STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

(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) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations: 300.610a) 300.1210a) 300.1210d)6) 300.1220b)3) 300.3240 Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care a) Comprehensive Resident Care Plan. A facility, with the participation of the resident and the resident's guardian or representative, as applicable, must develop and implement a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment, which allow the resident to attain or maintain the highest practicable level of independent functioning, and provide for discharge planning to the least restrictive setting based on the resident's care needs. The assessment shall be developed with the active participation of the resident and the	S9999	Attachment A Statement of Licensure Violations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 1 resident's guardian or representative, as applicable d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.1220 Supervision of Nursing Services b) The DON shall supervise and oversee the nursing services of the facility, including: 3) Developing an up-to-date resident care plan for each resident based on the resident's comprehensive assessment, individual needs and goals to be accomplished, physician's orders, and personal care and nursing needs. Personnel, representing other services such as nursing, activities, dietary, and such other modalities as are ordered by the physician, shall be involved in the preparation of the resident care plan. The plan shall be in writing and shall be reviewed and modified in keeping with the care needed as indicated by the resident's condition. The plan shall be reviewed at least every three months. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident These Requirements are not met as evidenced by:	S9999		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 2	S9999		

Based on interview and record review the facility failed to assess medications that could affect R4's function, gait and balance. The facility also failed to ensure post fall interventions were initiated, implemented and documented in the resident's careplan for one (R4) of three residents reviewed for falls in the sample of five. This resulted in multiple falls for R4, with the most recent fall resulting in hospitalization and an unsuccessful surgical repair of a left hip fracture.Also the facility failed to ensure R4 was free of unnecessary drugs by failing to have indications for use, assessing, identifying/monitoring targeted behaviors, clinical rationale for the medication dosage use above the recommended level, and completing a Gradual Dose Reduction (GDR) for one resident (R4) of three residents reviewed for falls and psychoactive medications on the sample of five. This resulted in R4 being continuously somnolent, having a reduction in ADLs (Activities of Daily Living) including bed mobility, dressing, eating, bathing, toileting and transfers) and having a fall with a hip fracture.

Findings:

According to the March 2015 Physician Order Sheet (POS) R4 is 74 years old with the following diagnoses: Alzheimer's, Neck of Femur Fracture, Senile Psychosis, Depression, Diabetes, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Obstructive Sleep Apnea and Dementia with Behavior Disturbances.

R4's Progress Notes dated 11/1/14 through 3/8/2015 document eight falls. The Fall Investigation dated 11/2/14 documents that R4 did not sustain injuries and that he stated he was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 3	S9999		

looking for night crawlers. The interventions were to add a floor alarm and a medication review which is not on R4's Care Plan dated 11/24/14.

The Fall Investigation dated 11/30/14 documents that R4 sustained a skin tear to his right hand and right elbow. The root cause was determined by the facility that R4 needed to use the restroom and the intervention was to remind him to wait for help which is not on the current Care Plan. R4's Nurses Notes dated 11/25/14 document that R4 is alert and confused.

The Fall Investigation dated 12/28/14 documents no injuries for R4 and a root cause determined by the facility of getting up without help. The intervention was a bed alarm. The intervention is on the Care Plan with a start date of 2/10/15.

The Fall Investigation dated 1/3/15 documents a skin tear to R4's right elbow and the root cause determined by the facility was getting out of bed without help. The intervention that was put in place was to re-educate R4 about not turning off his alarms. R4's non-compliance with the alarms was added to the Care Plan on 2/8/15 and there is no education documented. The Nurses Notes dated 12/28/14 document R4 as being alert and confused.

The Fall Investigation dated 1/13/15 documents that R4 complained of a headache and shoulder pain, left hip pain and was sent to the Emergency Room. R4 was admitted to the hospital and returned to the facility on 1/15/15. The facility's root cause determination was R4's poor judgement and there were no interventions for this fall documented or implemented.

The Fall Investigation dated 2/8/15 documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 4	S9999		

that R4 sustained a skin tear and he said that he was trying to get clothes out of his closet. The intervention added was non skid socks. This intervention was added to the Care Plan on 2/8/15.

The Fall Investigation dated 2/17/15 documents that R4 was sent to the Emergency Room for a laceration above his eye and on his knee. R4 stated that he was returning from the bathroom. There were no interventions documented or implemented after this fall.

The Fall Investigation Report dated 2/24/15 documents that R4 was trying to use the bathroom and fell and was sent to the Emergency Room. The report states R4 sustained a fracture to his left hip that required surgery. The intervention for this fall was to reinforce the use of the call light. R4's Care Plan documents to re-enforce to call for assistance added on 2/24/15.

