Illinois Department of Public Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6009922	A. BUILDING: ______ B. WING ______	12/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER VILLAGE	2025 EAST LINCOLN STREET BLOOMINGTON, IL 61701

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S 000	Initial Comments Facility Reported Incident of 11/13/2021-IL140750 Annual Licensure and Certification	S 000		
S9999	Final Observations Statement of Licensure Violations: Licensure Finding 1 of 2: 300.686b1)2)3)4) Section 300.686 Unnecessary, Psychotropic, and Antipsychotic Medications b) A resident shall not be given unnecessary medications. An unnecessary medication is any drug used: 1) In an excessive dose, including in duplicative therapy; 2) For excessive duration; 3) Without adequate monitoring; 4) Without adequate indications for its use This requirement is not met as evidenced by: Based on interview, observation and record review, the facility failed to document an appropriate medical indication, attempt a gradual dose reduction, and provide documentation of a consistent pattern of adverse behaviors to warrant the continued use of an antipsychotic medication for one resident (R102) reviewed for psychotropic medications in the sample of three.	S9999	**Attachment A** **Statement of Licensure Violations**	

Illinois Department of Public Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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Finding include:

The facility's Psychotropic Drug Policy and Procedure (revised May 2021) documents the following: "It is the policy of (facility) that psychotropic drugs are not to be used if avoidable and never a chemical restraint. They are to be used with a physician's order, written permission of the resident or legal representative, and an appropriate diagnosed indication need. Behavior Monitoring will document specific behavior that indicates the need for administration of the medication."

R102's current Physician's Orders document the following medication orders: Seroquel (antipsychotic) 25 milligrams by mouth two times a day related to Dementia with Behavioral Disturbance; and Seroquel 25 milligrams at bedtime.

On 12/07/21 at 3:00 PM, R102 was sitting in a wheelchair with eyes closed. R102 was pleasant and cooperative, and denied having any issues or concerns. No adverse behaviors were displayed by R102 at this time.

On 12/08/21 at 2:00 PM, R102 was sitting in a wheelchair with eyes closed. R102 appeared cooperative, and did not display any adverse behaviors at this time.

R102's Progress Notes (dated 6/01/21 - 12/08/21) were reviewed and document five episodes of verbal or physical aggression towards staff, no harm to self or other residents, were displayed by R102 throughout this time.

R102's Behavior Progress Note log (dated

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10/23/21 - 12/7/21) document that no adverse behaviors have been displayed by R102 during this time.

R102's Progress Note dated 7/20/21 documents the following: "Call placed to POA (Power of Attorney)- MD (medical doctor) office accepted decline in Seroquel, POA declines. MD office called and gave verbal order not to change Seroquel and that was their [sic] mistake..."

On 12/08/21 at 12:05 PM, V2 (Director of Nursing) stated R102 displays the following behaviors at times: Cussing, and Aggressiveness toward staff and family. V2 stated R102 is not a harm to herself or others. V2 confirmed that R102's Behavior Progress Note log (dated 10/23/21 - 12/7/21) document no adverse behaviors have been displayed during this time. V2 stated R102 will occasionally have a bad day, but does not display consistent daily adverse behaviors. V2 then verified R102's diagnosis of Dementia with Behavioral Disturbance is not an appropriate indication for the use for the antipsychotic medication, Seroquel.

On 12/08/21 at 3:05 PM, V1 (Administrator) stated that a gradual dose reduction was suggested for R102 in June 2021, "Initially the reduction was approved, and when V14, (R102's Power of Attorney) was contacted about the change, V14 refused the reduction and immediately contacted V10 (R102's Physician). V10 then contacted the facility and declined the reduction. I have had a conversation with (V10) about all of this, and his response has always been that he's the doctor and he orders the medications. It is all very frustrating."

R102's Consultation Report (dated 06/22/21)

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documents the suggestion for a gradual dose reduction of R102's Seroquel was declined for the following: "Have tried in the past with poor results."

