STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	146052	A. BUILDING _____ B. WING _____	**08/14/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ALHAMBRA REHAB & HEALTHCARE	**417 EAST MAIN STREET, BOX 310 ALHAMBRA, IL 62001**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
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 provide timely turning and repositioning to prevent pressure ulcers for 5 of 7 residents (R2, R7, R8, R9 and R11) reviewed for pressure ulcers in the sample of 17. Findings include: 1. R7's Minimum Data Set (MDS), dated [DATE], documents she is severely cognitively impaired, requires extensive assist for bed mobility and transfers. R7's Care Plan, revised 8/12/20, documents, (R7) has an ADL (Activities of Daily Living)/ self-care deficit related to limited mobility and balance issues and is unable to turn and position self without staff assistance, and that she is at risk of developing pressure ulcers related to needing staff assist with transfers/ bed mobility and she is incontinent of bowel and bladder. On 8/11/20 at 7:30 AM, V11, Certified Nursing Assistant (CNA), and V12, Nurse's Aide (NA), pulled back R7's bed linens to begin her AM care. R7's top and bottom sheets, two incontinent pads and her gown were saturated with urine. There was a brown urine ring around R7 on the bottom sheet from her mid back to the bottom of her feet. R7's skin on her back, buttocks, backs of her legs, and thighs was visibly wet with urine, were dark red in color, and had deep wrinkles where her skin was touching the mattress and bed linens. After completing R7's incontinence care, V11 and V12 raised R7 to standing with sit to stand mechanical lift to pull up her pants. R7's back, buttocks, backs of her legs, and thighs were still red and deep wrinkles were still visible. On 8/11/20 at 7:30 AM, V11 stated, I have seen residents left like this before, but not usually (R7). On 8/11/20 at 9:30 AM, V12 pushed R7 in her wheelchair (w/c) back to R7's room and left her there without repositioning R7. R7 remained in her w/c in her room until 10:30 AM, with no staff intervention. On 8/11/20 at 10:35 AM, R7 propelled herself in her w/c out into the hall. From 10:35 AM until 11:40 AM, based on 15-minutes observations, R7 remained in the hallway without staff repositioning her. On 8/11/20 at 10:45 AM, V12, stated that R7 had been up in her chair with no toileting, incontinent care, or repositioning since she had been transferred out of bed at 8:05 AM. V12 stated they do not do any rounds or incontinent care until breakfast is done. 2. R8's MDS, dated [DATE], documents she is severely cognitively impaired, requires extensive assist with bed mobility, and is dependent for transfers, personal care, and toileting. On 8/11/20 at 7:05 AM, V11 and V12 transferred R8 into her w/c and took her to the small dining room for breakfast. On 8/11/20 at 10:40 AM, R8 was pushed out into the hall by V11. R8 remain in the hallway in the same position without benefit of repositioning until 11:15 AM. At that time V5, Activity/Social Service Director, came and pushed R8 into the main dining room for an activity. On 8/11/20 at 11:36 AM, V12 stated she and V11 had not been able to do rounds to check and change incontinent residents because breakfast just got done and lunch was getting ready to start soon. On 8/11/20 at 11:40 AM, R8 was pushed in her w/c back into the hall. R8 had been up in her wheelchair without benefit of repositioning to relieve pressure from her buttocks for 4 hours and 35 minutes. 3. R9's MDS, dated [DATE], documents she is severely cognitively impaired and is dependent on staff for all ADLs. Her Care Plan, revised 8/12/20, documents R9 is dependent on staff for position changes and transfers. R9's Progress Note, dated 8/4/20, documents a hospice aide reported a fluid filled blister to R9's right upper thigh where the diaper tabs hook. Previous Progress Note on 5/4/20, documents R9 had blisters to her left and right thighs at that time. On 8/11/20 at 6:40 AM, V11 and V12 transferred R9 from her bed to her reclining w/c, and V12 pushed R9 to the dining room for breakfast. At 8:55 AM, R9 was pushed in her w/c into the hall outside of the small dining room. R9 remained in her reclining w/c in the hall until 11:00 AM. At that time, V5 pushed her into the main dining room for an activity. At 11:45 AM, R9 was pushed in her reclining w/c back out to the hall. R9 remained in her wheelchair without the benefit of repositioning to relieve pressure from her buttocks for at least 5 hours. On 8/11/20 at 6:35 AM, V11, CNA, stated, Staffing needs to get better here. It is hard to get showers and rounds done when there is only 2 CNAs or NAs here. 4. On 8/11/20 At 9:54 AM, R2 was sitting upright in bed. R2 had a dark brownish scar to the right outer thigh area and a dry cyst like area to the upper back. R2 stated she must wait three to four hours