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	IL6015192	A. BUILDING: _____ B. WING _____	05/21/2015

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S 000	Initial Comments Annual Licensure Survey.	S 000		
S9999	Final Observations Statement of Licensure Violations 330.790 Infection Control a) Policies and procedures for investigating, controlling, and preventing infections in the facility shall be established and followed. The policies and procedures shall be consistent with and include the requirements of the Control of Communicable Diseases Code (77 Ill. Adm. Code 690) and Control of Sexually Transmissible Diseases Code (77 Ill. Adm. Code 693). Activities shall be monitored to ensure that these policies and procedures are followed. b) A group, i.e., an infection control committee, quality assurance committee, or other facility entity, shall periodically review the results of investigations and activities to control infections. c) Depending on the services provided by the facility, each facility shall adhere to the following guidelines of the Center for Infectious Diseases, Centers for Disease Control and Prevention, United States Public Health Service, Department of Health and Human Services, as applicable (see Section 330.340): 1) Guideline for Hand Hygiene in Health-Care Settings 2) Guideline for Prevention of Nosocomial Pneumonia 3) Guideline for Isolation Precautions in Hospitals 4) Guidelines for Infection Control in Health Care Personnel	S9999		

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S9999	Continued From page 1 (Source: Added at 29 Ill. Reg. 12891, effective August 2, 2005) Based on observation, interview and record review facility failed to assure resident care attendants wash their hands promptly after providing direct care to residents and provide accessible hand washing supplies in resident bathrooms. Facility staff also failed to follow their hand washing protocol.. This applies to all 98 residents in facility. This requirement not met evidenced by: On 5/19/15 at 12:55 PM, in the "Memory Care" unit, E7 (Resident Care Attendant - RA), was observed providing incontinence care to R8 and then E7 walked out of the residents room, without washing her hands and proceed to the soiled utility room. E7 touched / handled the soiled utility room door knob. On 5/20/15 between 1:45 PM - 2:00 PM, in the "Memory Care" unit, E7 and E10 (RA's), was observed providing incontinence care to R9. R9 had just had a bowel movement in his brief and required staff assist with incontinence care. After cleaning feces off R9 and changing his incontinence brief, E7 and E10 walked out of the residents room and into the hallway without washing their hands. The facilities "Memory Care" unit houses 21 cognitively impaired residents that require hands on assistance with activities of daily living. On 5/19, 5/20 and 5/21/15 paper towel dispensers were not present in any of the residents individual toilet rooms on 3 of 3 resident	S9999		

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care units.

5/21/15 at 9:50 AM, during interview, E1 (Administrator), stated facility is going to order paper towel holders for resident toilet rooms "today."

5/21/15 at 10:50 AM, E7 stated paper towels are kept in residents individual toilet rooms medicine cabinets (not readily available without touching cabinet with soiled or wet hands).

5/21/15 at 11:00 AM, during interview, E5 (Maintenance director), stated, "The facility usually places paper towels inside medicine cabinets or in residents drawers." E5 also said the facility ordered paper towel dispensers for individual resident toilet rooms on 5/21/15.

The facility's "Hand Washing" policy and procedure include:

Hand washing is regarded as the single most important means of preventing the spread of infections. All associates should wash their hands to prevent the spread of infections and disease to other residents, other associates and visitors.

1) A minimum twenty (20) second hand washing should be performed in situations including but not limited to:

After offering incontinence care
After having prolonged contact with a resident (i,e,, bed bath, changing linen, etc.)
After handling used dressings, urinal, bedpans, catheters, contaminated tissues, linen, etc.
After contact with blood, feces, oral secretions, mucus membranes or broken skin.
After handling items potentially contaminated with

