STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	145683	A. BUILDING _____ B. WING _____	**03/12/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ABINGTON OF GLENVIEW NURSING	**3901 GLENVIEW ROAD GLENVIEW, IL 60025**

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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 ensure that a low air loss mattress was not layered with multiple linens and padding for one of nine (R11, R20, R28, R50, R61, R63, R69, R73, R239) reviewed for pressure ulcers. Findings include: R239 is an [AGE] year old was admitted to the facility on [DATE] with diagnoses, in part, of [MEDICAL CONDITION] and malignant neoplasm of the lungs. On 3/9/2020 at 1:55 pm, V9 (Registered Nurse, RN) and V10 (Certified Nursing Assistant, CNA) were observed changing R239's external urine collection catheter. R239 was observed laying flat on a low air loss mattress, with one clean diaper half way down on R239's legs. V9 turned R239 to the right side, and V10 cleansed R239's periarea. R239's sacral pressure ulcer dressing was observed intact, and R239 had a cloth incontinence and flat sheet in between the sacrum, and low air loss mattress. V9 turned R239 to the supine position and repositioned R239's external urine collection. V10 placed a second diaper against the first diaper half way on R239 and then pulled both diapers up in place, covering R239's periarea and sacrum. On 3/10/2020 at 2:09 pm, V4 (Assistant Director of Nursing, ADON) and V9 (RN) performed R239's sacral pressure ulcer wound care with no concerns noted for wound care. However, after the wound care was done, V4 turned R239, removed the cloth incontinence and placed a quadruple folded sheet on top of the flat sheet underneath R239. R239 also had on one diaper. R239 remained supine on the low air loss mattress. On 3/11/2020 at approximately 3:20 pm, V3 (Director of Nursing, DON) stated that the facility wound care coordinator is V4 (Assistant Director of Nursing, ADON) and that she is a wound care certified nurse. On 3/11/2020 at 11:25 am, V4 (ADON) stated that one thin, flat sheet should be used on top of a low air loss mattress to allow for the coils to inflate and alternate. V4 stated that too much padding or extra linen in between the resident and the low air loss mattress creates too many layers thus defeating the purpose of the low air loss mattress. V4 confirmed that a quadruple sheet was too many layers on a low air loss mattress. V4 also stated that nursing staff tries not to use diapers with residents due to concealing moisture against the skin and that nursing staff should never double diaper a resident. R239's care plan documents, in part, that the focus is that R239 has a sacral deep tissue injury and that the interventions are that R239 is provided with alternating pressure mattress. Facility policy, titled Prevention of Pressure Wounds and dated January 2017, documents, in part, Interventions and Preventative Measures: General Preventative Measures . 2. C. If a special mattress is needed, use one that contains foam, air, as indicated.
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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to answer call lights in a timely manner, turn a dependent resident every 2 hours, administer medications in a timely manner and assist residents in a timely manner with feeding. This failure affected 7 residents (R22, R25, R28, R36, R37, R61, R81) reviewed for staffing and has the potenital to affect all 100 residents in the facility. Findings include: R28's [DIAGNOSES REDACTED]. On 03/09/20 at 10:17 AM, R28 stated the facility is short staffed. I had a sore on my backside and there is a dressing there now. They usually change me three times a day because it takes 2 to 3 people to help turn me. I was changed and turned last at 5:00am. On 03/09/20 at 12:00 PM V15 (Certified Nursing Assistant, CNA) stated that I have 14 residents today and most of them need extensive or total assistance for care. We just do the best we can. We used to have 5 CNA's but the staffing has been like this for months (4 CNA's). When someone puts their call light on, sometimes we cannot answer right away because we cannot leave some residents alone so we just have to finish what we