of the bed. V15 applied a gait belt around R5's waist area loosely and placed a slide board with one end under R5's left thigh and the opposite end over the edge of the bed closest to R5. V15 pulled R5 up by the gait belt which moved up almost to R5's armpits and assisted R5 up to sit on the slide board. V15 did not ask for another staff assistance, did not apply the gait belt snuggly, and did not lock the brakes of the wheelchair during transfer. 2. R4's MDS, dated [DATE], documents R4 needs minimal assist during transfers, has a history of falls R4's Morse Fall Scale, dated 1/18/2020, documents R4 is at high risk for falls. R4's Care Plan, dated 2/27/2020, documents, I am at risk for falls related to requires assist with transfers and ambulation, balance issues and psychoactive drug use, history of dementia, [MEDICAL CONDITION], and wedge compression fracture of lumbar vertebra and fall prior to admission. Goal: Will have falls minimized through the management of risk factors while maintaining maximum independence and quality of life through next review. Approaches: transfer assist x 1 with gait belt. On 3/4/2020 at 10:02 AM, V19, CNA, assisted R4 to transfer from bed to wheelchair to toilet and back to wheelchair. V19 applied a gait belt loosely around R4's middle, pulled R4 up by the gait belt on one side and R4's armpit on the other side and transferred R4 to the wheelchair. V19 did not lock the wheelchair brakes before the transfer and the wheelchair was not steady. V19 wheeled R4 to the bathroom and assisted R4 to transfer from the wheelchair to the toilet. R4 still had the gait belt loosely around her body, but V19 grabbed R4's waistband in the back when she transferred R4 to the toilet. V19 did not lock the brakes during this transfer. After R4 was done voiding, and cleaning herself, V19 grabbed R4 by by the waistband of her pants to transfer her back to the wheelchair. Before this last transfer, V19 locked one of the brakes of the wheelchair. V19 did not properly apply the gait belt and use it, and did not lock the brakes before transfer to and from the wheelchair. 3. R1's MDS, dated [DATE], documents R4 requires minimal to moderate assist of one staff for transfers. R1's Fall Morse Scale, dated 12/21/19, documents R1 is at high risk for falls. R1's Care Plan, dated 12/31/19, documents, At risk for falls related to incontinence of bowel and bladder, psychoactive drug use, poor balance and attempts to self transfer. [DIAGNOSES REDACTED]. I transfer with gait belt assist x 1 and wheeled walker (non compliant). I am known for placing myself on the floor. R1's Fall Incident Log documents R1 had 9 fall incidents from 11/2019 through 3/2020. R1's Fall Incident Report, dated [DATE], documents at 11:30 AM R1 was found on the floor in hallway, no injuries noted. Intervention: Place in common area to be in line of site of staff as resident allows. R1's Fall Incident Report, dated 12/12/19, documents at 10:00 AM R1 was found on the floor in room. No injuries. Intervention: Toilet and lay down after meals as tolerated. R1's Fall Incident Report, dated 12/12/19, documents at 6:11 PM R1 self transferred from bed to wheelchair fell on mattress next to bed. No injuries. Intervention: Offer snacks in between smoking times, offer to listen to music. R1's Fall Incident Report, dated 12/13/19, documents at 1:20 PM R1 tried to get in bed fell to floor, no injuries. Intervention: PT/OT (Physical Therapy/Occupational Therapy) recommendation. R1's Fall Incident Report, dated 12/14/19, documents at 6:03 AM R1 was found on floor in bathroom, no injury. Intervention: Order for urinalysis with negative results. R1's Fall Incident Report, dated 12/17/19, documents at 2:19 PM R 1 was found on floor, wheelchair next to resident, no injury. Intervention: labs for [MEDICATION NAME]. R1's Fall Incident Report, dated 12/21/19, documents at 10:55 AM R1 was found sitting on the floor next to bed, no injuries. Intervention: Medication changes, behavior tracking. R1's Fall Incident Report, dated 1/7/20, documents at 8:42 PM R1 was pulling pants and fell to floor. No injury. Intervention: Refer to restorative. R1's Fall Incident Report, dated 2/1/20, documents at 3:43 PM R1 self transferred from wheelchair to toilet and fell , no injury. Intervention: Assist with toileting after activities. There was no documentation that a root cause analysis was done for each of R1's fall incidents documented above. 