"C"

Licensure Finding 2 of 2:

300.610a)
300.1210b)4)5)
300.1210d)6)

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

b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each

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resident to meet the total nursing and personal care needs of the resident. Restorative measures shall include, at a minimum, the following procedures:

4) All nursing personnel shall assist and encourage residents so that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's abilities to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. A resident who is unable to carry out activities of daily living shall receive the services necessary to maintain good nutrition, grooming, and personal hygiene.

5) All nursing personnel shall assist and encourage residents with ambulation and safe transfer activities as often as necessary in an effort to help them retain or maintain their highest practicable level of functioning.

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.

These requirements are not met as evidenced by:

Based on observation, interview and record review, the facility failed to provide supervision, after assisting a resident to the bathroom, for one

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of three residents (R125) reviewed for falls in a sample of 22. This failure resulted in R125 falling, while self-transferring from the toilet, sustaining a left distal femur fracture.

Findings include:

A Fall Prevention policy dated 5/2021 states, " A resident that has been identified as a moderate risk for falls but is at an increased risk for falling if left unattended while on the toilet, will not be left unattended while on the toilet."

R125's Minimum Data Set (MDS) assessment dated 09/28/21 documents R125 is moderately cognitively impaired and requires extensive assistance for transfers, toileting, and personal hygiene; is unsteady during transitions and is only able to stabilize with staff assistance when moving from a seated to a standing position.

R125's Fall Risk assessment dated 09/28/21 documents that R125 is at high risk for falls.

R125's Nurse's note dated 11/19/21 at 7:50p.m. documents that R125 was assisted to the toilet by a CNA (Certified Nurse Aide), and left alone in the bathroom while the CNA left to grab some hair curlers. This note further documents that as the CNA was returning to the bathroom, R125 was attempting to stand without assistance and fell before the CNA could catch R125. R125's nurse's note dated 11/20/21 at 6:50a.m. documents that R125's physician ordered X-rays to be taken because R125 was experiencing pain to her left hip and knee. R125's nurse's note dated 11/20/21 at 3:37p.m. documents R125's X-ray report showed that R125 had sustained an impacted fracture of R125's lateral distal femur. R125's nurse's note dated 11/21/21 at 11:49a.m.

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documents that the hospital reported to the facility that R125 was diagnosed as having a left distal femur fracture.

R125's fall investigations dated 11/21/21 and 11/26/21 documents that R125 fell in the bathroom on 11/19/21 when the CNA "turned away" from R125 to get more hair rollers. This investigation documents R125 was initially assessed as having no injuries but later R125 began to complain of knee and hip pain. Additionally, this investigation documents an X-ray showed that R125 had sustained a left lateral distal femur fracture at which time R125 was sent to the emergency room for further evaluation.

R125's left femur X-ray report dated 11/20/21 states, "There is subtle bony irregularity along the superior aspect of the lateral femoral condyle. This raises concern for an acute nondisplaced fracture in the setting of osteopenia."

On 12/7/21 at 9:01a.m. R125 was lying in bed with a large splint wrapped around R125's left upper leg. V6(Registered Nurse) was at R125's bedside and stated that R125 was unable to get out of bed at this time because R125 has a left distal femur fracture.

On 12/8/21 at 11:00a.m. V3 (Assistant Director of Nurses) stated that she investigated R125's fall, with fracture, which occurred 11/19/21. V3 stated that R125 needs supervision while on the toilet because R125 is a fall risk and has a history of trying to get up from the toilet without assistance, which could result in a fall. V3 stated that after R125's fall with fracture 11/19/21, V9, the CNA who was assisting R125 in the bathroom when she fell, was educated to never turn her back on

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S9999	Continued From page 7 a resident while that resident is sitting on the toilet. A document from V9's employee file dated 11/22/21 and signed by V2 (Director of Nurses) and V3 states, "Spoke with (V9) regarding (R125's) fall. Explained that when providing care that you never turn your back on a resident. CNA verbalized that she understood." "B"	S9999		