are doing then go answer the call light. We do get complaints that we are not answering the call lights in time. On 03/09/20 at 12:12 PM, R28 stated that V15 will clean me up next around 11:00 am-12:00pm, depending on how many other residents she has that day. That is our routine. I have not been turned or repositioned or cleaned up since 5am. 03/09/20 12:27 PM V15 CNA arrived to change and reposition R28 with 2 other staff members. R28 stated to V15 that they turned and changed me last at 5 o'clock this morning. V15 responded, ok. R28 turned to the side and redness and creases from sheet noted to bilateral lower extremities, buttocks, in between upper thighs, hips, lower and upper back. New adult brief slid under the front of her peri area. On 03/09/20 at 1:51 PM, V15 states I reposition her when I change her. That is the only time. She cannot do it herself and we need 2 to 3 staff to turn her. On 03/10/20 at 11:05 AM, R28 stated that I get turned three times a day if I am lucky. In the evenings, they slide out the wet adult brief under me then slide a new one under me because they don't have enough people to turn me. That is why I have them slide it under the front and not fasten it in the back. I was on my back from 1:00 pm yesterday when you were here and V15 turned me until 5am this morning. On 3/10/20 at 1:20pm, V3 (Director of Nursing,DON) stated that residents are expected to be turned every 2 hours if it is on the care plan. On 03/11/20 at 02:26 PM V3 stated that we are budgeted for 1 CNA to 10 residents on the 3rd floor and 1 CNA to 8 residents on the 2nd floor. 3 are ideal. R28's functional assessment dated [DATE] notes she requires extensive assistance from 2 staff plus physical assistance for bed mobility, toileting and has impairments to both upper and lower extremities. R28 is noted as always incontinent of urine and stool. R28's skin is noted to have moisture associated skin damage and is at risk for further skin impairment. R28's care plan notes she has a healed pressure sore, is at risk for skin impairment related to limited mobility and is incontinent. Intervention states that R28 needs assistance to turn and reposition at least every 2 hours. Check resident every two hours for incontinence. Facility staffing sheet on 3/9/20 notes there are 4 CNA's on the 3rd floor. Facility roster notes there are 56 patients. On 3/9/2020 10:30AM, while conducting round on the 3rd floor, noted V14, (Registered Nurse, RN) was still passing morning medication. Surveyor asked why she was still passing morning medication at this time and she responded, We have only 2 nurses and I have 30 residents. She also added that they have 4 Certified Nurse Assistants (C.N.A) on the third floor. On 03/09/20 1:05PM, observed lunch on the third floor dining room, and noted a couple of residents that needed to be fed by staff with their meal tray in front of them. There was no staff assisting them. V6 (Restorative Aide) was observed assisting R50 with his lunch and when he finished, he then moved over to R37 and started assisting her with her lunch after 45 minutes of her tray sitting in front of her. Another resident, R25 was observed sitting in her wheelchair, sleeping with her lunch tray in front of her and no staff assisted her with her food until 1:33PM. R61 was also sitting with his tray in front of him did not get any staff assistance until 1:23PM. Review of facility assessment document shows that R25, R37 and R61 all require one personal physical assist for feeding and such was also indicated in their care plans. On 03/09/20 1:38PM, R22's call light was on from 1:39PM to 1:45PM without any staff response. Surveyor asked R22 what she needs and she said that she would like to be changed. Surveyor notified a staff member who went to the room turned off the call light and walked out of the room. 5 minutes later, the call light was turned back on and when surveyor asked R22 what happened when the staff came in, she stated that the staff came and turned off her call light, told her that she will be right back and never came back. R22 added that this happens all the time, they never answer the call light and when someone finally comes, they will turn

