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	IL6014633	A. BUILDING: _____ B. WING _____	C 04/03/2022

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S 000	Initial Comments Complaint Investigation: 2292571/IL145323	S 000		
S9999	Final Observations Statement of Licensure Violations: 300.610 a) 300.686 b)1) through 6) 300.1210 b)4) 300.1210 d)3) 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 300.686 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;	S9999	**Attachment A** **Statement of Licensure Violations**	

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5) In the presence of adverse consequences that indicate the medications should be reduced or discontinued; or

6) Any combination of the circumstances stated in subsections (b)(1) through (5).

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 resident to meet the total nursing and personal care needs of the resident.

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.

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:

3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be

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made by nursing staff and recorded in the resident's medical record.

This REQUIREMENT is not met as evidenced by:

Based on observation, interview, and record review, the facility failed to assess and monitor residents for potential side effects of psychotropic medications and document adverse effects of psychotropic medications; and plan alternative interventions for these medications. This failure resulted in R4 having extended periods of non-responsiveness and inability to consume meals and participate in ADL (Activities of Daily Living). This applies to 1 of 3 residents (R4) reviewed for psychotropic medications.

The findings include:

The Face sheet shows that R4 was admitted to the facility on 1/28/2021. The Face Sheet shows R4's diagnoses that included dementia with behavioral disorder, CVA (cerebral vascular disease), depressive disorder, dysphagia, muscle wasting, weakness and lack of coordination, delusional disorder, and history of Covid -19.

On 4/1/2022 at 10:15 A.M., together with V3 (Registered Nurse) reviewed R4's psychotropic medications. V3 stated that R4 were taking the following psychotropic and other medications that would affect R4's alertness:
-Clonazepam 0.5 mg. (antianxiety) scheduled to be administered daily at 9:00 A.M.
-Depakote 250 mg. (use as mood stabilizer) twice a day to be administered daily at 9:00 A.M. and 5:00 P.M.
-Seroquel 25 mg. twice a day to be administered

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daily at 9:00 A.M. and 5:00 P.M.
-Gabapentin (neurological pain) 100 mg. to be given 3 times a day daily at 9:00 A.M.; 1:00 P.M. and 5:00 P.M.
-Memantine 10 mg. to be given twice a day daily at 9:00 A.M. and 5:00 P.M.
-Celexa 40 mg. every 9:00 P.M.
-Rivastigmine 4.6 mg. every 24 hours to be given daily at 10 P.M.
-Ativan 0.5 mg. every 8 hours as needed

During this time of medication review with V3, R4 was at the lounge area next to the nurse's station. R4 was lying in R4's reclining wheelchair. R4 was not responding to command, and to tactile stimuli. R4 was heavily sedated. R4's eyes were closed. V3 attempted to wake, arouse R4 for approximately 30 minutes but no avail. R4 remained in deep sleep and was not moving at all nor had open R4's eyes. V3 did a chest rub stimulation for at least 5 minutes, manipulate by touching and stimulating face, throat, and extremities but R4 remained unresponsive. V3 added that "(R4) is usually like that very sedated after scheduled morning medications were given to (R4). This is not something new. She might wake up later." When surveyor asked V3 how she will document R4's current observation: V3 replied "0 for no behavior (since R4 was asleep)/ NA (Not Applicable) for SE (Side Effects)." Continued observation was made for R4 from 10:15 A.M. through 2:30 P.M. Then an intermittent observation with R4 (every 20-30 minutes) was done from 2:30 P.M. to 4:30 P.M. R4 was propelled by a staff to the main dining room at 12:00 noon, R4 remained unresponsive. R4 was placed in the last table. Staff started serving lunch. R4's tray was placed on a table in front of R4. R4 eyes remained closed and was not responding. V11 (CNA/ Certified Nurse