4. R3's MDS, dated [DATE], documents R3 needs extensive assist with transfers R3's Morse Fall Scale, dated 2/5/2020, documents R3 is high risk for falls. R3's Fall Care Plan, target date 5/2020, documents, At risk for fall related to bilateral lower extremity weakness, Dementia and [MEDICAL CONDITION] of knees and incontinence. R3's Fall Incident Log documents R3 had 4 fall incidents from 9/2019 through 2/2020. R3's Fall Incident Report, dated 9/7/19, documents at 9:00 AM R3 was found on the floor in common area, grabbed her leg and fell to the floor, no injury. Intervention: Attempt to keep resident in site of staff members. R3's Fall Incident Report dated 11/13/19 documents at 4:30 PM R3 attempted to ambulate in dining room while holding a dining room chair, no injuries. Intervention: Diversional activity while up. Therapy evaluation for transfer and ambulation. R3's Fall Incident Report, dated 1/6/2020, documents at 7:45 AM R3 was found on the floor in the dining room, no injuries. Intervention: Monitoring, behavior tracking, PT/OT evaluation. gait belt and assist of 1 with transfer. R3's Fall Incident Report, dated 2/5/2020, documents at 9:31 AM R3 was at nurses station stood up out of wheelchair and fell , sustained a laceration above right eye. Intervention: Immediate first aid, neurochecks, transfer to hospital. R3 returned the same day from ER (emergency room). There was no documentation that a root cause analysis was done for each of R3's documented falls. On 3/4/2020 at 2:26 PM, V2, Director of Nursing (DON), stated she is in charge of Fall Investigations in the facility. V2 stated she just started as DON a couple weeks ago. V2 stated she will do root cause analysis and formulate progressive interventions when conducting investigations in the future. V2 stated the facility does not have a policy on fall prevention, but uses the Morse Fall Scale Assessment Form for fall incidents. The Facility's Transfer Belts/Gait Belts policy and procedure, revised 4/2014, documents, Policy: To promote safety in transferring residents, a gait belt is utilized when deemed appropriate. The Policy further documents, Procedure: 3. The resident is transferred by grasping the secured gait belt to provide stability and balance during movement.
F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide timely and complete incontinence care for 3 of 4 residents (R5, R6, R13) reviewed for incontinence care in the sample of 16. Findings include: 1. R5's Minimum Data Set (MDS), dated [DATE], documents R5 requires 50 to 75 percent of 2 staff assist to complete daily tasks including transfers and toilet use, and R5 has an indwelling urinary catheter and is totally incontinent of bowel. R5's Care Plan, dated 2/31/2020, documents, At risk for complications related to bowel incontinence. I have an indwelling urinary catheter related to obstructive and reflux [MEDICAL CONDITION]. I am at risk for urinary tract infections. Approaches: Provide me with incontinent care as needed for bowel incontinence. Perform catheter care every shift and as needed. R5 remained in his high back wheelchair from [DATE] at 9:10 AM until 1:15 PM without being checked for incontinence based on 15 minutes or less observation intervals. On [DATE] at 1:18 PM, V7, Certified Nursing Aide (CNA), provided incontinence care to R5 in bed. R5 had a large incontinence of soft bowel that spread up to the upper edge of his adult incontinent brief in the back and spreading to the bottom edge of R5's T-shirt. V7 cleansed R5 in the front and back using disposable wipes. V7 did not wash the shaft of the penis, both inner thighs and under the scrotum. V7 wiped the catheter tubing which had some almost-dried fecal material with one sheet of disposable wipe. 2. R6's MDS, dated [DATE], documents R6 needs 50 to 75 percent of staff assist to complete all daily tasks including transfers, dressing and toileting and R6 is frequently incontinent of bowel and bladder. R6's Care Plan, dated 12/30/19, documents, At risk for complications related to incontinence of bowel and bladder. Approach: Provide incontinence care as needed for each episode of incontinence. On [DATE] at 1:50 PM, V7 and V8, both CNAs, provided incontinence care to R6 in bed. R6's adult incontinent brief was heavily soaked with urine and R6's short pants and T-shirt were soaked in the back. V7 washed R6 in the genital area and buttocks with disposable wipes. V7 failed to cleanse the shaft of the penis, outer buttocks, inner thighs, and upper back which were in contact with the urine soaked brief and clothing. 