R4's Surgical Report dated 3/2/15 documents a diagnosis of "Left Acetabulum Fracture With Protrusio" and documents "attempted closed reduction left hip."

On 3/10/15 at 10:00am E2 Director of Nursing (DON) stated, "the nurses create the event in the computer following a fall then the Assistant Director of Nursing does the fall investigation then they give the interventions to the Care Plan people and they are suppose to put them on the resident's Care Plans." At this time E2 confirmed that not all of the interventions were on the Care Plan nor were they appropriate interventions for R4's cognition level.

R4's POS dated 2/11/15-3/11/15 documents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 5	S9999		

Haloperidol tablet (antipsychotic) 5mg (milligrams) given twice a day for Dementia with behavior disturbances.

On 3/10/15 at 12:05pm Z2 Pharmacist stated, "the Haloperidol is going to contribute to his (R4) falls."

According to the Daily Dose Thresholds for Antipsychotic Medications specified in the State Operations Manual, the recommended maximum dose of Haloperidol for the elderly residents with behaviors related to Dementia is 2mg per day.

The Lexicomp Drug Information Handbook dated 2014-2015 documents the Beers Criteria. According to the Beers Criteria-Potentially Inappropriate Medications for Geriatrics, Haloperidol is not recommended for use. The Beers Criteria documents, "avoid use for behavioral problems of dementia..." and an "increased risk of stroke and mortality in patients with dementia."

R4's Physician Visit Notes dated 11/18/2014, 11/24/14, 12/29/14 and 1/5/2015 do not document any review of falls or medications.

The facility's Falls-Clinical Protocol policy with a Revised date of October 2010 documents "....The physician will identify medical conditions affecting fall risk (for example, ...medications associated with increased falling risk)....After more than one fall, the physician should review the resident's gait, balance and current medications that may be associated with dizziness or falling.....the staff and physician will identify pertinent interventions to try to prevent subsequent falls and to address risks of serious consequences of falling....Examples of such interventions may

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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S9999	Continued From page 6	S9999		

include.....tapering, discontinuing or changing problematic medications...."

The Physician Order Report dated 2/11/15-3/11/2015 documents R4 as having the following diagnoses: Alzheimer's Disease, Fracture, Neck of Femur, Senile Psychosis, and Dementia, unspecific with Behaviors. The Minimum Data Set (MDS) dated 11/18/14 and 2/11/15 both document no behaviors for R4. The MDS dated 2/11/15 document that R4 needed extensive assistance of one person to move in bed, to walk in his room, to get dressed, to use the toilet and take a bath. R4 needed total assistance for locomotion of the wheelchair. The MDS dated 3/11/15 documents that R4 needs total assistance of two people to move in bed and extensive assistance of two people to get dressed, eat, take a bath and use the toilet. It also documents that he no longer transfers or gets in the wheelchair.

The form titled, "The Consultant Pharmacist Note to the Attending Physician/Prescriber" dated 11/7/14 documents, "Federal guidelines for long-term care facilities require an evaluation of antipsychotic usage within two weeks of admission. This resident was recently admitted with an order for Haloperidol to treat an unknown condition. Please consider a trial dose reduction to assess continued need for treatment." Z3, Nurse Practitioner check marked the option of "Medication to be continued as ordered...." and signed and dated 11/24/14.

R4's Physician Order Sheet (POS) dated 11/1/14 with an admission date of 11/1/14 documents an order for Haloperidol (antipsychotic) 5mg (milligrams) BID (twice a day) without a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 7	S9999		

diagnosis. The admitting diagnoses listed on this POS are COPD Chronic Obstructive Pulmonary Disease), Sleep Apnea, IDDM (Insulin Dependent Diabetes Mellitus), and Renal Failure.

The undated, unsigned Psychoactive Medication Evaluation Premier form for R4 is marked "Admission" with Haldol 5mg documented on it but has no further information. R4 has another Psychoactive Medication Evaluation Premier form dated 11/18/14 with Haldol 5mg BID with no diagnosis listed and no behaviors listed. The same form dated 2/9/15 documents R4 as having Haldol 5mg BID and does not have a diagnosis listed and the "Behaviors Warranting the use of Medication" are marked as "withdrawal and resists care" but are not specific to this medication as there are two antidepressants also listed on this form. There are no behavioral episodes documented and the Evaluation is marked as "Appears Controlled." On 3/10/15 E2 Director of Nursing (DON) stated these forms (Psychoactive Medication Evaluation Premier) are the assessments for R4's psychoactive medications.