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Assistant) tried to wake up R4 by tactile stimuli, and calling R4's name, shook R4's body/wheelchair but R4 did not move a muscle and no response at all. V12 (Assistant Director of Nursing) came over to try to wake up R4 by calling R4's name, touching most part of R4's body including face, throat, ears, hands, chest rub but R4 remained non-responsive and not a single moan /verbal response nor had R4 open her eyes. V12 attempted to have R4 drink an apple juice from a glass by placing the rim of the glass in R4's mouth. There were few drops of the juice that was placed in R4's mouth, but there was no swallowing reflex noted. Not even a mouth /oral stimulation had made R4 response. V12, then placed an approximate 1/2 teaspoon of the apple juice inside R4's mouth. Surveyor informed V12 that R4 was not responding at all and R4 might aspirate with the juice. V12 then manipulate R4's throat/neck area to induce swallowing reflex. R4 again had no response. V12 said, "I am just trying to moisten (R4's) mouth." During lunch observation, up to 1:20 P.M., R4 remained unresponsive and heavily sedated. V13 (Resident Assistant) propelled R4 back to R4's room. R4 had missed lunch due to being heavily sedated. V6 (CNA, been at the facility for 20 some years) who happened to be at the same dining room with R4 had stated that " (R4) is usually like that, in deep sleep." V11 and V14 (CNAs) transferred R4 back to bed by lifting R4 manually. V11 proceeded to turned R4 to sides while in bed and incontinence check was done. R4 was bone dry. V11 said the last time R4 had urine noted in R4's incontinence brief was at 7:30 A.M. There was no liquid/lunch that R4 had consumed during all these times. Observation was continued on an intermittent interval of 20-30 minutes from 2:30 P.M. to 4:30 P.M., V9, V10, V18 (CNAs) used the total lift

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transfer device to transfer R4 from bed to wheelchair at 4:30 P.M. V9 and V10 applied the sling under R4's back by turning R4 side to side while in bed, then hoisted R4 via the lift device for transfer to the reclining wheelchair. All this time, R4 remained with eyes closed, no response at all from all the verbal and tactile stimuli. V9, V10 and V18 have all said that "(R4) is usually like this, not responding, deep sleep and this is not something new. We cannot wake (R4) up. (R4) may wake up later." R4 was then propelled to the hallway by V10. V2 (Director of Nursing), then came over and touched, shook, did chest rub to R4. However, R4 remained unresponsive. V3 was asked at this time and stated that R4 had remained sedated all this time since in the morning as observed. The observation that R4 was heavily sedated was a total of 6 hours. R4 was left being still heavily sedated at 4:30 P.M. However, the progress notes dated 4/1/2022 at 9:00 P.M. shows that R4 was sleeping until dinner time. V2 confirmed on 4/3/2022 at 12:10 P.M. that dinner time for residents is 6:00 P.M. So, this is a total of around 8 hours that R1 was heavily sedated from the time R4 was seen in the morning.

On 4/1/2022 at 4:45 P.M., together with V2, the behavior monitoring form for the month of February and March 2022 was reviewed and discussed. There was no documentation that R4's excessive sedation was documented at all including the day of observation of 4/1/2022 for the morning shift. The behavior monitoring shows that there was no behavior observed and no side effects. There was no specific targeted behavior to justify the continued use of the psychotropic medications. V2 explained " because that was how the computer was set up, so it was all generalized behavior and symptoms." The

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S9999	Continued From page 6 Behavior Monitoring Form also shows some blank spaces that indicate behavior was not address and monitored. V2 has no explanation why R4's multiple occurrences of excessive sedation were not documented as side effects on the Behavior Monitoring Form nor on R4's EMR. The POS (Physician Order Sheet) was also reviewed with V2 and shows current psychotropic and other medications that can affect R4's alertness and sedation: - Ativan 0.5 mg. 1 tablet every 8 hours as needed ordered on 1/28/2021. - Seroquel 25 mg. originally ordered 1/28/2021. -Depakote Sprinkles 500 mg. BID with some changes in dosage but was initially ordered on 9/7/2021. V2 said Depakote is use as mood stabilizer. - Clonazepam 0.5 mg. with different dosages but originally ordered on 12/12/2021. - Gabapentin 100 mg. 3 times a day for nerve pain ordered on 1/28/2021 -Memantine 10 mg. 2 times a day ordered on 1/28/2021 -Celexa 40 mg every night ordered on 1/28/2021 -Rivastigmine 4.6 mg. every 24 hours ordered on 5/25/2021 V2 confirmed. that R4 is currently on 8 medications that can affect alertness and cause sedation. V2 said that R4 showed excessive sedation and is very confused and insight when awake. V2 also said that she does not know why the progress notes entered by V15 (Psychiatric Nurse Practitioner) showed that V15 had discussed all the treatment plan including side effects of psychotropic medication with R4 and that R4 was agreeable. V15 has conflicting assessment to reflect the actual condition of R4. V2 said that she had talked to V15 about the accuracy of his progress notes but V15 remained	S9999		

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documenting the same conflicting assessment and does not reflect the actual condition of R4. When asked why the staff showed no intervention during the prolonged time that R4 was heavily sedated as observed on 4/1/2022, V2 had responded with no answer.