daily for staff to clean her up after being incontinent due to a lack of staff. R2 states staff help her to turn and reposition in the bed when needs to go to the bathroom or has been incontinent. R2 states she would like to be turned and repositioned every hour for comfort. R2 states therapy wants her up in the wheelchair for two hours a day, but when she gets up, she's up for five to six hours and is incontinent because they won't lay her down due to lack of staff. The Face Sheet, undated, documents R2 as being admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The Minimum Data Set (MDS), dated [DATE], documents R2 is dependent upon staff for bed mobility, transfers, toileting and bathing. The MDS documents R2 as being at risk for developing pressure ulcers. The Care Plan, dated 1/3/20, identifies R2 as being at risk for developing pressure sores related to assistance needed with bed mobility and transfers, [MEDICAL CONDITION] and incontinence of bowel and bladder. Interventions included weekly skin checks, low air loss / pressure relieving mattress to bed, turn and reposition when providing care, as needed or when requested. The Care Plan documented R2 is at risk of an Activities of Daily Living (ADL) self-care deficit. Interventions include Assist with bed mobility and toileting with assistance of two to three staff. 5. On 8/11/2020 6:40 AM, R11 was up in her wheelchair in her room. On 08/11/2020 from 9:45 AM until 11:00 AM, based on 15-minute observations, R11was sitting in her wheelchair eating breakfast in the small dining room. On 8/11/2020 at 10:58 AM, V12 stated, We got a slow start this morning because (V11) was late coming in this morning. I couldn't start everything by myself. Usually we would have breakfast done and start toileting people and laying them down by now. On 8/11/2020 at 11:00 AM, V5 took R11in her wheelchair to the large activity area. V5 did not reposition R11 in her wheelchair prior to taking her to the activity area. On 8/11/2020 at 11:15 AM, V5 took R11 from the large activity room area to the C-hall TV room. Again, V5 did not attempt to reposition R11 in her wheelchair. At 11:20 AM, R11 stated, They don't take me to the bathroom as often as I would like them to. R11 stated They just leave me sit a lot. On 8/11/2020 from 11:30 AM to 12:24 PM, based on 15-minute observations, R11 remained in her wheelchair in the C-Hall TV room. No staff came to offer toileting or repositioning. At 11:45 AM, R11 stated, I need to go to my room. I could go to the bathroom. At 12:00 PM, R11 remained in the C-Hall TV room in her wheelchair. No staff came to offer toileting or repositioning. On 08/11/2020 at 12:24 PM, V11 took R11 to her room. V11 assisted R11 out of her wheelchair to the bathroom. R11 had on an incontinent brief on which was saturated with brownish color urine, and smears of bowel movement in the pad. Urine had leaked onto R11's pants. R11's peri area and buttocks were deep red color with wrinkles in the skin from sitting. On 8/11/2020 at 12:32 PM, V11 stated, We usually toilet her (R11) twice a shift. I would toilet her in the morning and after lunch, but this morning she was already up by midnight shift. R11's Minimum Data Set (MDS), dated [DATE], documents R11 has severe cognitive impairment, requires extensive assist with Activities of Daily Living (ADL's) such as bed mobility, toileting, and transfers, due to limitations to both arms and both legs. R11's Care Plan, dated revised 7/2/2020, documents R11 is at risk for pressure ulcer development related to needs assist with bed mobility, transfers, and is incontinent of bladder. The Care Plan documented Encourage to offload by lying down on side after meals.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder,**

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 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) **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 incontinent care and toilet residents to maintain bladder function for 5 of 12 residents (R2, R7, R8, R9 and R11) reviewed for incontinent care in the sample of 17. Findings include: 1. On 8/11/20 at 7:30 AM, V11, Certified Nursing Assistant (CNA), and V12, Nurses Aide (NA), pulled back R7's bed linens to begin her AM care. R7's top and bottom sheets, two incontinent , and her gown were saturated with urine. The bottom sheet had a brown ring around R7 from her mid back to the bottom of her feet. R7's skin on her back, buttocks, back of her legs, and thighs was visibly wet with urine, skin was dark red, and she had deep wrinkles where her skin was touching the mattress and bed linens. V11 cleansed R7's right and left groin using a back and forth motion, not turning the wash cloth to clean area before rewiping the area, causing cross contamination. V11 did not dry R7's skin after cleansing it. V11 turned R7 to her left side to cleanse her right buttock. V11 washed R7's lower