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	(continued... from page 1) the light off and walk away. On 03/09/20 at 2:05pm, R22's call light was blinking and she stated that the staff came in and I told her I had to have a diaper change. She said I would have to wait and she would be back. Its 2:05pm now and I need a new adult brief. I don't know when she will be back. On 03/09/20 at 02:05 PM, V15 (Certified Nursing Assistant, CNA) stated that I answer the lights that have been blinking fast, first because they have been on the longest. The nurse answers the light up front at the nurses station and puts the call light on hold sometimes. After a while, it starts blinking faster. On 3/9/20 at 2:10pm, V15 (CNA) entered R22's room to change adult brief. Review of care plan for R22 and another facility assessment documenst coded R22 as 2/2 for toilet use denoting limited assistance with one person physical assist. R22's care plan for urinary incontinence states that she needs to be checked and cleaned as required. On 3/11/20 at 1:20pm, V3 (Director of Nursing, DON) stated that whenever the call lights are seen, it needs to be answered as soon as possible. When staff they enter the room, the call light should remain on until the concern is addressed. Grievance log notes 2 concerns with call lights on 3/14/19, call light concerns on 3/26/19, 4/2/19, 4/11/19, 5/6/19, 5/29/19, staffing concerns on 6/6/19 and 7/29/19, call light concerns on 8/8/10, 8/10/19, 8/15/19, 8/30/19, 9/24/19, 9/25/19, 9/30/19, call light response time 10/4/19, 10/24/19, 12/2/19, 12/4/19, 12/13/19, 12/26/19, 1/3/20, 1/30/20, 2/1/20, 2/3/20, 2/4/20 and 2/18/20. On 3/10/2020 at 9:29 am, V12 (Licensed Practical Nurse, LPN) wheeled his medication cart to the central nurse ' s station, and R36 was observed wheeling up to V12 asking for R36 ' s morning dose of [MEDICATION NAME] medication for pain. V12 then asked V13 (LPN), who was sitting inside the central nurse's station, about R36 receiving the [MEDICATION NAME] medication, and V13 stated to R36, Your nurse isn't here yet. On 3/10/2020 at 9:30 am, V13 (LPN) walked to another medication cart at the central nurse's station, and R36 started wheeling over to V13. V16 (Rehabilitation Tech) was wheeling R81 to therapy and stopped by the central nurse ' s station. V16 stopped wheeling R81 because R81 said to V13 that R81 hasn ' t received any morning medications and is being taken to physical therapy. V13 stated that she would administer R81 ' s morning medications. V13 started getting ready to prepare R81 ' s medications, and V3 (DON) whispered to her; subsequently, V13 said to R81 that she has to give R81 the medications in R81 ' s room. V13 wheeled R81 to R81 ' s room and the medication cart in front of the room. On 3/10/2020 at 9:32 am, R36 wheels up again to V13 and says, I (R36) was here first. I want my [MEDICATION NAME]. V13 stated that she would administer the [MEDICATION NAME] to R36 in R36 ' s room. On 3/10/2020 at 9:35 am, V13 prepared and administered R36 ' s [MEDICATION NAME]. On 3/10/2020 at 9:54 am, V16 (Rehabilitation Tech) was observed at the elevator, getting ready to leave the 3rd floor. V16 stated that she was here to take R81 to physical therapy but will have to come back later for R81. R81 was observed still in the room waiting for R81 ' s morning medications. On 3/10/2020 at 9:56 am, this surveyor followed V13 to the 2nd floor ' s medication room, and this surveyor observed V8 (Registered Nurse, RN) working on the 2nd floor. On 3/10/2020 from 10:21 am to 10:25 am, V13 (LPN) administered medications to R81 per R81 ' s Medication Administration Record [REDACTED]. On 3/10/2020 at 10:28 am, when V13 was asked who was assigned to this wing of the 3rd floor for medication pass, V13 stated that it was V8 (RN) and that she is being split between the 2nd and 3rd floor and is still on the 2nd floor. Facility cenus on 3/9/20 notes facility census of 100 residents. 3/9/2020 at 10:30AM while conducting round on the 3rd floor, noted V14, RN still passing morning medication. Surveyor asked why she was still passing morning medication at this time and she responded, we have only 2 nurses and I have 30 residents. she also added that they have only 2 nurses and 4 Certified Nurse Assistants (C.N.A) on the third floor.