The progress notes dated 3/27/2022 documented by V15 (Psychiatric Nurse Practitioner) shows " (R4), was evaluated at (facility) for a follow up ...Nursing reports patient has been more sleepy the past couple days. Patient seen in room and appears calm. Patient with limited participation to interview. ..The patient has been medication compliant without side effects. MENTAL STATUS EXAM: Appearance; The patient appears stated age. Disoriented and confused...Thought process; unable to assess...Cognitive is poor, memory is poor. PLAN: Will continue with current treatment plan and monitor' Will monitor closely for efficacy, side effects or any possible interactions; Pt will report and changes in mood, affect, behavior; DISCUSSED WITH PATIENT THE RISK AND BENEFITS OF CONTINUED USE OF PSHOTROPIC MEDICATION USE AND THE PATIENT EXPRESSED CLEAR UNDERSTANDING OF THE INFORMATION DISCUSSED. Psycho-education provided about medication and worsening of depression or emergence of suicidal behavior, as well as psychotic s/s or mania and was told to stop meds and call 911, or go to closest ER if this occurs. Total time spent in the care on this date was 25 minutes. Over 50% of that time was spent in counseling regarding treatment compliance, pros and cons of various treatment options..."

The 3/13/2022 notes from V15 basically were the same assessment: " SOURCE OF INFORMATION: Patient interview

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RELIABILITY: Good. The patient has been medication compliant without side effects.
MENTAL STATUS EXAM...Disoriented and confused....Insight and judgment is good. Cognitive is poor, memory is poor.
PLAN: Will continue with current treatment plan and monitor; Will monitor closely for efficacy, side effects or any possible interactions; Pt will report and changes in mood, affect, behavior; Discussed with the patient the risks and benefits of continued psychotropic medication use and the patient expressed clear understanding of the information discussed; Psycho-education provided about medication and worsening of depression or emergence of suicidal behavior, as well as psychotic s/s or mania and was told to stop meds and call 911, or go to closest ER if this occurs; Total time spent in the care on this date was 25 minutes. Over 50% of that time was spent in counseling regarding treatment compliance, pros and cons of various treatment options..."

The EMR shows no documentation from V16 (Nurse Practitioner for V17 R4's Attending Physician) regarding R4's multiple episodes of excessive sedation.

The progress notes entered by V16 dated 3/22/2022 shows that R4 " resident seen today for continuing care and follow up on gen weakness, dementia. Pt is alert, nonverbal, make sound. seen pt is room, sitting in WC. No agitation noted or reported today. She is a poor historian due to advanced dementia."

R4's MDS (Minimum Data Set) Assessment dated February 3, 2022 codes R4 as being unable to assessed for cognition and could not be interviewed. R4's MDS also documents R4 as having no behaviors. The MDS documents that

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gradual dose reduction was not attempted for R4. R4's POA (Power of Attorney) did agree to the psychoactive medications, however most were signed in January of 2021. R4's Plan of Care dated February 15, 2021 documents the resident has behaviors, and use of psychotropic medications. Care plan interventions for behaviors and psychotropic medications lists interventions such as, "monitor for effectiveness of drug(s)", "Monitor/record occurrence of target behaviors" and "monitor and report adverse reactions".

The Behavior Monitoring Form and the EMR shows no documentation that monitor the responses to or effects of the change in R4's ADL's participation, and whether the change of condition was related to the psychotropic medications.

On 4/1/2022 at 3:00 P.M. V17 (R4's Attending Physician) stated that R4's excessive sedation was most likely due to R4's psychotropic medications and he will come the next day to evaluate R4.

The facility's policy for psychotropic medications with a revision date of 3/21/2021 shows: " It will be the standard of the facility that psychotropic medication therapy shall be used only when it is necessary to treat a specific condition. ...4. Nursing staff will document in the medical record and individual's target symptom/s. ...7. The staff will observe and report to the attending physician or psychological services information regarding effectiveness of any interventions, behavioral changes, or other pertinent data to assist with needed medication adjustments/recommendations...13. Nursing staff shall monitor and report any ill side effects to the

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S9999	Continued From page 10 attending physician." "B"	S9999		