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S9999	Continued From page 3 any resident blood, excretions or secretions. This policy was observed not to be followed. ---------- Section 330.710 Resident Care Policies 3) A policy to identify, assess, and develop strategies to control risk of injury to residents and nurses and other health care workers associated with the lifting, transferring, repositioning, or movement of a resident. The policy shall establish a process that, at a minimum, includes all of the following: A) Analysis of the risk of injury to residents and nurses and other health care workers, taking into account the resident handling needs of the resident populations served by the facility and the physical environment in which the resident handling and movement occurs. B) Education of nurses in the identification, assessment, and control of risks of injury to residents and nurses and other health care workers during resident handling. C) Evaluation of alternative ways to reduce risks associated with resident handling, including evaluation of equipment and the environment. Based on observations, interviews and record reviews, the facility failed to identify factors causing the fall incidents and failed to implement interventions to prevent future falls. These failures affect two of the four residents (R1, R5) reviewed for high risk for fall of seven sampled residents.. Findings include: A. R5 is an 87 year old female who has multiple medical diagnoses including increased confusion, wandering and altered mental status. The Incident Log and Progress Notes dated	S9999		

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S9999	Continued From page 4 March 2015 to May 2015 indicates, R5 had multiple fall incidents (3/28, 4/4, 4/19, 4/23). There was no evidence an intervention has been implemented for the prevention of R1's fall. There was no investigation made to identify the factors causing the fall incidents. B. R1 is an 88 year old male who has multiple medical diagnoses including Dementia. R1 had a fall incident on 5/20/15. R1 complained of pain in the lower back and was sent to the hospital for further evaluation. R1 came back to the facility the same day 5/20/15 (Evening shift). Post fall documentation was made addressing R1's present condition, however there was no post fall analysis made to investigate the cause of the fall. Facility's Fall Policy dated 3/2009 indicates: Policy Detail: When a resident sustains a fall, incident or accident, the nurse in charge should initiate the following: Complete post fall assessment. Identify approaches to implement if applicable. On 5/21/15 at 11:12 AM, E4 (District Director Clinical Services) stated, they (facility) have no tracking of analysis/interventions initiated after fall incidents. E4 added, they (staff) realized it's a problem and are moving forward. Section 330.1155 Unnecessary, Psychotropic, and Antipsychotic Drugs a) A resident shall not be given unnecessary drugs in accordance with Section 330.Appendix E. In addition, an unnecessary drug is any drug used: 1) in an excessive dose, including in duplicative therapy; 3) without adequate monitoring; 4) without adequate indications for its use. c) Residents shall not be given antipsychotic drugs unless antipsychotic drug therapy is necessary, as documented in the resident's	S9999		

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comprehensive assessment, to treat a specific or suspected condition as diagnosed and documented in the clinical record or to rule out the possibility of one of the conditions in accordance with Section 330.Appendix E.
d) Residents who use antipsychotic drugs shall receive gradual dose reductions and behavior interventions, in an effort to discontinue these drugs in accordance with Section 330.Appendix E unless clinically contraindicated.
e) For the purposes of this Section:
1) "Duplicative drug therapy" means any drug therapy that duplicates a particular drug effect on the resident without any demonstrative therapeutic benefit. For example, any two or more drugs, whether from the same drug category or not, that have a sedative effect.
3) "Antipsychotic drug" means a neuroleptic drug that is helpful in the treatment of psychosis and has a capacity to ameliorate thought disorders.

Based on interview and record review, the facility failed to identify specific target behavior symptoms for the use of anti psychotic medications, attempt to initiate non pharmacological interventions prior to use of antipsychotic medications, monitor the effectiveness of the medication on resident behaviors and develop resident specific plans for a drug reduction.

This applies to four residents (R1,R5,R6 and R7) residents reviewed for antipsychotic's in a total sample of seven.

The findings include:

R6 has a medical diagnoses of dementia Alzheimer type, as documented on the April 2015 physician order sheet.