F 0759 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure medication error rates are not 5 percent or greater.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to timely administer medications during the facility medication administration pass. There were 36 opportunities with 11 errors resulting in a 30.56% error rate. This effected one out of eight (R36, R41, R49, R63, R71, R78, R81, R240) residents when reviewed for medication administration. On 3/10/2020 at 9:43 am, V13 (Licensed Practical Nurse, LPN) prepared the blood glucose monitoring supplies and machine, performed hand hygiene and entered R81's room. V13 obtained R81's blood glucose appropriately, and the reading was 219 milligrams per deciliter (mg/dL). V13 checked R81's medication administration record (MAR) for the sliding scale [MEDICATION NAME]coverage required for the blood glucose reading of 219 mg/dL. R81's Physician order [REDACTED].= 2; 200 - 249 = 4 units; 250 - 299 = 7 units, subcutaneously four times a day for diabetes (HUMALOG; before meals and at bedtime). R81's MAR documents that Insulin [MEDICATION NAME] is scheduled for administration at 8:00 am. On 3/10/2020 at 10:05 am, V13 (LPN) performed hand hygiene, appropriately prepared the 4 units of [MEDICATION NAME]and placed the [MEDICATION NAME]pen on a tray on the medication cart. V13 then read R81's MAR and proceeded to prepare these medications for administration that were past due from 8:00 am and 9:00 am as follows per MAR: -[MEDICATION NAME] Tablet 10 mg by mouth one time a day (before breakfast); scheduled at 8:00 am -[MEDICATION NAME] Tablet 100 mg by mouth one time a day; scheduled at 9:00 am -Brimodine [MEDICATION NAME] Solution 0.2% instill 1 drop in both eyes two times a day; scheduled at 9:00 am -[MEDICATION NAME] Capsule 0.25 mcg by mouth one time a day; scheduled at 9:00 am -Carvedilol Tablet 25 mg by mouth two times a day; scheduled at 9:00 am -[MEDICATION NAME] Tablet 40 mg by mouth two times a day; scheduled at 9:00 am -[MEDICATION NAME] HCl tablet 25 mg by mouth four times a day; scheduled at 9:00 am -Indapamide Tablet 2.5 mg by mouth one time a day; scheduled at 9:00 am -Iron Tablet ([MEDICATION NAME]) 325 mg by mouth one time a day; scheduled at 9:00 am -Magnesium Capsule 500 mg by mouth one time a day; scheduled at 9:00 am On 3/10/2020 at 10:20 am, V13 (LPN) brought the prepared medications on the tray, took R81's blood pressure on left arm and answered R81's question about the Calcitrol. On 3/10/2020 at 10:21 am, V13 administered R81 the oral medications, and R81 swallowed the medications. The 8:00 am scheduled medication was administered over two hours late, and the 9:00 am scheduled medications were administered over one hour late. On 3/10/2020 at 10:23 am, V13 injected R81's [MEDICATION NAME] Insulin 4 units subcutaneously in R81's left upper arm. This 8:00 am scheduled medication was administered over two hours late. On 3/10/2020 at 10:25 am, V13 instilled R81's Brimodine [MEDICATION NAME] Solution 0.2%, one drop in each eye. This 9:00 am scheduled medication was administered over one hour late. On 3/10/2020 at 10:28 am, R81 stated that R81 ate breakfast prior to R81 receiving the insulin administrations. On 3/11/20 at 2:21 pm, V3 (Director of Nursing, DON) stated that during the medication pass, the nurses are to administer the medication one hour before or one hour after the scheduled time on the MAR. V3 stated the example of a medication being scheduled at 9:00 am, the nurse should give the medication between 8:00 am and 10:00 am. Facility document, titled Medication Pass Schedule and undated, documents, in part, Daily: 9 am. Two Times a Day: 9 am and 5 pm. Facility policy, titled 5.2 Medication Administration and dated May 2016, documents, in part, Purpose: To administer all medications safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms, and help in diagnosis . Procedure: . 18. Remain with the resident to ensure that the medication is swallowed. 19. Return to medication cart and document medication administration with initials in appropriate space on Medication Administration Record (MAR).

F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that staff followed standard infection prevention practices by failing to properly wash hands while assisting a resident with lunch, failing to wash hands and change gloves before moving from a dirty to clean area during dressing change and failing to sanitize a cap to an eye drop bottle before placing it back on the bottle after it was picked up from the floor. This failure affects three residents (R37, R50 and R63) reviewed for infection prevention practices. Findings include: On 03/09/20 1:05PM, observed lunch on the third floor dining room, and V6, restorative aide was assisting R50 with his meal and was observed helping the resident wipe his nose with a tissue, and continued with the feeding without performing any hand hygiene. V6 then finished with R50, removed his lunch tray, came back and moved his chair and started to assist R37 who was sitting at the same table with her meal. V6 did not wash his hands or use any form of sanitizer after the first resident and before assisting the second resident. V6 was also observed opening a small packet of crackers, touching the crackers with his bare hands, crumpled the crackers and added them to R37's bowl of soup, and continued with the feeding. 