back, but did not go all the way up as far as the skin was wet with urine. She did not dry the skin on R7's right buttock or lower back. V11 did not cleanse R7's inner thighs or left buttock, or her backs of her legs,which were all visibly wet with urine. On 8/11/20 at 7:30 AM, V11 stated, I have seen residents left like this before, but not usually (R7). On 8/11/20 at 9:30 AM, V12 pushed R7 in her wheel chair (w/c) back to her room and left her their without offering any care. R7 remained in her w/c in her room until 10:30 AM with no staff intervention. On 8/11/20 at 10:35 AM, R7 propelled herself in her w/c out into the hall. Frequent observation was done of R7 in the hall in her w/c until 11:40 AM. At that time, there were still other residents in the small dining room after breakfast. R7's Minimum Data Set (MDS), dated [DATE], documents she is severely cognitively impaired, requires extensive assist for bed mobility, transfers, and toileting and is dependent for personal hygiene and bathing. The same MDS documents R7 is occasionally incontinent of bowel and bladder. R7's Care Plan, revised 8/12/20, documents, (R7) has an ADL (activities of daily living)/ self care deficit related to limited mobility and balance issues and is unable to turn and position self without staff assistance, and that she is at risk of developing pressure ulcers related to needing staff assist with transfers/ bed mobility and she is incontinent of bowel and bladder. On 8/11/20 at 10:45 AM, V12, NA, confirmed that R7 had been up in her chair with no toileting, incontinent care or repositioning since she had been transferred out of bed at 8:05 AM. V12 stated they do not do any rounds or incontinent care until breakfast is done. 2. On 8/11/20 at 7:05 AM, during incontinent care, V11 cleansed urine and feces from R8's lower abdoment, groin, vagina and left buttock. V11 failed to cleanse R8's thighs and back that were visibly wet with urine. V11 did not dry any of the areas she cleansed. R8's Progress Notes, dated 7/30/20 at 11:22 AM, documented R8 had been sent to the emergency room in the early morning and was diagnosed with [REDACTED]. On 8/11/20 at 10:40 AM, R8 was pushed out into the hall by V11 and she stayed there until 11:15 AM, when V5, Activity/Social Service Director, came and pushed her into the main dining room for an activity. No care was offered. On 8/11/20 at 11:36 AM, V12 stated she and V11 had not been able to do rounds to check and change incontinent residents because breakfast just got done and lunch was getting ready to start soon. On 8/11/20 at 11:40 AM, R8 was pushed in her w/c back into the hall with no care offered. R8's MDS, dated [DATE], documents she is severely cognitively impaired, requires extensive assist with bed mobility, and is dependent for transfers, personal care and toileting. The same MDS documents she is always incontinent of bowel and bladder. 3. On 8/11/20 at 6:40 AM, V11 and V12 checked R9 for incontinence before transferring her from her bed to her reclining w/c. There was a small amount of dried blood on R9's gown, and a small, dime sized excoriated area was visible on her upper right buttock. V11 removed R9's adult diaper and stated, It's a little wet. V11 then put on a clean diaper without performing any incontinent care for R9. She left the same stained gown on R9. V11 and V12 then transferred R9 from her bed to her reclining w/c and V12 pushed R9 up to the small dining room for breakfast. On 8/11/20 at 8:55 AM, R9 was pushed in her w/c out into the hall outside of the small dining room. She remained in her reclining w/c in the hall until 11:00 AM, when V5 pushed her into the main dining room for an activity. At 11:45 AM, R9 was pushed in her reclining w/c back out to the hall with no care offered. R9's Progress Note, dated 8/4/20, documents a hospice aide reported a fluid filled blister to R9's right upper thigh where the diaper tabs hook. Previous Progress Note on 5/4/20 documents R9 had blisters to her left and right thighs at that time. R9's MDS, dated [DATE], documents she is severely cognitively impaired and is dependent on staff for all ADLs. Her Care Plan, revised 8/12/20, documents R9 is dependent on staff for position changes and transfers. On 8/11/20 at 6:35 AM, V11, CNA, stated, Staffing needs to get better here. It is hard to get showers and rounds done when there is only 2 CNAs or NAs here. 4. On 8/11/20 at 9:54 AM, R2 states she has to wait three to four hours daily for staff to clean her up after being incontinent due to lack of staff which has led to multiple UTI's (urinary tract infections). R2 states when they clean her up, sometimes they clean me good and sometimes they don't. R2 states they don't rinse the soap off and it leaves a residue on her skin that causes irritation. R2 states they don't change her bed pad when it's saturated with urine. R2 states therapy wants her up in the wheelchair