3. R13's MDS, dated [DATE], documents R13 is totally dependent on staff to complete daily tasks and is always incontinent of bowel and bladder. R13's Care Plan, dated 2/27/2020, documents, I am incontinent of bowel and bladder. I am at risk for skin breakdown. Approaches: Pericare after each episode of incontinence. On 3/3/2020 at 1:27 PM, V11 and V14, both CNAs, provided incontinence care to R13 in bed. R13 had a large bowel incontinence and was leaking out of R13's disposable adult brief. V11 used disposable wipes and cleansed R13. V11 did not spread the labial folds to thoroughly cleanse the inner vaginal folds of fecal material. On 3/4/2020 at 10:21 AM, V16, CNA Supervisor, stated she started working as CNA supervisor 7 months ago and was providing inservice training to the aides

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) on incontinent care including checking residents every two hours to make sure they are kept clean and dry, grooming and personal hygiene. The Facility Policy on Incontinent Care dated 7/2012 documents,Policy: To provide routine, preventive skin, perineal care to residents after an incontinent episode. It continues, Procedure: 10. Wash the entire perineal area, and all areas affected by incontinence with washcloths, soap, warm water, peri-wash or wipes. The policy does not address spreading the labial folds to thoroughly clean the inner folds and urethral opening.
F 0725 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Many	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, interview and record review, the facility failed to ensure there is sufficient direct care staff in the facility to provide care and respond to resident needs in the facility. This has the potential to affect all 99 residents in the facility. Findings include: On [DATE] at 8:15 AM, V1, Administrator, stated there were 99 residents living in the facility. On 3/4/2020 at 3:30 PM, a review of the Facility Staffing Working Schedule and Daily Staffing Patterns was done with V3, Staffing Coordinator. At this time, V3 stated the facility daily staffing ratios are 4 nurses and 8 aides for the day shift, 4 nurses and 8 aides for the evening shift, and 2 nurses and 6 aides for the night shift. The Facility Staffing Working Schedule documents a shortage of staffing on the following dates and shifts: [DATE]20 Thursday evening shift had 4 nurses and 6 unlicensed direct care staff (needed 2 more staff) [DATE]20 Thursday night shift had 2 nurses and 4 unlicensed direct care staff (needed 2 more staff) 2/10/2020 Monday night shift had 2 nurses and 4 unlicensed direct care staff (needed 2 more staff) 2/15/2020 Saturday day shift had 4 nurses and 7 unlicensed direct care staff (needed 1 more staff) 2/16/2020 Sunday day shift had 4 nurses and 8 unlicensed direct care staff (needed 3 more staff) [DATE] Monday evening shift had 4 nurses and 6 unlicensed direct care staff (needed 2 more staff) 2/21/2020 Friday evening shift had 3 nurses and 7 unlicensed direct care staff (needed 1 more nurse and 1 more staff) 2/22/2020 Saturday evening shift had 4 nurses and 6 unlicensed direct care staff (needed 2 more staff) 2/23/2020 Sunday day shift had 4 nurses and 6 unlicensed direct care staff (needed 2 more staff) 2/23/2020 Sunday evening shift had 4 nurses and 5 unlicensed direct care staff (needed 3 more staff) 2/25/2020 Tuesday night shift had 2 nurses and 4 unlicensed direct care staff (needed 2 more staff) [DATE] Monday day shift had 4 nurses and 7 unlicensed direct care staff (needed 1 more staff) On [DATE] at 10:27 AM, R14 stated there is definitely a shortage of staff on all shifts specially on weekends. On [DATE] at 10:34 AM, R15 stated she knows there is a consistent staffing shortage in the facility in all shifts on weekends and during the week as well. On [DATE] at 10:05 AM, R7 stated there is shortage of staff on evenings and weekends all shifts. R7 stated there are only 4 aides at night for a hundred residents. On [DATE] at 10:21 AM, R12 stated there seem to be not enough staff on evenings and nights. On 3/5/2020 at 9:26 AM, V2, Director of Nursing (DON), stated the facility does not have a policy on staffing but follows state guidelines.