On 3/10/15 at 12:30pm E2 supplied the behavior tracking forms for R4 and stated that the CNA (Certified Nursing Assistants) complete these forms. E2 also stated that they are not able to find behavior tracking for February for R4. There is no behavior tracking for Haldol for November 2014 related to R4. The untitled behavior tracking for R4 for December 2014 documents the behavior that is being tracked as "Agitation" and there is one day with two episodes of R4 having agitation and the interventions used were "explain care" and "calm approach" and the behavior stopped. The January behavior tracking form for R4 documents eight days with behaviors multiple

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	IL6009567	A. BUILDING: _____ B. WING _____	C 03/12/2015

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GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 8	S9999		

times per day and the interventions attempted were "explain care" and "calm approach" and they were not effective. There is no behavior tracking for February 2015 for R4 and there are no episodes of behaviors on the March 2015 tracking form for R4.

R4's Nursing Notes from 11/1/14 to 3/8/15 document one episode of being combative with care on 12/15/14 at 4:07am. The other behaviors documented in the Nursing Notes are "refusal of nebulizer treatments, attempts to get out of bed without assistance, restless, refusing to use the CPAP (Continuous Positive Airway Pressure) machine, turning off the pressure alarms, agitated and complained of pain at the same time, and removing oxygen nasal canula." According to the Nursing Notes, R4 had eight documented falls from admission on 11/1/14 to 3/8/15 and the last fall on 2/24/15 resulted in an irreparable hip fracture.

R4 was admitted to hospice on 3/6/15 with a diagnosis of Alzheimer's Dementia.

On 3/12/15 at 12:45pm E3 CNA stated that R4 was never combative with her. The only behaviors she witnessed was him getting out of bed without assistance. E3 also stated that "today (3/12/15) R4 woke up to drink a little juice at lunch but refused the meal and fell back asleep."

R4 was sleeping on 3/9/15 at 10:55am, and 1:17pm, on 3/10/15 at 9:15am, 12:00pm and 3:15pm, on 3/11/15 at 1:00pm and on 3/12/15 at 12:42pm. R4 was awake with garbled speech on 3/11/15 at 9:25am.

R4's Physician Progress Notes for 11/18/14, 11/24/14, 12/29/14 and 1/5/15 do not document

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009567	A. BUILDING: _____ B. WING _____	C 03/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GARDENVIEW MANOR	14792 CATLIN TILTON ROAD DANVILLE, IL 61834

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S9999	Continued From page 9	S9999		

any behaviors or the use of Haldol. On 3/10/15 at 10:50am E2 confirmed that there is no mention of Haldol or behaviors in the Physician Notes from these visits.

On 3/10/15 at 12:15pm Z2 Consultant Pharmacist stated that he made a recommendation to Z4 (R4's Physician) after the resident's admission in November 2014 to reduce or eliminate the Haldol and it was refused. He stated that he does not like to see Haldol used in the Dementia population at all and does not feel that this is an appropriate dose of Haldol for R4. Z2 also stated that he feels the Haldol contributed to R4's falls.

According to the Daily Dose Thresholds for Antipsychotic Medications specified in the State Operations Manual, the recommended maximum dose of Haloperidol for the elderly residents with behaviors related to Dementia is 2mg per day.

The Lexicomp Drug Information Handbook dated 2014-2015 documents the Beers Criteria. According to the Beers Criteria-Potentially Inappropriate Medications for Geriatrics, Haloperidol is not recommended for use. The Beers Criteria documents, "avoid use for behavioral problems of dementia..." and an "increased risk of stroke and mortality in patients with dementia."

According to R4's Current Orders dated 3/9/15 he receives 5mg twice a day for a daily total of 10mg.

The facility's Antipsychotic/Psychotropic Medication Use policy with a revision date of April 2007 documents the following: "...These medications will be considered for elderly residents with dementia only after medical,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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) COMPLETE DATE
S9999	Continued From page 10 physical, functional, psychological, emotional, psychiatric, social and environmental causes have been identified and addressed. These medications must be prescribed at the lowest possible dosage for the shortest period of time; are subject to gradual dose reduction and behavioral interventions; and re-review.....The Attending Physician will identify, evaluate and document, with input from other disciplines and consultants as needed, symptoms that may warrant the use of antipsychotic/psychotropic medications.....All antipsychotic/psychotropic medications will be used within the dosage guidelines listed in F329, or clinical justification will be documented for dosages that exceed the listed guidelines for more than 48 hours...." (B)	S9999		