for two hours a day but when she gets up, she's up for five to six hours and is incontinent because they won't lay her down due to lack of staff. The Face Sheet, undated, documents R2 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. The MDS, dated [DATE], documents R2 as being cognitively intact and dependent upon staff for bed mobility, transfers, toileting and bathing. The Care Plan, dated 1/3/20, documents R2 as being at risk of an ADL self care deficit. Interventions include: Assist with bed mobility and toileting with assistance of two to three staff. Assist with dressing, grooming and bathing with an assist of one to two staff. R2's Nurse's Notes were reviewed and documents the following: 6/10/20 at 10:58 AM - Urinalysis obtained using sterile technique. 6/25/20 at 12:20 PM - Results of Extended Spectrum Beta-Lactamase (ESBL) bacteria screen sent to R2's physician. 6/26/20 at 9:43 aM - New order received for Manurol (antibiotic) for one dose. 7/1/20 at 3:53 PM - R2's physician was notified of the ESBL screening results and R2 was treated with [MEDICATION NAME] (antibiotic) and Manurol (antibiotic). 7/1/20 at at 4:31 PM - R2's physician returned call and states no need to re-culture R2's urine unless showing symptoms of a UTI. R2's Physician order [REDACTED]. R2 received the following antibiotics to treat her UTI's:[MEDICATION NAME] 4/10/20 through 4/16/20, [MEDICATION NAME] 4/21/20 through 4/27/20, [MEDICATION NAME] 5/24/20 through 5/29/20, Manurol on 6/26/20. R2's laboratory resports document on 5/23/20, R2 had a UTI with ESBL producing Escherichia coli (E. Coli / bacteria). On 8/13/20 at 2:12 PM, V2, Director of Nursing (DON), stated she would expect dependent residents to be checked and changed (if incontinent) and repositioned between meals, with rounds being done every two to three hours when the residents are in bed. 5. On 8/11/2020 6:40 AM, R11 was up in her wheelchair in her room. On 8/11/2020 from 9:45 AM until 11:00 AM, based on 15-minute observations, R11was sitting in her wheelchair eating breakfast in the small dining room. On 8/11/2020 at 10:58 AM, V12 stated, We got a slow start this morning because (V11) was late coming in this morning. I couldn't start everything by myself. Usually we would have breakfast done and start toileting people and laying them down by now. On 8/11/2020 at 11:00 AM, V5 took R11 in her wheelchair to the large activity area. V5 did not ask if R11 needed to toileted prior to taking R11 to the activity area. On 8/11/2020 at 11:15 AM, V5 took R11 from the large activity room area to the C-hall TV room. Again, V5 did not ask or attempt to toilet R11. At 11:20 AM, R11 stated, They don't take me to the bathroom as often as I would like them to. When asked regarding incontinence, R11 stated, Yes, I have accidents sometimes. R11 stated, If they took me to the bathroom at least every few hours, I wouldn't have an accident. They just leave me sit a lot. I could go to the bathroom now. They just leave me sit a lot. On 8/11/2020 from 11:30 AM to 12:24 PM, based on 15-minute observations, R11 remained in her wheelchair in the C-Hall TV room. No staff came to ask if R11 need to go to the bathroom. At 11:45 AM, R11 stated, I need to go to my room. I could go to the bathroom. At 12:00 PM R11 remained in the C-Hall TV room in her wheelchair. No staff had come to ask if R11 needed to go to the bathroom. On 8/11/2020 at 12:24 PM, V11 took R11 to her room. V11 assisted R11 out of her wheelchair to the bathroom. R11 had on an incontinent brief on which was saturated with brownish color urine, and smears of bowel movement in the pad. Urine had leaked onto R11's pants. R11's peri area and buttocks were deep red color with wrinkles in the skin from sitting. On 8/11/2020 at 12:32 PM, V11 stated, We usually toilet her (R11) twice a shift. I would toilet her in the morning and after lunch, but this morning she was already up by midnight shift. R11's Minimum Data Set (MDS), dated [DATE], documents R11 requires extensive assist with Activities of Daily Living (ADL's) such as bed mobility, toileting, and transfers due to limitations to both arms and both legs. R11's Care Plan, dated revised 7/2/2020, documents, (R11) is on Restorative Toileting Program and has episodes of urinary incontinence. The Care Plan documented, Take her to the bathroom upon arising, before and after meals, and bedtime, as

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F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) needed or requested. The facility's undated Incontinence Care policy and procedure, documents, under Purpose: to keep skin clean, dry, free of irritation and odor; to prevent skin breakdown; to prevent infection. Take all incontinent residents to the bathroom or put on bedpan before and after meals and at least every two hours between meals. The bedpan should be offered at regular intervals throughout the night.