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S9999	Continued From page 6 On 5/20/1 at 11:15 AM, R6 was sitting at the activity table during an activity with her head down and her eyes closed. E8 was giving R6 her scheduled antipsychotic medication, Quetiapine 25 mg. E8 stated I just make sure she is awake and then I give it. She looks like she is sleeping but she is arousable so I gave it to her." On 5/20/15 at 1:10 PM, R6 was sitting on the couch with her head down and eyes closed, sleeping. E8 stated R8's Ativan was held because she was sleepy. E8 also stated, " R6 has a behavior of being combative when being changed and we usually document behaviors in the nursing notes as they occur." R6's most recent nursing notes document R6 had 1 behavior documented between 3/29/15 and 5/21/15. On 4/27/15 a resident aide attempted to bring R6 in her washroom and change her disposable brief , R6 became agitated and combative. The resident aid stated R6 was not like that all the time. It depends on her mood. There are no other documented behaviors for R6. R6 also gets scheduled Ativan, for anxiety three times a day as well as as needed. This medication also has sedative effects. It is documented R6 had received all of the schedule three times a day dose of Ativan in March, April and May up until 5/20/15 when E8 stated she felt R6 was too drowsy and held the afternoon dose. R6's Psychiatric evaluation notes of 2/18/15 document R6 was sleeping in the common area and was confused and calm. R6's consent for Seroquel use documents her	S9999		

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S9999	Continued From page 7 targeted behavior/symptom as "antipsychotic." R1 has a documented history of dementia, hypoglycemia and gastrointestinal bleed as documented in the April 2015 physician order sheet. R1's Psychiatric evaluation form dated 3/12/14 documents R1's diagnosis as "Alzheimer's." The past psychiatric history documents R1 to have dementia with aggressive behaviors. R1's consent for antipsychotic use (Seroquel) 50 mg three times a day does not say what targeted behaviors or symptoms that are being treated. On 5/20/15 at 1:15 PM , E9 stated, "We document any behaviors in the nursing notes. R1's behavior is confusion mostly. He gets really confused and he might tell staff to get out of his room or leave him alone and we just try and come back later." R1 was in the hospital for a fall occurring in his room that morning so, behaviors were not observed. R5 has diagnoses of increased confusion, wandering, hypertension, chronic kidney disease, altered mental status as documented on the April 2015 Physician order sheet. R5 was started on Seroquel on 5/11/15, 25 mg two times a day as needed and then clarified on 5/20/15 by the physician as Seroquel 25 mg two times a day for anxiety. There are no target behaviors or behavior monitoring for the use of anti-psychotic medications. R7 has medical history of Bipolar disorder, delirium, dialysis and end stage renal disease as documented on the April 2015 physician order	S9999		

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S9999	Continued From page 8 sheet. On 5/20/15 at 1:15 PM, R7 was in the "memory care" unit walking back and forth in the hallway. R7 was noted to have Extrapyramidal Symptoms (EPS) of hand/arm tremors and continuous tongue smacking. On 5/21/15 E2 (DON) stated R7 came to the facility with these symptoms and is being managed by Psychiatry. This documentation could not be found in R7's record. There are no target behaviors for this resident. ---------- - Section 330.1520 Administration of Medication a) All medications taken by residents shall be self-administered, unless administered by personnel who are licensed to administer medications, in accordance with their respective licensing requirements. Licensed practical nurses shall have successfully completed a course in pharmacology or have at least one year's full-time supervised experience in administering medications in a health care setting if their duties include administering medications to residents. Based on Observation, interview and record review the facility failed to administer medications as ordered, at the ordered times and the prescribed doses. This applies to one resident (R10) in the supplemental sample out of nine residents observed for medication pass. The findings include:	S9999		

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S9999	Continued From page 9 On 5/20/15 at 3:30 PM, R10 was given Docusate Sodium 100 mg, Glucosamine 1500 plus MSM (Osteo bi-flex), and Ranitidine 300 mg all oral by E11 (LPN). The Physician order sheet for May 2015 documents the evening medications to be Docusate sodium 100 mg, Osteo Bi-Flex, Simvistatin 40 mg and Ranitidine 300mg at bedtime. The Medication Administration Record (MAR) dated 5/1/15-5/31/15 documents the Ranitidine not signed off as given but visually saw E11 prepare the medicine and R10 take the medicine. Simvistatin 40 mg was not given as ordered. Please note E11 was told at the beginning of the medication pass if any meds were not available or being omitted now and given later to please let me know at that time and this was not expressed during the medication pass. The facility policy dated 8/1/2010 and revised on 5/2011 titled, "Medication ad Treatment-Assistance." documents, "The medication assistance and administration must be in accordance with the prescribers orders." The policy also states the nurse must initial the medication administration record on the appropriate line after administration. This policy was not followed. (B)	S9999		