03/09/20 at 1:30PM, Interviewed V6 with regards to hand hygiene while assisting residents with meals and he stated that he washed his hands before he stated feeding the first resident, but did not wash his hands between residents. With regards to touching resident's food (Cracker) with his bare hands, he said, that's what we do, we break the crackers with our hands and put it in their soup. 3/10/2020 12:42PM during an interview, V3, Director of Nursing (DON), stated that staff should wash hands between tasks, before and after contact with the residents, when hands are visibly soiled, or they can use a hand sanitizer. Facility policy presented by V3 (DON), titled handwashing/ hand hygiene and dated 11/2013 states in part that when hand are not visibly soiled, employees may use an alcohol-based hand rub containing 60-95% [MEDICATION NAME] or [MEDICATION NAME] in all

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) of the following situations; before direct contact with residents, after direct contact with a resident but prior to direct contact with another resident, during resident meal service in accordance with specifications provided in the facility diet manual. Facility infection control protocol dated March 10, 2020 states as its purpose to provide guidelines for general infection control while caring for residents. In the general guideline section item 3 states to wash hands thoroughly with soap and water after changing or removing gloves or any personal protective equipment. Findings include: R63 is a [AGE] year old with [DIAGNOSES REDACTED]. On 3/9/20 at 3:40 pm, R63 stated that R63's right posterior thigh pressure ulcer wound dressing fell off during the recent transfer back to bed from the wheelchair and that V8 (Registered Nurse, RN) will be coming to perform the wound care treatment. R63's Physician order [REDACTED]. On 3/9/2020 at 3:59 pm, V8 set up R63's wound care supplies on a tray from the facility treatment cart. V8 entered R63's room, placed the treatment tray on R63's bedside table and washed her hands. On 3/9/2020 at 4:03 pm, V8 donned gloves and removed R63's right foot dirty dressing and placed it in the garbage bag. V8 then washed her hands and donned new gloves. V8 cleansed R63's right foot wound with normal saline moist gauze and patted the wound with a dry gauze. V8 did not perform hand hygiene or change her gloves after cleaning R63's right foot wound. While wearing the same dirty gloves, V8 removed the scissors and petroleum impregnated gauze from the treatment tray, cut the petroleum impregnated gauze and placed it on the right foot wound and covered it with a foam dressing. V8 then removed her dirty gloves and washed her hands. On 3/9/2020 at 4:12 pm, R63 turned to the left side, exposing R63's undressed, right posterior thigh pressure ulcer wound. V8 washed her hands, donned new gloves and placed R63's sock back on the right foot per R63's request. V8 then removed her gloves, used alcohol based hand sanitizer and applied new gloves. V8 then cleansed R63's right posterior thigh wound with normal saline moist gauze and patted the pressure ulcer wound with a dry gauze. V8 did not perform hand hygiene or change her gloves after cleaning R63's right posterior thigh pressure ulcer wound. While wearing the same dirty gloves, V8 placed the petroleum impregnated gauze on the right posterior wound and covered it with a foam dressing. V8 then removed her dirty gloves and washed her hands. On 3/11/2020 at approximately 3:20 pm, V3 (Director of Nursing, DON) stated that the facility wound care coordinator is V4 (Assistant Director of Nursing, ADON) and that she is a wound care certified nurse. On 3/11/2020 at 11:25 am, V4 (ADON) stated that she expects the nurses to wash their hands and change their gloves after going from dirty to clean wound surfaces during wound care treatments to prevent contamination. V4 stated that the nurses are to wash their hands and change their gloves during wound care: after removing a resident's dirty wound dressing, after cleansing the wound bed and after applying the treatment and dressing to the wound. On 3/10/2020 at 8:47 am, during observation of the facility medication pass, V11 (RN) appropriately administered five drops of [MEDICATION NAME] Peroxide Solution 6.5% in both ears of R63. V11 removed her gloves and discarded them, then she took the ear drop bottle with the cap and went into R63's bathroom to wash her hands. The white cap from the [MEDICATION NAME] Peroxide Solution 6.5% fell on to the bathroom floor. V11 was observed picking up the white cap, rinsing it off in the sink with faucet water and placing the white cap back onto the [MEDICATION NAME] Peroxide Solution 6.5% bottle. V11 placed the capped ear drop bottle into the clear, pharmacy labeled bag and put the medication back in the fourth drawer of the medication cart. R63's Physician order [REDACTED]. On 3/10/2020 at 3:23 pm, V4 (ADON) stated if a cap of a medication container would fall onto the floor, the nurse should sanitize the cap with a bleach wipe per the sanitizer recommendations or the discard the medication and order a new one from pharmacy.